Joint Local Health and Wellbeing Strategy 2024 - 2029

19 steps to Health & Wellbeing

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Foreword

Wandsworth is a fantastic place to live. Our strong, vibrant and diverse communities represent the very best of life in the capital city. The Joint Local Health & Wellbeing Strategy sets out the council's vision over the next five years on how to meet the health and wellbeing needs of Wandsworth residents to ensure that Wandsworth continues to be a great place to live.

The council is committed to making Wandsworth fairer, compassionate, and more sustainable. Addressing the health and wellbeing needs of its residents is at the centre of that commitment. We want to focus on providing the most support to those who need it the most. There are several groups within our community who have poorer health outcomes due to health inequalities which are avoidable and unfair; and we also recognise that income, employment, housing, and transport, are important drivers for health. This strategy prioritises taking action on all factors contributing to health.

This plan will help to support and improve the health and wellbeing needs of Wandsworth residents, and work towards creating a fairer and more equal society.

Councillor Graeme Henderson
Cabinet Member for Adult Social Care and Health and Chair of the Health and Wellbeing Board

Executive Summary

The Joint Local Health and Wellbeing Strategy (JLHWS) is the Health and Wellbeing Board's five-year plan setting out how the local authority, NHS, and other partners including the voluntary and community sector will work together jointly to meet the health and wellbeing needs of Wandsworth residents. This plan addresses the health and wellbeing needs of residents identified in the refreshed Joint Strategic Needs Assessment for Wandsworth (JSNA), published in 2022.

Not all the issues identified in the JSNA can be addressed within the strategy and prioritisation is required. Following the publication of the JSNA in 2022, a series of prioritisation seminars were held; one focusing on children and young people 'Start Well', and another focus on working aged adults and older people, titled 'Live Well', and 'Age Well', respectively, to help decide on which priorities would be the focus of the strategy. The priorities identified were agreed by the Health and Wellbeing Board.

This strategy follows a life course approach which recognises a wide range of factors influencing mental and physical health and wellbeing which often cluster in the population at different life stages. The priority areas are grouped into three life stages i.e., Start Well, Live Well and Age Well.

'Start Well' identifies the main priorities as self-harm and mental health, obesity, immunisations, and A&E attendances or hospital admissions caused by unintentional and deliberate injury.

'Live well' identifies the main priorities as immunisations, a range of long-term conditions, cancer screening uptake, and the impacts of air quality & climate change on health. Priorities were also identified around mental health & suicide, and health behaviours such as smoking, alcohol, physical activity, and healthy eating.

'Age well' identifies the main priorities as falls, dementia, and social isolation.

The strategy was co-produced by a multi-agency task and finish group acting on behalf of the Health and Wellbeing board. Membership of the task and finish group is presented in appendix 1. The priorities set out in the strategy will be the primary driver of the forward plan of the Health and Wellbeing Board and will also inform the priorities for a future refresh of the NHS led Wandsworth Health and Care Plan.

A statutory public consultation was conducted in July and residents were invited to help ensure that the actions proposed by the strategy to address local priorities were bold enough to make a real difference. The results of the consultation and response from the Health and Wellbeing Board are published as an accompanying document alongside an Equality Impact Needs Assessment (EINA) which is a tool to ensure that equality is considered in the developing strategy.

A dashboard will be published alongside the refreshed strategy to provide an 'at a glance' summary of progress in delivering the actions in the strategy.

About the Health and Wellbeing Board

The Wandsworth Health and Wellbeing Board is a partnership between Wandsworth Council, local GPs, the Integrated Care Board (responsible for commissioning and overseeing health services) and the voluntary sector. Closer working between Wandsworth Council and local health professionals presents a great opportunity to improve the lives of our residents and promote a healthier borough.

The board was set up as part of the government's 2012 reorganisation of the health service. It brings together the council and the Integrated Care Board to agree shared priorities for improving the health and wellbeing of Wandsworth residents.

The focus of the board is to:

- Improve the population's health and reduce health inequalities.
- Help reform the way the health and care system work.
- Protect the health of residents.

It does this by:

- Leading the development of the council's role in integrating the commissioning of health, social care, and other services.
- Leading the development of local partnerships for health and social care which share a common view about local need, priorities, and service development.
- Ensuring the engagement and involvement of local people in the development of the health and social care system locally.
- Working with regional and pan-London bodies to ensure that the health and social care needs of local people are understood and considered when commissioning services at regional and pan-London level.

The Joint Local Health and Wellbeing Strategy

The Joint Local Health and Wellbeing Strategy (JLHWS) is a strategic plan that sets out how the local authority, NHS, and other partners including the voluntary and community sector will meet the health and wellbeing needs of residents. The health, care and wellbeing need of residents were assessed at a point in time and published in the refreshed Joint Strategic Needs Assessment for Wandsworth (JSNA), published in 2022.

The Strategy sets out the priorities for the borough which are evidence-based so that improvements can be made to existing services, so that new services can be commissioned, or action can be taken to improve the public's health and reduce unfair and avoidable differences in people's health outcomes. It also provides an opportunity for the local authority to embed health improvement and prevention in all policy and decision making. The JLHWS will determine what actions the local authority, the local National Health Service (NHS) and other partners need to take to meet health and social care needs, and to address the determinants of health and wellbeing, such as education, employment, transport, housing, and the environment.

The priorities set out in the strategy will be the primary drivers of the forward plan of the Health and Wellbeing Board and will also inform the priorities for a future refresh of the NHS led Wandsworth Health and Care Plan.

Strategy development

The process for developing the strategy is comprehensive, collaborative, and robust. Following the publication of the JSNA in 2022, a series of prioritisation seminars were held to identify a few key priorities that the Health and Wellbeing Board could focus on. Public Health developed a prioritisation framework that enabled many stakeholders to consider the issues that came out of the JSNA. Two seminars were held, one focusing on children and young people 'Start Well', and another focus on working aged adults and older people, 'Live Well', and 'Age Well.' The seminars helped those involved to narrow down many priorities to just a few that the Health and Wellbeing Board could focus on for the next few years. Stakeholders who were not involved in the prioritisation seminars were able to see the emerging priorities and understand the methodology supporting the prioritisation process, which was designed to increase objectivity and transparency when determining the key priorities for the JLHWS.

Our principles

The Health and Wellbeing board agreed that any actions proposed should be guided by a set of five principles that are at the core of the strategy and embedded across all priority areas. The agreed principles are as follows:

- **Tackling inequality:** We are committed to providing the most support to those who need it the most, and to work towards creating a fairer and more equal community. There are several groups within our community who have poorer health outcomes due to health inequalities which are avoidable and unfair, and we will ensure they are prioritised within our strategy. We recognise that the wider determinants of health, including income, employment, housing, and transport, are the most important drivers for health. Keeping them at the centre of our strategy will ensure we make health everyone's business. We will work closely with a wide range of stakeholders to address the wider determinants, reduce inequalities, and improve health.
- **Focus on prevention:** We want to promote positive health and wellbeing by delivering an evidence-based approach to prevention through embedding the Council's Prevention Framework within the JLHWS. This will include helping to make the healthy choice the easy choice supporting a tailored approach to prevention; connecting with policies and initiatives to enable prevention work to be sustainable; and creating supportive communities and health promoting environments.
- **Empowering our communities:** Communities are at the heart of everything we do, and we need to work with and empower our communities to produce positive, sustainable benefits for our residents. This strategy wants to add social value to our communities and ensure that the actions we take enable them to continue to improve their local communities after our initiatives are complete.
- **Holistic approach to individuals and families:** By considering individuals holistically and supporting families through their life course, we will ensure that no group gets left behind. We will make sure that we have considered the needs of each group at different stages of life and identify areas where we can improve health at each part of the life course, particularly transition periods which can present the most challenging times. We will ensure individuals are considered within their wider social context to ensure we are offering effective support that looks beyond a diagnosis and is personalised to the individual. This includes identifying carers and ensuring they have access to adequate support.
- **Place integration:** The new JLHWS provides a footprint which is owned and driven by all organisations working across the borough's health and care system, with a view to coordinate activity and bring about system wide change in response to the needs of our residents. We recognise that there are existing partnerships and strategies in place which will contribute to the success of the JLHWS. We will not seek to duplicate the work being done by existing strategies, but aim to recognise, coordinate, streamline and support a well-connected system working together to improve the health and wellbeing of our communities.

Prevention Framework

The Prevention Framework (PF) shown in figure 1.0 serves as the umbrella framework for delivering a whole-systems approach to preventing ill health and promoting positive health and wellbeing across the work of Wandsworth Council. Prevention is one of the guiding principles in the development of the Joint Local Health and Wellbeing Strategy. The PF is one of the ways in which the principle will be applied across the priority areas and actions.

The recent focus nationally on recovering from the COVID-19 pandemic and a policy shift towards working within an Integrated Care System across the NHS (National Health Service), local authorities and community partners locally, has significantly elevated prevention of ill-health and reducing health inequalities as key priorities beyond the health and care sector.

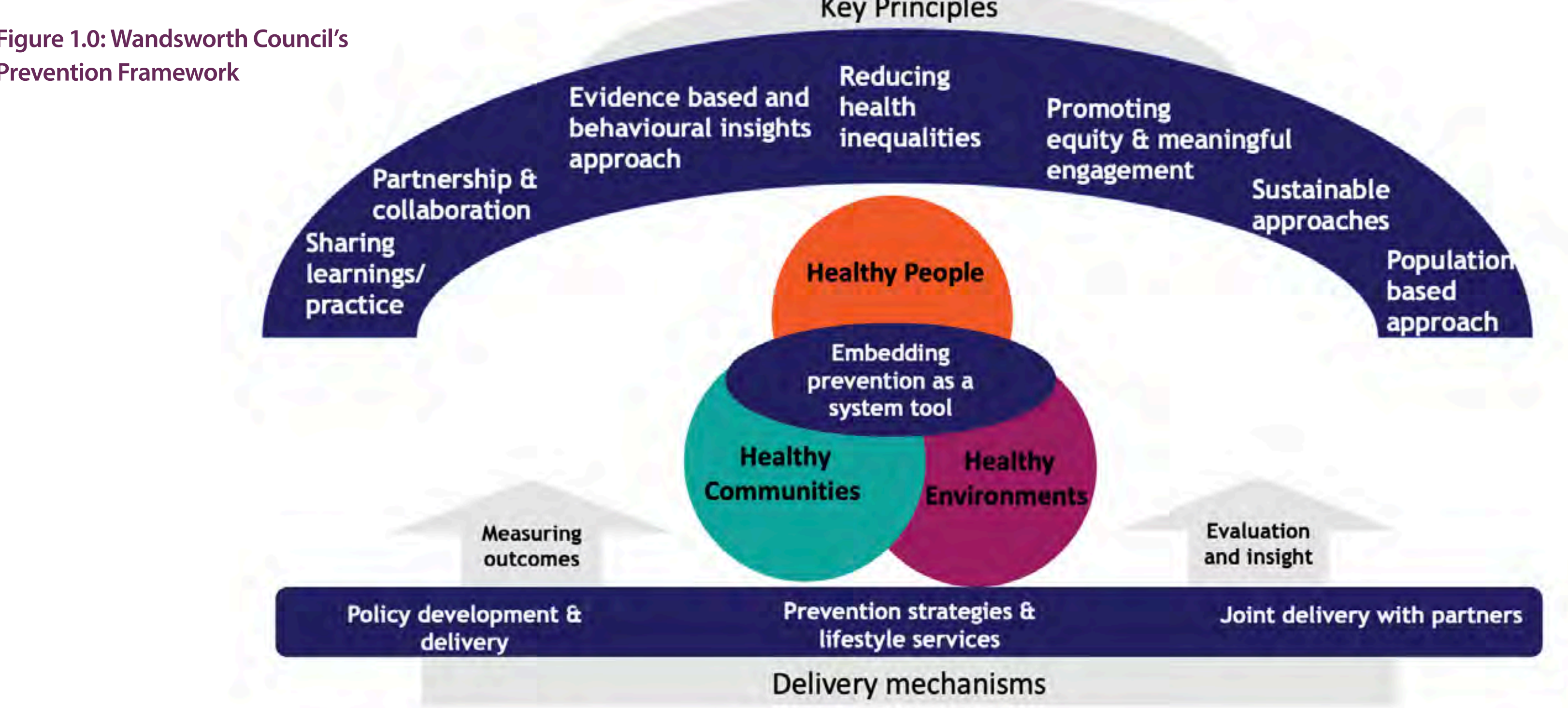
Prevention goes beyond the delivery of lifestyle services and messages about weight management, smoking cessation, and mental health support. It incorporates the wider determinants of health such as housing, crime, employment, and income. It will also stem the demand for health and social care services through promoting independence and self-care, using strengths and assets in the community thus delaying, preventing, or reducing the need for health and social care services.

The Prevention Framework's aims are to:

- **DELIVER** an evidence-based approach to prevention to support the wider council to strengthen delivery of prevention through its work.
- **FACILITATE** making the healthy choice the easy choice for our residents using positive and assets-based approaches.
- **SUPPORT** a tailored approach to prevention, defining key outcomes and agreeing success measures across Council Directorates and partners.
- **CONNECT** with existing and planned policies and initiatives to enable prevention work to be sustainable.
- **CREATE** supportive communities and health-promoting environments.

In June 2023, an update on Public Health delivery against the Prevention Framework was presented to the Health and Wellbeing Board and a commitment made to ensure that all matters presented to the board had taken a health in all policies approach modelled on the Prevention Framework.

Figure 1.0: Wandsworth Council's Prevention Framework



Wider Determinants of Health

The wider determinants of health shown in figure 2.0 are a diverse range of social, economic, and environmental factors which influence people's mental and physical health. They include, for example the built and natural environment, education, income, work and the labour market, crime, and social capital. [1]

Systematic differences in these factors create social inequality which is an important driver of the unfair and avoidable differences in people's experiences of health and care services, or their health outcomes.

Wider determinants of health are closely linked to prevention and have strongly influenced the development of the actions within the strategy to address the causes of Ill-health and poor wellbeing.

The following section of the Strategy presents the 19 Steps to Health and Wellbeing following a life course approach.

1 https://www.gov.uk/government/publications/health-profile-for-england-2018/chapter-6-wider-determinants-of-health

Figure 2.0: Wider determinants of health

Source: Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried? www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

19 steps
to Health &
Wellbeing
Start well

Start Well

STEP 1: Self-harm and mental health

Mental health problems affect about 1 in 10 children and young people. They include depression, anxiety and conduct disorder and often are a direct response to what is happening in their lives. An estimated 2,800 children aged 5-16 have mental health disorders in Wandsworth. As demand is going up, there is a need to shift the focus in mental health provision towards early intervention and prevention.

Further information can be found in the JSNA and Mental Health Needs Assessment

Action

- Preventing mental disorders and improving community resilience.
- Ensuring that all schools and colleges have access to Mental Health Support Teams.
- Consolidating whole school approaches to improve the mental health and well-being of children and young people.
- Establishing the i-Thrive integrated, person-centred, and needs-led approach to delivering mental health services for children and young people across the system.
- Promoting the self-harm and suicide prevention toolkits to schools, parents, children and young people and frontline staff to support a reduction in self-harm and suicide among children and young people.

Tracking progress

- Mental Health Services Dashboard (NHS England)
- Other MH dashboards
- Hospital admissions as a result of self-harm (10-24 years)
- Personal wellbeing estimates by local authority

What does success look like?

- Improved access to self-help, early intervention, and specialist support.
- An effective and well used digital offer is in place.
- Improved waiting times to four weeks.
- Improved services in the community for children and young people requiring crisis care, especially those with autism, a learning disability or both.

STEP 2: Childhood obesity

The National Child Measurement Programme (NCMP) tells us that more than 1 in 5 children in England are obese or overweight by the time they start primary school. This rises to one third by the time they are aged 11 years. When compared to other London Boroughs, Wandsworth has the third lowest number of children overweight and obese at reception. By the time they reach year 6, Wandsworth is the fifth lowest in London. Whilst overall this is encouraging, we can always do better.

Further information can be found in the JSNA.

Action

- Increasing promotion and support for breastfeeding and healthy weaning is an important start to sustaining healthy weight.
- Offering places on A Family Weight Management Programme for those identified as overweight or obese by the NCMP.
- Working with leisure and environment partners to encourage more use of open spaces, playgrounds, and sporting activities.

Tracking progress

- Breastfeeding at 6-8 weeks
- Prevalence of obesity (including severe obesity) Proportion %
- Prevalence of severe obesity

What does success look like?

- An increase in the number of babies who are breastfed.
- A reduction in the number of children identified as obese or overweight at reception and year 6.
- More children and young people engaged in active lifestyles.

STEP 3: Childhood immunisations

As highlighted in the latest JSNA, Wandsworth performed lower than the national average across all immunisation programmes. Vaccination coverage was lower than the benchmark goals for the first dose of MMR (in 5-year-olds), flu, and PPV (Pneumococcal Polysaccharide Vaccine). The borough faces challenges with regards to uptake due to high population mobility, increasing population and vaccine hesitancy. There is a need to work collaboratively to help increase the uptake, coverage and to reduce inequalities.

Further information can be found in the JSNA.

Action

- Improving community engagement to address inequalities. e.g.
  - To develop outreach programmes based on joint working with public health, Healthwatch, and voluntary sector and community groups, to support hard-to-reach groups to get vaccinated (tackling health inequalities).
  - Using a population health management approach to understand groups with lower uptake.
- Improving access to immunisation services.
- Improving and flexing the system to improve uptake.
  - e.g. centralised call centre for all immunisations.
- Improving access to better quality data to better identify gaps.

Tracking progress

- Population vaccination coverage: MMR for one dose (5 years old)
- Population vaccination coverage: MMR for two doses (5 years old)
- Population vaccination coverage: MMR for one dose (2 years old)
- Population vaccination coverage: Flu (primary school aged children)
- Population vaccination coverage: HPV vaccination coverage for one dose (12–13-year-old females)
- Population vaccination coverage: Dtap IPV Hib (1 year old)
- Population vaccination coverage: Dtap IPV Hib (2 years old)
- Population vaccination coverage: Hepatitis B (1 year old)
- Children in care immunisations

What does success look like?

- Improved vaccine coverage (especially in underserved groups).
- Improved access to data.
- Improved access to immunisation services.
- Improved engagement with underserved groups.

STEP 4: A&E attendances, and hospital admissions caused by unintentional and deliberate injury.

A&E attendances in children aged under five years are often preventable, and commonly caused by accidental injury. Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. They are also a source of long-term health issues, including mental health related to experience(s).

Further information can be found in the JSNA.

Action

- Maintaining the 0-5 Healthy Child Programme: reducing accidents and minor illnesses is one of the six high impact areas and includes:
  - Contact and liaison with parents following admission to A&E, where safeguarding risks may be identified.
  - Evidence-based accident prevention information and guidance within child health clinics / reviews.
  - Bespoke safety sessions with care leavers who are also parents.
  - Delivery of safety sessions for parents with children aged under 6 months.
- Improving understanding of data at a local level including top 10 A&E attendances and/or primary admissions to hospital within the defined age brackets.
- Exploring need to re-establish access to safety equipment for vulnerable families.
- Interagency training on the prevention of accidents & safer sleep messages e.g., Make Every Contact Count (MECC) module.
- Exploring the provision of first aid training for parents at Children's Centres.
- Expanding UNICEF Baby Friendly Initiative to Children's Centres.
- Considering public health targeted accident prevention campaigns, informed by local data.

Tracking progress

- Emergency admissions for falls in children aged 0-4
- Hospital admissions caused by unintentional and deliberate injuries in children aged 0 to 14 years

What does success look like?

- Reduced rate of emergency admissions for falls among 0–4-year-olds, A&E attendances for under-18s, and hospital admissions for unintentional and deliberate injuries for 0–14-year-olds.
- Health visiting teams consistently follow-up where concerns are highlighted such as repeat emergency department attendances, families where there are known vulnerabilities, delayed presentation of injury, inconsistent explanation, serious head injuries, burns and fracture or dental injuries.

19 steps to Health & Wellbeing
Live well

Live Well

STEP 5: Adult Immunisations

As highlighted in the latest JSNA, Wandsworth performed lower than the national average across all immunisation programmes. Flu vaccine uptake in adults aged 65+ in 2019/20 in Wandsworth was 69.8% (n= 25,601), which was lower than the 75% target. PPV was 64.1% (n= 22,735) which was lower than the 75% target.

The borough faces challenges with regard to uptake due to high population mobility, increasing population and vaccine hesitancy. There is a need to work collaboratively to help increase the uptake, coverage and to help reduce inequalities. The actions, progress, and goals for both childhood and adult immunisations were agreed by partners as being the same.

Further information can be found in the JSNA.

Action

- Improving community engagement to address inequalities by:
  - Developing outreach programmes based on joint working with public health, Healthwatch, and voluntary sector and community groups, to support hard-to-reach groups to get vaccinated (tackling health inequalities).
  - Using population health management approach to understand groups with lower uptake.
- Improving access and increase uptake to immunisation services through innovation of the system: e.g., creating a centralised call centre for all immunisations.
- Improving access to better quality data to better identify gaps.

Tracking progress

- Population vaccination coverage: Flu (aged 65 and over)
- COVID-19 dose 1,2 and 3 vaccinations
- COVID-19 Spring booster vaccination
- Population vaccination coverage: Flu (at risk individuals)

What does success look like?

- Increase in vaccination uptake and coverage, especially in underserved groups.
- Improved access to data.
- Improved access to immunisation services.
- Improved engagement with underserved groups.

STEP 6: Bowel Cancer Screening

Wandsworth's latest bowel cancer coverage in people aged 60 - 74 was 62.1% (2022), which meets the acceptable target level of ≥60%, which is similar coverage to regional levels with an improving trend. Although there has been an increasing trend over the last couple of years, the coverage is still below the England average (70.3%). Evidence suggests people in more deprived groups are less likely to complete bowel cancer screening (35% for the most deprived group compared to 61% for the least deprived) and the uptake of bowel screening in England is lower in the ethnically diverse areas (38% as compared to 52%-58% in other areas). It is therefore crucial to work collaboratively to help improve coverage and uptake and to help reduce inequalities.

Further information can be found in the JSNA.

Action

- Working in partnership to access and analyse more granular quantitative and qualitative data to help understand where the inequalities exist, the barriers to access and how to target them effectively.
- Targeting underserved populations and health inequalities by engaging with established programmes such as the Homeless Health Offer.
- Educating the eligible cohorts, highlighting the importance of screening to provide communication in a variety of languages and formats to increase accessibility (this also links with addressing health inequalities).
- Engaging with the voluntary sector, faith groups and via primary care to promote cancer screening.

Tracking progress

- Cancer screening coverage: Bowel cancer

What does success look like?

- Increase in screening uptake and coverage, especially in underserved groups.
- Better understanding of barriers to participation, especially amongst the more vulnerable groups/groups less likely to take up services and the development of action plans to address this.
- Identify screening leads in each PCN area to enable targeted discussions, that in turn would enhance the focus and uptake in primary care.

STEP 7: Cervical cancer screening

In 2022, cervical cancer screening for 25-49 years age group in Wandsworth shows a level of coverage (61.9%) better than the London average but lower than the England average. For 50-64 years age group, the coverage (68.7%) is lower than both the London and England averages, with a declining trend across both age groups since 2014/15 and there are marked inequalities. Evidence suggests that women from deprived areas, from certain ethnic minority groups and with any disability (including learning disabilities) are less likely to attend cervical screening. There was an 11% increase in general emergency hospital admissions where the patient had cancer as a diagnosis. It is therefore crucial to work collaboratively on these areas to improve coverage and uptake and to help reduce inequalities.

Further information can be found in the JSNA.

Action

- Working in partnership to access and analyse more granular quantitative and qualitative data to help understand where the inequalities exist, the barriers to access and how to target them effectively.
- Addressing health inequalities: targeting underserved populations and those less likely to take up services (example: utilising the Homeless Health Offer).
- Health education: - e.g. highlighting the importance of screening amongst eligible cohort, e.g., the role of school health in communicating messages around screening.
- Carrying out community engagement and communications: Engaging with women and people with a cervix through primary care services to promote cancer screening, engaging with faith groups. Provide communication in a variety of languages and formats to increase accessibility (also links with addressing health inequalities).
- Improving access: Opportunistically offering cervical screening through sexual health clinics (there is an NHSE/CLCH offer currently being developed). Also, potential to offer opportunistically via other sites and review appointment times.

Tracking progress

- Cancer screening coverage: cervical cancer (aged 25 to 49 years old)
- Cancer screening coverage: cervical cancer (aged 50 to 64 years old)

What does success look like?

- Increase in screening uptake and coverage, especially in underserved groups.
- Better understanding of barriers to participation, especially amongst the more vulnerable groups/groups less likely to take up services and the development of an action plan to address this. Connecting Health Communities is a project already underway to engage community, identify barriers to access and develop action to address this.
- Identify a screening lead in each PCN area to enable targeted discussions, that in turn would enhance the focus and uptake in primary care.

STEP 8: Breast Cancer screening

In 2022, Wandsworth's breast cancer screening coverage in females aged 53—70 years was 58.5%, this is significantly lower than the regional and England averages. The coverage has been gradually declining since 2018. Evidence suggests women in the most deprived groups and from certain ethnic groups are less likely to participate in breast screening and more likely to die from breast cancer. Therefore, it is crucial to work collaboratively on these areas to improve coverage and uptake and to help reduce inequalities.

Further information can be found in the JSNA.

Action

- Working in partnership to access and analyse more granular quantitative and qualitative data to help understand where the inequalities exist, the barriers to access and how to target them effectively.
- Targeting underserved populations to address health inequalities by engaging with established programmes such as the Homeless Health Offer.
- Improving the health education of eligible cohorts, highlighting the importance of screening.
- Providing communication in a variety of languages and formats to increase accessibility (also links with addressing health inequalities).

Tracking progress

- Cancer screening coverage: breast cancer

What does success look like?

- Increase in screening uptake and coverage, especially in underserved groups.
- Better understanding of barriers to participation, especially amongst the more vulnerable groups/groups less likely to take up services and the development of action plans to address this.
- Identify screening lead in each PCN area to enable targeted discussions, that in turn would enhance the focus and uptake in primary care.

STEP 9: Type 2 Diabetes

There are approximately 15,257 residents with diabetes in Wandsworth. The latest available data (March 2023), shows that 45.4% of these patients had completed their 8 care processes and 49.3% met their 3 treatment targets. Previous estimates indicate there could be up to 6,000 patients with undiagnosed Type 2 diabetes in Wandsworth. A further 11,780 people have been identified to be at high risk for developing Type 2 diabetes. There is variation in diabetes prevalence and management across the Borough.

Further information can be found in the JSNA.

Action

Focus on prevention:

- Raising awareness and improving patient engagement with structured education programmes such as NDPP and decathlon - particularly among sub-groups of the population at increased risk of developing diabetes.
- Ensuring there is adequate provision of health promotion interventions such as weight management programmes, smoking cessation, and healthy eating.

Find the missing thousands:

- Identifying and assessing people at high risk of diabetes through the NHS Health checks and community health clinics.

Treat the missing hundreds:

- Enabling enhanced and improved access to high quality information, treatment and care for people living with diabetes, through patient education and self-management, medication, review, and management of the three treatment targets (blood pressure, cholesterol, and blood glucose).
- Upskilling clinicians, diabetes champions and the wider primary and community care workforce such as health coaches, clinical pharmacists, link workers and social prescribers to provide high-quality, person focused care and support to individuals with established disease or at risk of developing diabetes.
- Ensuring patients have access to specialist care such as specialist foot teams and ophthalmology.

Close the variation gaps:

- Implementing of the quality improvement framework to support underperforming practices to improve their achievement of the three treatment targets - to reduce variation across the borough.

Improve our enabling assets:

- Strengthening Primary Care Networks as a vehicle for delivering collaborative working amongst front-line staff.
- Improving engagement and dynamic relationships with local communities to understand and address local health education needs.

Tracking progress

- Data available at PCN level [PCN code for Wandsworth U45098; U42598; U42154; U71206; U97650; U61963; U73458; U45842]
- Estimates of diabetes

What does success look like?

- Person-centred: empowering individuals to adopt a healthy lifestyle and to reduce risk or manage their diabetes, through education and support, which recognise the importance of lifestyle, culture, and religion.
- Outcomes oriented: minimising the risk of developing diabetes and its complications and maximising the quality of life for individuals by empowering staff to deliver, evaluate and measure care, whilst narrowing the inequalities gap.
  - Improved health and wellbeing outcomes with minimised risk of developing diabetes and its complications and maximised quality of life for individuals by empowering staff to deliver, evaluate and measure care, whilst narrowing the inequalities gap. Ensure 100% of the eligible population are offered an NHS Health check over the next 5 years.
  - Increased percentage of patients at risk of developing diabetes referred to structured education programmes such as the NDPP and Decathlon.
  - Increased percentage of patients who are treated to the recommended thresholds according to NICE guidelines and completing the 8 care processes. 5% increase in the number of patients with Type 2 diabetes meeting all three treatment targets. 10% increase in number of patients having all eight care processes completed.
- Equitable: ensuring services are planned to meet the needs of the local population and are appropriate to individual's needs by assessing and addressing gaps identified through the 8 care processes inequalities stratification.

STEP 10: Cardiovascular disease

Heart and circulatory disease, also known as cardiovascular disease (CVD), causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. This is the single biggest area where the NHS can save lives over the next 10 years. Approximately 31,966 Wandsworth residents have been diagnosed with hypertension against an expected prevalence of 57,040. 3,722 Wandsworth patients have been diagnosed with atrial fibrillation against an expected prevalence of 5,520. 3,250 Wandsworth residents have been diagnosed with chronic heart disease against an expected prevalence of 4,641 (Health Insights Data - March 2023).

There is variation in CVD prevalence, detection, and management across the Borough.

Further information can be found in the JSNA.

Action

Action plans focus on closing the gap between the expected prevalence and diagnosis and treatment of patients with hypertension, atrial fibrillation, raised cholesterol and chronic heart disease.

Prevention

- Ensuring there is adequate provision of health promotion interventions such as weight management programmes, smoking cessation, and healthy eating.
- Establishing a local CVD Decathlon programme.
- Identifying opportunities to improve healthy lifestyle advice through Making Every Contact Count (MECC).

Identification

- Increasing uptake of Community Health Checks (outside healthcare settings).
- Expanding and increasing the scope of the BP@Home programme.
- Identifying opportunities to increase uptake of BP & ABPM checks via the Community Pharmacy Hypertension Case Finding Service (BPCS).
- Improving the model and increase delivery of holistic health checks in faith and community settings.
- Use Core20PLUS5 data to target preventative strategies to support the most deprived and vulnerable communities.
- Upskill ARRS roles (health & wellbeing coaches / social prescribing link workers and pharmacists).

Optimisation

- Optimise care and treatment of people with hypertension in primary care using the UCLP proactive care frameworks.
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score >20% on lipid lowering therapies.
- Optimise the use of DOAC therapy in people with AF to reduce the risk of stroke.
- Increase access to Cardiac Rehabilitation.

Decrease variation

- Support primary care to reduce variation between practices across the borough.

Tracking progress

- Hypertension: QOF prevalence (all ages)
- patients aged 45 or over who have a record of blood pressure in the preceding 5 years (target 50 – 90%)
- patients with AF at risk of stroke receiving anticoagulants (>90%)

What does success look like?

- Person-centred: empowering individuals to adopt a healthy lifestyle and to understand and manage their CVD risk through education and support, which recognises the importance of lifestyle, culture, and religion.
- Outcomes oriented: minimising the risk of developing CVD and its complications by medication optimisation and maximising the quality of life for individuals by empowering staff to deliver, evaluate and measure care, whilst narrowing the health inequalities gap. Success will be measured by tracking:
  - increase in expected prevalence diagnosed with hypertension (>80%).
  - people with hypertension treated to target (>77%).
  - patients aged 45 or over who have a record of blood pressure in the preceding 5 years (target 50 – 90%).
  - BP & ABPM screening availability in non-clinical settings across the Borough.
  - expected prevalence diagnosed with AF (>85%).
  - patients with AF at risk of stroke receiving anticoagulants (>90%).
  - expected prevalence diagnosed with confirmed familial hypercholesterolemia (FH) (>25%).
  - people aged > 18 years with a CVD risk score >20% on lipid lowering therapies (>60%).
  - patients referred and successfully completing Cardiac Rehabilitation.
  - reduction in variation between Core20PLUS5 population.
  - availability of services such as community pharmacy BP checks in areas where the gap between expected prevalence and detection is greatest.
- Equitable: ensuring services are planned to meet the needs of the local population and are appropriate to individual's needs. Increased number of Community Champions upskilled to offer person centred, culturally appropriate CVD health checks for BPM, BMI and cholesterol identification, advice, and guidance.

STEP 11: Air quality

Air pollution is not always visible, but it can have a significant and detrimental impact on our quality of life and wellbeing in cities such as in London and inner-city boroughs like Wandsworth. Air quality is improving in Wandsworth but there are still areas, especially around our main roads and town centres, that exceed legal UK objective limits.

Air pollution can also contribute towards Climate Change in terms of emissions and greenhouse gases. The most common air pollutants can impact on health including exacerbation of asthma, impaired lung development in children, increased risk of chronic conditions such as cardiovascular and respiratory diseases as well as lung cancer, leading to reduced life expectancy. Vulnerable groups include children, pregnant women, the elderly, and those with long-term conditions.

The Greater London Authority estimated that in 2019 the equivalent of between 3,600 to 4,100 deaths were attributable to air pollution in the city. Estimated fraction of mortality or deaths attributable to particulate air pollution (OHID, Fingertips, 2021 data) place Wandsworth 13th out of the 33 boroughs in London at 6.6%, this is above the England and London averages of 5.5% and 6.5% respectively. More needs to be done to help tackle local air pollution and raise health awareness.

Further information can be found in the JSNA

Action

- Working collaboratively as a health and social care system in achieving Net Zero and reducing emissions.
- Implementing the new borough Air Quality Action Plan (following the recommendations from the Citizen's Assembly) and Climate Change Strategy to help tackle local sources of air pollution.
- Adopting and implementing the new borough Local Spatial Plan to ensure new developments in the borough help to limit and reduce local sources of air pollution.
- Working collaboratively with the partners including NHS bodies, local pharmacies, and voluntary sector organisations to help raise awareness of health and air quality co-benefits and to highlight the impact of air pollution on vulnerable groups.

Tracking progress

- National Atmospheric Emissions Inventory

What does success look like?

- Decreased levels of air pollution in the borough (via Annual Air Quality Status Report).
- Decreasing fraction of mortality attributable to particulate air pollution (OHID, Fingertips).
- Decreased levels of carbon emissions via actions, monitoring and reporting of local organisations and partners.

STEP 12: Climate Change

Climate change has been identified as one of the most significant health risks globally. There are also co-links between climate change and air pollution emissions.

The threats from Climate Change to human health are through direct and multiple or complex pathways from extreme weather events, food scarcity to rise in certain types of vector-borne diseases, as well as impact on mental health. Immediate dangers for residents of Wandsworth are increases in the frequency, magnitude, and duration of extreme weather events such as heatwaves, heavy rainfall, and flash flooding. For instance, excess heat can put pressure on the heart, brain, and lungs, increasing the death rate from cardiovascular, cerebrovascular, and respiratory diseases, particularly for those with pre-existing health conditions. Elderly people and babies for instance are particularly vulnerable to heat-related illnesses including dehydration.

Summer temperatures have steadily increased over recent years, 2022 saw the highest recorded temperature in England at 40.3°C, which prompted the first ever Level 4 Heat-Health Alert (HHA) and Red National Severe Weather Warning Service (NSWWS) Extreme Heat warnings to be issued by the Government. The UK Health Security Agency estimated 2,985 all-cause excess deaths were associated with the 5 heat episodes which occurred during the year for England, the highest number in any given year. For London all-cause excess mortality was estimated to be 387.

More excess deaths in those aged 65 and over occurred than any year since the Government's heatwave plan began since 2003 (Office for National Statistics, 2022). Premature deaths due to hotter summers are projected to triple by 2050 in London if no action is taken. More needs to be done in Wandsworth to tackle climate change and reduce its health impacts.

Further information can be found in the JSNA

Action

- Working collaboratively as a health and social care system in achieving Net Zero targets and in reducing emissions.
- Implementing the Climate Change Strategy to help tackle the impact of climate change.
- Adopting and implementing the new borough Local Spatial Plan to ensure new developments in the borough help to limit carbon emissions.
- Working collaboratively with the partners including NHS bodies, local pharmacies, and voluntary sector organisations to help raise awareness of health and climate change co-benefits and to highlight the impact of climate change on vulnerable groups.
- All partners developing adverse/extreme weather and health plans (heat/cold/drought/flood) as an adaptation measure to help minimise the risks to peoples' health.

Tracking progress

- Greenhouse Gas Emissions (GHG) borough data from the Department for Energy Security and Net Zero: UK greenhouse gas emissions: local authority and regional - data.gov.uk
- National Atmospheric Emissions Inventory

What does success look like?

- Decreased levels of carbon emissions via action plans and monitoring reports on emissions.
- Increased identification and engagement of communities including vulnerable groups in climate change risk locations (e.g., heat island locations via climate change risk map) within the borough to raise awareness of climate change and health.
- Borough adoption and implementation of the new Local Spatial Plan.
- Assurances from all borough partners and organisations regarding their adverse weather and health plans and their implementation to help protect individuals and communities from the health effects of adverse weather and to build resilience. E.g., via Table-top exercises.

STEP 13: Physical activity and healthy eating

Physical inactivity is the 4th leading risk factor for global mortality, is a contributing risk factor in 1 in 6 deaths in the UK and places a large burden on both healthcare and adult social care. People who are most likely to be physically inactive are:

- Older adults.
- Black, Asian, and Minority Ethnic (30% of the Wandsworth population).
- People in lower socio-economic group.
- Women are more physically inactive than men.
- Adults with physical disability, learning disabilty, long term health conditions (such as diabetes or cardiovascular disease), and multiple co-morbidities.
- Adults who have problems with weight management (men in particular have low participation in weight loss programmes).
- Carers (nearly half of carers, 46% are physically inactive).

An estimated 74.5% of adults (197,238) in Wandsworth report being physically active, defined as being physically active for more than 150 minutes per week. However, 17.7% (65,711) of adults are taking less than 30 mins of physical activity.

Further information can be found in the JSNA.

Healthy eating

Low fruit and vegetable intake and obesity contribute to one third of all deaths from cancer and cardiovascular disease.

Poor diet is also a driver for other long-term conditions such as Type 2 diabetes and musculoskeletal conditions.

Those groups most at risk of developing diet related disease are older adults, Black, Asian, and Minority Ethnic groups (Black African and Caribbean groups are three times more likely to develop Type 2 diabetes), carers, adults with learning disabilities (40% of adults which a learning disability are obese), people living on low incomes and adults who are overweight and obese.

An estimated 63.9% (169,175) of adults in Wandsworth are currently meeting the recommended '5 a day' on a 'usual day'. Based on 2020 population estimate of 264,749 people aged 18 and over, 95,574 are not meeting the recommended '5 a day'.

Further information can be found in the JSNA.

Action

Ensure these proposed actions are included in the forthcoming Leisure, Sport, and Physical Activity Strategy.

- Targeting and supporting inactive adults to become more active.
- Identifying barriers to participation and reduce them where possible.
- Creating pathways for inactive adults to take small steps or 'doses' of physical activity.
- Promoting the benefits of physical activity to Wandsworth adults – specifically targeting those groups who are the least physically active and improve signposting to opportunities to be physically active.
- Creatinge an on-line physical activity offer for those who are unable to leave home.
- Promoting the benefits of informal physical activity in parks and open spaces.
- Working with organisations who are supporting food insecurity to promote the benefits of healthy eating and consider providing a community recipe resource.
- Promoting the benefits of healthy eating when adults take their first step to join the physical activity ladder.
- Working with local food businesses as part of the Healthy Catering Commitment scheme to reduce the levels of saturated fat, salt and sugar in the food sold in their premises.'

Tracking progress

- Percentage of physically inactive adults
- Percentage of adults aged 16 and over meeting the '5-a-day' fruit and vegetable consumption recommendations (new method)
- Percentage of adults walking for travel at least three days per week

What does success look like?

- Wandsworth will be one of the most active boroughs in London (KPIs also included in the Sports. Leisure, and Physical Activity Strategy to be adopted in September 2023).
- A 40% decrease (from 2021 baseline) in inactive adults from 15% (2026) to 11% by 2031.
- Raising participation in physical activity amongst the inactive population by 2.5% year on year.
- 6,000 or more people who are currently inactive in Wandsworth to be more physically active as part of daily life by 2026 and 18,500 by 2031.

STEP 14: Alcohol

The NHS defines alcohol misuse as drinking 'in a way that's harmful' or dependence on alcohol, and advises all adults not to regularly drink more than 14 units a week.

There are 31.5 licenced premises selling alcohol per square km in Wandsworth – the 14th highest in London and 2392% higher than the national average.

The volume of alcohol sold via the off-trade is 6.1L/adult (n=1,525,456l), which is the 3rd highest in London and 10.1% higher than the England average. The alcohol-related admission rate among 40-65 year olds is 685.6 per 100,000 (n=565), which is 8.3% higher than the London average and 6.3% higher than the previous figure. The rate of alcohol-related road traffic accidents is 8.9 per 100,000 (n=27), which is the 13th lowest rate in London but 48.1% higher than the previous figure. The years of lives lost to alcohol-related conditions is 534.6 per 100,000 (n=1241), which is the 10th highest rate in London.

Further information can be found in the in JSNA.

Action

- Monitoring the number of new alcohol licences, licence renewals and change applications in Wandsworth by creating a pathway for reviewing applications received. Pathway will review on and off licence requests and make recommendations based on local data linked to crime, hospital admissions, surrounding premises, road traffic incidents and complaints.
- Keeping people engaged in treatment after release from prison by increased rate of successful engagement in drug treatment for adults within three weeks of prison discharge (adult).
- Improving engagement of people before they leave prison by reviewing rates of treatment engagement of those discharged with substance misuse needs and consider the actions needed if rates are below the London/England average (18-24).
- Maintaining the oversight of drug related deaths via the quarterly Drug related deaths panel.
- Mapping the Alcohol Care Team (ACT) provision in the 3 local hospitals (West Middlesex, St George's, and Kingston). Consider the feasibility of adopting the Chelsea and Westminster hospital model locally.
- Considering the next published rates of alcohol related hospital admissions for under 18's from Wandsworth to ascertain if action is required.
- Considering a process/pathway for those young people having an alcohol related hospital admission that do not reach the threshold for specialist treatment.
- Ensuring that all pupils receive a co-ordinated and coherent programme of evidence-based interventions to reduce harm through primary prevention and reduce harm escalation. Ensure there is a specific focus on alcohol related harm in PSHE in mainstream secondary and alternative schools in Wandsworth.
- Conducting an evidence review of effective alcohol interventions in school aged children.
- The Trading Standards Team carrying out enforcement work to ensure age-restrictions are complied with, and removing illegal and illicit alcohol from shelves to tackle non-duty paid and potentially contaminated alcohol from sale. Periodically reviewing licensing policy and ensuring compliance with licensing conditions.

Tracking progress

- Admission episodes for alcohol-specific conditions
- Hospital admission rate due to liver disease

What does success look like?

- Reduction in the rate of alcohol sales in the borough.
- Reduction of alcohol related hospital admissions in 40–65-year-olds.
- Reduction in number of alcohol related road traffic accidents in the borough.
- Reduction in the years lives lost to alcohol related conditions in the borough.

STEP 15: Smoking

The JSNA shows that smoking remains one of the biggest causes of death and illness in the UK. Every year around 76,000 people in the UK die from smoking, with many more living with debilitating smoking-related illnesses.

The JSNA highlights the need to reduce smoking rates and improve overall health outcomes in Wandsworth, with a particular focus on reducing health inequalities related to smoking.

Further information can be found in the JSNA.

Action

1. Providing targeted interventions for high-risk groups such as young people, pregnant women, and people with mental health conditions, while maintaining a universal offer.
2. Ensuring access to evidence-based smoking cessation services, including Nicotine Replacement Therapy (NRT), such as patches, lozenges, oral spray, nasal spray, gum, sublingual tablets and lozenges, behavioural support, and digital interventions, to support people to quit smoking.
3. Monitoring progress towards reducing smoking rates and improving health outcomes using clear and measurable indicators, such as smoking prevalence, quit rates, hospital admissions for smoking-related illnesses, and health inequalities related to smoking.
4. Develop new and strengthen existing smoking cessation pathways across different health organisations and partnerships across NHS Trusts, the local authority and voluntary sector, particularly those aimed at targeted groups and reducing inequalities.
5. Advocating across the ICS about the importance of stopping smoking on health outcomes and increase awareness of and visibility of smoking cessation services, pathways, and access points with a focus on targeted groups and reducing inequalities.
6. The Trading Standards Team carrying out enforcement work to ensure removal of illegal and illicit cigarettes and vapes from sale, and ensuring age-restrictions are complied with.

Tracking progress

- No. of people successfully quitting
- Smoking attributable hospital admissions
- Smoking prevalence in adults (18+)

What does success look like?

- Maintain and further reduce the smoking prevalence in the local population, particularly among high-risk groups such as young people, pregnant women, and people with mental health conditions.
- An increase in the number of people accessing evidence-based smoking cessation services and successfully quitting smoking from 2022-23 baseline.
- A decrease in the number of hospital admissions for smoking-related illnesses, such as lung cancer, heart disease, and stroke.
- A reduction in health inequalities related to smoking, particularly among disadvantaged communities.

STEP 16: Mental Health and Suicide Prevention

Suicidal thoughts and behaviours are associated with high levels of distress for those affected. Suicides are preventable. Each life lost is a tragedy. One suicide will always be one too many. Certain groups are at increased risk of suicide including young and middle-aged men, people in the care of mental health services, people with a history of self-harm or suicide attempt, people in the criminal justice system and specific occupational groups (e.g., doctors, construction workers). Additional risk factors include being gay, lesbian, or transgender (with risk arising from the prejudice faced), being in debt, developing a serious mental health condition and stressful life event.

Further information is available in the JSNA and the Wandsworth Suicide and Self-Harm Prevention Strategy 2022-2025.

Action

In addition to the Wandsworth Suicide Prevention and Self-Harm Strategy which highlights specific actions:

1. Prevention – Raising awareness, signposting residents to support services/offers.
2. Tackling inequality – Reducing stigma particularly for LGBT, ethnic minorities, men, carers population groups.
3. Holistic approach to individuals and families and empowering our communities - Engagement campaigns to raise awareness of resources, services, offers offered and accessible to community groups individuals and families.
4. 'Place' Integration – Using a targeted approach, allocate local resource to support the geographic areas and resident cohorts of greatest need.

Tracking progress

- Suicide rate
- Hospital admission due to intentional self harm (10-24 years)

What does success look like?

- Using an evidence-based approach to identify existing suicide prevention initiatives (H&CP, MHNA, Suicide Strategy, Healthwatch Report and JSNA) which the HWB will own.
- Influence gaps in provision using existing strategies and data sources and meet these needs.
- Encourage non health communities, network, forums, and residents across Wandsworth to talk about wellbeing, promote suicide prevention and self-harm initiatives amongst working aged adults and signpost to support offers particularly targeting cohorts from ethnic minorities, men, LGBTQ, neurodiversity, and carers.
- Improve crisis care, self-harm, and suicide prevention pathways.
- Reduce ethnic inequalities in mental health care by improving access, experience, and outcomes through the expansion of co-produced community mental health programmes.

19 steps
to Health &
Wellbeing
Age well

Age Well

STEP 17: Falls

A fall is defined as an event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event or overwhelming hazard. As people get older, they are more likely to fall over. Falls can become recurrent and result in injuries including head injuries and hip fractures. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall.

Falls are the largest cause of emergency hospital admissions for people aged 65+, and impact on long term health outcomes of older adults; often resulting in people moving from their own home to long-term nursing or residential care. Emergency admissions put additional pressure on local services, as well as the negative experience for patients and their families.

Wandsworth's latest rate of emergency admission due to falls in people aged 65+ was 2,467 admissions per 100,000 (n=775), the 6th highest rate in London, 11.0% higher than the England average and 11.4% higher than the London average. The latest Borough figure was also 0.7% lower from year 2010/11, in comparison with a 4.5% increase in England's rate in the equivalent period. Although the rate has been steadily decreasing in the last 3 years, mainly due to substantial reduction in falls in residents aged 80+, it remains significantly higher than the average rates for England and London.

The Public Health Outcomes Framework reported that in 2021-22 there were around 700 emergency hospital admissions related to falls among patients aged 65 years and over in Wandsworth, with 415 of these emergency admissions for people aged over 80 years. However, about a quarter of this number are where a person has been transferred between hospital sites. However, about a quarter of this number are where a person has been transferred between hospital sites. This has meant that Wandsworth has the 27th lowest rate of falls for people 65 and over compared to the 150 boroughs in England. The number of falls has also reduced over the last year and is currently achieving the Better Care Fund ambition within the 2023-25 Better Care Fund Plan.'

Further information can be found in the JSNA.

Action

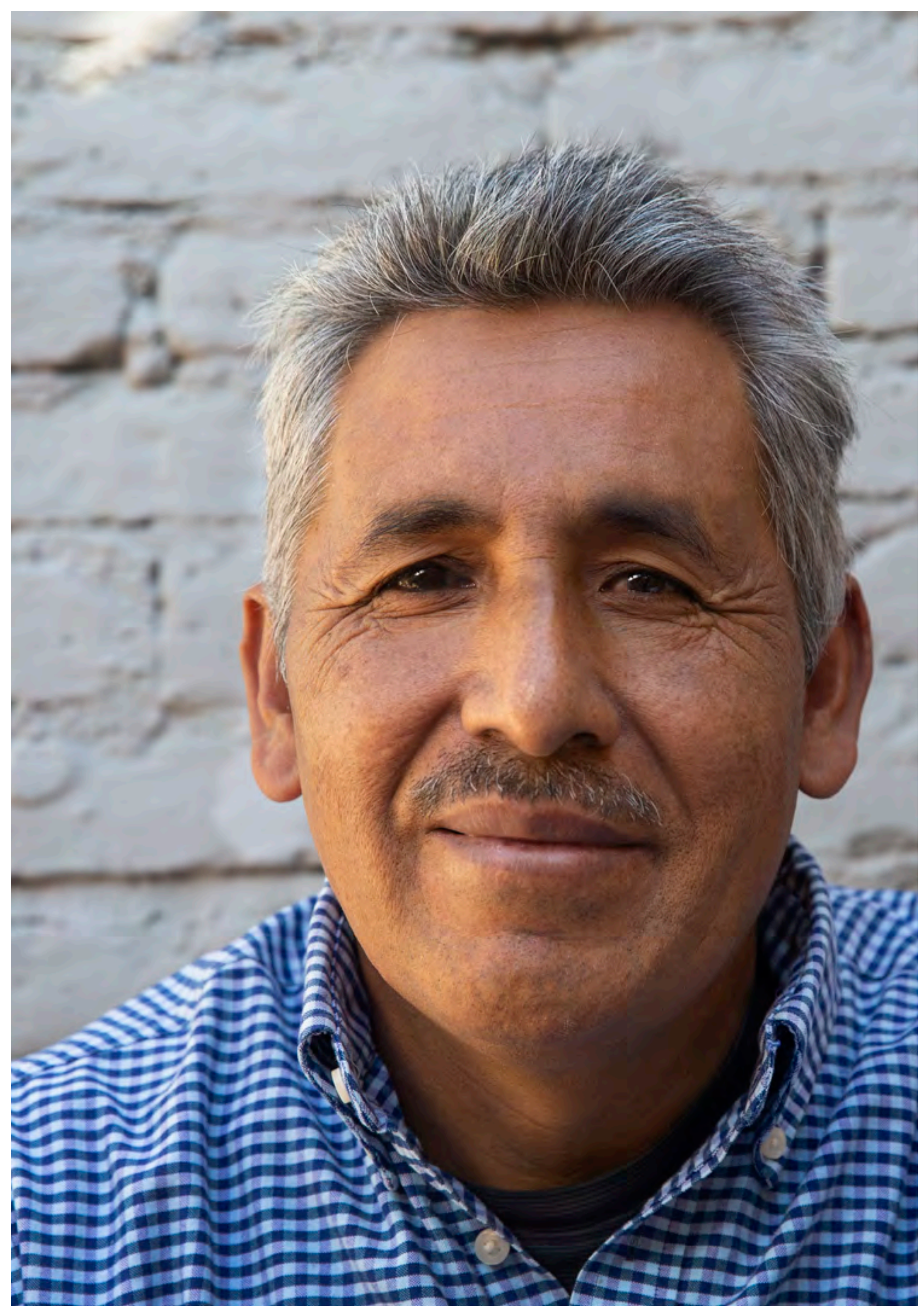
- Revising membership of the falls task & finish group, to ensure representation from services in the pathway and a collaborative approach.
- Revising falls prevention and rehabilitation pathways, to ensure clarity of inclusion and exclusion criteria, so that patients are seen by the appropriate service sooner.
- Organising pop-up assessment clinics, which will form part of the wider community engagement strategy.
- Developing a stronger community presence of falls services, enhancing the public's knowledge on falls prevention.
- Care home work with UCR falls pickup services, embedding falls acoustic monitoring into care homes, working with care homes that have increased falls rates or no-pickup policies in place.
- Understanding the numbers of people who are admitted as an emergency for less than 1 day/ Same Day Emergency Care as a proportion of those people being admitted for a fall and working with the Wandsworth community providers to consider alternative pathways away from Hospital.
- Utilising population health management data from hospitals and community providers to ensure that falls recovery services are accessible for the Wandsworth population.

Tracking progress

- Emergency hospital admissions due to falls in people aged 65 and over
- Emergency hospital admissions due to falls in people aged 80 plus

What does success look like?

- Reduction in the rate and number of emergency admissions related to falls for people agreed 65 and over, with emphasis on those people aged 80 years and over.
- Reduced bed days in hospital.
- Increase the number of appropriate individuals receiving a falls and bone health risk assessment.
- Increase in the number of people in target groups undergoing an individually tailored community or home-based therapeutic exercise programme.
- Improve access to services in addition to addressing inequalities.
- More people on appropriate medication and are adhering to medication advice, to reduce the risk of falls and resulting injuries.
- Reduction in the rate of fragility fractures.
- Improved quality of life for people at risk of falls.
- Reduction in the fear of falling.
- Improved physical measures.
- Review of the falls position in Wandsworth. Establish revised datasets, so that the system is a better position to monitor the impact of local initiatives, in all parts of the falls response and prevention pathways.
- Updated falls prevention and response pathways.
- Increased level of referrals into community falls services from:
  - Acute hospitals, as part of fracture liaison service.
  - Care homes, via the Urgent Community Response service.
  - London Ambulance Service, via the Alternative Care Pathways.
- Increase the number and proportion of people with a Universal Care Plan in place.
- Improving the scale and reach of falls prevention service by working in partnership with the voluntary care sector (VCS) to deliver more services in the community.
- Improved referral pathways between specialist services and the VCS.
- Community watch service.
  - Falls response for nursing and care homes.
- Digital falls monitors.
  - Falls response early warning devices.



STEP 18: Dementia

Dementia is a progressive disease often associated with complex health and social care needs which have an impact on both the individual and the family/friends supporting them. These needs are expected to rise in Wandsworth because of increases in the number of older adults living in the Borough. In 2020, the recorded prevalence of dementia in people age 65+ was 4.7%, the 4th highest rate in London, which was 18.7% higher than England average and 13% higher than London average.

Enacting comprehensive dementia prevention and support will be undertaken by focusing on the dementia pathway, utilising the following headings -

- Prevention
- Diagnosis
- Dementia Care and Support
- End-of-life Care

Inequalities will be addressed under each of these.

Further information can be found in the JSNA.

Action

General

- Establishing a Dementia Working Group: to implement objectives in the Strategy.
- Data and policy: Working with local partners to ensure local dementia data is up-to-date, accurate and accessible to all partners, that national and local policy is reflected in the work going forward, and that partners in the Wandsworth system can utilise this data to understand and address variations in the diagnosis rate by population cohort.

Prevention

- Building on the 'Think Brain Health Campaign' dementia awareness training public health offer, linking to the prevention framework, targeting those identifying themselves as Black, Asian and Mixed ethnicity.
- Dementia Friendly Wandsworth: Review learning from 'Dementia Friendly London' and work with partners to create a plan for Wandsworth.
- Linking with Live Well priorities: helping to reduce modifiable risk factors for dementia.

Diagnosis

- Dementia diagnosis: Ensure diagnosis rates remain high, with a particular focus on identifying people in care homes; ensure local support available and easily accessed to help the person and their family post diagnosis.

Dementia Care & Support and & End-of-Life care

- Undertake Pathway work: address gaps, duplications, make improvements and create consistent approach.
- Information booklet: explore opportunity to update booklet in attached link https://www.wandsworth.gov.uk/media/9566/dementia_services_in_wandsworth.pdf.
- Universal Care Plan (UCP): ensure every person diagnosed with dementia has a UCP and the person's needs at the end of their lives are addressed fully.
- Carer respite: explore opportunities to ensure good access to short breaks for unpaid carers.
- Young Onset Dementia: understand current needs and most suitable solutions and develop a plan.
- Care Homes: support and utilise learning from range of work on dementia being undertaken in Care Homes.
- Training: ensure good training opportunities exist for staff working with people with dementia.

Tracking progress

- POPPI (projecting older people population information system) provides estimated dementia prevalence by age and local authority.
- Estimated dementia diagnosis rate (aged 65 and over)

What does success look like?

- Establishment of Working Group with key partners.
- Decisions based on most up-to-date data and policy.
- Robust dementia strategy.
- Established prevention programme.
- A local population, particularly those identifying themselves as Black, Asian & Other Ethnic Minorities, who are better informed about dementia and the modifiable risks.
- A Borough that is increasingly understanding and accommodating of the needs of people with dementia and their families.
- Clear dementia pathway which is well communicated and understood by stakeholders.
- High dementia diagnosis rates, including identification of people in care homes.
- Clarity about the local services available to people post diagnosis and their families, and where further investment may be required.
- Up-to-date information booklet of local services in Wandsworth.
- Good support to residents with dementia in care homes and their families, including at the end of the person's life.
- Universal Care Plans in place for people with a dementia diagnosis.
- Carer respite opportunities explored and developed further.
- Plan developed for Young Onset Dementia.
- Comprehensive training programme for staff on dementia.
- Establishment of strong links with social isolation.

STEP 19: Social isolation

One in twelve Londoners experience severe loneliness, according to a report published in 2022 (Fitzpatrick, N. 2022). In 2019/20, Wandsworth's proportion of adult social care users who have as much social contact as they would like was 40.6%. Wandsworth's latest percentage of adult carers who have as much social contact as they would like was 11.1%, the lowest rate in London.

Further information can be found in the JSNA.

Action

- Developing skills, resource and knowledge sharing across the system.
- Developing a mechanism to address gaps in data and identify gaps/issues that contribute to social isolation.
- Map transport systems identifying how to better link people with social opportunities and places.
- Building/investing in 'Social Capital' and the use of local networks and community assets to increase resilience.
- Identifying gaps/issues that contribute to social isolation.
- Using digital technology to reduce social Isolation for those it will benefit and providing support to use technology for those who need it.
- Factoring in outcomes of Voluntary Sector Needs Assessment regarding addressing social isolation and loneliness.

Tracking progress

- Social Isolation: percentage of adult social care users who have as much social contact as they would like
- Social Isolation: percentage of adult carers who have as much social contact as they would like (18+yrs), embed the following hyperlink for both these indicators

What does success look like?

- A mechanism for partners to better understand social isolation and the people who experience it, so that they can plan actions to address issues and gaps in support. Creating more opportunities for people to connect and engage with their communities, in ways that suit them.
- Improved resource and knowledge sharing across system, particularly with VCSE (including with volunteer-led and more informal community groups/developing community initiatives).
- Good system awareness of community assets that can reduce loneliness and isolation and how to connect people to them.
- More opportunities for people to connect and engage with their communities in ways that suit them. Including digital opportunities as an option or alternative opportunity.
- Transport systems effectively connecting people with communities and places.
- "Friendly" community spaces (physical and virtual) that consider individual needs.
- Reduced prevalence of social isolation and loneliness generally but especially among older people, unpaid carers, and other groups at high risk of social isolation.

Glossary of terms

ABPM	Ambulatory blood pressure monitoring
A&E	Accident & Emergency
ACT	Alcohol care team
ADL	Activities of daily living
ARRS	Additional Roles Reimbursement Scheme
AF	Atrial Fibrillation
BPCS	Blood pressure check service
BMP	Blood pressure monitoring
BMI	Body mass index
CLCH	Central London Community Healthcare
COPD	Chronic obstructive pulmonary disease
Core20PLUS5	NHS England approach to support the reduction of health inequalities at both national and system level. It identifies '5' focus clinical areas requiring accelerated improvement.
CVD	Cardiovascular disease
DOAC	Direct Acting Oral Anticoagulants
EINA	Equality Impact Needs Assessment
H&CP	Health & Care Professionals
HHA	Heat-Health Alert
HWB	Health & Wellbeing Board
ICS	integrated care systems
JLHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
KPIs	Key Performance Indicators
LGBTQ	lesbian, gay, bisexual, transgender, queer
LSOA	Lower Layer Super Output Areas
MECC	Making Every Contact Count
MHNA	Mental health nurses association
MMR	Measles mumps rubella
NCMP	National Child Measurement Programme
NDPP	National Diabetes Prevention Programme
NHS	National Health Service
NHSE	NHS England
NRT	Nicotine replacement therapy
NSWWS	National Severe Weather Warning Service
OHID	Office for Health Improvement and Disparities
PCN	Primary care Network
PHOF	Prevention Health Outcomes Framework
PF	Prevention Framework
POPPI	Projecting older people population information system
PPV	Pneumococcal Polysaccharide Vaccine
PSHE	Personal, social, health and economic education
QOF	Quality Outcomes Framework
UCLP	Ultimate Cholesterol Lowering Plan
UCP	Universal care plan
VCS	Voluntary care sector

APPENDIX 1:
Membership of the Task and Finish Group

Richmond and Wandsworth Councils	
Ian Dodds	Director of Children's services, Achieving for Children
Shannon Katiyo	Director of Public Health
Nike Arowobusoye	Consultant in Public Health
Natalie Daley	Consultant in Public Health
Usman Khan	Consultant in Public Health
Sakeella Meiyanathan	GP SPIN FELLOW
Patricia Mighiu	GP SPIN FELLOW
Alexandra Brooke	GP SPIN FELLOW
Riya Verma	GP SPIN FELLOW
Lynn Wild	Associate Director - Health and Care Integration
Paul Martland	Head of Child Health Wellbeing and Early Help
Kay Willman	Assistant Director (Housing Strategy, Compliance and Enabling)
Lesli Good	Interim Assistant Director of Environment and Community Services (Leisure)
Michael Liu	Housing Policy and Performance Officer
James Armitage	Head of the Regulatory Services Partnership
Andrew Hagger	Head of Climate Change and Sustainability
Trudy Jones	Partnerships and Programmes Manager
Wendy Phillips	Public Relations Manager
Effie Lochrane	Head of Communications
Katherine Foreman	Senior Communications Officer
Katrina Waite	Head of Resident Engagement
Catherine Pierce	Consultation Manager

Richmond Partners	
Kathryn Williamson	Director, Richmond CVS
Jennifer Allan	Chief Operating Officer South West London and St George's Mental Health NHS Trust
Rachel Tucker	Consultant Clinical Psychologist Disorders - South West London & St George's Mental Health NHS Trust
Mike Derry	Chief Officer, Healthwatch Richmond
Alison Danks	Associate Director of Health Services, Achieving for Children
Denise Madden	Director of Strategic Partnersips and Integration - Kingston Hospital and Hounslow and Richmond Community Healthcare, Kingston Hospital
Anne Stratton	COO and Director of Clinical Services, Hounslow and Richmond Community Healthcare NHS Trust
Anubha Prasad	Integration and Partnerships manager, SWL and St George's Mental Health NHS Trust
Melissa Wilks	Chief Executive, Richmond Carers Centre
Attracta Asika	Primary Care Commissioning, NHS SWL Integrated Care Board
Nicolas Grundy	Primary Care Lead, NHS SWL Integrated Care Board
Heather Bryan	Primary Care Lead, NHS SWL Integrated Care Board
Sue Lear	Deputy Director of Transformation (Kingston and Richmond) , NHS SWL Integrated Care Board
Tara Ferguson-Jones	Director of Communications and Engagement, Kingston Hospital and Hounslow and Richmond Community Healthcare NHS Trust

Wandsworth Partners	
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Jason Edgington	CEO, Wandsworth Care Alliance
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