Wandsworth Joint Health and Wellbeing Strategy

First Version – September 2012

THE BRIGHTER BOROUGH
Wandsworth

NHS
South West London

Wandsworth Joint Health and Wellbeing Strategy

Contents

Introduction

This Joint Health and Wellbeing Strategy is prepared in accordance with the Health and Social Care Act 2012. The Health and Social Care Act requires local authorities and clinical commissioning groups, through the Health and Wellbeing Board, to prepare a strategy for addressing the needs identified in the Joint Strategic Needs Assessment.

Wandsworth Council and Wandsworth Clinical Commissioning Group come to this strategy with closely aligned ambitions. The Clinical Commissioning Group's vision is for 'better care and a healthier future for Wandsworth', and it is committed to work for this by being patient focussed, outcomes driven, principled, collaborative, and progressive and professional. The Council's corporate objectives include:

- improving opportunities for children and young people with an emphasis on early intervention and preventative work;
- making Wandsworth an attractive, safe, sustainable and healthy place; and
- promoting health and wellbeing for all adults with personalised and preventative care and support for adults in need.

The starting point for this Joint Health and Wellbeing Strategy is the Joint Strategic Needs Assessment agreed by the Health and Wellbeing Board in 2011. The first section of this document therefore sets out the priorities emerging from the Joint Strategic Needs Assessment, and the arrangements and actions that are in place to address them. It reviews the progress that is being made, and the challenges to be overcome.

The work described in Section One is already under way, and all members of the Board are committed to seeing that this is carried forward by the agencies they represent. The Health and Wellbeing Board is concerned that the Joint Health and Wellbeing Strategy should not merely re-state this work, but add value to it. The priorities identified through the Joint Strategic Needs Assessment are challenging ones, many of which have been significant issues in Wandsworth for many years. The Board has agreed that most value will be added by a clear focus on a small number of actions designed to enable progress. These actions, and the rationale for their selection, are set out in the second section of this document. They are very much at the heart of the strategy.

The Joint Health and Wellbeing strategy does not exist in isolation, but builds on a history of partnership working, with a substantial legacy of partnership arrangements and plans. The third section of this paper draws on the review of action on local priorities presented in Section One, and considers how to maximise the efficiency and effectiveness of partnership arrangements.

The Health and Social Care Act 2012 gives Health and Wellbeing Boards a duty to promote integration and specifically requires that Joint Health and Wellbeing Strategies should consider whether the needs addressed in the strategy could be better met through the use of formal arrangements for pooling of resources or governance under section 75 of the NHS Act 2006. The fourth section of the report looks at the current use of such formal arrangements and considers potential developments.

The final section of the strategy sets out implementation arrangements. It sets out the way in which the Board will review progress against its priorities and how it will hold itself and local agencies to account for their delivery of the agreed actions. It also describes how the strategy itself will be reviewed and updated.

The overall ambition of this strategy is to bring about an improvement in the health and wellbeing of the Wandsworth population. This cannot be brought about without the active

participation of the people living in Wandsworth. This strategy should therefore, be read as a 'call to action' to the Wandsworth population to take heed of the critical messages about healthy lifestyles: enjoy a healthy diet; take regular physical activity; do not smoke; drink alcohol only in moderation; and pay attention to your emotional wellbeing. However, it is acknowledged that some population groups will find it harder than others to move towards healthier lifestyles, and this strategy also signals a commitment to provide support that will help to overcome these difficulties.

Section 1: Progress against the key messages from the JSNA

The Joint Strategic Needs Assessment published in 2011 set out eleven 'key messages'. Through the Health and Wellbeing Board, Wandsworth Council, NHS Wandsworth and the Wandsworth Clinical Commissioning Group have agreed to give priority to addressing these key messages. The following sections set out action and progress on these areas, and identify key challenges in achieving improvements.

(a) *Tackling health inequalities*

The Joint Strategic Needs Assessment highlighted the gap in life expectancy between those living in the most and least deprived parts of Wandsworth. The Slope Index of Inequality shows that, in 2006-10, men living in the least deprived 10% of neighbourhoods in Wandsworth could expect to live 8.9 years longer than those in the most deprived 10% of neighbourhoods, and women in the least deprived neighbourhoods could expect to live 6.8 years longer than those in the most deprived. In the period between 2001-05 and 2006-10, the gap widened, reflecting a national trend.

A detailed analysis setting out the local approach to tackling health inequalities has been prepared and will guide this area of work. In line with the Marmot report, the national review of evidence on the extent of health inequalities and the effectiveness of action to tackle them, this focusses on six goals:

- giving every child the best start in life;
- empowering people living in the most deprived communities;
- addressing the wider determinants of health;
- promoting healthier lifestyles in the whole population;
- offering prevention and early intervention for long term conditions; and
- ensuring equality of access to health and social care.

It will be noted that this extends well beyond the remit of health and social care services, and covers a much wider range of programmes. A key challenge is to influence these programmes in a way that will maximise their positive impact on health and wellbeing.

On each goal, the current position and plan is described, and a number of indicators of progress in tackling inequalities is presented. It is not proposed to create a separate strategy, 'action plan' or governance arrangement for tackling health inequalities. Instead, it is intended that a commitment to tackle inequality becomes embedded in all relevant policy-making areas. In line with the expectation that tackling of health inequalities should be at the heart of Joint Health and Wellbeing Strategies, the Health and Wellbeing Board itself will champion this commitment, and will ensure that a process of systematically auditing the impact of policies and investment on health inequalities is put in place.

(b) *Childhood obesity*

Since the introduction of the National Child Measurement Programme (NCMP) in 2007, the proportion of children in Reception and Year 6 in Wandsworth schools who are obese has remained approximately constant at approximately 10% of Reception pupils and just over 20% of year 6 pupils. This gives some hope that the long-term increase in obesity may have levelled off. However, there remains an upward trend in the proportion of children who are overweight, especially in the reception year. This raises concerns about the effectiveness of services and the borough-wide strategy to promote healthy weight.

Some inequalities exist in the prevalence of obesity in Wandsworth. There is a higher prevalence of obesity in boys than girls in year 6. The proportion of pupils who are a healthy weight has been decreasing in both reception and year 6 within Black ethnic groups whereas the prevalence has been increasing in white ethnic groups.

A Healthy Weight Strategy and action plan for Wandsworth was developed in late 2010 and is due to be updated in 2012. This strategy is the responsibility of the Health Overview Group which reports to the Children and Young Peoples Board. The development of the Healthy Weight Strategy resulted in a several time-limited working groups but there isn't an on-going or regular group. Childhood obesity is an identified as a priority in the Children and Young Peoples Plan (CYPP) and the Active Wandsworth strategy, and is a key issue for the Cardiovascular Disease Clinical Reference Group and the Healthy Schools Steering group.

NHS Wandsworth, in consultation with relevant Children's Services department partners, has recently commissioned MyTime Active and Carnegie Weight Management to deliver weight management and healthy living activities within early years' and schools' settings. Action in schools, child health services and children centres has been strengthened through local programmes such as the Wandsworth Healthy School Enhancement Programme, Healthy Wandsworth Early years Accreditation scheme, school based weight management programmes, and the NCMP. However, more progress is needed on actions that will support a health promoting environment. Planning powers to control the density of fast food outlets, use of contracts for the provision of food in leisure centres and schools, and action to promote retail of fresh food in parts of the borough where supply is currently poor are all important tools that should be more effectively used. There are also gaps around supporting breastfeeding, a key obesity prevention initiative and local breastfeeding rates have seen a decline with reduced investment in the last year. St George's Healthcare NHS Trusts has not yet achieved UNICEF Baby Friendly accreditation for either its acute or community services. Research has shown that this is a model that leads to increases in breastfeeding initiation rates.

In order to fully realise the impact of the range and capacity of the obesity prevention and management programmes commissioned for Wandsworth, there needs to be much greater engagement of parents and families. All parents with children who were identified as obese through the NCMP are contacted by their school nurse to offer advice, support and referral to a family weight management programme but, disappointingly, only 50% of parents who are called accept this offer. GPs and primary care staff have the potential to engage, influence and motivate parents to engage take up services and change their lifestyle, but less than 20% of children in Wandsworth have had their BMI measured in their GP practice and only a handful are referred onto weight management services.

Training and practical tools are available to primary care staff to help them identify obesity and refer but we propose that greater incentives to refer children are offered to GPs to help them to be more active partners in addressing obesity in our community. Likewise, obesity awareness training for front-line staff should be encouraged by managers and local leaders to ensure all opportunities to raise the issue sensitively and motivate children and adults to take up available services.

(c) *Teenage pregnancy.*

Wandsworth has a Teenage Pregnancy Strategy which is overseen by the Teenage Pregnancy and Sexual Health Steering Group, chaired by the Assistant Director for Young People and Learning. Implementation of the strategy is led by a Teenage Pregnancy Coordinator, employed by the Public Health Department and based in the Council's Professional Centre. The Teenage Pregnancy and Sexual Health Steering Group reports through the Health Overview Group to the Children and Young People's Partnership. Each year the Steering Group agrees a detailed action plan, and reports to the Education and Children's Services Overview and Scrutiny Committee on progress.

Between 1998 and 2010, the teenage pregnancy rate in Wandsworth declined by 38.9%, to 43.6 per 1,000 girls aged 15-17. Although the target of a 55% reduction over this period was not achieved, this is the 17th largest drop in the country and the 7th largest reduction in London. It equates to a fall in the number of conceptions from 230 in 1998 to 120 in 2010. Nevertheless, Wandsworth's rate remains well above the London and national averages (37.1 per 1,000 and 35.4 per 1,000, respectively) and continued effort is required to maintain the downward momentum.

Whilst there is good engagement of all relevant partners in the steering group and effective management and delivery of the action plan, routes through which the steering group can influence wider factors that may affect teenage pregnancy, such as commissioning of sexual health services and educational attainment of teenage girls, are not so clear.

Engagement of individuals, families, and communities is important in achieving a sustained reduction in the teenage pregnancy rate, but is difficult to achieve. Sexual health and, specifically, teenage pregnancy remain areas that are associated with stigma and embarrassment. Young men have been particularly difficult to engage with around the issue of sexual health and preventing teenage conception. Not all front-line workers are comfortable in dealing with these issues, and some may have inaccurate perceptions both about the rate of teenage pregnancy and its adverse impacts, so that there is a risk of mixed messages.

(d) *Sexual Health.*

One of the key messages from the Joint Strategic Needs Assessment is that Wandsworth has a high rate of sexually transmitted infections. In 2011 there were 5,095 sexually transmitted infections diagnosed in Wandsworth residents – a rate of 1,759.5 per 100,000 population. This is the 8th highest rate within London and higher than in any local authority area outside London. The rate partly reflects the high proportion of the Wandsworth population in the age group at most risk of sexually transmitted infections. Good access to Genito-Urinary Medicine (GUM) clinics may also mean that the proportion of infections diagnosed is higher than in some other areas. Nevertheless, this high rate is a very serious cause for concern.

This concern is heightened by the fact that rate is increasing: by 2.7% between 2009 and 2010 and by 4.7% between 2010 and 2011.

The Sexual Health Action Group, chaired by the Deputy Director of Public Health, brings together treatment providers with PCT commissioners and the Council. It does not have any formal reporting or accountability structure. Some services are commissioned across South West London, South London and the whole of London, and separate governance arrangements are in place for these budgets. The Teenage Pregnancy and Sexual Health Steering Group maintains an oversight of sexual health services for young people.

There is no formal plan for tackling sexually transmitted infections, and the development of such a plan is recognised as an urgent priority. There is, however, a consensus around some of the key elements. We are working towards integrated provision of Genito-Urinary Medicine (GUM) and Reproductive Sexual Health Services and to promoting greater uptake of long-acting reversible contraceptives and of HIV screening. A uniform baseline of provision across primary care and effective prevention programmes are priorities.

Sexual health commissioning is being strengthened through the creation of a dedicated sexual health commissioner post within the Joint Commissioning Unit. However, the future division of commissioning responsibilities for sexual health services between the Council, the Clinical Commissioning Group and the NHS Commissioning Board also brings challenges. It is therefore proposed that a new partnership structure is initiated. This would consist of:

- *The Joint Commissioning Board* bringing together the three major commissioners of sexual health services. Its aim will be to ensure that the best use is made of the overall resources available, and consideration will be given to the use of Health Act flexibilities for pooling of budgets in order to achieve this; and
- *The Provider Development Group*. This would bring together providers of sexual health services, with input from commissioners. It will promote integrated provision and co-operation between different providers.

Finally, it must be acknowledged that the outcomes of this area of work are entirely dependent upon individual lifestyle choices and behaviour. If the number of people presenting to GUM clinics continues to rise, provision of these services will absorb an ever-increasing share of the limited Public Health Grant allocated to local authorities, removing the opportunity to invest in prevention programmes and other areas of work. This Joint Health and Wellbeing Strategy is therefore a call to action to the Wandsworth community to make the choices that will reduce the spread of sexually transmitted infections. To support this, all member agencies of the Health and Wellbeing Board will agree and promote a consistent message on personal responsibility for sexual health. The population groups particularly affected include the African and gay communities and young adults, and we will work with community organisations and other agencies engaging with these population groups to develop programmes that will support people in making healthy and responsible choices.

(e) *Alcohol misuse.*

Synthetic estimates indicate that approximately 45,000 Wandsworth residents whose alcohol use increases their risk of injury or chronic ill health. This includes approximately 7,000 adults who are alcohol dependant.

In overall terms, indicators for alcohol related harm in Wandsworth or broadly in line with or better than the average for London and England. The exceptions to this are rates of alcohol specific and attributable hospital admissions for males which are higher than the average for London and England. Wandsworth also has a higher rate of alcohol recorded crimes than the England average.

Action to tackle alcohol misuse is guided by an alcohol harm reduction strategy adopted in 2008. The Joint Commissioning Group for Drug and Alcohol Adult Treatment, chaired by the Director of Public Health, is responsible for the commissioning of alcohol misuse services. There is also an Alcohol Advisory Group, with a less senior membership, that maintains an overview and co-ordinates action in relation to alcohol misuse, but does not have formal decision-making powers. In the period since 2008 progress has been made in developing a number of innovative models of alcohol treatment:

- the creation of the locality-based primary care led alcohol hubs;
- a project designed to reduce repeat alcohol-related attendances at hospital; and
- a joint engagement and enforcement project for street drinkers.

This has delivered significant gains, most notably increasing the estimated proportion of alcohol dependant adults engaged in structured treatment from less than 5% in 2008 to 15% in 2011.

Reducing the levels of alcohol-related risk within Wandsworth's population and its impact on public health and community safety is an identified priority within NHS Wandsworth's Quality, Innovation, Prevention and Productivity program for 2012/13. The recent establishment of an integrated drug and alcohol treatment service is also intended to improve access to alcohol treatment. Reducing alcohol related crime and antisocial behaviour is also a key target of the alcohol harm reduction strategy and there has been some progress with the work to tackle street drinking and alcohol-related risk in probation service caseloads.

However, the investment in treatment has been heavily dependent on the use of-non-recurrent funding, and there are thus risks as to whether it will be maintained. Additional investment will be required to increase the proportion of dependent drinkers in treatment to 25%. A further priority is to improve identification of and early intervention with people who are not dependent drinkers but whose level of alcohol consumption puts them at risk of liver disease and other alcohol-related conditions. This can be achieved through 'mainstreaming' of screening and brief advice in a range of services including primary care, mental health and the criminal justice system. This will require training, systems development and the capacity for referral on.

Despite the efforts that have been made, there remains an apparently relentless increase in the rate of alcohol-related hospital admissions occurring both locally and nationally. Between 2002/03 and 2010/11 the rate of alcohol-related admissions per 100,000 population in Wandsworth increased from 859 to 1,840, an increase of 114%. This rate of increase is only just above the national rate of increase over this period (105%) and below the rate of increase across London (140%).

In the light of this, there appears to be an emerging national consensus on the need for an increased focus on alcohol misuse, with the recent publication of a national Alcohol Strategy and the adoption by the London Health Improvement Board of alcohol misuse as one of three pan-London health improvement priorities. It is proposed to build on this consensus by establishing an Alcohol Task Force, with a

more senior cross-agency membership than the existing Alcohol Advisory Group, reporting to both the Health and Wellbeing Board and Community Safety Partnership and with responsibility for both strengthening the treatment response to alcohol misuse and injecting additional urgency into preventive programmes, including the use of licensing powers, to tackle alcohol-related harm.

(f) *Mental health.*

The Mental Illness Needs Index 2000 (MINI 2K) estimates the level of mental health need in Wandsworth is 45% over the national average (1.45 compared to 1.00 for England), and well above that for any borough in South West London (0.82 in Sutton, 0.79 in Croydon, 0.70 in Merton and 0.63 in Kingston and Richmond and Twickenham). This is reflected in higher prevalence rates of all types of common mental disorders and of people experiencing symptoms of severe mental illness than those seen nationally and in neighbouring boroughs.

Performance is currently mixed. The target for Improving Access to Psychological Therapies is that 50.6% of patients recovering from mental ill health should have access to talking therapies, with the proportion currently standing at 43.1%. The Early Intervention in Psychosis and Crisis Resolution Home Treatment Teams are achieving their performance targets and seeing increasing numbers of patients. However, the Mental Health Trust achieved its targets for only two out of the five priorities set out in its quality account for 2011/12: 97% of inpatients discharged received follow-up within seven days (target 95%) and 97% of patients under a care programme approach had a care review meeting within a twelve month period (target 95%). Targets for improved use of the Health of the Nation Outcome Scale; reduced use of temporary nursing shifts and reduced numbers of ward transfers during admission were not met. External reviews of the Mental Health Trust by Mental Health Strategies and Beacon UK have raised questions about its management of inpatient services and its responsiveness to user experience.

The key partnership group, the Mental Health Partnership, is in the process of being replaced by the Mental Health Clinical Reference Group. This group will report directly to the Clinical Commissioning Board (CCG), but further consideration is needed to ensure a direct route into the Council's governance structures is incorporated into new partnership arrangements. There are good levels of engagement from stakeholders at a partnership level including service user, carer and black and minority ethnic involvement. However, there is scope for increased involvement of service users and carers, including those that are most vulnerable and seldom heard. There is a formal Section 75 agreement between the Council, the Primary Care Trust and the Mental Health Trust, under which the mental health trust has delegated responsibility for social care services for mental health, but this is currently being reviewed in the light of the need to improve performance and governance arrangements. There are separate and well established joint commissioning arrangements between the Children's Services Department and NHS commissioners and providers, including representation from the Clinical Commissioning Group, for all four tiers of child and adolescent mental health services (CAMHS).

The Mental Health Commissioning Strategy 2010-13 sets out the following priorities: promoting mental health and preventing suicide; delivering safe high quality services; achieving recovery and transformation; reducing health inequalities and improving access; and improving outcomes and achieving value for money. A continued focus on mental health promotion, early intervention and recovery is key

to improving the population's mental health. In order to achieve this it is vital to further strengthen joint commissioning arrangements and to develop more formal integrated working processes. In particular, a review of the rehabilitation of patients following episodes of mental ill health and their re-integration into the community through appropriate placements will lead to improved outcomes and a longer term reduction in costs.

Building upon the progress made through the implementation of the Dementia Strategy is also a priority. Currently, only 40% of people with dementia have a formal diagnosis. Increasing diagnosis rates with an emphasis on early intervention is vital to improve outcomes and ensure that those with dementia, their carers and their families get the support they need.

Mental health and physical health are inextricably linked; action is needed to improve the physical health of people with mental health problems, and to make mental health a key public health priority. Poor mental health is associated with an increased risk of diseases such as cardiovascular disease, cancer and diabetes, while good mental health is a known protective factor. Poor physical health also increases the risk of people developing mental health problems.

The national strategy for mental health, *No health without mental health*, calls for a 'parity of esteem' between physical and mental health within the care system, and for local planning and priority setting to reflect mental health need across the full range of services, agencies and initiatives. This is a challenge for the Health and Wellbeing Board in reviewing all areas of partnership working.

(g) *Cardiovascular disease (CVD)*

CVD is one of the main health issues identified in the Wandsworth Joint Strategic Needs Assessment for 2011. In 2010 (most recent data available) there were 493 deaths related to cardiovascular disease (CVD) in Wandsworth. CVD is the leading cause of death (all ages) in Wandsworth accounting for one-third (32%) of all deaths in 2010. Compared to the national average the latest (2008-10) under 75 years old mortality rate for CVD in Wandsworth was significantly higher. It is also significantly higher than the rates in PCTs which are considered to be of similar socioeconomic composition as Wandsworth. The CVD mortality rate in 2008-10 for people living in the most deprived areas of Wandsworth is 2.1 times higher than the overall mortality rate for persons who live in the least deprived areas of Wandsworth. Addressing these rates is therefore an important priority.

A Cardiovascular Disease Clinical Reference Group has been established for a number of years. This group currently reports to the CCG Board and covers CVD Prevention and treatment. The representation on the group and the terms of reference are currently under review to take into account the new responsibilities arising from the recent organisational changes.

There is no formal published plan for CVD, although the CCG Operating Plan and Commissioning Strategy Plan have a number of priority actions for CVD. Both the CCG and the Adult Care and Health Overview and Scrutiny Committee have recently approved the development of a joint CVD prevention strategy which is in the process of being produced. The key elements with regard to the improvement of the CVD mortality rate include:

- primary prevention aimed at reducing the incidence of cardio-vascular disease through changes to lifestyle such as reducing smoking, levels of obesity and levels of alcohol consumption, and increasing physical activity;

- prevention at a population level through the implementation of the NICE CVD prevention guidelines aimed at making the environment more conducive to healthy living;
- continued implementation of the NHS Health Check programme in primary care to assess individual's risk of developing CVD with a particular focus on the prevention of disease in those at highest risk;
- reducing variation in the prevention of CVD in primary care;
- ensuring that appropriate evidence based services are in place for those who do develop cardio vascular disease including secondary prevention services such as cardiac rehabilitation;
- ensuring that secondary prevention services are in place; and
- improving the patient/user experience of services.

The CVD Clinical Reference Group is in the process of considering how communities can be more engaged in achieving improved outcomes. A workshop for the Health and Well Being Partnership took place in February of this year to focus on this. Key themes which came out of the workshop included the following:

- the value of networks in influencing people's behaviour, including faith and cultural life, work life, how people spend their leisure time, etc.;
- having services located in these settings therefore has huge potential to build capacity of individuals and communities and to improve the understanding of practitioners with regard to how to best effect positive change in patients;
- the importance of positive messages from key family members whose opinion might make more difference than a professionals: communicating with these key people as well as patients themselves is vitally important;
- understanding the influence that collective family actions and lifestyles can have in habit forming and habit breaking; and
- professionals across agencies should come together to explore how their interventions interact, based on an understanding of patients or consumer pathways and the ways that service users experience their help.

A patient representative has been recruited to the CVD Reference Group and arrangements are in place to develop a CVD virtual group which will include representation from patients, carers and members of the general public with an active interest in cardiovascular disease. The group will contribute to decision making and take part in virtual discussions on service development and provision.

We will explore co-production of some services through working with local community groups and networks, and a shared commitment for all Member agencies of the Health and Wellbeing Board is to raise awareness of the risk factors for CVD within the local community.

The partnership arrangements and pathways are particularly complex for CVD with prevention, screening, diagnosis, acute management and long term care being sited in different parts of the system but with a very clear need to integrate health and social care and ensure the pathways are clear, especially at the potential interfaces between agencies. The new NHS management structures will see a transfer of responsibility for commissioning of prevention services to the local authority, whilst specialist services will become the responsibility of the NHS

Commissioning Board. Thus, whilst local partnership arrangements have generally been effective, there will be a need for these to be reviewed and more integrated governance and accountability arrangements are desirable.

(h) *Cancer*

Cancer is the leading cause of premature (under-75) death in Wandsworth. 37% of all deaths in the Wandsworth population aged under 75 are due to cancer. The cancer mortality rate in Wandsworth for people aged under 75 increased between 2003-5 and 2006-8 and has only recently started to reduce. Lung, colorectal and breast cancer were the most common causes of cancer mortality in Wandsworth between 2005 and 2009. England has poor 1-year cancer survival rates (the proportion of people still alive after one year) compared with Europe, and it is widely accepted that this is linked to the late stage at which cancers are diagnosed. For some cancers, Wandsworth's survival and mortality rates are worse than the England average. Within Wandsworth the 2009 all age cancer mortality rate was 32% higher in areas of highest socio-economic deprivation compared to areas of least socio economic deprivation.

The Wandsworth Annual Public Health Report for 2011 provides a set of detailed recommendations aimed at reducing the cancer mortality rate by improved prevention, awareness raising, screening and early diagnosis. There is particular focus on the most significant lifestyle choices which affect the risk of getting cancer which include smoking, diet, obesity and excessive alcohol consumption. There is also an Annual Report (2010-11) on cancer screening which includes cervical, breast and bowel screening and which sets out a detailed action plan on recommendations for improving uptake and coverage of these screening services.

Whilst there are weaknesses in programme budgeting data, the latest available output from the national programme budgeting programme suggests that Wandsworth is in a group of PCTs with both relatively low spend on cancer and poor outcomes. Whilst there have been a number of initiatives around prevention and early diagnosis, these have relied heavily on the use of non-recurrent funding and there is therefore a risk that they will not be sustained in the long run.

Current partnership arrangements are largely informal and project specific. There is a Wandsworth Cervical Screening Steering Group which comprises all stakeholders involved in screening e.g. laboratories, Primary Care Support Service, GPs, GUM services etc., and which reports to Wandsworth PCT Management Team. There is a South West London sector wide steering group meeting on bowel, breast and cervical cancer. There are also a number of task-orientated working groups which are set up to progress particular issues, and there is a range of groups led by the South West London Cancer Network which look at specific topics or projects across the sector.

A strength of the local arrangements is good engagement with voluntary and community groups. A number of joint projects have taken place with Paul's Cancer Support Centre, a charity based in Battersea, and Macmillan Cancer Support have funded a Macmillan GP working within the public health department to improve early diagnosis of cancer. A mapping exercise to understand whether there are other voluntary or charitable groups within Wandsworth may be helpful. Such groups possess a wealth of knowledge about their local communities and support is required to fully harness this intelligence to provide further in-depth knowledge about the behaviour and perceptions of cancer among different population groups.

The South West London Cancer Network has an active user group, members of which participate in the majority of projects which are undertaken in SW London.

The design of the new health and social care system means that different organisations and groups will, in the future, have responsibility for different aspects of the prevention, early detection, diagnosis and treatment of cancer as well as end of life care, with commissioners include the Council, the CCG, the NHS Commissioning Board and Public Health England. The work of all of these different organisations will need to be co-ordinated and there would be benefit in bringing together all partners into a formal partnership arrangement. There is a need to ensure that the far reaching changes that are being made to the organisation of local cancer services, including the dissolution of the Cancer Network in its current form, are reflected in new partnership arrangements. There would also be benefit in having clearly identified championing of cancer issues at the executive level in both the Council and the Clinical Commissioning Group, with a specific focus on promoting earlier diagnosis.

(i) *Excess winter deaths.*

Excess winter deaths are defined as the number of deaths in the winter period (December to March) which occur, over and above the expected number for that period. The Wandsworth excess winter deaths needs assessment of March 2012 identified that there are on average 109 excess winter deaths per year in Wandsworth and suggested that a number of these deaths are preventable. There are around 26,400 people aged 65 years or older living in Wandsworth and the proportion of the very elderly among them is predicted to rise. The prevalence of long term conditions such as diabetes, coronary heart disease and chronic obstructive pulmonary disease in the local population is growing. In addition to this, the numbers of people living in fuel poverty is increasing, mainly due to the increase in fuel prices in recent years. In Wandsworth, the largest differences in cause of death between the winter and summer periods result are attributable to seasonal flu, pneumonia, and falls. The vulnerable elderly and people with long term conditions, living in cold homes, are most at risk.

The excess winter deaths needs assessment of March 2012 set out a number of recommendations. To address these recommendations, an Excess Winter Deaths Steering Group was established in August 2012, bringing together a range of partners including public health, housing, primary care, community pharmacy, older people's forums and charities, and it is now developing an action plan. The aims are to ensure that a number of practical interventions are systematically offered or signposted. These include assessment and uptake of energy efficiency and affordable warmth schemes, increased uptake of seasonal flu vaccinations, falls prevention and adoption of assistive technologies such as personal alarms.

The Steering Group currently reports to the Older People's Clinical Reference Group of Wandsworth Clinical Commissioning Group and reporting arrangements are under review. There is also a Fuel Poverty Strategy, which has been approved by the Council's Executive and on which the Housing Overview and Scrutiny Committee receives annual reports. As partnership arrangements across the Borough become more formalised, there are opportunities to be gained from a more formal linking of existing operational groups working on seasonal flu vaccinations, fuel poverty, pensions and benefits, and falls prevention.

The key challenge for Health and Wellbeing Board member agencies and for Wandsworth's community and voluntary sector is to tackle social isolation and

improve identification of vulnerable and isolated individuals. As a partnership we can do more to identify individuals at highest risk through information sharing and the systematic offering of interventions which are proven to be effective. Enhanced communication with front-line staff and the public is important, especially in ensuring increased uptake of energy efficiency and home improvement opportunities, as well as uptake of benefit entitlements and seasonal flu vaccinations. Making full use of member agencies' engagement activities with service users will help to ensure that preventive messages are meaningful and tailored appropriately.

(j) *Accidental falls*

Falls in older people and the injuries resulting from them can lead to disability and a loss of independence. Hip fractures are the most serious consequence of a fall and the commonest cause of accident-related death in older people. Treating the consequences of falls incurs considerable cost to the health and social care system but falls are preventable. The rate of hospital admissions for fractured neck of femur has been on an upward trend since 2005 and the mortality rate from accidental falls in those aged 65-74 years was significantly higher than the London and national average. With the anticipated ageing of the population over the next 20 years, there will be an increased demand for bone health, falls prevention and home adaptation services in the Borough.

A falls and bone health needs assessment was conducted in 2010 and a Falls Prevention and Bone Health Strategy was ratified by NHS Wandsworth in 2010. Early identification of people at risk and improved management of falls and fragility fractures are key aims of the strategy. In April 2011 a business case for the investment required to implement the strategy was agreed by Wandsworth Clinical Commissioning Group, who committed £700,000 expenditure on a non-recurrent 'spend to save' basis for on-going development of a prevention-focused care pathway, including active case-finding of people at risk.

A Falls Prevention, Management and Bone Health Working Group was established in November 2011. This group currently reports to the Older People's Clinical Reference Group of Wandsworth Clinical Commissioning Group but reporting arrangements are under review. The Wandsworth Housing Adaptation and Repairs Forum brings together a range of commissioners and providers of home improvement services. Home improvement services support vulnerable householders to remain independent in their homes for long as possible through undertaking minor and major disability adaptations and carrying out repairs.

Current partnership arrangements are largely informal but effective. For example, the Public Health Department from NHS Wandsworth, the Housing Team of the Council's Environmental Health Service and the Integrated Falls Service worked together to fund Wandsworth Borough Council to undertake a falls risk assessment in Furzedown and Graveney, visiting 1,368 households from September to November 2011. However, there may be benefits in a more integrated structure, which would be conducive to the development of a holistic falls prevention strategy for the Borough. There are immediate opportunities to be gained from a more formal linking of existing operational groups such as the Wandsworth Housing Adaptation and Repairs Forum and the Falls Prevention and Bone Health Implementation Group. There is scope for further integration of the falls prevention strategy in the dementia care pathway.

As with reducing excess winter deaths, a key challenge for both Health and Wellbeing Board member agencies and the voluntary and community sector is in tackling social isolation and sharing of information to identify vulnerable and isolated older people. It is also important that member agencies present consistent messages on issues such as the association of alcohol with the risk of falling. Use of agencies' channels for engagement with service users will ensure that messages and services are tailored appropriately.

(k) *Carers*

The role of informal carers in supporting the needs of their loved ones or those that they care for continues to be highlighted in both national and local policy. The Carers Strategy (2009-2014) was jointly prepared by the Council, NHS Wandsworth and key partners and stakeholders within the community. This has deliverable actions against two overarching objectives: to support carers in their caring role and to enable them to have a life outside of caring. Priorities include identifying and supporting children and young people who care for family members who are ill, disabled or with problems related to mental health or substance misuse.

The delivery of these actions and review of future plans is overseen by the Carers Strategy Group. The Key Performance Indicator by which performance is currently assessed relates to the number of carers assessments undertaken by Adult Social Services, and on this indicator performance year on year is showing significant improvement. Against a 2011/2012 target of 25% the outturn performance of assessments offered to carers eligible for an assessment was nearer 38%.

As a result of the significant progress being achieved in the alignment of health and adult social care, the governance framework will be reviewed in 2012-2013. Part of this review will look at the approach to engagement, with a view to widening participation.

Currently, carer support services are commissioned separately by the PCT and the Council, with contracts due to expire on March 31st 2014. It is intended that the future specification for services required by carers will be jointly prepared, with the expectation that this can deliver both an improved of service and both cashable and non-cashable efficiencies.

(l) *Enabling the over-75s to maintain their independence*

People aged over 75 place a very high proportion of all demand on health and social care services. There is already good practice in Wandsworth in the provision of services to older people. For example, rates of delayed discharge of Wandsworth residents admitted to hospital are low. A high proportion of older people in Wandsworth are concentrated in the most deprived wards, and it is expected that there will be an increase in the number of very frail older people.

Provision for older people is very much 'core business' for Adult Social Services and Community Health Services, and there are strong partnership arrangements for oversight of the development of services for older people. Provision for older people is a central focus of both The Future Today programme, which focuses upon the redesign of adult social care to continue the implementation and embedding of personalisation for those people with unmet eligible needs, and the Planning Care Together programme, with its complementary focus on the closer alignment of primary health and adult social care to promote people's independence and quality of life in community settings.

Whilst the initial census data confirms that the population in Wandsworth over 65 is projected to remain stable for the foreseeable future, it is anticipated that, when the more detailed breakdown is made available, this will forecast a significant increase in the local population of those aged 85 and above. In rising to the challenges this will present we will need to work in partnership to build upon the established foundations.

The Wandsworth Strategy for Older People, prepared in 2008, detailed actions identified against the 'Seven Dimensions of Independence' these being; Health and Healthy Living, Housing and the Home, Neighbourhood, Social Activities and Keeping Busy, Getting Out and About, Income, and Information. Actions were refreshed annually through the life of the Strategy and against each dimension there has been considerable achievement resulting in improved outcomes for older people. Amongst these are; the establishment of the Community Ward where health and social care work closely with people with complex needs to reduce inappropriate hospital admissions, an increase of referrals to the WATCH Lifeline Community Alarm Service, provision of crime prevention talks to older people, addition of extra routes to the Walk 4 Life programme targeted at older people, improved access at Clapham Junction rail station for people with reduced mobility, improved waiting times in the Council's Benefit Service contact centre and improved access to information through the newly commissioned open access day service across the borough.

However, this Strategy is fast approaching the end of its originally anticipated life. The consultation around the Health and Wellbeing Strategy will provide a clear opportunity to engage with stakeholders on whether the original strategic aims of the Older People's Strategy need to be refreshed within the existing framework or whether the changing landscape demands a fresh approach.

The fact that people are generally living longer is something to be celebrated, but one of the challenges of this trend nationally is the increasing number of people diagnosed with and suffering from dementia. In Wandsworth we have worked in partnership to deliver training to health, social care, and housing colleagues and also taken this out to providers and the third sector. However, much remains to be achieved to improve the lives of both those people diagnosed with dementia and their close family, friends and carers. A focus of our strategic work targeted at people aged 75 and over will be to take account of the National Dementia Strategy recommendations in implementing local actions that will help raise awareness, improve diagnosis, and encourage services that contribute to providing for dementia friendly communities.

Section 2: Adding Value - The enabling actions

The Health and Wellbeing Board's primary concern for the Joint Health and Wellbeing Strategy is that it should add value to the work already being done in relation to the key messages from the Joint Strategic Needs Assessment. The priorities identified through the Joint Strategic Needs Assessment relate largely to concerns that were already known well before the Joint Strategic Needs Assessment was undertaken and, in many cases, ones on which there have been jointly agreed plans and strategies in place for many years. In preparing this strategy, a key concern for the Board is to understand why improvements have been difficult to achieve, and to consider how the Joint Health and Wellbeing Strategy can enable faster progress.

The Board has identified key areas of work, at three complementary levels, which will facilitate improved outcomes on the priorities identified through the Joint Strategic Needs Assessment. Firstly, a cross-cutting theme of many of the key messages in the JSNA was the need for individuals to make choices that would achieve healthier outcomes. Critical to this is the promotion of resilience at individual and community levels, especially in more deprived communities. The ambition is to generate a sense of empowerment and self-efficacy that ensures people are enabled to make healthy choices. Secondly, the Board recognised that for prevention programmes to achieve their full potential, they require a commitment to large-scale change with support and engagement at the highest levels. It recognised its own responsibility in securing such commitment, and agreed that work relating to alcohol should be the first area to be addressed, taking into account both the adverse trends over the past decade and the opportunity offered by the emerging consensus at national and pan-London levels that work related to alcohol misuse is a top priority. Thirdly, the Board's specific responsibility for promoting the integration of health and social care was felt to be important in achieving improved outcomes from investment in care and treatment. The Board therefore committed to reviewing opportunities for more integrated commissioning and delivery of health and social care, with a specific focus on the way in which such integration will aid progress on the priorities identified through the Joint Strategic Needs Assessment.

(a) *Promoting resilience to promote wellbeing*

The promotion of resilience has a particular resonance in tackling health inequalities, specifically addressing the recommendation from the Marmot report on the importance of empowerment in achieving improved health outcomes in deprived areas. There is a synergy between the Board's focus on resilience and the Council's 'aspirations' programme, developed in response to the Kinghan inquiry into the disorders occurring in August 2011. Under the aspirations programme, physical regeneration in Latchmere and Roehampton will be allied with work to promote a greater sense of aspiration and engagement, in particular amongst young adults.

Resilience is central to individual and communal wellbeing and contributes to addressing all of the priorities arising from the JSNA. Challenges that emerge from reviewing progress on these priorities include:

- only 50% of parents whose children are identified through the National Child Measurement Programme as obese take up the offer of support around their child's weight management;
- the need for sexual health services is determined by individual choices over lifestyle and behaviour;
- critical to the effectiveness of work around cancer is increased population awareness of the early symptoms of cancer; and
- a key factor in the improvement of outcomes around falls and excess winter deaths is an inclusive community that will reduce the proportion of elderly people who are isolated.

In essence, the ability of local health and social care services to meet population needs is dependent on members of the population being fully engaged in their own health and wellbeing. A challenge for all member agencies of the Health and Wellbeing Board is to develop ways of working that will promote such resilience, and both individual and community levels.

There are ways in which this already takes place. Building resilience in children, young people and parents is a key driver in the work of Children's Centres, which focus most intensively in the more disadvantaged areas of the Borough. The Family Recovery Programme works intensively with a small number of families with complex needs with a view to promoting the skills and coping strategies that will reduce their need for such intensive support. The co-creating health programme piloted ways in which health professionals can support patients to take a more active part on their own care, and the Expert Patients Programme provides a regular programme of training for people with long-term conditions in management of their own condition. We will build on these foundations to review systematically the way in which our services work with their users, to ensure that opportunities to promote resilience at individual and family level are fully taken.

The Board has chosen to focus initially on Roehampton as an area in which to pilot and develop approaches to community resilience. Key features will include:

a. using an evidence based approach with development of Area Plans to ensure that the range of services are focused on delivering key outcomes across a range of activities (e.g. improving key health determinants, increasing educational attainment standards, reducing levels of unemployment, improving the physical environment);

b. auditing current spend and service delivery and identifying and building on the strengths and resources in the area, including those of statutory bodies, the voluntary sector, and the community itself;

c. flexibility, allowing local people the opportunity to define their own ambitions and goals;

d. a focus on delivering against key outcomes that are agreed with the local community;

e. identification of and engagement with voluntary groups, informal social networks and activists and leaders in the local community;

f. sign-up to the programme at all levels of agencies working in the area, from front-line staff to Chief Executives;

g. bringing together local programmes and commitments within the area, to achieve the greatest value and most effective targeting; and

h. a long-term commitment.

The community development resources of the Public Health Department will be committed to establishing this programme of work.

Alongside this, the Adult Social Services Department will be engaging with 'vintage communities' to develop a resilience programme specifically focussed on promoting of inclusion of older people, within a locality yet to be determined.

(b) *Strengthening prevention programmes – with an initial focus on alcohol*

The review of work on the JSNA priorities demonstrates that much work is already taking place on prevention programmes, but it is often relatively small-scale and low profile, with a high level of reliance on short-term funding of specific projects. The Board is committed to using its potential to strengthen this area of work. This may involve:

- *Establishing shared partnership ambitions for large-scale change.* In prioritising prevention programmes, the Board will be looking to achieve substantial and measurable outcomes that will justify a significant investment of resources.
- *Providing prominent and visible leadership*. The Board will ensure that the prevention programmes it prioritises are seen as not just the responsibility of the project team, but as the responsibility of all the Board's member agencies.
- *An agreed approach to the dissemination of prevention messages.* The Board will develop a common identity and Brand for the promotion of health in Wandsworth. For each prevention programme, there will be cross-agency agreement on a core set of messages and the ways in which they will be disseminated.
- *A common understanding of the use of resources.* This will underpin joint agreement on priorities and identification of ways of shifting resources away from crisis management and remediation and towards prevention, where this represents overall value of money.

The first area of prevention work the Board has chosen to prioritise is tackling alcohol misuse. Building on the work already taking place, and described on page 6 above, the Board has identified three target groups:

- *Persistent hazardous or harmful (but not dependent) drinkers.* The emphasis here would be on establishing a consistent and rigorous approach to brief interventions. Clearly delivery of these interventions across primary care is central to this, and work here would link very closely to that being developed under the QIPP programme. However, the model should extend across all the professional groups who have contacts with people that might trigger them to think about their drinking. There would need to be a protocol across all agencies defining the triggers for delivery of a brief intervention, and specifying the brief intervention to be used.
- *The group of primarily younger drinkers whose drinking is associated with community safety concerns, even if their overall drinking is not necessarily particularly heavy or particularly regular.* Effective enforcement, including the use of new licensing powers, and good intelligence through transfer of A & E data to those responsible for licensing, will be the key measures. The guidance that is being produced by the London Health Improvement Board on best practice in the use of licensing powers will be key to defining what can be done.
- *Chaotic drinkers.* These would be dependent drinkers whose dependency is aggravated by co-morbidity (especially with psychiatric conditions), complex social needs, or an unwillingness to engage. Most street drinkers would fall into this group. This would also build on work being undertaken as part of the QIPP programme. Central to the model for working with these people would be mapping of current public investment into individuals and families, with a view to unified commissioning for this group, either on an individual or group basis, so as to achieve best value for money and to shift from a reactive to a planned and preventive approach.

Through the proposed task group on implementation of the Alcohol Strategy, the Board will agree shared ambitions and will secure high-level commitment from all agencies to bringing about the required change. The experience of work on the strategy will inform the development of the Board's approach to integrated prevention programmes.

(c) *Integrating health and social care*

This priority confirms the commitment of the Board to meet its statutory duty to promote integration. It relates particularly to three of the JSNA priorities: meeting the mental health needs of the community; identifying and meeting the support needs of carers; and helping those aged over 75 to maintain their independence.

Locally, there are two specific drivers for the integration of adult social services and health care:

- the need for community provision to support a sharp reduction in the use of acute hospitals as an essential enabler for 'Better Services, Better Value'; and
- the need to achieve savings through a reduction in the use of nursing and residential home provision.

The priority of the Board is to achieve operational rather than structural integration: the measure of success is user experience of integrated services, rather than integrated organisational structures. Whilst structural integration may become necessary to support operational integration, it is not to be considered as an end in itself. The core ambitions of the Board are:

- to support the development of a culture in which staff, irrespective of agency affiliation, feel a shared commitment to service users; and
- to empower staff, where appropriate, to think 'outside the box' as to how best to meet service users' needs.

There are challenges in bringing together health and social care. Whilst NHS services are universal and free at the point of use, social care services are targeted and subject to both eligibility criteria and means testing. However, there is a substantial overlap between user groups. Within Wandsworth, there are 31,000 patients registered with GPs who are known to have a long term condition, of whom around 2,500 have three long term conditions. There are around 5,000 people on the Adult Social Services caseload, the vast majority of whom are older people, with about 90% having one or more long-term conditions.

The approach to be adopted by the Health and Wellbeing Board will be informed by evidence on successful change management, with a clear focus on a limited number of objectives and through step-by-step implementation informed by continuous evaluation. The programme will include:

- support for alignment of cultures;
- identification and alignment of incentives;
- commissioning a review of health and social care records for clients with a high level of need (perhaps around 3,500 cases) to review the overall package of care received and identify the scope for improvements and efficiencies;
- making a reality of a 'no wrong door' approach to health and social care information – ensuring that all access points have sufficient information to guide the client to the most appropriate service; and
- developing a unified approach to communications.

The Board will also support and maintain oversight of work to integrate services for children. A formal agreement has been reached between all partners who commission or provide health services for children and young people in

Wandsworth. This serves as a top level framework within which integrated working can continue and new co-ordinated arrangements can evolve. It reinforces the view that not only Health, but all other service providers, including school, the Council, and the voluntary sector, contribute to improving children and young people's physical and mental health. Key features include integrated governance, strategy, planning and management, delivery, and processes, along with an assumption that information is shared, based on NHS protocols, and that consent is proactively sought from parents and young people to enable this.

Section 3: How we work together

In carrying forward the Joint Health and Wellbeing Strategy, the Board will promote adherence to the following principles:

- *achieving the best possible use of public funding.* The NHS and the local authority have separate funding streams, accountability and legal responsibilities. However, as far as possible we will seek to work in an 'organisation-blind' way to achieve the best possible overall use of public resources for health and wellbeing;
- *treating every interaction with the public as an opportunity for health promotion;*
- *ensuring that the health improvement opportunities are considered in all areas of our work;*
- *engaging with a wider partnership and involving the local community in the promotion of health and wellbeing;*
- *maximising resources available for the promotion of health and wellbeing, including grant and charitable funding and voluntary efforts;*
- *focussing on clear and measurable outcomes.*

The Joint Commissioning Executive, reporting to the Health and Wellbeing Board, maintains an oversight of partnership arrangements in Wandsworth. These operate through a number of different structural frameworks.

(a) *The Children and Young People's Partnership (Wandsworth's Children's Trust.* The Children and Young People's Partnership is the over-arching body for all partnership arrangements for children and young people. The strategic priorities of the Partnership are encapsulated in the Children and Young People's Plan 2011-2015, which is reviewed annually. The Partnership Board is supported by seven Overview Groups which maintain oversight of different strands of work. One of these is the Health Overview Group, which maintains oversight of partnership arrangements in relation to children's health and wellbeing. The terms of Reference for this group are being adapted so that it also fulfils the role of Clinical Reference Group for Children, and in future it will oversee the work of the various multiagency forums which jointly commission health interventions for children and young people. The JSNA priorities overseen through these arrangements are tackling childhood obesity and reducing the teenage pregnancy rate.

(b) *Adult care partnership arrangements.* A number of groups oversee partnership arrangements between the Council's Adult Social Services Department and NHS Wandsworth. These include the Wandsworth Strategy Group for Older People, the Mental Health Partnership Board, the Learning Disability Partnership Board and the Carers' Strategy Group. Together, these partnerships oversee work on the priorities in relation to mental health needs, meeting the needs of carers, and supporting older people to maintain their independence.

(c) *Clinical Reference Groups.* The Clinical Commissioning Group is establishing a number of clinical reference groups, chaired by the relevant clinical leads, with responsibility for strategic development and redesign around various patient pathways. Areas overseen by these groups include asthma and chronic obstructive pulmonary disease, cardio-vascular disease, cancer, and end of life care. One group has been established specifically to deal with falls prevention, and another group is being established to work on reducing the number of excess winter deaths. The priorities from the Joint Strategic Needs Assessment being overseen within these arrangements include reducing the rate of premature mortality from circulatory disease and cancer, reducing the number of excess winter deaths, and reducing mortality from accidental falls.

(d) *Public health led groups.* A number of partnership groups led by public health have responsibility for areas of health improvement. These include the Sexual Health Advisory Group, the Tobacco Control Alliance, and the Drug and Alcohol Adult Treatment Joint Commissioning Group. These groups maintain oversight of work in relation to the priorities around tackling alcohol-related admissions to hospital and reducing the number of sexually transmitted infections.

(e) *Health and Social Care Integration Board.* The Health and Social Care Integration Board oversees the programme of work to integrate the provider functions of Wandsworth Council's Adult Social Services Department with the relevant activities undertaken by the Wandsworth Community Services division of the St George's Healthcare NHS Trust.

(f) *The Future Today Advisory Board.* This is a large multi-agency partnership, including substantial user and carer engagement, advising Adult Social Services on the review of its transformation programme.

(g) *Section 75 agreements.* There are specific arrangements to oversee two partnerships established under Section 75 of the NHS Act 2006. One of these, between Wandsworth Council, NHS Wandsworth and the South West London and St. George's Mental Health NHS Trust, covers community mental health services. The other, between Wandsworth Council and the St George's Healthcare NHS Trust, covers the Wandsworth Integrated Community Equipment Service.

(h) *Community Safety Partnership.* Whilst the Community Safety Partnership's focus is on the reduction of crime and disorder, it is responsible for some programmes of work in which health and social care are central, including integrated offender management and protection of vulnerable victims.

(i) *Safeguarding Boards.* There are multiagency Safeguarding Boards for both children and vulnerable adults, which bring together senior staff from key local agencies to agree expected good practice in relation to safeguarding, and which provide a means by which these agencies are held to account on the impact of their delivery in relation to safeguarding issues. The Wandsworth Safeguarding Children Board and the Adults Safeguarding Board have agreed to set up a joint sub-committee to address the safeguarding issues associated with transition between services and of vulnerable adults who are also parents.

It will be noted that this picture is a complex one. As noted in the review of work on JSNA priority areas, there may be scope to simplify structures, eliminate duplication and clarify accountability. Historically, some professional groupings have been less well represented than others within partnership arrangements, with pharmacists being one group whose

knowledge, based on extensive direct contact with almost all service user groups, has not been well utilised.

Specific proposals in relation to partnership structures are that:

- the Health and Wellbeing Board will take direct responsibility for oversight of work on tackling health inequalities;
- current partnership arrangements for sexual health services will be replaced with a Sexual Health Commissioning Board working alongside a Provider Development Group;
- a high-level task force on tackling alcohol misuse will be established.

The Health and Wellbeing Board will maintain oversight of all partnership arrangements for health and wellbeing. Whilst it does not seek to establish a single hierarchy and reporting route for partnership groups concerned with health and wellbeing, questions that it will ask are:

- whether there is duplication within these structures that can be eliminated;
- whether there are adequate communications between different groups dealing with related issues;
- whether the groups identified are both necessary and fit for purpose;
- whether all relevant parties are engaged.

The Joint Commissioning Unit will support the Board by undertaking a review of partnership arrangements and recommending improvements.

In order to assure itself of the robustness of arrangements for addressing the priorities identified through the Joint Strategic Needs Assessment, the Health and Wellbeing Board will regularly review a dashboard of both outcomes and process measures for all priority areas and will, at each meeting, review work on one of these areas, with the schedule for review being determined by the dashboard.

Councillors have had relatively little direct involvement in local partnership arrangements, with their primary input being through Overview and Scrutiny Committees prior to sign-off of partnership plans by the Council's Executive. There are tensions between this model and the ambition of achieving greater integration, and consideration will be given to whether the power to delegate some Council decision-making powers to Health and Wellbeing Boards could be used to achieve a more integrated approach to the involvement of elected members in agreeing partnership plans and their implementation. For a fully integrated approach to be achieved, it is desirable that arrangements should permit a parallel delegation of decision-making powers from the Clinical Commissioning Group to the Health and Wellbeing Board.

Section 4: Formal pooling of budgets and governance

The Health and Social Care Act requires that Joint Health and Wellbeing Strategies consider whether the needs identified through Joint Strategic Needs Assessments could be better met through the use of partnership arrangements under Section 75 of the NHS Act 2006. The Health and Wellbeing Board does not believe that such partnership arrangements should be considered as an end in themselves, but is ready to use them when they contribute to better outcomes for service users or the achievement of better value for money.

There are currently formal 'Section 75' partnership arrangements in Wandsworth covering Mental Health and Learning Disability services and the Wandsworth Integrated Community Equipment Services. The commissioning of the structured day programme for adults who are dependent on alcohol is also subject to a Section 75 agreement, but this will no longer apply following the transfer of funding and responsibility for commissioning of substance misuse services from the NHS to local authorities.

In addition to these formal arrangements, there has been some informal pooling and alignment of budgets – notably for substance misuse service where both Council and NHS spending has been reported to the Drug and Alcohol Action Team and its successor Joint Commissioning Group, and overall spend has been aligned to agreed strategic priorities.

Work is under way to formalize and build on the arrangements for the joint commissioning of the nine broad strands of health provision for children and young people: Child and Adolescent Mental Health Services, Obesity, Teenage Pregnancy and Sexual Health, Substance Misuse, Children with Special Educational Needs and Disabilities, Community Paediatrics, Children's Therapies, school nursing and health visiting. This will enable relevant staff from the health provider and commissioner services, along with those from the Council's Children's Services Department, to agree priorities for service development and delivery and how best to make use of existing resources in each service.

Plans are now well advanced for the development of a Joint Commissioning Unit, which will support the commissioning of adult social care, community health services, public health services. A unit head has been appointed and a staffing structure agreed, and staff within the unit will be co-located from the start of October 2012. Whilst the Unit will have a unified management structure and be overseen by a joint management board accountable to the Joint Commissioning Executive, it will not involve either secondment or transfer of staff, and health and social care budgets will remain distinct. Benefits will accrue through greater alignment of health and social care commissioning plans and budgets. Its implementation is thus governed by a memorandum of understanding and is not dependent on agreement under Section 75 of the NHS Act.

Joint Commissioning for children and young people's health services includes some joint funding arrangements and some arrangements with joint planning but single service funding. The scope to further develop the current arrangements is being explored by the Clinical Commissioning Group, the PCT, Public Health and the Council's Children's Services Department and, following this, the extent of the Joint Commissioning Support Unit's involvement in the commissioning of children's services will be clearer.

As described on on page 19 above, the Health and Wellbeing Board has chosen to champion a programme for integrating the delivery of adult social care and health services. Likewise, the Health and Social Care Integration Programme does not involve transfers of staff between organisations. Instead, the focus is on achieving an integrated user experience of services, through unified provision of information, an integrated system for accessing care, and integration of case management for those in need of complex services.

As the Board reviews progress on the priorities from the JSNA, it will systematically consider whether progress would be advanced through the use of formal 'Section 75' arrangements. An initial appraisal suggests that the benefits are likely to be greatest at two opposite ends of the spectrum. At one end, preventive programmes that will have benefits in terms of reduced need for health and social care, but whose specific impacts cannot be readily ascertained, are more likely to be considered affordable when funding from the different service areas that may benefit is pooled. At the other end, savings and

efficiencies may be found through pooling of budgets covering the costs of care for those with the most complex needs involving health and social care.

Section 5: Making it happen

Delivery of this Joint Health and Wellbeing Strategy can be described in three stages: putting the essentials in place; implementation, monitoring progress; and reviewing and refining the strategy. However, the process is a cyclical one and the stages will not be entirely discrete.

(a) *Putting the essentials in place.* The following preparatory steps will be required:

- agreeing the programme for tackling health inequalities, and arrangements for its oversight and monitoring (by December 2012);
- agreeing timetabled action plans for implementation of the programmes on the three 'enabling actions', as set out on pages 16 to 20 above (by December 2012);
- agreeing the 'dashboard' by which progress and outcomes on the priorities emerging from the JSNA are reviewed (by December 2013).

(b) *Dissemination and implementation.* The following are the initial steps in implementation of the strategy:

- issue of the strategy to inform the 2013-14 commissioning round (by October 2013);
- review action taken by commissioners in response to the strategy (by March 2013);
- wider dissemination of the key messages from the strategy as a community 'call to action' (from October 2013);
- establishing the proposed new partnership groups for tackling alcohol misuse and the development of sexual health services (by March 2013); and
- commencing the systematic reviews of progress on priorities identified through the Joint Strategic Needs Assessment (by March 2013);
- reviewing the case for and feasibility of delegating specific powers from the Council and Clinical Commissioning Group to the Health and Wellbeing Board in relation to partnership functions (by March 2013).

(c) *Monitoring progress.* There will be three main elements to the Board's monitoring of progress and outcomes:

- *Monitoring progress on tackling health inequalities.* The 'Marmot' indicators, currently published by the London Health Observatory for all local authorities in England, provide a nationally validated and annually updated set of outcome measures for work on Health Inequalities. The local analysis of health action to tackle health inequalities will be used to produce a data set including both indicators of local performance and milestones of progress on agreed actions;
- *The 'dashboard' on priorities emerging from the JSNA.* Headline measures for outcomes on the priorities identified through the JSNA will be drawn, as far as possible from the NHS, Social Care and Public Health Outcomes frameworks. The measures initially proposed are as follows:

- Tackling health inequalities - Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities). (Public Health Outcomes Framework)
- Childhood obesity - Excess weight in 4-5 and 10-11 year olds (Public Health Outcomes Framework)
- Teenage pregnancy - Under 18 conceptions (Public Health Outcomes framework)
- Sexual health – Rate of acute sexually transmitted infections diagnosed per 100,000 population (Health Protection Agency data)
- Alcohol misuse - Alcohol-related admissions to hospital (Public Health Outcomes Framework)
- Mental health - Proportion of adults in contact with secondary mental health services in paid employment (Social Care Outcomes Framework), people with mental illness or disability in settled accommodation (Public Health Outcomes Framework), and excess under 75 mortality rate in adults with serious mental illness (NHS Outcomes Framework and Public health Outcomes Framework)
- Circulatory disease - Mortality from all cardiovascular diseases (including heart disease and stroke) (Public Health Outcomes Framework)
- Cancer - Mortality from cancer (Public Health Outcomes Framework)
- Winter deaths - Excess winter deaths (Public Health Outcomes Framework)
- Accidental falls - Falls and injuries in the over 65s (Public Health Outcomes framework), hip fractures in over 65s (Public Health Outcomes Framework), and the proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 and 120 days (NHS Outcomes Framework)
- Carers - Carer-reported quality of life (Social Care Outcomes Framework), overall satisfaction of carers with social services (Social Care Outcomes Framework), and the proportion of carers who report that they have been included or consulted in discussion about the person they care for (Social Care Outcomes Framework)
- Enabling the over-75s to maintain their independence - Permanent admissions to nursing and residential care homes, per 100,000 population (Social Care Outcomes Framework), and proportion of older people (65 and over) who were still at home 91 days after discharge into rehabilitation (Social Care Outcomes Framework and NHS Outcomes Framework)

These headline measures will be supported in the dashboard by a number of local measures, including performance indicators for services contributing to the key outcomes, progress against agreed action plans, and measures of the health of partnership working;

- *Progress against the action plans agreed by the Health and Wellbeing Board for the three 'enabling actions'.* These actions represent the value that the Health and Wellbeing Board adds to implementation of the priorities identified through the joint strategic needs assessment, and they are intended to have cross-cutting benefits. Each action plan will set out clear milestones for progress, and the Board will regularly review the extent to which they have been achieved.

(d) *Reviewing and revision.* Following agreement to this initial version of the Joint Health and Wellbeing Strategy by the Health and Wellbeing Board and the wider Health and Wellbeing Partnership, the following will be the key stages of review and revision:

- issue of the Joint Health and Wellbeing Strategy for public consultation (by November 2012);
- agreement on revised Joint Health and Wellbeing Strategy, taking account of public consultation outcome and requirements arising from NHS Commissioning Board mandate (by March 2013);
- minor revision of Joint Strategic Needs Assessment, to give a greater emphasis to understanding of community assets and analysis of current use of resources (by Autumn 2013);
- more substantial review and updating of Joint Strategic Needs Assessment (by Autumn 2014);
- review and update of the Pharmaceutical Needs Assessment (by February 2014); and
- regular review and updating of Joint Health and Wellbeing Strategy to take account of new JSNA findings, community and partnership feedback, and changes to the NHS Commissioning Board mandate (at least annual).