Wandsworth Health & Care Plan Discussion Document
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Introduction – our partnership

Health and Social Care partnership organisations across Wandsworth have been involved in shaping and developing the Wandsworth Health & Care Plan. We are more effective when we work together and we have a shared commitment to partnership working and to focus where we can add value and have the greatest impact.

With our growing and ageing population we have increasing numbers of people living with long term conditions, this places additional demands on health and social care services. We want to ensure we have quality health and social care services that meet the needs of Wandsworth residents and will continue to do so for future generations. To meet these challenges and ensure the sustainability of our services for the future we need to rethink the way we work as a system to tackle problems, improve care and get better value for money.

The Wandsworth Health and Care Plan is one element of work being undertaken by partners in Wandsworth and across South West London to improve health and wellbeing. In developing this plan we have focused on how we can work together to prevent ill health, keep people well and support them to stay independent.

The priorities within the Wandsworth Health & Care Plan are focused on the areas where we can have the greatest impact by working collectively. They have been developed recognising we all share a responsibility to ensure our social care, community, wellbeing and hospital services are as joined up or integrated as possible in a whole system approach.
Wandsworth Local Health and Care Plan - Our health & care priorities in context

Our Health & Care Priorities - our partnership has focused the priorities within the Health & Care Plan on the areas where we can have the greatest impact by working collectively

Start Well
We want children to be healthy from the start so they can grow up to be healthy adults achieving their full potential. We are concerned about risky behaviours, obesity and mental wellbeing in young people.

Live Well
We know that there is no physical health without mental health and integrating our approach to physical and mental health is a priority. We want people with long term conditions to be able to help themselves and Diabetes is a specific concern we want to explore.

Age Well
We want to join up health and social care services to provide a better service to residents. We want to continue to increase awareness and early diagnosis of Dementia and look at social isolation amongst older people.

Our approach is focused on Prevention and Integration, where it is appropriate to deliver a better service and supporting individuals and local communities to become more resilient.

In Context - The Wandsworth Health and Care Plan is one element of work in Wandsworth and across South West London to improve health and wellbeing. Others include:

Wandsworth Joint Health and Wellbeing Strategy
Led by London Borough of Wandsworth the HWBB Strategy set out three key priorities: healthy places, targeted interventions and mental health alongside an overarching principle of Needs Based Commissioning:

South West London Health and Care Partnership
A partnership of the organisations providing health and care in the six South West London boroughs which enables commissioning and transformation of services such as cancer commissioning and specialist mental health where this is best done across more than one borough.

NHS Long Term Plan
The NHS Long Term Plan lays out a set of expectations for the NHS over the next 5-10 years.

The St Georges Strategy 2019-2024
Sets out the vision to provide outstanding care every time and the priorities that will drive and influence decisions over the next five years
As a vibrant and well-connected borough with many community assets, attractions and facilities Wandsworth is recognised as a great place to live and work.

Wandsworth has a large number of working age adults and a population which is more affluent than the population in general. However, Wandsworth also has pockets of deprivation throughout the borough and there are inequalities with small populations at either end of the age spectrum who are deprived and have significant health issues.

Publicly accessible parks make up almost a quarter of the total area of Wandsworth and this green space promotes active living and provides important physical, psychological and social health benefits for individuals and the community.

43% of the borough’s schools are rated as outstanding, double the proportion nationally, our examination results regularly exceed local and regional averages.

The borough has the second highest employment rate in London and there are over 18,000 active businesses in the borough, providing 134,000 jobs.

Wandsworth is the safest inner London borough, in terms of rate of notifiable crimes per head of the population. The borough also has the lowest rate of violence with injury and knife crime of the inner London boroughs.
Local Challenges

Key local issues:
Emotional Wellbeing and Mental Health, Risky Behaviours, Overweight and Obesity, Long Term Conditions and supporting wellbeing and independence
Rising Demand

Wandsworth is already the largest inner London Borough, with a population that is much younger than both the London and England average. Nearly half of residents are aged between 25-44 years and we have the highest proportion of people aged 30-34 years nationally; creating a unique young, diverse population.

![Wandsworth population predictions according to age category (2018-2050)](chart)

We also have a growing population and the number of older people in Wandsworth is set to grow faster than the overall population.

We have huge issues with rising demand – with the greatest demand concentrated in care of the elderly and those with complex care needs.

Four out of every five people aged over 65 have at least one chronic illness.

Dementia mainly affects older people and after the age of 65 the likelihood of developing dementia roughly doubles every five years.

- People are living longer with long term conditions
- Patient expectations are changing; people are applying the same principles of instant gratification to health and care services.
- We have workforce shortages in nursing and general practice
- Funding is causing financial challenges as is the cost of provision.
- Within Health we have some estates and IT systems which aren’t really fit for purpose
- High needs in specific services (sexual health, drugs & alcohol)
Quality, performance and financial context

There are a number of challenges to the quality and performance of our health and care services, set against the context of significant financial challenges across the public sector.

- Some of our health estate and IT infrastructure is not fit for purpose.
- Significant financial pressures continue across the health and care system.
- Expected growth in population, and demand for new treatments and therapies, projected to significantly outstrip any growth in the budget.
- We need to think of innovative ways to create new roles and career pathways. Technology will be really important to enable us to deliver care in a way that’s effective. Staff need to feel supported, empowered and valued.

Therefore partners must work together to deliver efficiencies and redesign services if we are to achieve financial targets and ensure a sustainable health and care system for future generations.
A focus on prevention

Prevention is a key cornerstone of our approach across health and social care. Prevention is better than a cure, so it’s important to focus on doing things well early on.

The health map produced by World Health Organisation and University of Bristol helps us to understand what effects our health.

Health is affected by our make up, lifestyle and environment.

Only 10% of our health is affected by healthcare.
Defining Prevention

National Policy Context
The 2014 Care Act and NHS Five Year Forward View both emphasise the importance of a shift towards a preventative approach that promotes wellbeing and maintains independence to ensure the future sustainability of the health and social care system.

Primary prevention aims to promote population health and well-being and prevent disease and harm before it occurs – i.e. for cardiovascular disease primary prevention would be addressing risk factors through smoking cessation, physical activity.

Secondary prevention aims to reduce the impact of a disease that has already occurred or preventing a recurrence. i.e. for cardiovascular disease taking a statin or aspirin secondary prevention after a heart attack or a stroke and we are trying to prevent another one.

Tertiary prevention treats disease with cost-effective interventions to slow or reverse disease progression; it includes rehabilitation for disability – seen as a “downstream approach”. i.e. in diabetes, preventing amputation by good foot care.

Local Policy Context
Wandsworth’s Joint Strategic Prevention Framework outlines that preventative interventions should focus on:
• Making the health and wellbeing of our communities everyone’s responsibility
• Creating environments where the healthier choice is the easier choice every time
• Harnessing local communities and their assets to build resilience amongst people and their carers
• Embedding self-care and promoting a recovery model
• Promoting prevention and independence across all health and social care pathways.

The agreed approach is centred on implementation across the life-course and across three levels;

• Place and policy level solutions e.g. environment and planning, legislation and regulation;
• Community level solutions e.g. volunteering, connectivity, community cohesion; and
• Individual level solutions e.g. intensive services for vulnerable individuals in most need and online ‘E-solutions’ to offer a less intensive, cost-effective approach to the community more broadly.

Implementation of the Prevention Framework
Delivery of the Local Health and Care Plan - scaling up four prevention interventions:

1. Supporting healthy workplaces by encouraging local employers to become accredited with the London Healthy Workplace Charter.
2. Reviewing and embedding Making Every Contact Count (MECC) training across all frontline staff.
3. Scaling up the Social Prescribing programme

Source: Adapted from Donaldson & Donaldson (2003)
Our workforce is our greatest asset and at its best is able to deliver world class exemplary care. The current financial challenges are paralleled by shortages of clinicians and other health and social care staff in most areas of the system who commonly describe ‘fishing from the same pond’ as they compete for staff.

We will work together in a system wide approach to:

• Uphold a learning culture and ‘grow your own’ approach that supports newly qualified staff to flourish.
• Support the resilience of the workforce via regular high-quality professional supervision and reflective learning opportunities.
• Encourage the continuing professional development of staff via a varied and flexible training programme and regional teaching partnership.
• Work together with multiagency colleagues in order to support the wellbeing of our residents and help people to achieve the best outcomes possible.
• Ensure our services are well led with consistent messages and expectations around our Practice Standards set at an early stage.
• Care for our staff supporting their health and wellbeing
• Make the best use of our scarce resources: collaborating where it is right to
• Recognise the work and commitment of our staff through reward and recognition programmes that mirror best practice
• Involve our staff in what we do - engaging our staff, who know our services and patients best, to help us transform and improve the way we work.
Ensuring a sustainable market

As the needs of our residents change and increase the social care market and workforce needs to adapt and one of our biggest challenges to ensuring quality and market stability is a sustainable workforce.

National information provided by Skills for Care forecasts show that if the adult social care workforce grows proportionally to the projected number of people aged 65 and over in the population between 2017 and 2035, an increase of 40% (650,000 jobs) would be required by 2035 and many of these roles will be as paid carers. In Wandsworth there was an estimated turnover rate for social care staff of 38% which is higher than the regional (24%) and national (28%) average.

In Wandsworth certain type of home care packages have been particularly difficult to source, this includes support to people with complex support needs. The demand for this has increased as we have moved towards supporting increasing numbers of people with high and complex support needs to remain in their own home.
What local people have told us

- People with long term conditions wanted more guidance and support in managing their condition
- People wanted their GP practices to offer more services - so they did not have to go to the hospital
- Better identification of and support for Carers
- Mental Health access - there are long waiting times to be seen. Generally, people are happy to go to locations closer to home
- People wanted better support after discharge from a hospital setting
- Children’s mental health - more support to ensure young people are able to speak up about their mental health
- Accessibility - services are very good however it takes a long time to be able to access them
- Services can seem disjointed, all services needed to work better together to support families
- Open to the idea of new technology in supporting enhanced health and social care. Some options, such as telephone advice lines, mobile phone apps, were more popular than others
- Supportive of social prescribing and other innovations
We held a partnership health and care event on 21st November to get feedback on the areas of focus within the Wandsworth Health and Care Plan.
The priorities within the Wandsworth Health & Care Plan are focused on the areas where we can have the greatest impact by working collectively to tackle the causes of health and well-being issues. Whilst these priorities have been developed under the themes of Start Well, Live Well, Age Well many of the priorities and actions we have identified will impact across the whole life course.
Cross cutting themes

Whilst we have identified priorities within Start Well, Live Well, Age Well there are a number of issues which require a cross cutting thematic approach as they impact on health and wellbeing throughout life. Examples are:

• Economic factors and housing stability both of which inter-relate with health inequalities

• Carers – unpaid carers and young carers are important groups which cut across the Start, Live, Age Well themes, who require support

• The preparation for adulthood and the transition from child to adult services covering the 16-25 age range which cuts across the Start Well, Live Well themes.

As a key overarching principle we will focus on evidence-based initiatives across the system
Our priorities for Wandsworth

We want people to remain as healthy as they can for as long as they can and the priorities within our plan run throughout the life course. Our partnership approach is focused on prevention, integration and supporting local communities to become more resilient.

Start Well – Childhood Obesity, Children’s and Young People’s Mental Health, Risky behaviours
We want children to be healthy from the start so that they can grow up to be healthy adults achieving their full potential. We are concerned about risky behaviours, obesity and mental wellbeing in young people.

Live well – Integration of physical and mental health approaches and chronic disease management- Diabetes
We know that there is no physical health without health mental health and integrating our approach to physical and mental health is an important live well priority. We want people with long term conditions to be able to help themselves and Diabetes is a specific concern in Wandsworth that we want to explore.

Age Well – Health and Social Care Integration, Dementia and Isolation
We want to join up health and social care services to provide a better service to residents. Increased awareness amongst front line staff has led to earlier diagnosis of Dementia and helps us to look at how we can best support people living with and caring for someone with dementia. We are also looking at social isolation amongst older people; this is not a medical problem but this can adversely impact all areas of their lives.
What happens in pregnancy, childhood and adolescence, impacts on physical and emotional health and lays down a foundation for the whole of life. The focus of the Wandsworth Health and Care Plan is to drive system change by encouraging all services to take a whole family perspective to strategic decision making, commissioning and delivery processes.

We want to give every child the best start in life and help them develop into healthy and resilient adults. The patterns of healthy behaviours are often established early in life through education and what is observed at home and childhood outcomes can function as indicators of later health problems.

Therefore it’s important to focus on prevention and doing things well early on and supporting the health & wellbeing role of schools is a key element of our strategic approach.
In Wandsworth

- Mental health problems, including depression, anxiety and conduct disorder affect about 1 in 10 children and young people and are often a direct response to what is happening in their lives. An estimated 2,800 children aged 5-16 have mental health disorders.

- Half of lifetime mental disorder has arisen by the age of 14 and 75% by the mid-20s. Therefore, services to prevent mental disorder have greatest impact in pre-teenage years.

- In a class of children you are likely to find 3 children with a diagnosable mental illness.

- We are seeing an increase in anxiety and depression in young people, impacted by social media and cyber bullying.

What we will do:

- Youth Mental Health First Aid training for Schools, Colleges and Youth Services

- Whole school emotional resilience programme in primary schools

- Social and Emotional Learning programmes for secondary Schools

- BAME Mental Health through Community Pilot Project
In Wandsworth

• We measure the height and weight of children on entering primary school and leaving school. On starting school, 18.2% of children are overweight (including obese). By year 6 this has increased to 33.9%.

• Obesity is largely preventable.

• Childhood overweight and obesity disproportionately affects children in low-income and black and minority ethnic families.

• The impact of childhood obesity is not only felt in youth, it can lead to conditions such as type 2 diabetes and heart disease in early life.

• Over time childhood obesity increases an individual’s risk of cancer, stroke and liver disease, amongst other debilitating and life-threatening diseases.

What we will do:

• continue to implement the Daily Mile across all primary schools in the borough

• Work with leisure and environment partners to encourage more use of open spaces, playgrounds and sporting activities

• Support breastfeeding through maternity and early years services and wider community venues

• Encourage healthy weight in early years through appropriately focused family based weight management interventions

• Support children and young people to maintain a healthy weight through the creation of healthy places
Start Well - Risky Behaviours

In Wandsworth

- It is estimated that 12% of 15-year-olds partake in 3 or more risky behaviours including taking drugs and alcohol.

- A higher proportion of those aged 15 are reported having tried cannabis than in the rest of London.

- Wandsworth has significantly higher rates of sexually transmitted infection (excluding chlamydia) than the rest of London.

- There has been an increase in youth violence and knife crime. The number of victims of serious youth crime per year has increased from 115 (December 2011-2012) to 202 (December 2016-2017). Over the same period the annual count of knife crime events with injury amongst those <25 years also increased, from 36 to 51.

What we will do:

- Focus on prevention and early intervention initiatives and approaches to reduce the take up of risky behaviours

- The focus of our approach will be:
  - Identifying Young People involved or likely to be involved in risky behaviour
  - Whole family support for those that are at risk
  - Engagement with Youth
  - Developing a multi-agency approach
  - Addressing the inter-play between vulnerability and risk and what we can do as a system to keep children and young people safe
Good mental health is the foundation for living well and there is a clear link between an individual’s mental and physical well being.

We know that the impact of a person’s mental and physical health, their social and environmental surroundings (including employment, housing and factors such as loneliness and isolation) influence the uptake of unhealthy behaviours.

These in turn go on to account for a high proportion of disease and long term health issues such as Diabetes.

The prevalence of Diabetes in Wandsworth is driven by demographics and related to lifestyle choices. The subsequent impact of poor health and mental wellbeing results in huge costs to the individual, the economy and the health and social care system.
Live Well – Integrating Physical and Mental Health Approaches

In Wandsworth

• An estimated 44,000 people aged between 16 and 74 have a common mental health disorder such as depression and anxiety.

• A survey of local people indicates that 44% of adults drink more than the recommended 14 units of alcohol per week; the highest proportion in London.

• An estimated 3,743 adults are alcohol dependent with the highest rate in men aged between 25 and 34.

• The link between mental wellbeing and physical health has been well documented; the ability to manage chronic conditions can be impaired in those suffering from mental health issues.

• The life expectancy of people with severe mental illness is reduced, on average by 15-20 years, mainly due to preventable physical illness.

What we will do:

• Physical Health Checks for people with Serious Mental Illness.

• Talking Therapies (IAPT) - increase access to psychological therapies

• IAPT Long Term Conditions Pathway providing support to people with Diabetes, COPD and Cardiovascular conditions

• CAHS Home Based Support – proposal for a mental health support worker to work alongside community staff to identify patients with Long Term Conditions that could benefit from support with mental health needs.
Live Well – Chronic Disease Management – Diabetes

In Wandsworth

• 4.2% of the population over 17 years are registered with Diabetes against expected prevalence of 6%.

• An estimated 9.0% of people in Wandsworth are at increased risk of developing Diabetes and 15 people are told that they have Diabetes every week.

• South Asian and black communities are two to four times more likely to develop Type 2 Diabetes

• Diabetics are more likely suffer from poor eyesight, kidney problems, knee problems and amputations.

• Prevalence is driven by demographics and related to lifestyle choices.

• 80% of cases of Type 2 diabetes can be delayed or prevented by making simple lifestyle changes.

What we will do:

Implement new models of care to:

• support consistent care for diabetic and pre-diabetic patients across primary care

• enable Consultant deep-dives within primary care

• provide additional clinical capacity in community settings to enable more patients to be supported closer to home

Targetted education programmes:

• National Diabetes Prevention Programme

• Diabetes Book & Learn

• Online structured education

• Tailored education for BAME patients
Many older people in Wandsworth enjoy active, healthy lives and have limited contact with health and social care services.

It is important that everyone has access to advice and information they need to keep them well, helping them to look after their own physical and mental health. This will include access to “Social Prescribing” from GP practices and other preventative services.

Although life expectancy continues to increase incrementally, healthy life expectancy is much shorter than overall life expectancy and the average person in Wandsworth can expect 15 years of deteriorating health in old age.

For older people with the greatest health and social care needs in the borough, this plan outlines what we will be doing to improve services.
Age Well – how are we currently doing?

It is important for residents that the health and social care services they use perform well. One of our successes in Wandsworth is how we perform against national targets set through the Better Care Fund. These targets set out to measure how the success of health and social care integration in the borough.

Unplanned admissions to hospital
We are performing well in reducing unplanned admissions to acute hospitals. This shows that we have good primary care and community services that can respond when people becoming unwell at home.

Permanent admissions in Care Homes
There has been a reduction in older people moving into residential and nursing care homes. This shows that we have good health and social care support in the community to keep people living in their own homes for longer.

Supporting people home from hospital
We have some of the best performance nationally in supporting people home from hospital, with low numbers of people who are “delayed” in hospital while waiting for community health or social care services. This shows that we have responsive services and we work well across health and social care services to plan someone’s discharge from hospital.
Age Well – Health & Social Care Integration

In Wandsworth

• The number of people aged 65 or over is projected to increase by 44% in the next 20 years.

• The average person can expect 15 years of deteriorating health in old age.

• The accumulated impact of behaviours and exposures earlier in life, combined with functional decline leads to increased levels of disease in older people.

• The rate of hospital admissions for injuries due to falls in those aged 65 and over is significantly higher than the national and regional averages.

• In Wandsworth, 9,000 people aged 50 years and older are unpaid carers

What we will do:

• Improve access to intermediate care and reablement services, with better coordination between services

• More coordination of community services for people with the most complex health and social care needs, including support for their carers

• Improve falls prevention services including an enhanced community exercise programme with access to evidenced based training

• Improve health care support to the very frail, including residents in care homes

• Map existing health and social care services for frail, older people in the borough
The number of patients with a diagnosis of Dementia recorded on GP registers is growing with greater awareness amongst front line staff.

This timely diagnosis helps with planning care and support leading to better quality of life for the patient and their family.

Dementia mainly affects older people and after the age of 65 the likelihood of developing dementia roughly doubles every five years. With the number of older people in Wandsworth set to grow faster than the overall population and as people live for longer, dementia presents us with a growing challenge.

There are almost two women to every man with Dementia.

**What we will do:**

- Improve Care Navigation and planning, integrating dementia care into other care planning streams
- Improve support to unpaid carers of people with dementia, with aligned pathways for unpaid carers for people having specialist mental health dementia services and more proactive engagement with carers
Age Well – Isolation

In Wandsworth

- 39% of > 65s in Wandsworth live alone. Isolation in older age is an important focus as it is a preventable cause of both physical and mental health problems.

- Currently, over 10,000 older people live alone in Wandsworth and over 20% of older people are on low incomes. Isolation in older age often disproportionately affects people living in more deprived areas or who are on low incomes.

- Social isolation is also a factor in increased alcohol use - nationally there has been a marked increase in alcohol related hospital admissions for older people. Isolation is known to increase health service demand.

- Isolation in older age is an important focus as it is a preventable cause of both physical and mental health problems, including depression, dementia and cardiovascular disease.

What we will do:

- Improve the preventative services offer provided by the Voluntary sector with a focus on intergenerational activities

- Improve the coordination of services through the commissioning of an enhanced Voluntary Sector Coordination programme

- To support our digital Social Prescribing offer (the Wandsworth Wellbeing Hub), we will be aiming to launch our face to face Social Prescribing service in Wandsworth for service commencement by September 2019.
Challenges such as increased demand and complexity of care, workforce shortages as well as changing national policy means we must transform how primary care is delivered

Wandsworth has a GP registered population of 410,000

- The primary care workforce has changed with a shift towards more GPs working part time and in a salaried or locum capacity. This can cause gaps in frontline clinical time for consultations but also in a reduction in leadership capacity within practices.
- National policy demands the provision of primary care 8am-8pm 365 days a year.
- There is an increasing number of elderly and more complex patients needing care in the community.
- There are differences in the quality of services between different GP practices in Wandsworth.
- There are significant health inequalities within the borough.
- The existing infrastructure (IT & estates) are not always fit for purpose to deliver high quality care.
Primary Care - What are we doing to improve services?

A new GP contract sees practices increasingly working together to improve resilience and sustainability, increase capacity and provide local population based care which is integrated with wider system partners.

We will realise the benefits of the new GP contract by:
- Supporting all practices to come together in networks to deliver a range of new services;
- This will include significant new investment for the creation of new front line posts, embedded at network level;
- Identifying opportunities to align community contracts and staff with these network arrangements.

We will work to support our workforce by:
- Enhancing skill mix and using community services staff appropriately;
- Training existing practice staff to work in different ways e.g. receptionists sign posting people to community resources;
- Delivering economies of scale;
- Ensuring staff want to work in Wandsworth and are retained.

We will continue to improve access by:
- Development of the locality access hubs;
- Embracing opportunities from technology and innovation where it makes sense to do so;
- Explore the possibility of a single point of triage for all;
- Joining up urgent care systems with primary care so that patients are seen in the most appropriate place to meet their needs;
- Improving public education in relation to self-care.

We will improve organisational efficiency by:
- Maintaining and scaling up back office functions in practices;
- Investigating how efficiencies of scale could be achieved and also utilisation of collective purchasing power.

What will be the impact?

- High quality, sustainable Primary Care which is accessible, pro-active and co-ordinated, delivered across the Borough.
- Direct booking of appointments from NHS111 and A&E into all GP practices.
- All patients will have access to digital first primary care, including web and video consultations, online booking of appointments and electronic repeat prescriptions.
- All patients have access to social prescribing services.
- Patient care is holistic and joined up across multiple agencies.
Creating the Right Environment – What we will do?

Some parts of the health and social care system have critical challenges in remaining sustainable and we recognise that we need to make significant changes to the way health and care services work to create the right environment for change.

Providers of services do not always work together proactively
We will ensure that services work together towards a common goal and have a demonstrable impact on health and wellbeing.

Person centred care can mean different things to different people and whilst we aspire to this different professionals approach it in different ways.
We will define a common approach to person centred care.

Our contracts with providers do not always encourage integrated care and in some cases make it more difficult
We will review our contracting and incentives to ensure that contracts for services encourage integration and reward person centred care.

Some of the health estate is not fit for purpose
We will develop a estates strategy that supports integration and ensures community based integrated care.

We have an ageing workforce and there are challenges recruiting to certain professions
We will work with partners across South West London to address workforce gaps and training and development needs.

The use of technology to improve the delivery of services is limited
We will make use of the opportunities afforded by the NHS Long Term Plan to incorporate digital approaches to the delivery of services for people in Wandsworth.
Creating the Right Environment – Key Enablers

**Embracing transformation and partnership working** - increasing demand on parts of the health and care system and tighter finances will need to be managed by working in partnership to transform the way services are delivered.

**Increased focus on prevention** by its very nature prevention is not a clinical intervention and is delivered most successfully in convenient local environments that people are familiar and comfortable with, such as those provided by community and voluntary organisations.

**Supporting unpaid carers** - their input is really important.

**Making better use of our estate** and the green spaces in the Borough to promote health and wellbeing.

**Activation of the voluntary and community sector** - The Wandsworth Health and Care Plan priorities have been developed with recognition that statutory and voluntary sector stakeholders share a responsibility to ensure that our social care, community, wellbeing and hospital services are as joined up or integrated as possible in a whole system approach to collectively tackle the causes of health and well-being issues.
Creating the Right Environment - Activating the Voluntary Sector

The voluntary and community sector presents us with some of the greatest untapped potential resource to meet local health and wellbeing challenges, as part of an integrated health and care system, through prevention and coproduction.

Voluntary and community sector organisations:

- play an increasingly important role in the health and care plan

- understand local needs and local solutions. They can engage with communities that statutory organisations struggle to reach.

- have a growing appetite to work collaboratively not only with each other but with our commissioning bodies and providers.

- can provide added value through local knowledge and intelligence, involving volunteers, attracting additional external funding and utilising local venues.

Investment in infrastructure to support the development of the voluntary and community sector potential is already underway.
Creating the Right Environment - Activating the Voluntary Sector in Wandsworth

The voluntary and community sector in Wandsworth consists of several hundred voluntary groups and organisations, including charities, condition support groups, and faith groups. Many of these organisations are small and informal. Whilst there is no comprehensive list of all the organisations within Wandsworth, the Charity Commission lists 565 registered charitable organisations in the borough.

A “Thinking Group” of local voluntary organisations has been established. This group meets to consider and address local challenges and opportunities. Alongside the “Thinking Group”, the Wandsworth Voluntary Sector Coordination Project has been responsible for developing the well-attended Voluntary Sector Forum.

Wandsworth CCG and Wandsworth Council are seeking new voluntary sector capacity to achieve their shared vision of a sustainable and vibrant voluntary and community sector.

The CCG is commissioning a voluntary sector support service to act as a liaison between the voluntary sector and the CCG and build capacity and connections with local organisations to help deliver more broadly on local health priorities.
Acute Transformation: Planned Care and Urgent & Emergency Care

Other work
Outside of the Wandsworth Health and Care Plan partners are working to ensure the quality and sustainability of services meets our aspirations

Planned Care
- Developing primary care to support people outside of hospital where possible
- Cancer: new diagnostic tests to reduce the need for invasive procedures
- Psychological support for people living with and beyond cancer
- Effective Commissioning Initiative, ensuring that procedures are evidence based
- New community services to manage hospital demand e.g. community ophthalmology services
- Clinical Assessment Services
- Outpatient redesign. Development of virtual clinics online and over the phone
- Diagnostic pathway improvement

Urgent and Emergency Care
- Ambulatory care. Same day medical support for adults and children to avoid admissions to hospital
- Integration of primary care expertise and capacity to avoid A&E attendances where possible
- Alternative Care Pathways: working with London Ambulance Services to identify where patients can receive support quickly rather than attend A&E
- Older Peoples’ Advice and Liaison Service: providing tailored support to older people when in A&E
- Integrated Urgent Care (NHS 111)
Preventing Ill Health

The Public Health Team are working with partners across health and social care.

Air Quality

Health professionals (GPs, hospital doctors, nurses) have a pivotal role to play:

1) In helping to raise awareness of the health impacts of air pollution as well as promoting actions that help to address both air pollution while maximising the health outcomes e.g. reducing sedentary behaviour by encouraging a shift from car use to walking, cycling and use of public transport when possible.

2) Advising those more vulnerable to the health impacts of air pollution, for example the young, the old and individuals with lung and/or heart problems, on how to reduce their risk.

Making Every Contact Count

All frontline staff will be offered the opportunity to access training to deliver information, brief advice and signposting to health and wellbeing support in Wandsworth.

Prevention in procurement programme will reinforce efforts for a standardised and scaled approach to MECC, as well as embed prevention into service delivery.

E-learning modules provide flexibility for staff across different work settings to access the same standard of training at their convenience.

This workforce development approach is mapped alongside social prescribing to ensure that the right level and type of support is accessed at the right time.
St George’s strategy at a glance....

**Delivering outstanding care, every time**

Our strategy for 2019-2024

Our vision is to provide outstanding care, every time for our patients, staff and the communities we serve. We have agreed four priorities that will drive what we do and influence the decisions we will take over the next five years.

### Strong foundations

- To provide outstanding care, every time
  - We will provide outstanding care, every time
  - We will provide the right care, in the right place, at the right time
  - We will invest in our staff
  - We will manage our funding and spending, and invest in our future
  - We will improve our buildings and hospital estate
  - We will make sure our staff and patients have access to the digital technology and information they need, when and where they need it

### Excellent local services

- To provide excellent local hospital services for the people of Wandsworth and Merton
  - We will provide planned care that fits around our patients’ lives using the latest technology
  - We will provide more same day emergency care

### Closer collaboration

- To work with others to provide health services for people across south west London
  - We will work with our partners to provide care closer to patients’ homes
  - We will work with neighbouring hospitals to make sure patients get the care they need
  - We will work with others to meet the changing needs of our ageing population

### Leading specialist healthcare

- To provide specialist healthcare for the people of south west London, Surrey, Sussex and beyond
  - We will continue to be the main provider of specialist services for our region, including as the major trauma centre
  - We will be a major centre for cancer, children’s and neuroscience services
  - We will take part in commercial opportunities that enable us to invest more in NHS care
  - We will develop tomorrow’s treatments, today, through innovation, research and training
Quality improvement benefits which will be delivered by the initiatives outlined within the Health & Care Plan are common across the Start Well, Live Well, Age Well programmes.

These will be delivered through the focus on:

**Prevention** - maintaining good health, independence and promoting wellbeing.

**Resilience** – Promoting self care and halting or slowing progression of disease, together with interventions to improve the existing condition.

**Integration** - resulting in patients being able to access services quickly and efficiently in a community setting where their needs are fully understood.
Discussion document engagement overview

**Governance path**

- April/May: Leadership Partners recommend the LHCP discussion document to their own organisation's decision making bodies.
- June/July: Feedback to HCP Lead/Leadership group -- and the final version LHCP published in summer.
- Autumn: Six LHCPs form foundation of SWL response to NHS Long Term plan (plus SWL clinical conference work + enablers) — back to Borough Leadership Groups/Decision making committees and SWL Programme Board for discussion/feedback/then publication.

**Partners “constituent” engagement**

- April/May: Leadership Partners ensure engagement on LHCP discussion document with their organisation’s key constituents e.g. staff, their key stakeholders.
- June/July: Feedback to HCP Lead/Leadership group—final version LHCP published in summer.
- Autumn: SWL response to NHS LT Plan shred with partners “constituents” for discussion and then published.

**Targeted engagement with service users on “what” and also “how”**

- April/May: Healthwatch and Borough Comms and Eng group to sense check LHCP discussion document with target groups in start well, live well, age well.
- June/July: Feedback to HCP Lead/Leadership group—final version LHCP published. Leadership group to agree targeted engagement with patient reps/key vol Orgs on how we implement elements the LHCP. Begin engagement.
- Autumn: Continue to deliver Targeted engagement with key service-user groups on how we implement the LHCP. Ongoing.

**Next Steps**

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Appendix 1 – What we will do

• Governance
• Plan overview
• Start Well
  • Cross cutting issues
  • Children and Young Peoples mental health
  • Childhood obesity
  • Risky behaviours
• Live Well
  • Integrating approaches to Physical and Mental Health
  • Chronic disease management - Diabetes
• Age Well
  • Integrating Health & Social Care
  • Dementia
  • Social Isolation
**Governance**

**Wandsworth Health & Wellbeing Board**
The Wandsworth Local Health & Care Plan (LHCP) is overseen by the Wandsworth Health & Wellbeing Board (HWB). The HWB has mandated officers to develop a single plan, working with partners, through the Wandsworth Transformation Group.

**Wandsworth Transformation Group**
Is formed of partners across the Wandsworth Health and Care system who are working together to develop clinically and financially sustainable health and social care services.

**Start Well work stream**

**Age Well work stream**

**Live Well work stream**

**Board Oversight – outcome feedback**

- **WCCG Board**
- **Battersea Healthcare CIC**
- **Wandsworth Council**
- **CLCH**
- **St George's Foundation Trust**
- **St George's Mental Health Trust**
- **St George's University Hospital Trust**
- **South West London and St George's Mental Health NHS Trust**
- **Central London Community Healthcare NHS Trust**
- **Wandsworth Voluntary Sector Co-ordination Project**
- **Battersea CARE Alliance**

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# Wandsworth Health & Care Plan

## Our Vision:

We want people to live and remain as healthy as they can and our partnership approach is focused on priorities throughout the whole life course through prevention, supporting independence, good health and wellbeing and enabling local communities to become more resilient.

## Responding to the needs of Wandsworth Residents

### Start Well

<table>
<thead>
<tr>
<th>Rationale - the health divide is evident from childhood; what happens in childhood lays down the foundation for health and wellbeing throughout life</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Childhood Obesity</strong></td>
</tr>
<tr>
<td>- In Wandsworth 1 in 6 children are overweight when starting school and this grows to 1 in 3 when leaving school.</td>
</tr>
<tr>
<td><strong>Children’s and Young People’s Mental Health</strong></td>
</tr>
<tr>
<td>- An estimated 2,800 children aged 5-16 have mental health disorders in Wandsworth; half of lifetime mental disorder has arisen by the age of 14 and 75% by the mid-20s. Therefore, services to prevent mental disorder have greatest impact in pre-teenage years.</td>
</tr>
<tr>
<td><strong>Risky behaviours</strong></td>
</tr>
<tr>
<td>- It is estimated that 12% of 15-year-olds in Wandsworth partake in 3 or more risky behaviours</td>
</tr>
</tbody>
</table>

### Live Well

<table>
<thead>
<tr>
<th>Rationale - Good mental health is the foundation for living well</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Integrating Physical and Mental Health approaches</strong></td>
</tr>
<tr>
<td>- Increasing numbers of people aged between 16 and 74 have a common mental health disorder such as depression and anxiety</td>
</tr>
<tr>
<td>- 22% of people attending A&amp;E had mental health issues</td>
</tr>
<tr>
<td>- 44% of adults in Wandsworth drinking more than the recommended limit of per week</td>
</tr>
<tr>
<td><strong>Chronic disease management - Diabetes</strong></td>
</tr>
<tr>
<td>- Increased diabetes prevalence</td>
</tr>
<tr>
<td>- An estimated 9.0% of people in Wandsworth with nondiabetic hyperglycaemia who are at increased risk of developing diabetes</td>
</tr>
</tbody>
</table>

### Age Well

<table>
<thead>
<tr>
<th>Rationale - healthy life expectancy is shorter than overall life expectancy and the average person can expect 15 years of deteriorating health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health and Social Care Integration</strong></td>
</tr>
<tr>
<td>- More people are living into older age; the number of people aged 65 or over is projected to increase by 44% in the next 20 years.</td>
</tr>
<tr>
<td>- The rate of hospital admissions for injuries due to falls in those aged 65 and over is significantly higher than the national and regional averages</td>
</tr>
<tr>
<td><strong>Health and Social Care Integration</strong></td>
</tr>
<tr>
<td>- Proactive and preventative services, rapid response, improving discharges, enhanced support to care homes and falls prevention</td>
</tr>
</tbody>
</table>

### Focus on

- **Childhood Obesity** |
  - The prevention and management of childhood obesity |
- **Children’s and Young People’s Mental Health** |
  - Improving resilience and emotional and mental wellbeing, and experience of and access to mental health services |
- **Risky behaviours** |
  - Protecting children from the impact of risky behaviours |
- **Integrating Physical and Mental Health approaches** |
  - Improved access, earlier diagnosis and improved recovery rates |
  - Improved wellbeing and independence |
- **Chronic disease management - Diabetes** |
  - Developing a care model that underpins a holistic approach to self-management and focuses on prevention and health inequalities. |
- **Health and Social Care Integration** |
  - Improved patient experience |
  - Reduction in falls and ambulance callouts |
- **Dementia** |
  - Improved patient experience |
  - Reduction in falls and ambulance callouts |
### Start Well Cross-cutting issues / actions

<table>
<thead>
<tr>
<th>What will we do</th>
<th>Description of initiative</th>
<th>What will be the impact</th>
<th>How will we measure success</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support the Health and Wellbeing role of Schools</strong></td>
<td>Develop a long term strategy and programme to support health and wellbeing in schools. This would include a range of topic areas such as mental wellbeing, physical activity, healthy eating and substance misuse. Encourage whole school approach across all schools in the borough</td>
<td>Ensure there is a clear strategic direction to ensure cumulative effect of different initiatives to improve overall health and wellbeing in schools Establish the evidence base and what priorities should be focused on which can help to strengthen the case for funding key initiatives or programmes Working with partners to ensure a collaborative strategic approach to support schools</td>
<td>The development and adoption of a clear strategy Public Health Outcome Framework indicators over longer term School surveys</td>
</tr>
<tr>
<td><strong>Support schools in their delivery of mandatory RSE and HE</strong></td>
<td>Working with partners to support schools in delivering relationships and sex education and health education (including mental and physical health education)</td>
<td>Implementation of RSE and HE from September 2020 across all schools</td>
<td>All schools meeting the 2019 regulations</td>
</tr>
<tr>
<td><strong>Parenting Strategy, including universal and targeted parenting courses and programmes</strong></td>
<td>Universal and targeted evidence based parenting programmes focussing on attachment security, behavioural self regulation and cognitive development. Comms Strategy to enable parents to increase protective factors and reduce risk factors relating to mental disorder.</td>
<td>Improved attachment, self-regulation and self-esteem Reductions in adverse childhood experiences and emotional psychological distress</td>
<td>Course evaluation, parent/child feedback</td>
</tr>
</tbody>
</table>


## Start Well – Children and Young People’s Mental Health - what we will do

<table>
<thead>
<tr>
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</table>
| **Youth Mental Health First Aid training for Schools, Colleges and Youth Services** | Mental Health First Aid equips people to help individuals developing a mental health problem, experiencing a worsening of an existing mental health problem or in a mental health crisis. The training teaches people how to offer initial support until appropriate professional help is received or until the crisis resolves. | • Improved access to services for young people experiencing psychological distress  
• Greater numbers of CYP receiving early intervention  
• Improved numbers of CYP recovering from mental health disorders  
• Reduced stigma and discrimination | Increases in service utilization  
Feedback from children and young people, schools, colleges and universities |
| **Whole school emotional resilience programme in primary schools** | Universal Whole School Approach to develop social and emotional learning of children aged 5 - 11 | • Improvements in self-esteem, self control, emotional intelligence, and conflict resolution  
• Reduction in emotional distress, aggressive behavior and conduct problems. | Number of schools delivering PATHS  
Longitudinal assessment against baseline using Strengths and Difficulties Questionnaire |
| **Social and Emotional Learning programmes for secondary Schools** | Universal and targeted programmes to support adolescent mental health | • Improvements in self-esteem, self control, emotional intelligence, and conflict resolution  
• Reduction in emotional distress, aggressive behaviour and conduct problems | Number of schools delivering evidence-based programmes  
Longitudinal assessment against baseline using appropriate validated evaluation tool |
| **Improving access and effective support** | Map of CAMHS Services and interventions within the new Pathways documents for anxiety, low mood, depression, social & communication difficulties, self-harm, and behaviour. Work with Local Authority colleagues to jointly commission new programme of ASD pre and post diagnostic support for children and their families. | Clear pathways, referral criteria and specifications which will deliver improved services  
To help young people know where to go when they need help. | Increases in service utilization  
Through co-production work and feedback from children and young people |
| **BAME Mental Health through Community Pilot Project** | A scheme to train young people to provide peer support around emotional/ mental health. | This will include a comprehensive creative and cultural curriculum, building young people’s self-awareness and confidence | Feedback from children and young people |

**Summary Description of the programme**

We want more children and young people to access emotional well-being and mental health support at the right time and place.

Promoting Resilience, Prevention and Early Intervention. Early intervention is associated with improved outcomes. Our ambition is for evidenced based interventions to be available to every child and young person as soon as they need it. From 2019 there will be more preventative work in schools, and by 2021 we hope all schools with have emotional resilience programmes and early help.
## Start Well – Childhood Obesity - what we will do

### Summary Description of the programme

**Action to reduce childhood obesity as measured by the National Child Measurement programme**

A whole child/young people/think family approach will be taken. This will commence antenatally and will continue through early years services and into primary phase education, and also involve the wider community.

### What will we do

<table>
<thead>
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<tr>
<td><strong>Move more</strong></td>
<td>To continue to implement the Daily Mile across all primary schools in the borough and to work towards a sustainable model of delivery for the long term; Work with leisure and environment partners to encourage more use of open spaces, playgrounds and sporting activities</td>
<td>To expand the Daily Mile Programme and encourage schools to implement it. University of Stirling found that the Daily Mile makes primary school children more active, less sedentary and improves their fitness and body composition. Increase in physical activity for children and families</td>
<td>Number of schools and children who take part in the DM on a regular basis Participation in sports across borough Use of green space</td>
</tr>
<tr>
<td><strong>Encourage healthy weight in early years</strong></td>
<td>Universal support across maternity and early years services and wider community venues, to support mothers breastfeeding and healthy weaning Appropriately focus family based weight management interventions towards early years and children in primary school, post-natal women who are obese, children aged 2 years and children who have been identified as overweight or obese through the National Child Measurement Programme Work with Health Visiting Team and Children’s Centres to promote and advise on benefits of breastfeeding to improve initiation and sustained rates. Work with Health Visiting Team, Children’s Centres to promote, advise and model benefits of healthy weaning and healthy diet Work with the child’s school and family, School Nursing and the Health Weigh Management Service post 1st NCMP measurement (reception) to develop a Heath and Wellbeing plan for the child and their family</td>
<td>Approximately one in five children are overweight or obese in reception but this rises to one in three by year 6. It is important to focus towards early help and prevention to reduce the number of children going on to become overweight or obese. Improved initiation and sustained rates of breastfeeding Higher proportion of children making health transition from breast to healthy solid food Reduction in weight/BMI at the end of each academic year</td>
<td>Reduction in BMI Increase in hours of physical activity Changes in family diet Change in self-efficacy measures Improved breastfeeding rates at 6-8 weeks Number of children receiving a health diet obtained through survey in CC</td>
</tr>
<tr>
<td><strong>Build and create healthy environment</strong></td>
<td>Work with planning and licensing to implement the 400m exclusion zone around schools for new ‘fast food’ retailers. Explore changing license permits to only be valid for owners rather than the premise Work with partners to encourage healthy environments for children and their families</td>
<td>To manage environments around schools to encourage healthier choices and reduce the availability of unhealthy foods Encourage all environments to support healthier choices for parents and families</td>
<td>Number and concentration of unhealthy fast food retailers within 400m of schools Partners and organisations offering healthier choices</td>
</tr>
</tbody>
</table>
Focus on prevention and early intervention initiatives and approaches to reduce the take up of risky behaviours

The focus of our approach will be:

- Identifying Young People involved or likely to be involved in risky behaviour
- Whole family support for those that are at risk
- Engagement with Youth
- Developing a multi-agency approach

Key initiatives in development:

**Improving partnership working and strategic planning** - Early Help, Community Safety and Schools Partnership to develop a consistent local strategy and response to knife crime and serious youth violence with schools.

**Sharing and promoting good practice in relation to exclusions and managed moves** – Working with schools partnership to review and update as necessary the local response to exclusion and managed moves.

**Coordinating early help and prevention** - Develop Early Help service offer and response to support inclusion of children at risk.

**Improving information sharing** – Working with school partnership to improve early identification and communication in relation to children at risk.

**Teaching the curriculum and supporting children to achieve** – Early Help services to collaborate with schools to support effective PSHE and awareness of key risks for children.

**Preventing and tackling knife crime** - Develop a multi-agency strategy to prevent and tackle knife crime, through taking a Public Health approach
Live Well - Integration of physical and mental health approaches – what we will do

<table>
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</table>
| Physical Health Checks for people with Serious Mental Illness. | Primary care teams (GP’s) will be incentivised for carrying out 50% of the annual physical health assessments targets including follow-up care. | • Patients with a diagnosis of severe mental illness will live longer.  
• Fewer patients will attend A&E and GP surgeries with chronic physical health problems.  
• GPs will be able to maintain close contact with their higher-risk mental health patients.  
• SMI patient will benefit from peer support which can assist them to access vital medical assessment appointments and to receive healthy living lifestyle support. | to ensure that 60% of patients with SMI to have an annual health check (50% in primary care and 10% in secondary care). |
| Talking Therapies (IAPT) | In 2019-20 we will be increasing access to psychological support to 22% of the population estimated to have either anxiety and/or depression. Working alongside GP’s and the mental health providers we will seek opportunities to provide access to clinical support in less formal settings including GP Practices. | • Earlier diagnosis leading to higher recovery rates  
• Embedding the service within GP Practices and other informal settings will enable improve access from hard to reach groups such as men, and those from a BME background | Success will be measured against national standards i.e:  
• Access = 22%  
• Recovery Rates = 50%  
• Access to first treatment = 75% of referrals in < 6 weeks  
• Access to second treatment = 95% in <18weeks |
| IAPT Long Term Conditions Pathway | Around 40% of people with depression and anxiety disorders also have a long-term physical health condition. By providing support to people with diabetes, COPD and Cardiovascular conditions the evidence shows that we can reduce the number of unnecessary hospital admissions as a result of these conditions, maintain positive wellbeing and also support people to manage their conditions better within the community setting. | • A multi disciplinary approach enhances whole team’s capability to provide more comprehensive, accessible and holistic care to patients  
• Promotes mental health awareness and faster diagnosis identifying and addressing a person’s needs more quickly and accurately can in turn reduce the number of frequent attenders and repeat assessments  
• Promotes coordination and encourages the development of a single jointly-developed care | Success will be measured against national standards i.e:  
• Access = 22%  
• Recovery Rates = 50%  
• Access to first treatment = 75% of referrals in < 6 weeks  
• Access to second treatment = 95% in <18weeks  
• A reduction in A&E attendances and inpatient admissions. |
| CAHS Home Based Support | Following pilots commissioned in 2019-20, it is proposed that a mental health support worker is commissioned to work alongside Central London Community Health Trust to identify patients with Long Term Conditions that could benefit from support with mental health needs. | • A multi disciplinary approach enhances whole team’s capability to provide more comprehensive, accessible and holistic care to patients  
• Promotes mental health awareness and faster diagnosis identifying and addressing a person’s needs more quickly and accurately can in turn reduce the number of frequent attenders and repeat assessments  
• Promotes coordination and encourages the development of a single jointly-developed care  
• Reduction in the number of unnecessary GP referrals and/or A&E Attendances. | The measures of success are to be confirmed but could include measures such as:  
• Improved confidence to manage their wellbeing  
• Reduction in London Ambulance conveyances  
• Reduction in the number if unnecessary A&E attendances. |
# Live Well - Chronic disease management – Diabetes -what we will do

<table>
<thead>
<tr>
<th>Summary Description of the programme</th>
<th>What will be different about our approach</th>
</tr>
</thead>
</table>
| There is an increasing prevalence of diabetes in Wandsworth and the current service model will not be able to provide sufficient proactive and holistic support. The new model of care enhances the ability of primary care and community services to support patients outside of acute hospital settings, thus managing their disease more proactively and reducing the likelihood of complications. | The new service model will result in:  
• Prevention of Type 2 diabetes through increased screening and annual recall of patients at risk of developing diabetes  
• Early identification, improvement in treatment of and prevention of the complications of diabetes  
• Improved access through patients can access diabetes care closer to home, in the right place and at the right time.  
• Reduced attendances in acute settings as more patients will be supported in primary and community settings.  
• Improved patient experience and outcomes  
• Patients to be better supported to self manage  
• Improved sustainability and reduction in variation in quality of care for people living with diabetes  
• Upskilling of primary care workforce and enhanced collaborative working across all providers |

## What we do

<table>
<thead>
<tr>
<th>Description of initiative</th>
<th>What will be the impact</th>
<th>How will we measure success</th>
</tr>
</thead>
</table>
| **New Model of Diabetes Care**  
- A Primary Care Local Incentive Scheme (LIS) which will support primary care to offer consistent care for diabetic and pre-diabetic patients  
- Consultant deep-dives in primary care  
- Additional clinical capacity in community settings to enable more patients to be supported closer to home |  
• Improved prevention and management approaches of patients at an earlier stage, with pre-diabetic registers established in all GP practices.  
• Improved detection and diagnosis of non-diabetic hyper-glycemia and Type 2 diabetes.  
• Reduced hospital admissions and lengths of stay. |  
• Reduction in prevalence of Type 2 diabetes  
• Reduction in hospital admission and length of stay  
• Improvements in quality of life indicators/patient experience and reduction in diabetes-related complications |
| **National Diabetes Prevention Programme (NDPP)**  
A free education programme for those who are at risk of developing Type 2 diabetes or have Non-diabetic Hyperglycaemia. NDPP is a tailored, personalised support including education on healthy eating and lifestyle, help to lose weight and physical exercise programmes. |  
• Reduction in the number of patients at risk of developing diabetes |  
• Increased notification of patients with NDH  
• Increase the number of patients accessing NDPP programme. |
| **Diabetes Book & Learn**  
An on-line booking service for patient diabetes education courses. The service accessible to both patients and GPs across south London for both Type 1 & 2.  
The Diabetes Book & Learn Service also holds a directory of lifestyle and community services including mental health services and patients may be signposted to services available in their own local areas |  
• Improve access and take up of diabetes structured education  
• Improve choice for patients  
• Standardise processes across south London which will reduce and streamline administration. |  
• Increase in the number of referrals for diabetes structured via both GPs and self-referrals. |
| **Diabetes Structured Education**  
Diabetes Structured Education for patients with both Type 1 &2 Diabetes. The accredited structured education covers traditional education, online/digital education which is accessible via the Diabetes Book & Learn Hub, extra capacity during evenings & weekends and sessions targeting primarily BAME patients. |  
• Increase in referrals and attendances at diabetes education courses  
• Improved glycemic control and quality of life. |  
• Year in year increase in attendance at structured education courses and improvement in patient reported confidence to self-manage |

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## Summary Description of the programme

**What will be different about our approach**

There is an increasing prevalence of diabetes in Wandsworth and the current service model will not be able to provide sufficient proactive and holistic support. The new model of care enhances the ability of primary care and community services to support patients outside of acute hospital settings, thus managing their disease more proactively and reducing the likelihood of complications.

The new model of care will deliver the following:

- A Primary Care Local Incentive Scheme (LIS) which will support primary care to offer consistent care for diabetic and pre-diabetic patients
- Consultant deep-dives in primary care
- Additional clinical capacity in community settings to enable more patients to be supported closer to home

**What will be the impact**

- Improved prevention and management approaches of patients at an earlier stage, with pre-diabetic registers established in all GP practices.
- Improved detection and diagnosis of non-diabetic hyper-glycemia and Type 2 diabetes.
- Reduced hospital admissions and lengths of stay.

**How will we measure success**

- Reduction in prevalence of Type 2 diabetes
- Reduction in hospital admission and length of stay
- Improvements in quality of life indicators/patient experience and reduction in diabetes-related complications

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**Description of initiative**

- **New Model of Diabetes Care**
  - A Primary Care Local Incentive Scheme (LIS) which will support primary care to offer consistent care for diabetic and pre-diabetic patients
  - Consultant deep-dives in primary care
  - Additional clinical capacity in community settings to enable more patients to be supported closer to home

- **National Diabetes Prevention Programme (NDPP)**
  - A free education programme for those who are at risk of developing Type 2 diabetes or have Non-diabetic Hyperglycaemia. NDPP is a tailored, personalised support including education on healthy eating and lifestyle, help to lose weight and physical exercise programmes.

- **Diabetes Book & Learn**
  - An on-line booking service for patient diabetes education courses. The service accessible to both patients and GPs across south London for both Type 1 & 2.
  - The Diabetes Book & Learn Service also holds a directory of lifestyle and community services including mental health services and patients may be signposted to services available in their own local areas

- **Diabetes Structured Education**
  - Diabetes Structured Education for patients with both Type 1 &2 Diabetes. The accredited structured education covers traditional education, online/digital education which is accessible via the Diabetes Book & Learn Hub, extra capacity during evenings & weekends and sessions targeting primarily BAME patients.
## Summary Description of the programme

**To integrate (join up) health and social care services to provide a better service to residents.**

We currently have strong joint working across health and social care, including developing joint strategies and jointly commissioned services. We need to focus on the next stages of integration around the individuals’ experience of care.

### What will we do

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<tr>
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<td>Integration of intermediate care and reablement pathways and services with a focus on: a) rapid response to avoid admissions to hospital b) home first principles to support more people to receive services in their own home</td>
<td>- Improved access into intermediate care services, and better coordination of services - Increased resource and activity provided closer to home, reduction of unnecessary admissions in hospital and shorter length of stay - Integrated services available in the community on a rapid response basis, with a re-provision of intermediate care beds to home based rehabilitation</td>
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<td>Enhanced Support to Care Homes</td>
<td>More integrated health and social care for very frail, including residents in care homes Better access to care at home following a fall and access to falls prevention training and strategies to reduce the number of falls in the future</td>
<td>- Better care provided in care homes as better and quicker access to NHS care - Improved training provided on an ongoing basis to care home staff - Better communication between GPs, the hospitals and the care homes through the use of the Red bag and better proactive care planning - Regular MDT meetings to develop strong care planning in care homes led by the GPs and supported by a wider MDT team - Greater collaboration with the LA regarding quality improvements in homes</td>
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<td>- More timely provision of services - Reduce duplication/transfers between health and social care organisations - More efficient provision of equipment services</td>
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## Age Well – Dementia - what we will do

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| Improve Care Navigation and planning, integrating dementia care into other care planning streams | Streamlined pathways of dementia services, with better interface between community services and specialist mental health S1 services | • Improved access to information  
• More people able to maintain independent living in their own home or place of care  
• Reduced number of NELs for people on GP dementia registers | Early diagnosis rates  
Fewer emergency admissions |
| Improve Support to unpaid carers of people with dementia | Aligned pathways for unpaid carers for people having specialist mental health dementia services  
More proactive engagement with carers | • Improved access to information for unpaid carers  
• Improved support for unpaid carers | Improved satisfaction  
Carer support for people with Dementia  
Reduction in NELs A and E attendance and outpatient attendances |
# Age Well – Isolation - what we will do

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| Commissioning of Voluntary sector preventative services | Reshaping of preventative services including: Commissioning of Age Well services in Battersea and Roehampton, with a focus on intergenerational activities | • Reduction in social isolation  
• Healthier lifestyles for older residents  
• Increased opportunities for people to have support from and to make contributions in their community  
• More support to older people in their on homes  
• Creating a more coordinated, better connected third sector | Improved satisfaction  
Increased number of people accessing services |
| | Commissioning of enhanced Voluntary Sector Coordination programme community navigation service for individuals and their carers | Enhancement of Better at Home service | |
| | | • Reduction in social isolation  
• Healthier lifestyles for older residents  
• Increased opportunities for people to have support from and to make contributions in their community  
• More support to older people in their on homes  
• Creating a more coordinated, better connected third sector | |
| Social Prescribing | To support our digital Social Prescribing offer (the Wandsworth Wellbeing Hub), we will be aiming to launch our face to face Social Prescribing service in Wandsworth for service commencement by September 2019. This will allow 16 Practices across the 3 localities to deliver face to face social prescribing for their patients. | • Reductions in secondary care usage  
• Further support for those with mental health, who are socially isolated and those who have a social determinant of health | Reduction in secondary care usage will be capture and reported by NEL CSU, which will then be measured against the Social Prescribing QIPP target.  
The Prescribers will continue to use the Wellbeing Star evaluation tool to monitor the health and wellbeing of patients of have accessed the service. |