



South West London

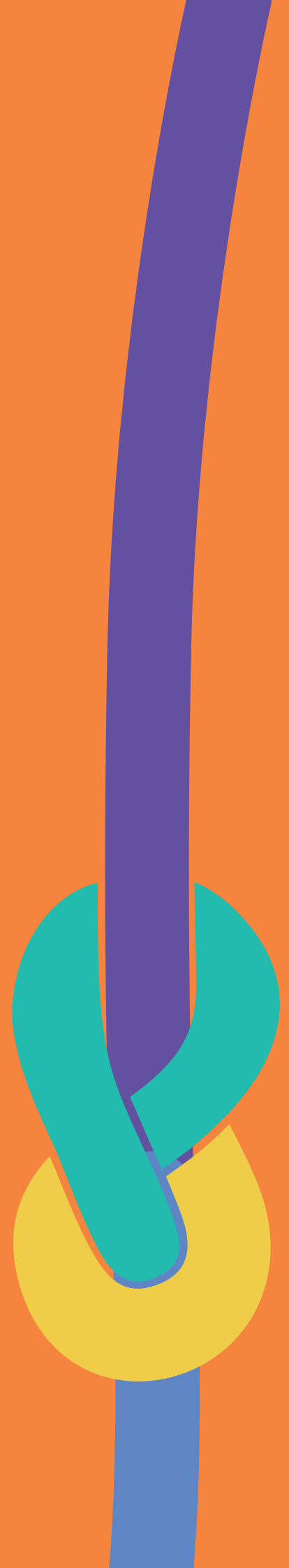
Health & Care  
Partnership

Start well, live well, age well

The Royal Borough of  
Kingston upon Thames

# Health and Care Plan

2019-2021



# Kingston's Health and Care Plan 2019-2021

## – an introduction from Cllr Liz Green, Chair of the Health and Wellbeing Board

Local people have been involved in the development of this two year Health and Care Plan for Kingston which brings together our commitment to deliver on the health and care priorities important to them.

This plan focuses on the actions which no single organisation could achieve alone. In addition to all the other work we do, this plan is about our local NHS, the Council, voluntary and community services working better as a whole system to improve health and care together.

Across all of our organisations, there are significant financial challenges ahead and this plan is, therefore, incredibly important for prioritising our resources where they are needed most.

These priorities and actions identified for children to start well, for adults to live well, for people to age well, for carers to be supported and for prevention to be championed across all ages, have been endorsed by local people, the voluntary and community sector and professionals across the health and care system.



**Cllr Liz Green**  
Chair of the Health and Wellbeing Board  
August 2019

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Our health and care  
partnership and joint vision

# Our health and care partnership and joint vision

The plan has been developed in partnership with local people, voluntary community groups and health and care partners in the borough of Kingston.

Here's a list of the partners involved:

- Achieving for Children
- Camden & Islington Mental Health NHS Trust
- Community pharmacists
- Healthwatch Kingston
- Kingston GP Alliance / Kingston GPs
- Kingston Hospital NHS Foundation Trust
- Kingston Voluntary Action (voluntary sector)
- Local people
- NHS Kingston CCG
- Royal Borough of Kingston upon Thames
- South West London and St George's Mental Health NHS Trust
- Staywell
- Your Healthcare Community Interest Company

## Our vision

Kingston partners have a history of working together with local people to design, develop and implement health and care strategies and services that improve the health and wellbeing of the local population.

Key themes within these strategies include:

- Greater preventative and early intervention approaches to enable people to improve and maintain their health, retain their independence, and develop their confidence in managing their care
- Greater involvement of the community and voluntary sector to help people to be connected to their community, stay healthy and look after themselves
- Greater joined-up care by increased collaboration between acute, primary, community, mental health and voluntary sector providers
- Consistent high quality care closer to home, and access to more specialised services within the community
- An increased focus on holistic health, bringing together physical and mental health to improve outcomes for people, reducing health inequalities, including for those with a long term health condition, or serious mental illness
- Access to improved technology that improves the ability to access necessary services, advice or information relevant to their needs
- Empowered communities, families and individuals by investment in **preventative, early intervention and self-care approaches**
- **Recognise and value the huge contribution carers make**, support them in their caring role and enable them to have a life outside of caring

**Kingston Coordinated Care (KCC)**, our alliance of partner organisations from across all sectors in Kingston, comprising providers and commissioners, have been working together to develop and implement this new model of community care provision for the population of the Royal Borough of Kingston upon Thames. This approach places a greater focus on preventative and early interventions to enable people to become more independent and confident in managing their care, with greater involvement of the community and voluntary sector to help **people to be connected to their community, stay healthy and look after themselves.**

## The aims of Kingston Coordinated Care are to:

- Integrate and transform the health and social care system, providing person-centred care whilst shifting care away from the acute setting and into the community. It will provide the right care in the right setting
- Develop active and supportive communities in which people are enabled to stay healthy and well, seeking care when they need it closer to their home

This model of care is the result of a multi-agency design piece, underpinned by the ‘voice of the customer’ through public engagement to understand the changes required within the system to deliver desired outcomes.

Kingston partners have been working together with local people to develop this health and care strategy which aims to improve the health and wellbeing of the local population, covering all ages but divided in to different life stages:

**Start well** for babies, children and young people

**Live well** for working age adults;

**Age well** for people of increasing years and at the end of their life.

### Start well

What happens in early life, starting from conception, affects health and wellbeing in later life. Prevention is critical to ensuring that all children and young people can fulfil their potential.

### Live well

Healthy choices are influenced by our environment, communities and wellbeing. Preventative approaches are needed at all levels; engaging communities, utilising local assets and targeting those most at risk.

### Age well

Whilst people are living longer, many older people are also living with a reduced quality of life due to ill health or disability, or experience loneliness and isolation.





# The Kingston story



# The Kingston story

The Royal Borough of Kingston upon Thames in south west London has the smallest population of any borough in London (after the City of London) and is the seventh smallest borough in terms of geographical area. The residents of Kingston are, on the whole, healthier and more affluent than the average London borough. There is variation across the population, with some people doing less well than others.

## Kingston's population

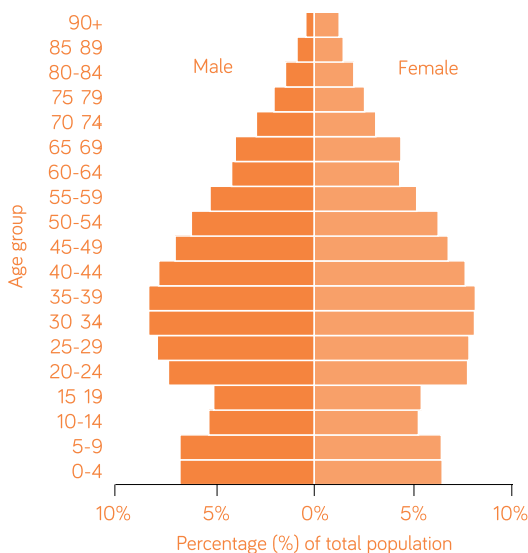


Figure 1: Kingston's population pyramid  
Source: ONS 2016 mid-year estimates

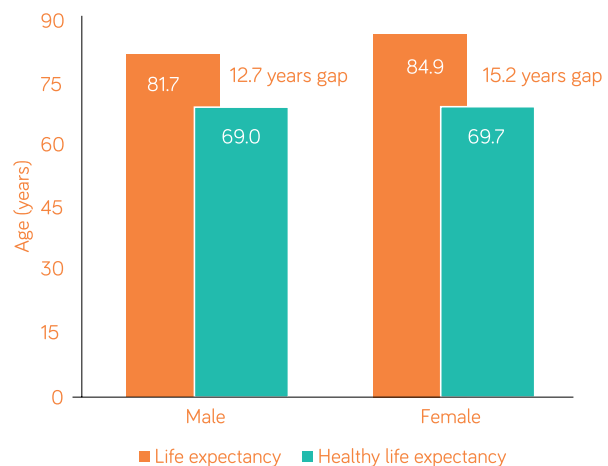


Figure 5: Life expectancy gap in Kingston (2014-16)  
Source: Public Health England

- 176, 107 people living in the borough (209,515 registered with Kingston GP practices)
- Young population, with a median age of 36.2 years
- Projected to grow by 9% between 2017-27, with more very old (over 90 years)
- One third (31%) are from Black, Asian and Minority Ethnic backgrounds
- Last years of life are lived with disability for an average of 12.7 years for men and 15.2 years for women

## Deaths and their main causes

The three leading causes of deaths in people of all ages in the borough Kingston are:

- cancer (27%)
- diseases of the circulatory system (26%); and
- diseases of the respiratory system (15%).

Deaths among those aged under 75 years, known as premature deaths, are an important public health indicator, with many of these premature deaths being preventable.

Leading causes of death amongst those aged under 75 years were:

- cancer (46.7%)
- diseases of the circulatory system (23.7%)
- diseases of the respiratory system (19.2%)

The suicide rate in the borough of Kingston (7.0/100,000 population) is not significantly different to the England average (9.9/100,000 population).

Smoking attributable mortality in the borough of Kingston is significantly lower than the regional and national averages (2014 -16).

Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity: there were 106 deaths in the borough of Kingston during 2014-16, which is significantly better than the rate for England.

The mortality rate from influenza and other infectious disease in the borough of Kingston was similar to England.

## Self-reported health

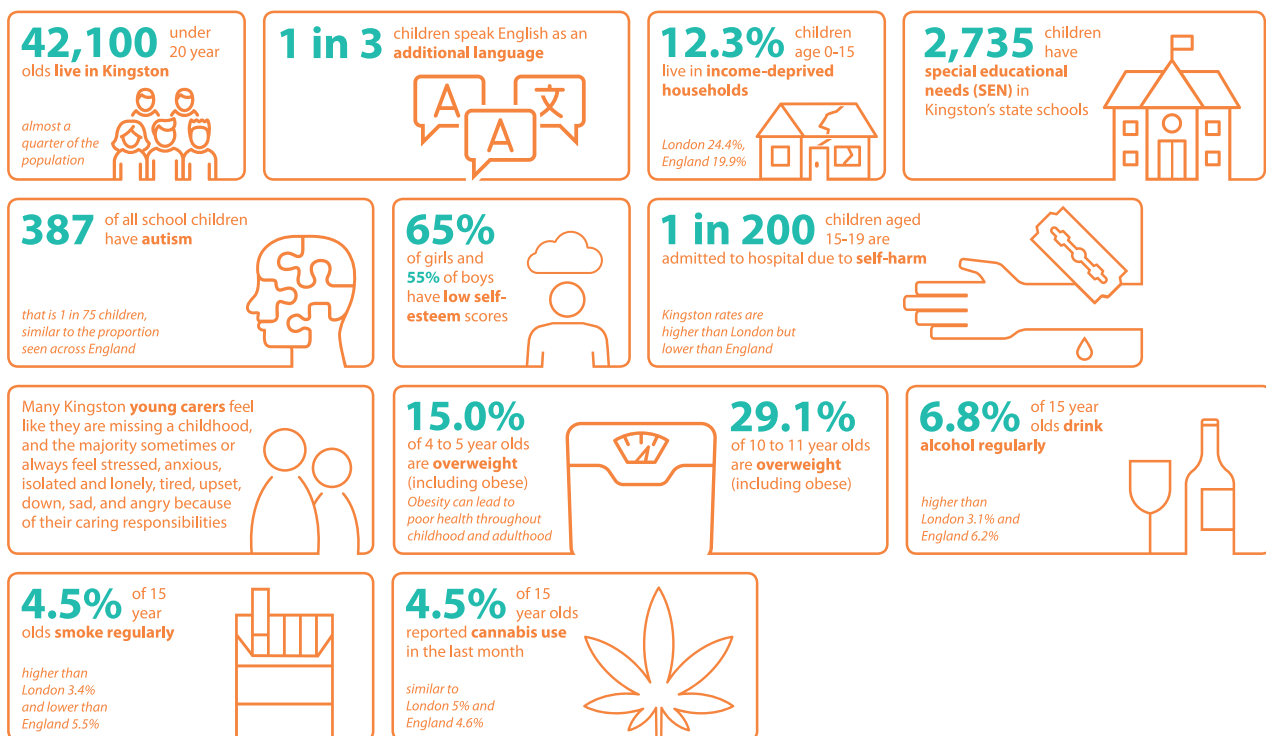
A higher percentage of Kingston residents (86%) reported that they were in good or very good health compared to the London average (84%). The percentage of Kingston residents that stated that their day to day activities were limited a lot (5%) was less than the London average of 7%.

## Prevalence of main health conditions

Recorded illness in general practice can help to present a picture of the burden of ill health within the population. High blood pressure (hypertension), depression, asthma, obesity and diabetes were the most commonly diagnosed conditions among people registered with Kingston GPs.

# Start well

What happens in early life, starting from conception, affects health and wellbeing in later life. Prevention is critical to ensuring that all children and young people can fulfil their potential.



The health and wellbeing of children in Kingston is generally better than the England average. Good educational attainment is linked to better physical and mental health, as well as income, employment and quality of life. Intervening effectively when children and adolescents are starting to develop mental health problems could prevent between a quarter and a half of adult mental illness. Nationally, up to half of all lifetime mental health problems start before the age of 14.

Children and young people with learning disabilities are among the most vulnerable in a community and can have a wide range of support and access needs. Many will have additional health problems, including physical disabilities and sensory impairments.

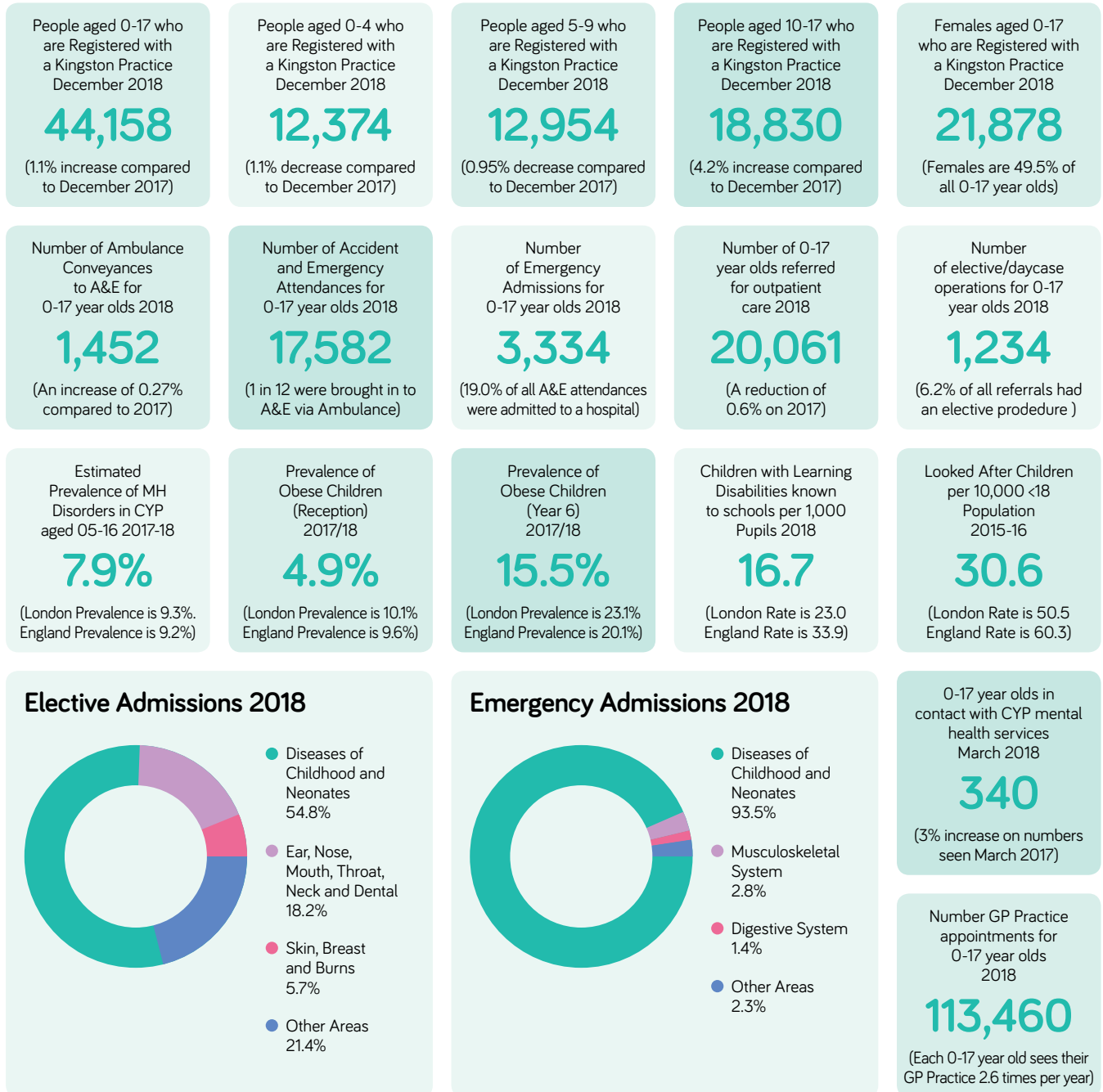
Speech, language and communication needs are the second most common primary care need. Children with disabilities or special needs are also more likely to experience or live in poverty.

Obesity in children can cause social and emotional problems and increases the likelihood of developing long term conditions. Obesity persisting into adulthood can lead to type 2 diabetes, cardiovascular disease, joint problems and poor general health. Our Start well plan will drive forward a preventative approach, engaging local children and young people, utilising local assets.

## How are we doing in the borough of Kingston

- Children make up a quarter of the population
- 53.1% school children are from black and minority ethnic groups
- 13.4% children live in **low income families** (lower than London)
- 30% school children have **low self-esteem** with 81% of girls and 65% of boys worrying 'often' or 'quite often' about aspects of their life. The top worry for both genders are exams and tests
- Over 2,000 (7.9%) school children are estimated to have **a mental health problem** (conduct disorder, anxiety, depression, ADHD, ASD, eating disorders), and the numbers are rising
- There were 48 hospital admissions for self-harm in 15-19 year olds ( 1 in 200) which is higher than London rates
- **Risky behaviours in adolescence** – a higher proportion of young people smoke, there is **rising harm from 'party' drugs**, and risky sexual behaviour at a younger age, including accessing sexual images and drugs through the internet and social media. These are linked to emotional issues and poor mental health and resilience
- 2,735 children have **special educational needs** (SEN Support, Statements and Education, Health Care Plans (EHCPs)). Two thirds of this cohort are boys. The most common disability is autism spectrum disorders (46.3% of all SEN pupils) which is much higher than the proportion nationally (30.5%)
- 481 children with **learning disabilities** and 1 in 60 children under 18 in Kingston have a moderate, severe or profound multiple learning disability. This equates to 16.6 per 1000 pupils, which is lower than London's and England's rates
- 387 children with **autism** are known to schools, equating to one in 75 children. This is similar to the proportion of children known to schools in England
- 29% of 10-11 year olds are **overweight or obese** (lower than seen across London)
- Rates of admission to hospital for extraction of **decayed teeth** is a third higher than London
- Rates of **attendance at A&E** for any reason is higher than England, and admission to hospital for injuries is higher than London
- **MMR immunisation rate** (86.1%) too low to protect the population (95% coverage)

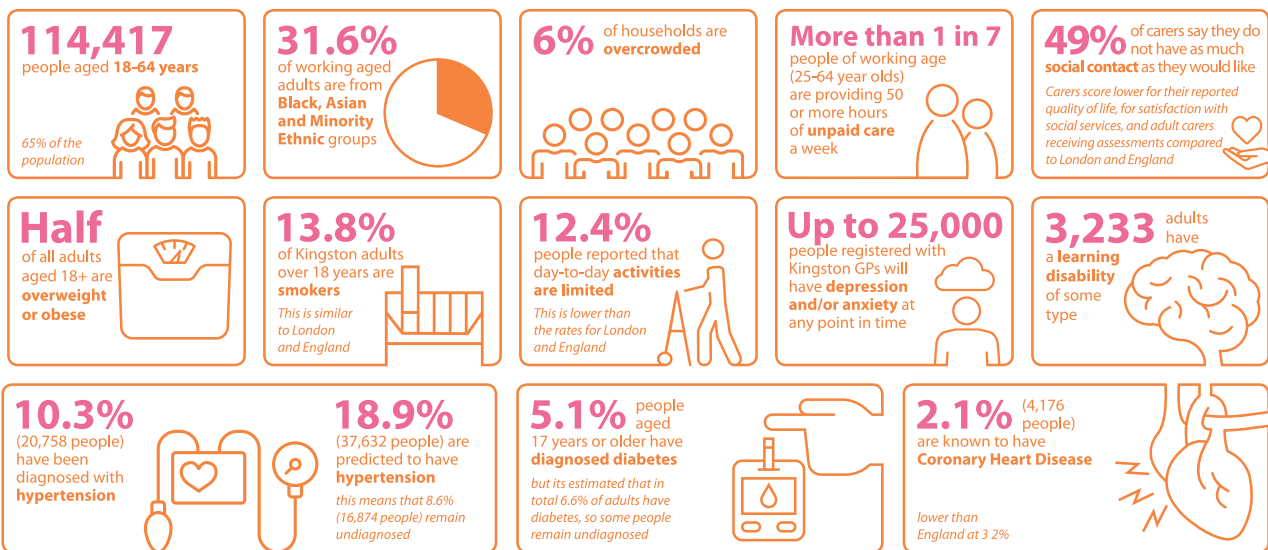
## Kingston Clinical Commissioning Group Start well



Source: NHS

# Live well

Wellbeing is influenced by our environment, communities and access to healthy choices. This plan will drive forward preventative approaches at all levels; engaging communities, utilising local assets (e.g. parks and open spaces) and targeting approaches to reach those most at risk.



The health and wellbeing of our working age population impacts not just individuals, but also families, children, workplaces, business and communities. Although people of working age are relatively less likely to suffer ill health than younger and older people, because they are the largest population group they are an important source of activity for public services. Promoting good health in adulthood can also prevent the development of many long-term conditions and disability in older age.

Health is influenced by many factors. These include fixed factors (like age, gender and genetics) but other factors we can change play a key role. These include individual behaviours, the environment and access to health and care services. Healthy choices are influenced by the information we have, our surroundings and the communities around us.

As a health and care system we are moving beyond a focus on individual behaviour towards a wide range of social and environmental interventions to improve the health of the population and reduce preventable diseases. We are also taking a more proactive approach to certain health conditions, intervening earlier, preventing the serious consequences of these conditions and delivering more efficient care.



Some working age adults are ‘at risk’ and or will be diagnosed with a long-term condition (a condition that cannot, at present, be cured but is controlled by medicines and/or other therapies) and these can be limiting long-term conditions, i.e. a health problem, or disability which limits someone’s daily activities or the work they can do.

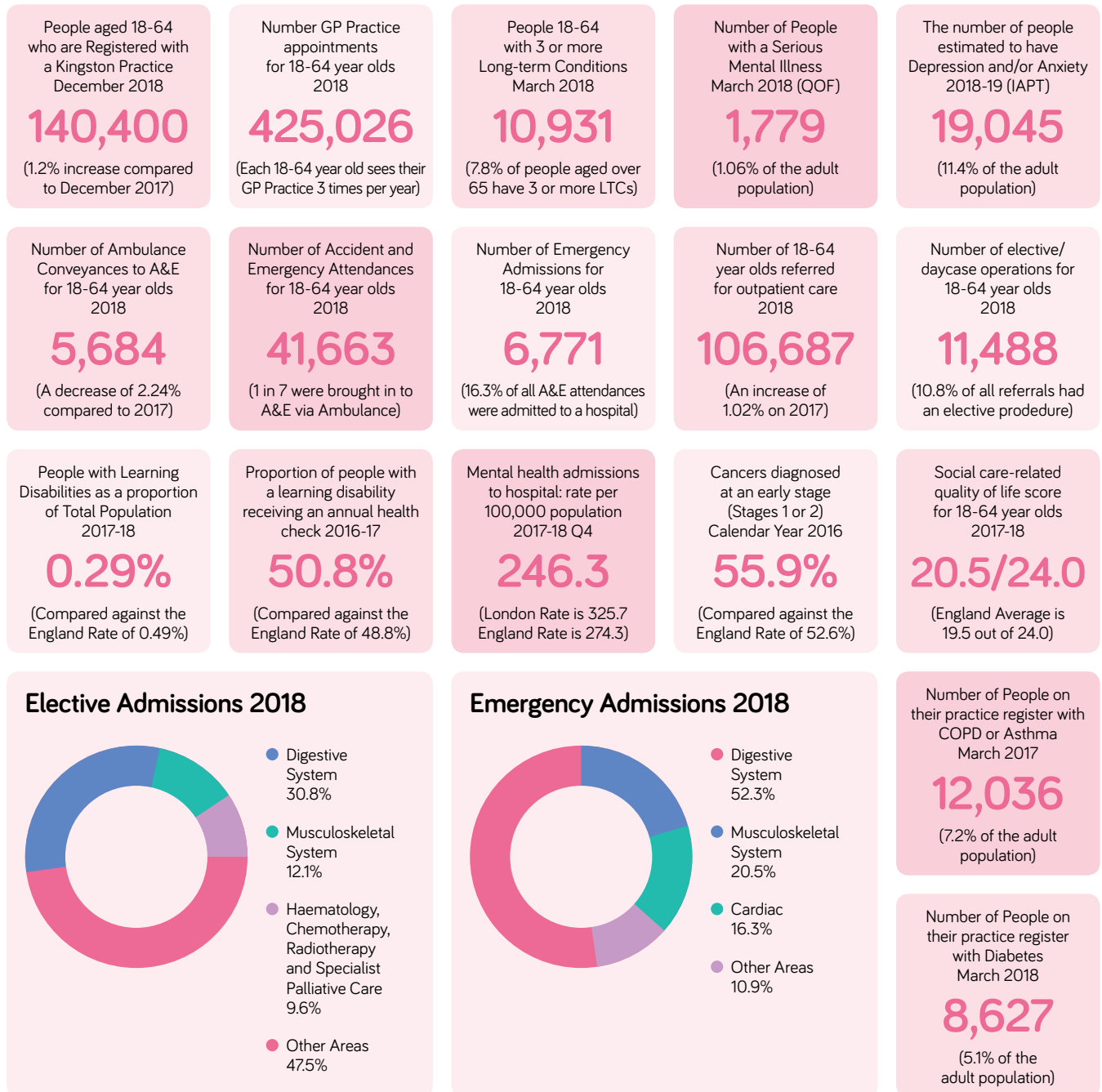
Having one or more long-term condition generally reduces quality of life and increases the chances of requiring support from health or social care services. It is recognised that if people with long-term conditions are managed effectively in the community, they should remain relatively stable and enjoy a quality of life free from frequent crises or hospital visits. Local health and care partners are working together to work in more integrated ways to support people with long-term conditions to manage their own conditions and improve the care they receive when they come into contact with health and care services.

Our Live Well plan will drive forward a preventative approach at all levels; engaging communities, utilising local assets and targeting interventions to reach those most at risk.

## How are we doing in the borough of Kingston

- There are 114,417 working age adults living in the borough of Kingston
- One in four people will experience **mental illness** in a year.
- 21,000 adults have common mental illnesses such as **depression or anxiety**. Under-diagnosis and under-treatment is likely.
- People are living longer and there is an increased incidence of people living with one or more **long-term conditions**. Nearly one in three people have a long-term condition and nearly one in ten people are living with three plus long-term conditions.
- **Cancer screening** coverage for breast (70%), cervical (66.2%) and bowel (55%) are all lower than England. Cancer is the leading cause of death in under 75 year olds.
- Over 40, 000 people are predicted to have **high blood pressure**, but only half have been identified.
- 3.8% of people are thought to have coronary heart disease, although only 2.1% have been identified. Whilst the prevalence is lower than England, **coronary heart disease** is the leading cause of death in men.
- 6.9% of people are predicted to have **diabetes**, but many people have still to be identified and diabetes is a major cause of ill health in the borough of Kingston.
- There are **hidden needs** in certain population groups, including those living in more deprived locations in the borough of Kingston, people from Black and Minority Ethnic groups, Koreans, Tamils, the homeless, gypsies and travellers and people with learning disabilities.
- Adults in the borough of Kingston have **healthier habits** compared to Londoners (26.7% are **physically active**, 54% eat five fruit and veg a day, 58.2% are overweight or **obese**), although nearly 1 in 3 adults drink more than the recommended 14 units of **alcohol** per week.

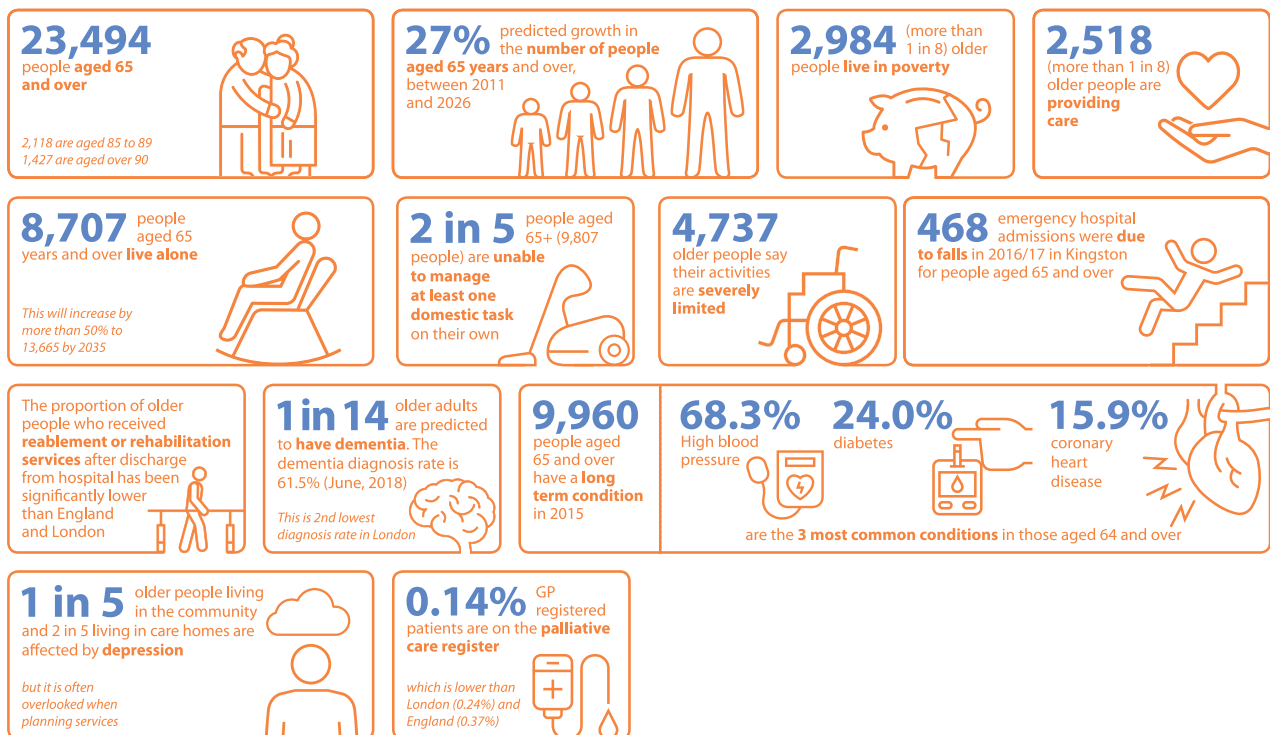
## Kingston Clinical Commissioning Group Live well



Source: NHS

## Age well

Whilst people are living longer, many older people are also living with a reduced quality of life due to ill health or disability, or experience loneliness and isolation. Wellbeing is influenced by our environment, communities and access to healthy choices. This plan will drive forward preventative approaches at all levels; engaging communities, utilising local assets (e.g. parks and open spaces) and targeting approaches to reach those most at risk.



Maintaining health into older age will increase people's chances of remaining independent and in control of their lives. Healthy lifestyles continue to be important, as does staying socially connected and being able to manage long-term conditions. Many older people also find themselves in a caring role. Health and social care provision needs to adapt as the population over the age of 65 continues to increase.

Meeting the needs of an ageing population has considerable consequences for planning health and social care services. One of the highest risks in older age is loneliness. Widowed homeowners living alone with long-term conditions are at particular risk.

Housing is a key determinant of health, and the need for suitable accessible accommodation and adapted properties increases with age. People generally prefer to stay in their own home rather than move into residential or nursing care. Being unable to afford to sufficiently heat a home can lead to heart disease and respiratory diseases, and to excess deaths in winter that should be preventable.

Illness or disabilities can restrict a person's ability to take part in social activities.

Long-term conditions are more common in older people and people with long-term conditions are three times more likely to have mental health problems than the general population.

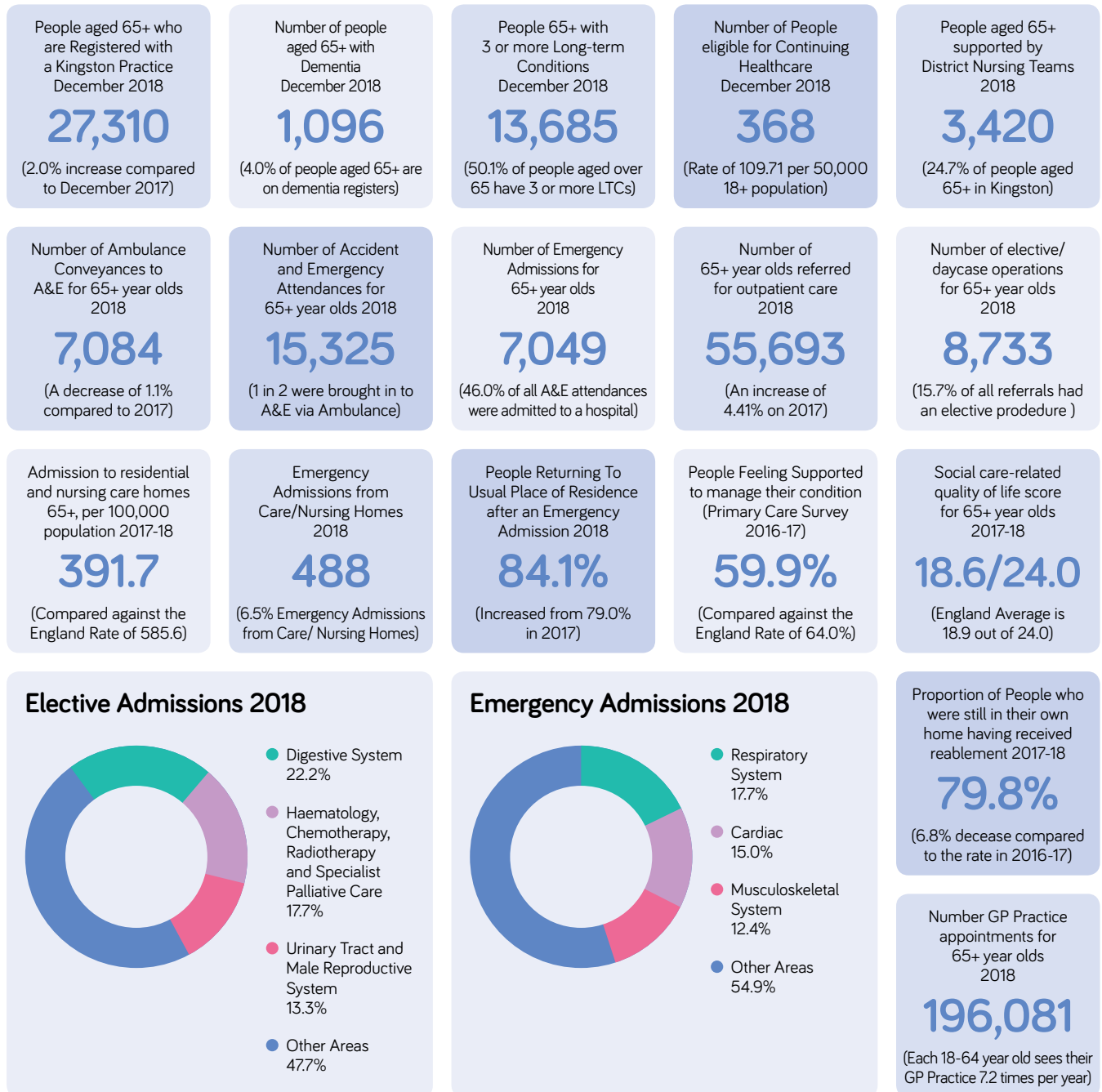
Delaying and reducing the need for care and support with earlier diagnosis, intervention and reablement, delivered in the most appropriate setting, is more cost-effective and means that older people and their carers are less dependent on intensive services and can retain their independence.

Good end of life care enables residents to have a dignified, controlled and peaceful end to their life. We aim to support people approaching the end of their life to have control over how their last days are lived, and for them to be able to die with dignity.

## How are we doing in the borough of Kingston

- There are 23,500 people age 65 and over living in the borough of Kingston
- Over the next 10 years the number of people aged over 65 will rise by 25% to 30,340 people
- 8,707 (10.6%) people aged 65 years and over live alone, this will rise to 13,665 by 2035; an increase of 56.9%
- 8,060 people aged 65 and over are **unable to manage at least one self-care activity** on their own. This number is projected to increase to 12,922 by 2035; an increase of 60.3%
- Only 27.8 adult **carers** have as much **social contact** as they would like
- **Cancer is the leading cause of death** (46.7%), followed by **circulatory disease** (23.7%) and **respiratory disease** (19.2%)
- **High blood pressure** (42.4%); **diabetes** (11.6%) and **chronic kidney disease** (10.7%) are the **three most prevalent conditions** within those aged 65 and over
- 6,511 **admissions to hospital** for over 75 years' olds for a stay less than 24 hours, which is higher than England
- 2,166 **injuries due to falls** in people 65 and over
- 601 **unplanned admissions for chronic ambulatory sensitive conditions**
- Less than 1 in 3 people felt supported to manage their condition
- 1600 people have **dementia**, of which 64% are diagnosed (Dementia diagnosis rate)
- One in five older people, and two in five living in **care homes**, have **depression**, although it is not always recognised and treated

## Kingston Clinical Commissioning Group Age well



Source: NHS

See Kingston's Strategic Needs Assessment for more information about local health and social care needs [www.kingston.gov.uk/jsna](http://www.kingston.gov.uk/jsna)



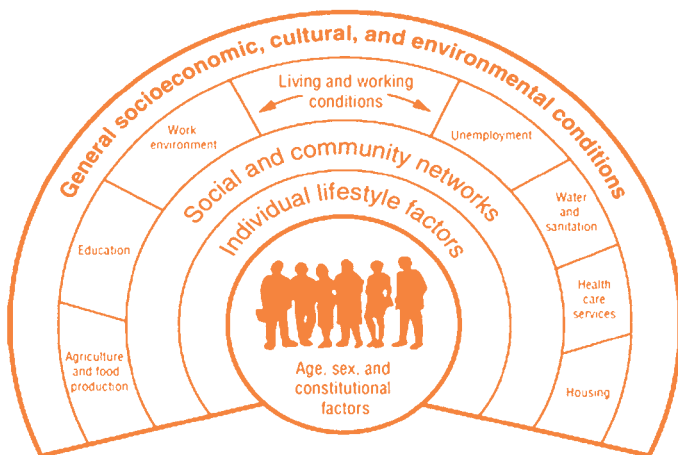


## The wider determinants of health in Kingston



# The wider determinants of health in the borough of Kingston

The wider determinants of health are a diverse range of social, economic and environmental factors which impact on people’s health.



Source: Dahlgren and Whitehead (1991)

Child poverty: 13.9% of children in the borough of Kingston (4,705 dependent children under 20) lived in low income families during 2014. According to the ONS 2011 Census, 3.6% of young people aged 16-24 were providing at least one hour of unpaid care per week in the borough of Kingston.

- Unemployment: The unemployment rate (4.4%) was not significantly different to the England rate (4.8%) during 2016. There were 240 people aged 16-64 years claiming long term Jobseeker’s allowance
- Having an income is a factor associated with better health in older people. 12.7% of people aged 60 and over in the borough of Kingston are living in income deprived households (English Indices of Multiple Deprivation)

- 9.4% of households in the borough of Kingston experience fuel poverty. Recent data (2015/16) indicate that Kingston’s excess winter death index (17.4) is similar to the England figure (15.1)
- Housing, in general, is not affordable. Kingston has a high ratio of house prices to annual earnings, with median house prices being 12.8 times the median gross annual residence-based earnings
- Overcrowded housing can lead to poorer health. According to the ONS 2011 Census, around 6% of households in the borough of Kingston are classified as overcrowded. Overcrowding in the borough of Kingston households is significantly worse in comparison to the national average
- Social isolation and loneliness have a detrimental effect on health and wellbeing. Older people are particularly vulnerable to social isolation and loneliness due to loss of friends and family, mobility or income. According to the ONS 2011 Census, around 4% of all households in the borough of Kingston were occupied by a single person aged 65 or above. The percentage of older people living alone in the borough of Kingston is significantly below the national average. Living alone does not always lead to loneliness, but it is a commonly measured indicator and so is included here



## What local people have told us





In November 2018, we held an engagement event for local people, health and care staff, and representatives from community organisations to test our early thinking and talk about things which no single organisation can achieve alone.

We wanted to check whether we were focusing on the right areas for the borough of Kingston, and how to ensure the action we take has maximum impact for local people. There was great energy and fresh ideas in the room. It was clear that people were passionate about health and care in our borough and wanted to support us. You can read more about our engagement event here:

[www.kingstonccg.nhs.uk/have-your-say/health-and-care-plan-event-2018.htm](http://www.kingstonccg.nhs.uk/have-your-say/health-and-care-plan-event-2018.htm)

Some areas for action which were highlighted at the engagement event are summarised below:



In March 2019, a mix of health and care professionals from NHS, Council and voluntary sector and Healthwatch Kingston came together for a working session to build on the information we have about Kingston and what we heard from local people to agree the key actions and outcome measures to support our health and care priorities.

These conversations informed Kingston's Health and Care Plan discussion document. This was published at the beginning of May 2019, and during this month targeted engagement took place to sense check and test the proposals with groups in the Start Well, Live Well and Age Well cohorts. This work has been led by the borough's communications and engagement group with representation from key health and care partners, Kingston Voluntary Action and Healthwatch Kingston.

Information about the discussion document and how to provide feedback was shared with health and care partner networks and to a range of local voluntary and community organisations and groups. This included completing a short online survey hosted on Kingston Council's website.

Where possible we also used relevant forums and groups meeting during May to discuss the document and seek feedback.

An engagement report providing an overview of the insight and engagement activities has been produced and you can find it, along with a 'You Said, We Did' document which summarises the actions we have taken in response to what we heard from local people, and health and care partners here:

[www.kingstonccg.nhs.uk/have-your-say/Developing-our-health-and-care-plan.htm](http://www.kingstonccg.nhs.uk/have-your-say/Developing-our-health-and-care-plan.htm)

Following publication of Kingston's Health and Care Plan we will continue to work with those most involved in and affected by the plan as we deliver the actions.





## Financial context



# Financial context

Good, sustainable and adaptive health and care services need to be underpinned by sustainable financial balance, however health and social care sectors both face significant financial challenges.

The health sector has been set challenging financial targets for the 2019/20 financial year. Kingston CCG operated with a marginal £1.08m in year surplus in 2018/19 financial year and has a £0.6m underlying surplus. Funding for services is expected to increase by £40.3m in 2023/24 however in the same period our costs are expected to rise by £48.1m.

Kingston Council reported a £3.9m forecast overspend for 2018/19, this is 3.1% of the overall budget of £123m (excluding the ring-fenced money for housing and schools), meaning that tough decisions were needed to set a balanced budget for 2019/20.

Overall, the council needs to save £22m in the 2019/20 financial year and is working hard to recover the current forecast overspend. Of the £22m savings, some are currently at risk of not being delivered and recovery plans are being put in place to bring it back into balance. These savings do not start to tackle the £11m deficit in the special educational needs and disability schools budget.

Kingston is now in a position where it no longer receives any revenue support funding from central Government. Alongside these reductions to our funding, the demand on local services is greater than it's ever been and inflation is adding to the costs of providing them. Kingston has a growing population, which has increased by 20,000 since 2011, reaching 179,600 this year. The elderly population (65+) has also grown from 20,500 in 2011 to 24,300 in 2018 and is projected to reach 32,000 by 2030.

This is adding to the pressure on council services, particularly those that support the most vulnerable. Over the next four years the demand for adult social care services is forecast to cost over £7m more than we currently spend. Added to that, schools funding and supporting children with special educational needs and disability continues to be a challenge both locally and nationally.

The new NHS Long Term Plan shows a clear intention to move towards making all NHS organisations and systems financially sustainable within 5 years. This is supported by a clear national intention that local systems move to a more transparent and collaborative approach to planning and delivery, to reduce costs but also to maintain and improve services.

In the borough of Kingston there is a clear shift towards collaborative working, both within the health sector and with Local Authority and other partners in terms of an increased focus on preventative and early intervention support, together with planning and providing services in an integrated way that is focused around the person.

Effective reduction of costs whilst providing quality services is possible, and as such system leaders in the borough of Kingston are determined to maintain financial balance to support and enable this ambitious Health and Care Plan.

As part of implementation planning, work will be undertaken to model the financial implications of the proposed actions in this plan. However, a significant focus of the plan is on service transformation within existing resources.



**Our priorities and the actions we will take to deliver them**

# Our priorities and the actions we will take to deliver them

Based on the conversations we have had with local people, the Kingston story and the case for change we have agreed some priority areas for actions.

Within this report priorities and actions are grouped in the following areas:

**Prevention and early intervention**

**Start well**

**Live well**

**Age well**

**Unpaid Carers**

# Prevention and early intervention

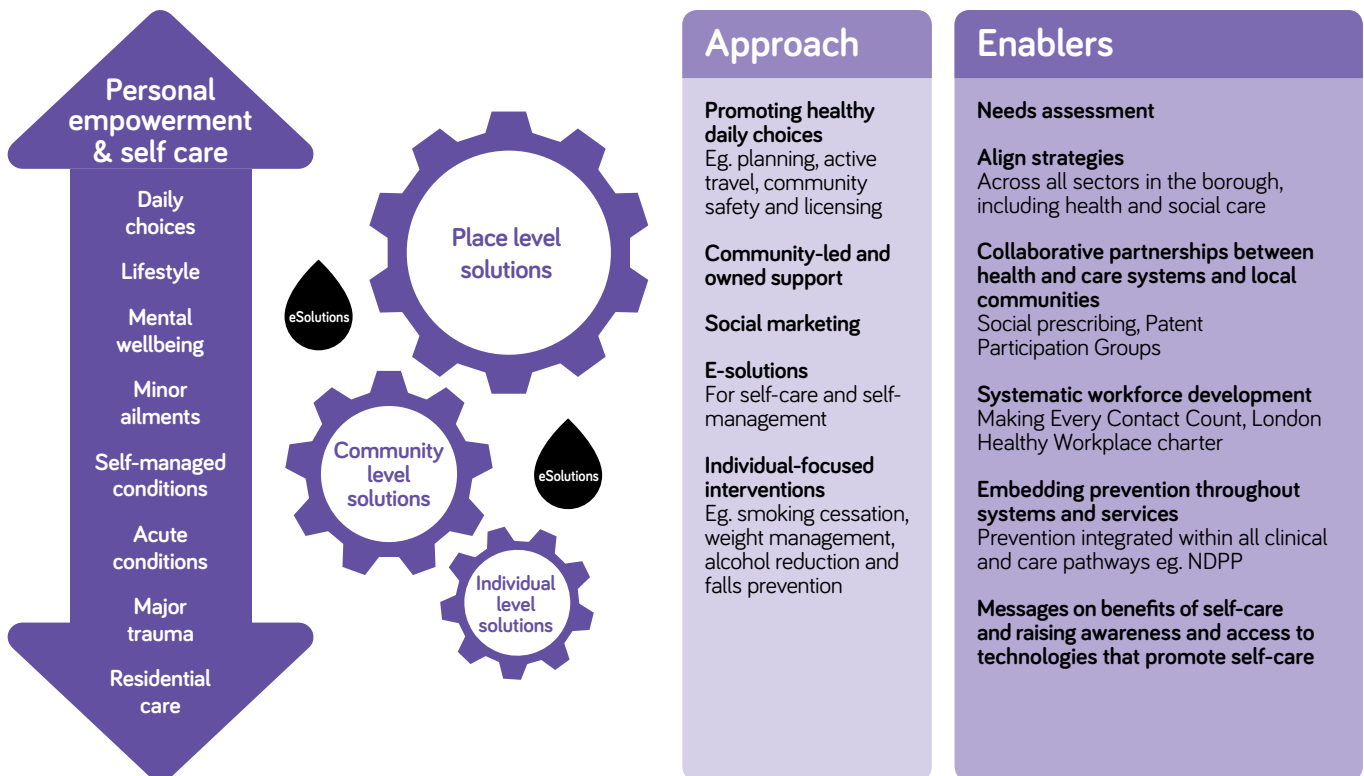
In developing our plan we identified prevention and early intervention, and carers as themes which were important to consider across the life stages. We have included a section about meeting the needs of carers later in the document.

## The NHS Long-Term Plan




The NHS Long Term Plan states that we need to shift focus to prevention and public health or we will be faced with a sharply rising burden of avoidable illness. It is therefore essential that prevention is embedded into every aspect of health and care provision. Health and care partners in the borough of Kingston have agreed that prevention is a cross cutting priority and we should create environments and enable communities and individuals to lead healthy lives and be confident in their ability to care for themselves and others.

## A whole system approach to self care

The diagrams below illustrate that we need to take a whole systems approach to prevention, and self-care, with a focus on maintaining independence and social connections.



Young and old: prevention matters

Best start in life	Adulthood	Later life
<p>Pregnancy services</p> <p>Childhood immunisations</p> <p>School environment</p> <p>Secure home</p> <p>Healthy eating and physical activity</p> 	<p>A safe and secure job</p> <p>Mental wellbeing</p> <p>Exercising</p> <p>Healthy diet</p> <p>Not smoking</p> <p>Drinking moderately</p> 	<p>Safe and accessible home environment</p> <p>Keeping physically active</p> <p>Eating a healthy diet</p> <p>Maintaining social connections</p> 

Source: Public Health England

Here is a summary of the work which is ongoing in the borough of Kingston in the area of prevention.

**The first 1,000 days**

The first 1,000 days of life, from conception to age 2, is a critical phase during which the foundations of a child’s development are laid. If a child’s body and brain develop well then their life chances are improved. Exposure to stress or adversity during this period can result in a child’s development falling behind their peers. Left unaddressed, experiences can stay with children throughout their lives, can cause harm to them and to others, and might be passed on to the next generation.

Intervening more actively in the first 1,000 days of a child's life can improve children's health, development and life chances and make society fairer and more prosperous. Improving support for children, parents and families during this vulnerable period requires a long-term and coordinated response with high-quality local services for children, parents and families founded on the following six principles:

- services are available to all but targeted in proportion to the level of need
- prevention and early intervention is vital
- community partnerships are needed
- there should be a focus on meeting the needs of marginalised groups
- there needs to be greater integration and better multi-agency working
- provision must be evidence-based

We will work to develop a plan to improve support for children, parents and families in the first 1,000 days of life, which reflects these principles.

### Making every contact count

- Many long-term diseases in our population are closely linked to known behavioural risk factors. Around 40% of the UK's disability adjusted life years lost are attributable to tobacco, hypertension, alcohol, being overweight or being physically inactive
- Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor health significantly. Making every contact count (MECC) is an approach to behaviour change that utilises the millions of day-to-day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations
- Using every appropriate opportunity to have a health conversation, to help and encourage people to make healthier choices, so they can achieve positive long term behaviour change to improve their health and wellbeing

### Social prescribing

Social prescribing enables a wide range of people who meet the public, including GPs, nurses and other primary care professionals, to connect and refer people to a range of local, non-clinical services and activities in their community. Recognising that people's health is determined by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way and support them to take greater control of their own health.

Kingston's social prescribing programme is called Connected Kingston. It is made up of three elements: a web-based directory of activities in the community, searchable by topic or geographical location; a network of Community Champions, trained to have motivational conversations and sign-post people to local activities; a group of Community Connectors who have a series of one-to-one coaching sessions with people who need additional support to access opportunities in the community.

Social prescribing schemes involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports. There are many different models for social prescribing, but most involve a link worker or navigator who works with people to access local sources of support.

Social prescribing is designed to support people with a wide range of social, emotional or practical needs, and many schemes are focused on improving mental health and physical wellbeing. Those who could benefit from social prescribing schemes include people with mild or long-term mental health problems, people who are socially isolated, and those who frequently attend either primary or secondary health care.

### Prevention into care pathway design

NHS health checks and prevention programmes such as smoking cessation, exercise promotion, moderating alcohol intake, weight management, and mental wellbeing will increasingly be embedded in all care pathways.

### London Healthy Workplace Award

The London Healthy Workplace Award provides a framework for employers which can be used to help them focus on the health and wellbeing of the workforce. The business benefits of having a healthy, fit and committed workforce are clearly recognised e.g. lower absence rates, fewer accidents, improved productivity, staff who are engaged and committed to the organisation and fitter employees as they grow older. The award supports employers to build good practice in health and work in their organisation. It covers a range of health and wellbeing themes including mental health and wellbeing, smoking, physical activity, healthy eating and problematic use of alcohol and other substances



## Start well

What happens in early life, starting from conception, affects health and wellbeing in later life. Prevention is critical to ensuring that all children and young people can fulfil their potential.

Within **Start well** we have identified three priority areas for actions:

- 1 **Maximise the mental wellbeing and resilience of our children and young people**
- 2 **Improve the health of children and young people with a focus on tackling childhood obesity**
- 3 **Give children and young people with special educational needs and disabilities opportunities to flourish and be independent**

Within each of these priority areas we now describe the specific actions we will take and the expected outcomes.

### 1 Maximise the mental wellbeing and resilience of our children and young people

#### The actions we will take:

Ensure that there is an **emotional wellbeing programme** in all of our schools, by April 2021. This will include wellbeing support, training and information to students, parents and staff.

Provide easy access to **online resources and digital counselling by March 2020** to improve emotional wellbeing and strengthen resilience.

Work with young people to develop mechanisms to involve them in the design, commissioning, delivery and **promotion of peer-led** services to reduce involvement in **risk-taking behaviours**.

Improve the quality of the experience and outcomes for young people who **transition from children's to adult mental health services**.

Provide **support and advice** to parents and carers to develop their confidence in **caring for their child**.

#### The impact of these actions will be:

**Timely access to support and local counselling** will be available for children and young people, seven days a week through the digital offer.

**Incidences of self-harm and its impact** will reduce because children and young people will receive better support.

Young people, with identified mental health needs, will have a **planned and smooth transition between child and adult mental health services.**

Children and young people, including those who are caring for others, will have their **emotional wellbeing and mental health needs** identified early. And they will be referred to appropriate services for support.

The number of **young people who smoke, drink alcohol and use cannabis** regularly, will reduce.

## 2 Improve the health of children and young people with a focus on tackling childhood obesity

### The actions we will take:

Implement **healthy campaigns** and initiatives in partnership with schools and other community organisations. This will improve the dietary habits and weight management of children and young people.

Promote and support **roll out of the Daily Mile** (getting all children to run for 15 minutes a day in school), in all the borough's primary schools by April 2021.

Support vulnerable families to access **healthy and affordable food** by implementing a **Good Food Group** and tackling food insecurity in partnership.

Enhance parent programmes **that promote healthy eating and active play** for 0-5 year olds in children's centres & in the community by March 2021.

Support the statutory, voluntary and community sector to **develop and promote the prevention activities on offer**, including use of **Connected Kingston**, Kingston's Social Prescribing platform.

### The impact of these actions will be:

**The number of children and young people who are overweight**, including those who are obese, will reduce

**Healthy eating and active play** for 0 to 5-year-olds will be available in children's centres through enhanced parent programmes.

A Good Food Group will be put in place to help vulnerable families to **access healthy and affordable food.**

The Transport for London STARS programme (which inspires young Londoners to think differently about travel and its impact on their health and wellbeing) will expand. **School travel plans** will also be developed to ensure children and young people are engaged in active travel

**Practitioners & champions** will be trained to use Connected Kingston and in the **Make Every Contact Count** approach, and be able to provide advice on healthy eating and active lifestyles to parents and young people.

### 3 Give children and young people with special educational needs and disabilities opportunities to flourish and be independent

#### The actions we will take:

Work with children and young people, parents and carers to ensure they can have their say and are **involved in decisions about their own education, health and care support**.

Promote the local **SEND website** so that more children, young people, parents, carers and professionals are aware of its value as a one-stop shop for information on local health and care services.

Provide all schools with **specialist therapeutic consultation support** so that they can modify and improve their school spaces and environments for learners with SEMH needs.

Improve the quality and timeliness of **education, health and care plan assessments** and reviews to ensure they support and achieve the agreed outcomes, promote resilience and independence and provide good value for money.

Co-design with young people, parents/carers and professionals an **improved local therapies offer**, to be in place by March 2020.

Establish a **local neuro developmental service** for children and young people to include access to pre-and post-diagnostic support, by March 2020.

#### The impact of these actions will be:

Children, young people, parents and carers will be **actively involved in the planning of health and care services** which impact them. They will also be more aware of how to access local health and care services, and because of this use of services will increase.

**Children and young people's needs will be better met** in local schools and by health and care services.

Children and young people who use local therapy services will have **shorter waiting times** for assessment appointments. And feedback from parents about therapy services will improve

**Neuro-developmental assessment** will be completed within 12 weeks of referral.

## Live well

Wellbeing is influenced by our environment, communities and access to healthy choices. This plan will drive forward preventative approaches at all levels; engaging communities, utilising local assets (e.g. parks and open spaces) and targeting approaches to reach those most at risk.

- 1 Support people to have good physical and mental health and prevent ill health
- 2 Support people to manage long-term conditions
- 3 Reduce health inequalities for those with poor health

Within each of these priority areas we now describe the specific actions we will take and the expected outcomes.

### 1 Support people to have good physical and mental health and prevent ill health

#### The actions we will take:

Build on Connected Kingston, the **social prescribing model** across the borough of Kingston, ensuring that the web-site of community based activities, community champions and community connectors can be accessed by partners, residents and unpaid carers

Promote **health checks and national screening** programmes, particularly amongst those at greatest risk of ill health.

Promote **health improvement initiatives** for weight management, stop smoking services, physical activity opportunities and reduce alcohol consumption.

Implement the **Thrive Kingston** mental health and wellbeing strategy. This will focus on wellbeing; early intervention; community connections; access to services and support, joined up care and employment.

#### The impact of these actions will be:

**Local people will be supported to manage their health and wellbeing.** This will reduce the reliance on health and care services.

The uptake of **health checks and screening** will increase, and people will receive timely advice and treatment as required, with improved outcomes.

More local people will join or be referred to **health improvement initiatives** which are available across the borough.

Health outcomes for **people with serious mental health issues will improve**. This will include an increase in access to health checks.

There will be **more support for people who have a serious mental illness to get employment** through the Individual Placement Support Programme.

## 2 Support people to manage long-term conditions

### The actions we will take:

Promote **prevention and early identification** of long-term conditions by increasing the uptake of health checks.

Build the capacity and capability within the community to **support self-management** promoting health and independence including social prescribing options.

Proactively **support people with complex health and care needs** by bringing health and care professionals together around the individual – through primary care networks, across the borough by March 2020

**Expand IAPT (psychological therapies)** to include people **with long-term conditions** to receive support for their mental wellbeing and provide referrals to social prescribing support, by March 2020.

### The impact of these actions will be:

People “at risk”, or diagnosed with long-term health conditions, will have the **knowledge to self-manage** their conditions. They will recognise the triggers to take early action to prevent a deterioration in their condition.

The number of people living with long-term conditions, who have an **annual health check**, will increase

People with complex health and care needs will be supported to better manage their conditions. They will experience **joined up care and support** which avoidable hospital admissions will reduce

People with long-term health conditions will report good **mental wellbeing**.

## 3 Reduce health inequalities for those with poor health

### The actions we will take:

Promote **health improvement initiatives and services**, particularly to those at most risk of health inequalities.

Ensure **multi-disciplinary case management** allows individual access to services required to support them to optimise their health, regardless of the complexity of their underlying conditions.

Proactively support people with complex health and care needs by bringing health and care professionals together around the individual – through **primary care networks**, across the borough by March 2020.



Ensure people with a learning disability or a serious mental illness have an **annual physical health check** with their GP.

Implement the **Kingston All Age Learning Disabilities Strategy** with a focus on: health and wellbeing; developing and maintaining independence; developing and maintaining social and community connections.

### The impact of these actions will be:

Increased uptake of **prevention services** by disadvantaged groups and those living in areas of deprivation.

More people with complex health and care needs will experience **joined up holistic care**.

60% of people registered with a GP practice, who have a serious mental illness or learning disability, will receive an **annual physical health check** and follow up interventions.

The number of people with a learning disability or a serious mental illness **dying prematurely** in the borough of Kingston will reduce.

**Referrals to healthy lifestyle services** for people from disadvantaged backgrounds will increase.

Health and social care services will **recognise the individual needs of people with a learning disability** and adjust their approach when supporting or delivering care.

## Age well

Wellbeing is influenced by our environment, communities and access to healthy choices. This plan will drive forward preventative approaches at all levels; engaging communities, utilising local assets (e.g. parks and open spaces) and targeting approaches to reach those most at risk.

Within **Age well** we have identified three priority areas for actions:

- 1 **Maximise people's independence and resilience to enable them to live well at home where that is their choice**
- 2 **Reduce loneliness and isolation for everyone particularly older people and their carers**
- 3 **Enable people to live and end the last years of their life well**

Within each of these priority areas we now describe the specific actions we will take and the expected outcomes.

### 1 **Maximise people's independence and resilience to enable them to live well at home where that is their choice**

#### The actions we will take:

Review the community offer, which includes **day centres and voluntary sector activities**, so that people have access to information and support that promotes independence and self-help and enables people to access the right services first time by March 2020.

Help people to **reduce risks in the home** such as falls, reducing fuel poverty and increasing the use of assistive technologies (such as alarms).

Re-design the pathways for **integrated community based urgent care services and home services** for people following discharge from hospital by March 2020.

Identify and proactively support older people **with complex health and care needs** by bringing health and care professionals together around the individual – through primary care networks, across the borough by March 2020.

Explore opportunities to improve local **sheltered accommodation provision** and housing support for older vulnerable people.

### The impact of these actions will be:

**People will be supported to live independently and in their own homes** for as long as they are able to.

The number of people using **assistive technology** will increase.

The number of people who require a **social care assessment** will reduce.

More people will still be at home 91 days after being discharged from hospital into **reablement**.

**Unnecessary hospital admissions will be reduced** by 15% for people with complex health and care needs who have a care plan.

## 2 Reduce loneliness and isolation for everyone particularly older people and their carers

### The actions we will take:

Create opportunities for **social connections** so that people have local places to go that bring together the young, adults and older people by: increasing the range and coverage of befriending groups, promoting dementia friendly communities and public places, and developing community hubs.

Promote **wellbeing and healthy lifestyles** and activities for all older people through **social prescribing and Making Every Contact Count**.

Work with **local care home providers** to ensure the mental health and emotional wellbeing of older people is promoted, and actively reduce people experiencing depression/anxiety due to loneliness and isolation.

### The impact of these actions will be:

Opportunities for people in Kingston to **remain connected to others** and improve their health and wellbeing, will increase.

Social prescribing will be available for local people across the borough.

Reduction in people who report feeling lonely and isolated.

Care homes will have programmes in place to **support the mental wellbeing** of their residents.

### 3 Enable people to live and end the last years of their life well

#### The actions we will take:

Improve services and support for people with dementia by implementing the **Kingston Dementia Strategy together**, and developing new dementia care home facilities in the borough.

Support people to **plan for their old age** and train staff to have **compassionate conversations**, including about **death and dying**.

Improve end of life care by developing a compassionate approach, to include progressing delivery of Kingston's **end of life care strategy**, and improved advanced care planning.

#### The impact of these actions will be:

The **number of people diagnosed early with dementia and have access to support**, will increase. This will be at least in line with the national dementia diagnosis standard (66.8%).

The **coverage of advance care planning** and use of Coordinate My Care will increase across all settings.

The number of people who **die in their place of choice will increase by 50%**.

**Emergency admissions** to hospital and A&E attendance in the last year of someone's life will be reduced by 50%.

## Unpaid carers

### Priority

Recognise the importance of carers of all ages, improve how people's caring responsibilities are identified and enable them to be linked into support options, allowing them to have a life beyond their caring responsibilities, reducing the negative emotional, social, financial and health impacts they may face.

### The actions we will take:

Support **the implementation of the Kingston Carers Strategy** by 2020 and work with Kingston Carers Network to review how carers' needs are assessed and responded to in their own right and to ensure they are 'not forgotten'.

Improve the approach and practice in relation to **carer assessments and support planning**.

Improve the **recognition of young carers** and develop a range of support options including within school and learning environments.

Improve the recognition and identification of carers by GPs and increase the use of social prescribing.

Support carers to **stay well and look after themselves and be socially connected** with their community.

Recognise the impact **after caring**.

### The impact of these actions:

**Carers needs are taken into consideration** as well as the person being cared for.

Carers are **better supported** in their caring role and have **access to a range of support options**.

**Young carers are better supported** educationally, emotionally and physically.

Carers experience **improvements in their physical and mental health wellbeing**.



## Creating the right environment – enablers



# Creating the right environment – enablers

In delivering our plan there is a number of enablers – which are summarised below.

## Workforce

The borough of Kingston faces several workforce challenges that are affecting the health and care services nationally: the numbers of nurses (particularly in the community and mental health) and GPs have fallen and social care faces difficulty in recruiting to specialist roles for more complex work.

The increase in demand means our valued health and care professionals are overstretched.

In addition, there are difficulties in attracting staff to Kingston due to the high cost of living in the borough. Kingston can only offer outer London wage supplements which means it is hard to attract staff from neighbouring London boroughs.

We will work together to:

- Offer flexible working patterns and improve working environments to retain our staff
- Develop our staff to embrace new ways of working and models of care
- Take innovative approaches to the recruitment of staff
- Provide job opportunities through apprenticeships
- Provide job opportunities for vulnerable groups in our community, such as young people leaving care, and those with physical disabilities or learning disability

## Digital

Technology is developing fast. We will embrace technologies to support the delivery of care and management of care exploiting interoperability technology. We will work together to provide and support:

- Online access to information, advice and community support
- Online interventions e.g. talking therapies and counselling
- Online access to GP practice appointments and prescriptions
- Virtual consultations across all core settings
- Patient self-management of their long-term conditions
- Using assistive technologies to enable people to remain living in their own homes
- Share information and care records between practitioners and across care settings
- Technological advances in treatment

## Estates

The council and health providers have a wide range of estate across the borough from which they provide and deliver services.

We will work together to:

- maximise the use of our estate
- co-locate services where appropriate
- explore access to estate by community groups to support community connections



## Delivery of the Kingston Health and Care Plan

# Delivery of the Kingston Health and Care Plan

A delivery plan is being developed mapping the actions to be taken to implement this plan and will provide a framework to support implementation and evaluation. Many of the actions align to existing programmes of work, such as social prescribing and the borough's dementia strategy. Whereas others may require a new programme for work to be established. Delivery will be reported into the Health and Wellbeing Board and the governance of partner organisations.

We want to continue to work with local people and health and care professionals across our organisations to deliver the plan. In particular, we also want to involve people with lived experience to help us shape and deliver the actions and ensure the health and care outcomes for local people are met. We will provide more information about opportunities to get involved in the months ahead. If you would like us to contact you about involvement opportunities in a particular programme of work please email us at [kingstonccg.engage@swlondon.nhs.uk](mailto:kingstonccg.engage@swlondon.nhs.uk)





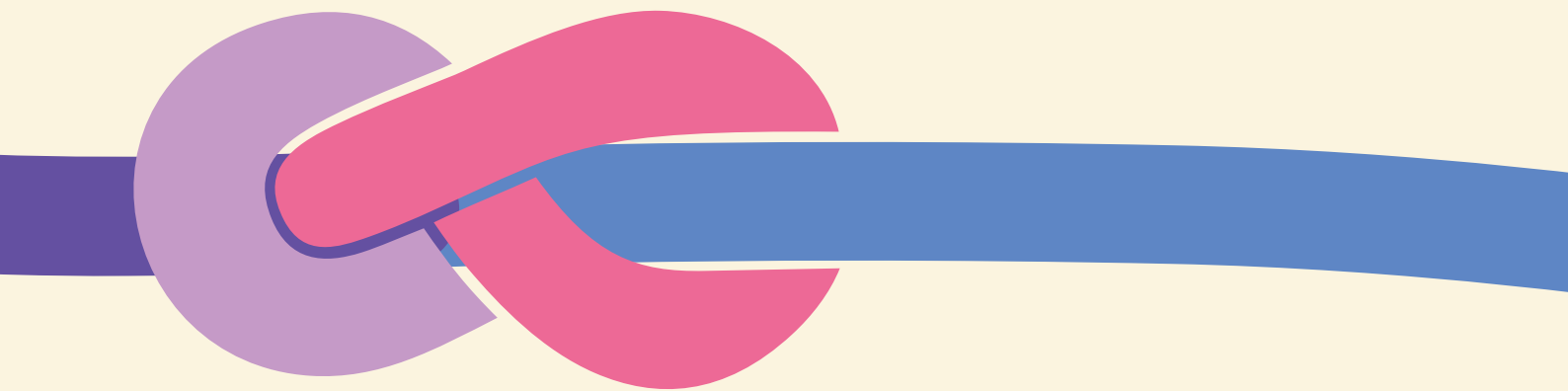
## Other work we are doing in the borough of Kingston

# Other work we are doing in the borough of Kingston

Here's a list of existing plans which health and care colleagues in the borough of Kingston have been working on, together with local people, to design, develop and implement to improve the health and wellbeing of the local population. Some of the actions within the Kingston Health and Care Plan will be delivered and monitored within these strategic plans.

- [Connected Kingston](#)
- [Health and Wellbeing Board Strategy](#)
- [CAMHS transformation plan](#)
- [SEND Partnership Plan](#)
- [All age learning disability strategy](#)
- [Thrive Kingston - mental health and wellbeing strategy](#)
- [Dementia strategy](#)
- [Kingston Coordinated Care](#)
- [Carers Strategy](#)
- [Refugee and Migrant Strategy](#)
- [NHS Long Term Plan](#)
- [End of Life Care](#)

# Appendix: Actions and impacts summarised





**Start well** in Kingston 2019/2021

What happens in early life, starting from conception, affects health and wellbeing in later life. Prevention is critical to ensuring that children and young people can fulfil their potential.

Maximise the mental wellbeing and resilience of our children and young people	Improve the health of children and young people with a focus on tackling childhood obesity	Give children and young people with special educational needs and disabilities opportunities to flourish and be independent
Action	Action	Action
<ul style="list-style-type: none"> <li>Ensure that there is an <b>emotional wellbeing programme</b> in all of our schools by April 2021. This will include wellbeing support, training and information to students, parents and staff</li> <li>Provide easy access to <b>online resources and digital counselling by March 2020</b> to improve emotional wellbeing and strengthen resilience</li> <li>Work with young people to develop mechanisms to involve them in the design, commissioning, delivery and <b>promotion of peer-led services</b> to reduce involvement in <b>risk-taking behaviours</b></li> <li>Improve the quality of the experience and outcomes for young people who <b>transition from children's to adult mental health services</b></li> <li>Provide <b>support and advice</b> to parents and carers to develop their confidence in <b>caring for their child</b></li> </ul>	<ul style="list-style-type: none"> <li>Implement <b>healthy campaigns</b> and initiatives in partnership with schools and other community organisations. This will improve the dietary habits and weight management of children and young people</li> <li>Promote and support <b>roll out of the Daily Mile</b> (getting all children to run for 15 minutes a day in school) in all the borough's primary schools by April 2021</li> <li>Support vulnerable families to access <b>healthy and affordable food</b> by implementing a <b>Good Food Group</b> and tackling food insecurity in partnership</li> <li>Enhance parent programmes that <b>promote healthy eating and active play</b> for 0-5 year olds in children's centres &amp; in the community by March 2021</li> <li>Support the statutory, voluntary and community sector to <b>develop and promote the prevention activities on offer</b>, including use of <b>Connected Kingston</b>, Kingston's Social Prescribing platform</li> </ul>	<ul style="list-style-type: none"> <li>Work with children and young people, parents and carers to ensure they can have their say and are <b>involved in decisions about their own education, health and care support</b></li> <li>Promote the local <b>SEND website</b> so that more children, young people, parents, carers and professionals are aware of its value as a one-stop shop for information on local health and care services</li> <li>Provide all schools with <b>specialist therapeutic consultation support</b> so that they can modify and improve their school spaces and environments for learners with SEMH needs</li> <li>Improve the quality and timeliness of <b>education, health and care plan assessments</b> and reviews to ensure they support and achieve the agreed outcomes, promote resilience and independence and provide good value for money</li> <li>Co-design with young people, parents/carers and professionals an <b>improved local therapies offer</b>, to be in place by March 2020</li> <li>Establish a <b>local neuro developmental service</b> for children and young people to include access to pre-and post-diagnostic support by March 2020</li> </ul>
<p>We will take action to <b>improve our practice in identifying and recognising carers of all ages</b> so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.</p>		
Impact	Impact	Impact
<ul style="list-style-type: none"> <li><b>Timely access to support and local counselling</b> will be available for children and young people, seven days a week through the digital offer</li> <li><b>Incidences of self-harm and its impact</b> will reduce because children and young people will receive better support</li> <li>Young people, with identified mental health needs, will have a <b>planned and smooth transition between child and adult mental health services</b></li> <li>Children and young people, including those who are caring for others, will have their <b>emotional wellbeing and mental health needs</b> identified early. And they will be referred to appropriate services for support</li> <li>The number of <b>young people, who smoke, drink alcohol and use cannabis</b> regularly, will reduce</li> </ul>	<ul style="list-style-type: none"> <li><b>The number of children and young people who are overweight</b>, including those who are obese, will reduce</li> <li><b>Healthy eating and active play</b> for 0 to 5-year-olds will be available in children's centres through enhanced parent programmes</li> <li>A Good Food Group will be put in place to help vulnerable families to <b>access healthy and affordable food</b></li> <li>The Transport for London STARS programme (which inspires young Londoners to think differently about travel and its impact on their health and wellbeing) will expand. <b>School travel plans</b> will also be developed to ensure children and young people are engaged in active travel</li> <li><b>Practitioners &amp; champions</b> will be trained to use Connected Kingston and in the <b>Make Every Contact Count</b> approach, and be able to provide advice on healthy eating and active lifestyles to parents and young people</li> </ul>	<ul style="list-style-type: none"> <li>Children, young people, parents and carers will be <b>actively involved in the planning of health and care services</b> which impact them. They will also be more aware of how to access local health and care services, and because of this, use of services will increase</li> <li><b>Children and young people's needs will be better met</b> in local schools and by health and care services</li> <li>Children and young people who use local therapy services will have <b>shorter waiting times</b> for assessment appointments. And feedback from parents about therapy services will improve</li> <li><b>Neuro-developmental assessment</b> will be completed within 12 weeks of referral</li> </ul>



**Live well in Kingston 2019/2021**

Healthy choices are influenced by our environment, communities and wellbeing. We will drive forward preventative approaches at all levels – engaging communities, utilising local assets and targeting approaches to reach those most at risk.

Support people to have good physical and mental health and prevent ill health	Support people to manage long-term conditions	Reduce health inequalities for those with poor health
<p><b>Action</b></p> <ul style="list-style-type: none"> <li>Build on Connected Kingston, the <b>social prescribing model</b> across Kingston, ensuring that the web-site of community based activities, community champions and community connectors can be accessed by partners, residents and unpaid carers</li> <li>Promote <b>health checks and national screening</b> programmes, particularly amongst those at greatest risk of ill health</li> <li>Promote <b>health improvement initiatives</b> for weight management, stop smoking services, physical activity opportunities and reduce alcohol consumption</li> <li>Implement the <b>Thrive Kingston</b> mental health and wellbeing strategy. This will focus on wellbeing; early intervention; community connections; access to services and support, joined up care and employment</li> </ul>	<p><b>Action</b></p> <ul style="list-style-type: none"> <li>Promote <b>prevention and early identification</b> of long-term conditions by increasing the uptake of health checks</li> <li>Build the capacity and capability within the community to <b>support self-management</b> promoting health and independence including social prescribing options</li> <li>Proactively <b>support people with complex health and care needs</b> by bringing health and care professionals together around the individual – through primary care networks, across the borough by March 2020</li> <li><b>Expand IAPT (psychological therapies)</b> to include people <b>with long-term conditions</b> to receive support for their mental wellbeing and provide referrals to social prescribing support by March 2020</li> </ul>	<p><b>Action</b></p> <ul style="list-style-type: none"> <li>Promote <b>health improvement initiatives and services</b>, particularly to those at most risk of health inequalities</li> <li>Ensure <b>multi-disciplinary case management</b> allows individual access to services required to support them to optimise their health, regardless of the complexity of their underlying conditions</li> <li>Proactively support people with complex health and care needs by bringing health and care professionals together around the individual – through <b>primary care networks</b>, across the borough by March 2020</li> <li>Ensure people with a learning disability or a serious mental illness have an <b>annual physical health check</b> with their GP</li> <li>Implement the <b>Kingston All Age Learning Disabilities Strategy</b> with a focus on: health and wellbeing; developing and maintaining independence; developing and maintaining social and community connections</li> </ul>
<p>We will take action to <b>improve our practice in identifying and recognising carers of all ages</b> so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.</p>		
Impact	Impact	Impact
<ul style="list-style-type: none"> <li><b>Local people will be supported to manage their health and wellbeing.</b> This will reduce the reliance on health and care services</li> <li>The uptake of <b>health checks and screening</b> will increase, and people will receive timely advice and treatment as required, with improved outcomes</li> <li>More local people will join or be referred to <b>health improvement initiatives</b> which are available across the borough</li> <li>Health outcomes for <b>people with serious mental health issues will improve.</b> This will include an increase in access to health checks</li> <li>There will be <b>more support for people who have a serious mental illness to get employment</b> through the Individual Placement Support Programme</li> </ul>	<ul style="list-style-type: none"> <li>People “at risk”, or diagnosed with long-term health conditions, will have the <b>knowledge to self-manage</b> their conditions. They will recognise the triggers to take early action to prevent a deterioration in their condition</li> <li>The number of people living with long-term conditions, who have an <b>annual health check</b>, will increase</li> <li>People with complex health and care needs will be supported to better manage their conditions. They will experience <b>joined up care and support</b> which will result in reduced avoidable hospital admissions</li> <li>People with long-term health conditions will report good <b>mental wellbeing</b></li> </ul>	<ul style="list-style-type: none"> <li>Increased uptake of <b>prevention services</b> by disadvantaged groups and those living in areas of deprivation</li> <li>More people with complex health and care needs will experience <b>joined up holistic care</b></li> <li>60% of people registered with a GP practice, who have a serious mental illness or learning disability, will receive an <b>annual physical health check</b> and follow up interventions</li> <li>The number of people with a learning disability or a serious mental illness <b>dying prematurely</b> in Kingston will reduce</li> <li><b>Referrals to healthy lifestyle service</b> for people from disadvantaged backgrounds will increase</li> <li>Health and social care services will <b>recognise the individual needs of people with a learning disability</b> and adjust their approach when supporting or delivering care</li> </ul>



**Age well** in Kingston 2019/2021

Whilst people are living longer, many older people are also living with a reduced quality of life due to ill health or disability, or experience loneliness and isolation.

Maximise people's independence and resilience to enable them to live well at home where that is their choice	Reduce loneliness and isolation for everyone particularly older people and their carers	Enable people to live and end the last years of their life well
<p><b>Action</b></p> <ul style="list-style-type: none"> <li>Review the community offer, which includes <b>day centres and voluntary sector activities</b>, so that people have access to information and support that promotes independence and self-help and enables people to access the right services first time by March 2020</li> <li>Help people to <b>reduce risks in the home</b> such as falls, reducing fuel poverty and increasing the use of assistive technologies (such as alarms)</li> <li>Re-design the pathways for <b>integrated community based urgent care services and home first services</b> for people following discharge from hospital by March 2020</li> <li>Identify and proactively support older people <b>with complex health and care needs</b> by bringing health and care professionals together around the individual – through primary care networks, across the borough by March 2020</li> <li>Explore opportunities to improve local <b>sheltered accommodation provision</b> and housing support for older vulnerable people</li> </ul>	<p><b>Action</b></p> <ul style="list-style-type: none"> <li>Create opportunities for <b>social connections</b> so that people have local places to go that bring together the young, adults and older people by: increasing the range and coverage of befriending groups, promoting dementia friendly communities and public places, and developing community hubs</li> <li>Promote <b>wellbeing and healthy lifestyles</b> and activities for all older people through <b>less social prescribing and Making Every Contact Count</b></li> <li>Work with <b>local care home providers</b> to ensure the mental health and emotional wellbeing of older people is promoted, and actively reduce people experiencing depression/anxiety due to loneliness and isolation</li> </ul>	<p><b>Action</b></p> <ul style="list-style-type: none"> <li>Improve services and support for people with dementia by implementing the <b>Kingston Dementia Strategy together</b>, and developing new dementia care home facilities in the borough</li> <li>Support people to <b>plan for their old age</b> and train staff to have <b>compassionate conversations</b>, including about <b>death and dying</b></li> <li>Improve end of life care by developing a compassionate approach, to include progressing delivery of Kingston's <b>end of life care strategy</b>, and improved advanced care planning</li> </ul>
<p>We will take action to <b>improve our practice in identifying and recognising carers of all ages</b> so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.</p>		
<p><b>Impact</b></p> <ul style="list-style-type: none"> <li><b>People will be supported to live independently and in their own home</b> for as long as they are able to</li> <li>The number of people using <b>assistive technology</b> will increase</li> <li>The number of people who require a <b>social care assessment</b> will reduce</li> <li>More people will still be at home 91 days after being discharged from hospital into <b>reablement</b></li> <li><b>Unnecessary hospital admissions will reduce</b> by 15% for people with complex health and care needs who have a care plan</li> </ul>	<p><b>Impact</b></p> <ul style="list-style-type: none"> <li>Opportunities for people in Kingston to <b>remain connected to others</b> and improve their health and wellbeing, will increase</li> <li>Social prescribing will be available for local people across the borough</li> <li>Reduction in people who report feel lonely and isolated</li> <li>Care homes will have programmes in place to <b>support the mental wellbeing</b> of their residents</li> </ul>	<p><b>Impact</b></p> <ul style="list-style-type: none"> <li>The <b>number of people diagnosed early with dementia and have access to support</b>, will increase. This will be at least in line with the national dementia diagnosis standard (66.8%)</li> <li>The <b>coverage of advance care planning</b> and use of Coordinate My Care will increase across all settings</li> <li>The number of people who <b>die in their place of choice will increase by 50%</b></li> <li><b>Emergency admissions</b> to hospital and A&amp;E attendance in the last year of someone's life will reduce by 50%</li> </ul>



## Health and care partners in Kingston have worked together to develop and write this Health and Care Plan.

- Achieving for Children
- Camden & Islington Mental Health NHS Trust
- Community pharmacists
- Healthwatch Kingston
- Kingston GP Alliance / Kingston GPs
- Kingston Hospital NHS Foundation Trust
- Kingston Voluntary Action (voluntary sector)
- Local people
- NHS Kingston CCG
- Royal Borough of Kingston upon Thames
- South West London and St George's Mental Health NHS Trust
- Staywell
- Your Healthcare Community Interest Company





If you have any questions or would like to know more about our local health and care plan you can contact us on [kingstonccg.engage@swlondon.nhs.uk](mailto:kingstonccg.engage@swlondon.nhs.uk)