Kingston
South West
London
Integrated
Care System

The Royal Borough of
Kingston upon Thames

Refreshed Health and Care Plan 2022-2024

Kingston's Health and Care Plan 2022-2024

The Kingston Health and Care Plan 2022-2024 has been developed with the aim of making sure that Kingston residents start life well as children, live well as adults and older people age well for longer.

No single organisation could achieve this alone. Our local NHS organisations, the council and voluntary and community services will continue to work together towards these goals in partnership with our communities. This plan forms the first two years of Kingston's Joint Health and Wellbeing Strategy.

This is a refreshed plan of action, following on from and building on the last 2019-2021 plan. The focus of the plan is where health, care and the voluntary sector can work together to have the greatest impact on the health of the local population.

Some of the previous plan's actions continue to be a priority and therefore continue to feature in this refreshed version, taking into account updated population health needs and trends, as presented in the first section: the Kingston Story.

In March 2021, the Health and Wellbeing Board agreed to ensure this Health and Care Plan considers and adopts the Marmot Review's recommended policy objectives[1]:

- **giving every child the best start in life**
- **enabling all people to maximise their capabilities and have control over their lives**
- **ensuring a healthy standard of living for all**
- **creating fair employment and good work for all**
- **creating and developing healthy and sustainable places and communities.**

By considering these, this plan aims to tackle inequalities in health and improve the lives of all Kingston residents, especially in light of the pandemic.

This refresh is being made 18 months into the global Covid-19 pandemic which has greatly affected the borough, like all parts of the country. Sadly, we have lost one in every 600 residents and almost 20,000 have had a confirmed Covid-19 infection in this period. Despite all of our best efforts, many people have missed routine medical care and treatment and there is increased pressure on the health system to now provide this care, while Covid-19 remains.

Covid-19 has been shown to hit those who are older and those in poor health, with existing conditions hardest. It has also adversely affected people living in areas of deprivation and certain Black, Asian and minority ethnic communities have been disproportionately affected[2]. This shows there is an increased need as we go forward to reduce preventable ill health (such as diabetes Type 2, obesity and high blood pressure, amongst other conditions that pose additional risks from Covid-19).

Like all areas, Kingston residents have 'stayed home' or 'shielded' when requested, 'socially isolated' when called upon by NHS Test and Trace and many have experienced home-schooling, the impact on businesses by closures and control measures and many other huge changes over 2020/2021.

Despite the enormous challenges and impact on everyone in the borough, the people and organisations of Kingston have risen to the challenge to protect residents and find new ways of doing things. We need to build on these new ways of working in our work of the refreshed Health and Care Plan. These include: increased use of digital communication, enhanced joint working between statutory and voluntary sectors to reach all parts of our community at scale, the use of data to focus work and recognition and enhanced targeting to address health inequalities and disparities.

This new plan continues to have sections focused on children starting life well, adults living well and for older people to age well. However, this plan also sets out four themes or 'golden threads' across the life course (for all ages) that have been identified by the borough's Health and Wellbeing Board and Kingston's local system leaders as priority areas for focus over the next two years:

1) **Recognising all carers;**
2) **Tackling inequalities in health to reduce disparities for those most disadvantaged (especially in light of the Covid-19 pandemic);**
3) **Tackling obesity; and**
4) **Promoting the mental health and resilience of residents to improve health and wellbeing across the life course.**

This will be achieved by creating the right environment through enablers such as our workforce, embracing and using digital technology, supporting transitions between the ages and maximising the use of our assets and estates. The approach aligns with the borough's commitment to be a 'Marmot' borough - supporting the reduction of health inequalities[3].

The pandemic has further highlighted a need to 'build back better' and this includes reducing carbon emissions as part of all of our work. As part of our overall goals to keep Kingston residents in the best health for as long as possible, our efforts through this refreshed Health and Care Plan will also support this ambition.

The Kingston story

The Royal Borough of Kingston upon Thames in South West London has the third smallest population of any borough in London (after the City of London and Kensington and Chelsea)[4] and is the smallest Outer London 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.

- There were 177,502[5] people living in the borough in 2021 (226,761[6] registered with Kingston GP practices).
- Relatively older population for London, with a median age of 37.4 years compared to the London median of 35.6[7].
- Projected[8] to grow by 12% between 2020-30, including a 37% increase in people aged 80 and over.
- One third (34%)[9] are from Black, Asian and Minority Ethnic backgrounds.
- Last years of life are lived with disability for an average of 13.3 years for men and 17.5 years for women (2017-19)[10].
- There are over 10,500 people in the borough who were defined as clinically extremely vulnerable and advised by the Government to shield from Covid-19 during the last lockdown period.
- The UK 2011 census reports that in Kingston 13,288 carers (8.3% of the population) provide care for people with physical and mental disorders, mostly in their own homes and of these, 2,346 provide care for over 50 hours a week[11].
- Health disparities exist within the borough, with residents in the most deprived areas having an average life expectancy at birth six years shorter than those in less deprived parts[12] (2017-19). This disparity is greater than the London average for women.
- At age 65, the life expectancy difference between residents of the least and most deprived areas of Kingston is 3.8 years for men and 4.4 years for women[13] (2017-19), again greater than the London average for women.
- In terms of 'healthy life expectancy at birth', male residents of more deprived areas have 8.4 fewer years of healthy life on average than those in less deprived parts, with a difference of 7.2 years for women[14] (2009-2013).

Deaths and their main causes

The three leading causes of death (in 2020) in people of all ages in the borough of Kingston were:

- cancer (28%)
- diseases of the circulatory system (26%); and
- diseases of the respiratory system (12%)[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. From 2017-19, almost half of residents in the most deprived areas of Kingston who died were aged under 75, compared to just over a quarter of residents in the least deprived parts[16].

The suicide rate in the borough of Kingston (10.3/100,000 population) is not significantly different to the England average (10.1/100,000 population) (2017-19)[17].

Smoking attributable mortality in the borough of Kingston is significantly lower than the regional and national averages (2016-18)[18].

Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity: there were 165 deaths or serious injuries in the borough of Kingston during 2017-19, which is significantly better than the rate for England[19].

The mortality rate from influenza and other infectious diseases in the borough of Kingston is similar to England (2020)[20].

Up to the end of September 2021, almost 20,000 residents had tested positive for Covid-19, and over 300 had died within 28 days of a positive Covid-19 test[21].

Self-reported health

In the 2011 Census, a higher percentage of Kingston residents (86%) reported that they were in good or very good health compared to the London average (84%)[22]. 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%[23].

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, obesity, diabetes and asthma were the most commonly diagnosed conditions among people registered with Kingston GPs (in 2019-20)[24].

Start well

What happens in early life, starting from conception, affects health and wellbeing in later life. A good start to life, and early intervention where this is necessary, are 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. Yet, while the overall borough outcomes for children are good, we have gaps in outcomes between our most and least deprived communities. Childhood obesity rates (from 2017-20) are 70% higher in the more deprived parts of the borough on starting school, with an even larger gap in secondary education[25]. Early educational attainment for children in Kingston in receipt of free school meals is the second lowest in London (2018-19), with only 56% achieving a good level of development at the end of reception year, and 65% with a satisfactory phonics test score in Year 1[26]. Attainment at age 16 is 20-30% lower in the most deprived areas compared to least deprived parts (2013-14[27] . Intervening early and effectively when children and adolescents are starting to develop mental health problems could prevent between a quarter and a half of adult mental illness[28]. Nationally, up to half of all lifetime mental health problems start before the age of 14[29].

Nationally there appears to be a slight increase over time in the prevalence of mental disorder in 5 to 15 year olds, rising from 9.7% (1999) to 11.2% (2017[30]). The total number of referrals to Child and Adolescent Mental Health Services (CAMHS) increased by 13% between 2019/20 and 2020/21. There were significant increases in contacts to Accident and Emergency and in urgent referrals to more specialist CAMHS services[31]. The Covid-19 pandemic has further increased the number of referrals to CAMHS with an increasing number of children presenting with more complex needs. The increasing number of referrals has led to longer waiting times for CAMHS assessments and treatment[32].

Children and young people with learning difficulties are among the most vulnerable in our community and can have a wide range of support and access needs. Many will have additional health conditions, including physical disabilities and sensory impairments. Autistic spectrum conditions and speech, language and communication needs are the most common primary care needs[33]. Children with disabilities or special needs are also more likely to experience or live in poverty[34].

Obesity in children can cause social and emotional problems and increases the likelihood of developing long term conditions[35]. In one school year alone (Year 6: 10-11-year-olds) there are an estimated 230 obese children in Kingston (2019-20)[36]. Obesity persisting into adulthood can lead to type 2 diabetes, cardiovascular disease, joint problems and poor general health. Our Start Well plan will focus on a preventative approach, targeting our efforts based on the data available to ensure that we reach those most in need, engaging local children and young people and families and utilising local assets to create an environment that supports healthy weight, physical activity and reduces childhood obesity.

Three Focus Areas:

1. Maximise the mental wellbeing and resilience of our children and young people.
2. Improve the health and wellbeing of children and young people by tackling childhood obesity.
3. Give children and young people with special educational needs and disabilities (SEND) opportunities to flourish and be independent.

Four golden threads:

1. Carers: We will take action to improve our practice in identifying and recognising carers of all ages so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.
2. Tackling inequalities: We will take action to tackle inequalities in health and reduce disparities for those most disadvantaged of all ages, tackling wider determinants of health and targeting resources where there is a proportionate need to improve life chances.
3. Obesity: We will take action to tackle obesity in all ages, enabling people to be physically active with healthy lifestyles and a healthy weight to prevent ill-health and improve wellbeing.
4. Promotion of good mental health and resilience: We will take action to promote the mental health and resilience of residents of all ages.

Children in the borough of Kingston

- **Children make up a quarter of the 2021 population**[37].
- 51% of school children are from black and minority ethnic groups (in 2019)[38].
- 8% of children (2019-20) live in **low income families**[39] (lower than the rest of London).
- 19% of Year 8 and 20% of Year 10 school children (2017) **have low or medium-low self-esteem. 16% say they are 'quite' or 'very' unhappy with their life.** The top worries for both genders are exams and tests[40].
- Over 3,200 (12.5%) school children are estimated to have a **mental health problem** (conduct disorder, anxiety, depression, ADHD, ASD, eating disorders) (2017-18), and the numbers are rising[41].
- There were 60 **hospital admissions for self-harm** in 15-19 year olds (1 in 150) in 2019-20, which is the highest London borough rate[42].

- A review of Youth Offending Service outcomes between 01/04/2018 and 30/09/2020 highlighted that 77.4% of the cohort had drug offences, a violent offence, or both. Substance misuse, emotional wellbeing, physical health and speech, language, communication and neuro disability concerns were factors in a high proportion of the cohort as well as recent missing episodes[43]. There are clear links between drug misuse, criminal exploitation and serious violence[44].
- **Risky behaviours in adolescence** – a higher proportion of young people smoke in Kingston compared to other London boroughs[45], there is **rising harm from 'party' drugs**, and concerns around harmful sexual behaviour at a younger age. Social media is a factor including exposure to adult material and sexual images online as well as the ability to buy drugs via the internet and social media (2017-18). These are linked to emotional issues and poor mental health and resilience[46].
- 3,444 children (in 2020-21) 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 speech, language and communication needs (24.7% of all SEN pupils) which is higher than the proportion nationally (22.3%)[47].
- There are 539 children with **learning disabilities** known to Kingston schools (in 2020), 61 of whom have a profound multiple learning disability. This equates to 23 per 1,000 pupils, which is higher than London's and England's rates[48].
- 599 children with **autism** are known to schools (in 2020), equivalent to one in 45 children. This is higher than the proportion of children known to schools in England[49].
- 31% of 10-11 year olds are **overweight or obese** (2019-20) (lower than seen across London)[50].
- **Childhood obesity** rates in the most deprived parts of Kingston (2017-20) are almost double those in the least deprived areas[51].
- Rates of admission to hospital for extraction of **decayed teeth** (2017-2020) are higher than the national average[52].
- Admission to hospital for injuries in children 0-14 years is higher than London (2019-20)[53].
- **MMR immunisation rate** (87% in 2019-20) is too low to protect the population (95% coverage required)[54].
- Kingston Carers' Network supports over **3,000 adult carers, and over 700 of these are young carers**[55]. 251 carers were known to be aged under 16 in Kingston from the 2011 Census[56].

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, businesses 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 disabilities in older age, enabling people to live longer in good health.

Health is influenced by many factors. These include fixed factors (like age, gender and genetics) but other factors that we can change play a key role. These include housing quality, individual behaviours (like smoking, alcohol intake and physical activity levels), literacy and language barriers, the environment and access to health and care services. Healthy choices are influenced by the information we have, our income, 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 conditions generally reduces quality of life and increases the chances of requiring support from health or social care services. It is recognised that if people manage their long-term conditions 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.

Three Focus Areas:

1. Support people to have good physical and mental health, have a healthy weight and regular physical activity to prevent ill health.
2. Support people to manage long-term conditions.
3. Reduce health inequalities for adults with or at risk of having poorer health.

Four 'golden threads':

1. Carers: We will take action to improve our practice in identifying and recognising carers of all ages so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.
2. Tackling inequalities: We will take action to tackle inequalities in health and reduce disparities for those most disadvantaged of all ages, tackling wider determinants of health and targeting resources where there is a proportionate need to improve life chances.
3. Obesity: We will take action to tackle obesity in all ages, enabling people to live physically active and healthy lifestyles and at a healthy weight to prevent ill-health and improve wellbeing.
4. Promotion of good mental health and resilience: We will take action to promote the mental health and resilience of residents of all ages.

Adults in the borough of Kingston

- There are 114,756 working-age adults living in the borough of Kingston (in 2021)[57].
- One in four people are experiencing **mental illness in a year**[58].
- 19,000 working-age adults have common mental illnesses such as **depression or anxiety**. Under-diagnosis and under-treatment is likely[59].
- People are living longer and there is an increased incidence of people living with one or more **long-term conditions**. More than one in three adults (in 2021) has a long-term condition and over one in ten people are living with two or more long-term conditions[60].
- **Cancer screening** coverage (2020) for breast (74.2%), cervical (72.5%) and bowel (62.3%) are all lower than for England as a whole. Cancer is the leading cause of death in under 75 year olds[61].
- Over 40,000 people (2019-20) are estimated to have **high blood pressure**, but only around half have been identified[62].

- 3.8% of people (8,200) (2019-20) are thought to have coronary heart disease[63], although only 2.0% (4,400) have been identified. Whilst the prevalence is lower than England, **coronary heart disease** is the leading cause of death (2001-18) in men nationally[64].
- 5.3% of people (9,200) (2019-20) have been diagnosed with **diabetes**[65], but over 2,500 people with diabetes are still to be identified. Diabetes is a major cause of ill health in the borough of Kingston.
- There are **additional and sometimes hidden needs** in certain population groups, including those living in more deprived locations in the borough of Kingston, people from Black, Asian and Minority Ethnic groups, the homeless and people with learning disabilities.
- Adults (in 2019-20) in the borough of Kingston have healthier **habits compared** to other Londoners (72% are physically active, 57.6% eat five fruit and veg a day, 50.4% are overweight or **obese**), although nearly 1 in 5 adults drink above the lower risk level of 14 units of **alcohol** per week[66].

Age well

In Kingston we want to promote an ethos of 'active, healthy ageing' and an environment to support this. We know that within Kingston, people have different experiences of older age, with residents in some of our more deprived areas having both a shorter overall older age and having less good health in their older years. We want our residents to enjoy life in Kingston and be in the best health possible in older age. We will promote and facilitate enjoyable physical activity for all ages, making best use of the abundant green space, active travel opportunities and sport and social groups in the borough. We want to promote volunteering and social connection, including strong bonds between the generations.

To keep people as well as possible, we want to ensure that preventable conditions are diagnosed as early as possible where an effective intervention is available. For those who require help, we will work together, to try and ensure the conditions are treated as early as possible. For those who have faced a major health challenge, getting back to the best stage of health possible (reablement), will be a key priority within the overall aim of maximising the independence of our residents. Our carers, estimated to number around 15,000 in Kingston, are our biggest health and social care workforce in the borough. Yet, our carers are often unrecognised for their tireless and crucial contributions and are also in need of support themselves. Through this plan, we will aim to support our carers.

We will strive for as good health as possible throughout life and, in the end, aim for good end of life care, enabling residents 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.

The pandemic has had a particular impact on our older residents - age has been found to be a risk factor for poorer outcomes - and many people in Kingston have had their health impacted over the last 18 months. Further, many have faced a challenging time through isolation over the various 'lockdown' periods and difficulties in accessing healthcare. At the same time, many people have also embraced digital technology in new ways, including accessing health and wellbeing advice and social connections. Others have rediscovered the local green space and new local opportunities for physical activity.

As part of our refreshed plan, we will continue our focus on three priority areas set out in our original plan.

Three focus areas:

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.

Four golden threads:

1. Carers: We will take action to improve our practice in identifying and recognising carers of all ages so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.
2. Tackling inequalities: We will take action to tackle inequalities in health and reduce disparities for those most disadvantaged of all ages, tackling wider determinants of health and targeting resources where there is a proportionate need to improve life chances.
3. Obesity: We will take action to tackle obesity in all ages, enabling people to live a physically active and healthy lifestyle and at a healthy weight to prevent ill-health and improve wellbeing.
4. Promotion of good mental health and resilience: We will take action to promote the mental health and resilience of residents of all ages.

Older people in the borough of Kingston

- There are 25,400 people age 65 and over living in the borough of Kingston (in 2021)[67].
- Over the next 10 years the number of people aged 65 and over will rise by 27% to 32,320 people[68].
- 8,072 people aged 65 years and over live alone (2020), this will rise to 11,188 by 2035; an increase of almost 40%[69].
- 7,141 people aged 65 and over are **unable to manage at least one self-care activity on their own** (2020). This number is projected to increase to 9,963 by 2035; an increase of 40%[70].
- Only 34.3% of adult **carers** have as much **social contact** as they would like (2018-19)[71].
- **Cancer is the leading cause of death** (in 2020) (28%), followed by **circulatory disease** (26%) and **respiratory disease** (12%)[72].
- **High blood pressure** (58%); **high cholesterol** (53%) and **depression** (21%) are the three most prevalent conditions within those aged 65 and over (in 2021)[73].
- 1 in 15 residents over 75 years old were **admitted to hospital** for a stay of less than 24 hours (2015), which is higher than England[74].
- 6,700 **falls** in people 65 and over (2020)[75].
- 1,260 **unplanned admissions for chronic ambulatory sensitive conditions** (2018-19)[76].
- Fewer than 3 in 5 people felt supported to manage their condition (2018-19)[77].
- 1,700 people have **dementia** (2019-20), of which 61% are diagnosed (Dementia diagnosis rate)[78].
- One in five older people, and two in five living in **care homes**, have **depression**, although it is not always recognised and treated.

Across the life course in Kingston 2022-24

We will take action to improve our practice in identifying and recognising carers of all ages so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.	We will take action to tackle inequalities in health and reduce disparities for those most disadvantaged of allages tackling wider determinants of health and targeting resources where there is a proportionate need to improve life chances.
Action	**Action**
Review and develop all age **Carers' strategy** Promote the wide range of social opportunities available via Connected Kingston to carers. Promote the wide range of **social activities, opportunities for physical activity, personal development** and health and wellbeing courses available for carers. Promoting and increasing referrals to counselling, **emotional support and targeted courses (social prescription)** for carers, including carers' networks and support forums. Offer and promote 'Working for Carers' Programme to support **unpaid carers to move closer to employment**. Programme of financial management / budgeting courses for carers. Promote and increase opportunities for carers to have respite (flexible breaks and relief care). Improve information and advice offer for unpaid carers/ young/ young adult carers. Support unpaid carers to have emergency plans in place.	Targeted promotion and support amongst **disadvantaged sections for the community and those who experience poorer health outcomes due to Covid-19** (i.e. older people, people from Black, Asian and minority ethnic communities and people on low incomes) through the delivery of: 1. **Infection and outbreak control**, supporting people to prevent their risks of contracting Covid-19. 2. **Increasing vaccine take-up** by tackling vaccine hesitancy or reluctance, promoting vaccine confidence and safety. 3. **Promoting and enabling testing** and 4. **Self isolation support**, especially practical, financial and emotional support to enable people to self isolate and prevent further onward spread of the disease. 4. **Address Post Covid (Long Covid)** by working together accross the health and care system to join up and develop new offers of care and support. **Tackle food, fuel and financial insecurity** by enabling residents to access support (including courses) to prevent or deal with financial concerns or problems and help to secure employment, preventing poorer health outcomes i.e. through referrals to and the provision of appropriate community support and appropriate services. Improve access to healthy, affordable food for disadvantaged communities. Work towards enabling disabled and disadvantaged people to always have warm homes. **Tackle digital inequalities** by linking in with education providers to access funding to provide digital equipment (on loan) to residents whilst they engage in learning and improve their digital, financial, language, employability, social and wellbeing (mental and physical) skills. Tackle digital exclusion in partnership. Enable people to have a **secure home and prevent homelessness** by continuing to invest in and promoting good quality advice, information and advocacy services. Work to **reduce inequlaities experienced by physically disabled people**. Support disabled people to have access to healthy lifestyles and physical activity services. Review and development of commissioned services including collaborative commissioning approaches **(pooling money across organisations and buying services together)** in the Section 75 Agreement between Local Authority and NHS organisations with a particular emphasis on proportionate universalism (proportionate and targeted services where the need is greatest), to tackle inequalities. Create fair employment with the **London Living Wage** where possible and linking with education and training providers for employability initiatives aimed at supporting people into employment. Support **Refugees, socially excluded migrant population groups and unaccompanied asylum seeking children** by developing joint action plans to reduce inequalities and poor health outcomes. Develop a person centred integrated model to reduce barriers to support and treatment for those experiencing **complex lives** (for example those who may be socially excluded with co-morbidity issues) with the aim of improving health and wellbeing outcomes.

We will take action to tackle obesity in all ages, enabling people to live physically active with healthy lifestyles and a healthy weight to prevent ill-health and improve wellbeing	We will take action to promote the mental health and resilience of residents of all ages.
Action	**Action**
Publish and deliver the council's **Obesity Strategy and Action Plan 2022-24.** Develop a system-wide **2 year Obesity Task Force 2022-24.** Develop a L**ong Term (minimum 5 year) system-wide Obesity Strategy and programme plan** involving a multi-agency response to tackling obesity. Take joint **action to address inequalities and align plans where possible** i.e. in the production of the council's long term Local Plan (2023-2041) and the system-wide Obesity Strategy ensuring the environment, where we build homes, facilities and greener transport and how we move around are all taken into account to prevent avoidable health inequalities. Continue to **tackle food insecurity across the life course** through education, the Good Food strategic group and community food distribution groups. **Promote physical activity** across the life course through the development of a local Community Sport and Physical Activity Network. **Promote active travel and green infrastructure**. Support school streets and encourage sustainable travel choices such as walking and cycling. **Support locality based ways of working to tackle obesity** by promoting healthy weight and ophysical activity with whole schools and communities.	Review the **Thrive Kingston mental health and wellbeing strategy** updating action plans in light of the findings of Better Mental Health Joint Strategic Needs Assessment (JSNA) recommendations and emerging Covid-19 related mental health needs. Review Kingston's **suicide prevention strategy and develop appropriate partnership plans** following the South West London review. **Tackle social isolation and loneliness** accross the lifecourse, espescially targeting those significantly impacted due to deprivation. Further **develop, strengthen and promote social prescribing** from health and community services to education and community services. Consider mental health specific services. Within the context of a compassionate community model, we will engage with the community to understand how to **support the bereaved** and to develop an appropriate response. We will **improve transitions** of young people from children to adult mental health services and of older adults from adult to mental health services for older people. Linking in with adult education, health services and community groups, **develop and deliver a mental wellbeing provision** across the borough ensuring delivery is where people need it most.

Cross cutting enablers; Workforce development, digital and assets

Workforce

- Create healthy working environments promoting healthy lifestyles to workforces, making healthy choices easy choices to make and recommend to all. Use the London Healthy Workplace Award framework for good practice.
- Provide training for staff in having healthy conversations and awareness of the local community offers available i.e. through ConnectedKingston.uk and making every contact count (MECC).
- Make available and promote free access to mental wellbeing and healthy lifestyles services such as Practical Ideas for Happier Living (for mental wellbeing) weight management support and smoking cessation (for healthy lifestyles) for all workers and their eligible users.
- Strengthen the roles of social prescribers; community connectors, wellbeing coaches and other allied health professional roles and build a workforce able to make interventions to tackle social inequalities, help people improve their lifestyles and, hence, their health outcomes.
- Seeking to ensure workforce policies and commissioned services look to understand and support communities facing inequalities within the borough.

Digital

- Support digital first where appropriate to do so, enabling people to self serve and access what they need online with ease i.e. GP practice appointments and prescriptions and social prescription offers (i.e. via Connected Kingston.uk).
- Support digital inclusion and tackle digital exclusion.

Assets

- Make use of community buildings, green spaces and community assets available to our local communities i.e. by opening up for community hubs and spaces.

[1] https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

[3] https://www.kingston.gov.uk/downloads/file/1005/inclusive-kingston-full-strategy

[15] ONS, mortality statistics https://www.nomisweb.co.uk/datasets/mortsa (accessed 8th September 2021)

[16] NHS Digital, Primary Care Mortality Database (PCMD), unpublished

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Start Well in Kingston 2022-2024

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 and wellbeing of children and young people by tackling childhood obesity.	Give children and young people with special educational needs and disabilities (SEND) opportunities to flourish and be independent.
Action	**Action**	**Action**
Ensure that there is an **emotional wellbeing programme** in all schools. This will include wellbeing support, training and information for students, parents and staff. Promote access to online resources and **digital mental health** care to strengthen the emotional wellbeing and resilience of young people. Implement a **new model of mental health care for children and young people aged 0 to 25** to provide swift and flexible support based on their holistic needs with an emphasis on prevention and early intervention. Develop a community hub-based approach to provide **integrated support** to children and young people with emotional health needs from a range of professionals with specialist skills. Work with young people to co-produce and promote peer-led services that reduce involvement in **self-harm and harmful behaviours**, such as substance misuse. Improve the quality of the experience and outcomes for young people who **transition from children's to adult mental health services**. Provide **advice and support to parents and carers** at all developmental stages to develop their confidence in caring for their child and supporting their mental health and emotional wellbeing. Provide additional support for those supporting looked after children. Strengthen the early identification and assessment of **young carers** to ensure their mental health and wellbeing needs are met and supported. Implement preventative programmes that increase the safety and emotional wellbeing of young people and reduce serious **youth violence** and exploitation. Ensure that children and young people have access to the support they need to help with **bereavement, grief and loss**.	Promote **breastfeeding and safe infant feeding** practices to support the nutrition of babies and infants in their first 1,001 days. Work with all **schools** to implement initiatives that actively promote pupils' healthy weight through healthy eating and regular physical activity. Expand parent-led programmes that **promote healthy eating and active play for children in their early years**, and implement a healthy lifestyle programme for parents and children aged 5 to 11. Create more opportunities for children and young people to take part in **active play, sport and adventurous activities**, including targeted programmes for those who need support to reach and maintain a healthy weight. Use **school travel planning** to maximise opportunities for children to safely walk, scoot or cycle to school. Develop a system-wide **obesity strategy** with a particular emphasis on whole- family approaches to reducing obesity and maintaining healthy weight. **Promote healthy lifestyle activities** for families via online platforms such as Connected Kingston and through social media campaigns.	Improve the **early identification** of children and young people with SEND through better coordinated multi-agency working and information-sharing. Work with children and young people and their parents and carers to ensure they can have their say and are involved in decisions about their own **education, health and care** support. Improve the range, quality and accessibility of **information on local education, health and care services** for children and young people with SEND, their parents and carers and the professionals who support them. Support schools to deliver **Quality First Teaching** so that they can support more children and young people in mainstream settings and achieve good outcomes for them. Improve the quality and timeliness of **education, health and care assessments, plans and reviews** to ensure they support and achieve agreed outcomes, promote resilience and independence, and provide good value for money. Implement a balanced model for the delivery of an **improved therapy offer** for children and young people with SEND. Develop the local **neuro-developmental service** for children and young people to improve the timeliness of assessments and the provision of pre-and post-diagnostic support. Improve early planning for all **young people's transition to adulthood** and independence, particularly those who will need ongoing support from adult health and care services.

- We will take action to **improve our practice in identifying and recognising carers of all ages** so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.
- We will take action to **tackle inequalities in health and reduce disparities for those most disadvantaged of all ages** tackling wider determinants of health and targeting resources where there is a proportionate need to improve life chances.
- We will take action to **tackle obesity in all ages, enabling people to live physically active with healthy lifestyles and a healthy weight** to prevent ill-health and improve wellbeing.
- We will take action to **promote the mental health and resilience of residents of all ages.**

Impact - Outcome	Impact - Outcome	Impact - Outcome
More children and young people have timely access to emotional wellbeing support seven days a week through a well-used digital offer. There is a reduction in incidences of self-harm and suicide because children and young people receive earlier and better coordinated support for their mental health and wellbeing. Young people with identified mental health needs have a better planned and smoother transition between child and adult mental health services. More children and young people have their emotional wellbeing and mental health needs identified earlier and receive more timely support from the most appropriate services, particularly those from groups at higher risk of mental health problems. More children and young people have access to support with bereavement, grief and loss. There is a reduction in the number of children and young people who smoke, drink alcohol, and misuse substances. More young carers have an assessment of their needs and appropriate support for their mental health and wellbeing. There is a reduction in youth violence and exploitation.	There is an increase in the number of new mothers who breastfeed their baby for the first six to eight weeks. There is a reduction in the number of children and young people who are overweight, including those who are obese. More vulnerable families who have regular access to healthy and affordable food. More schools achieve the Healthy Schools London Award and participate in the Daily Mile. There is an increase in the number of children and young people who take part in physical activity for at least 60 minutes every day.	Participation in local services for children and young people with SEND increases due to greater awareness of local health and care services. More children, young people, parents and carers are engaged in the co-production of SEND services. More children and young people with SEND are in mainstream schools and education settings with support from local health and care services. Children and young people who use local therapy services have shorter waiting times for assessment and therapy programmes. The identification of neurodevelopmental happens earlier and assessments are completed within 12 weeks of referral, Young people with SEND have a better planned and smoother transition to post-16 education and support from adult health and care services where this is needed.

Live Well in Kingston 2022-2024

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, have a healthy weight and regular physical activity to prevent ill health.	Support people to manage long-term conditions.	Reduce health inequalities for adults with or at risk of having poorer health.
Action	**Action**	**Action**
Train **staff and volunteers to become Connected Kingston champions** to increase awareness of the offers available in the community that support good physical and mental health and wellbeing. Improve the **detection of people at risk of developing long term conditions** through **the promotion of health checks and national and local screening programmes**, particularly amongst those at greatest risk of ill health. Increase **health checks** and target at those most at risk: Screening interventions such as Vital 5 to be piloted in clinical settings such as General Practice and/ or in hospital. **Mental health screening tools** to be rolled out in community settings (such as pharmacies and health and wellbeing clinics). **Community health and wellbeing coaches** to be trained and work proactively with target communities who are at risk of developing long term conditions i.e. using the 'Know Your Risk Tool' and referring to preventing diabetes support offers. Increase referrals through the promotion of services via Connected Kingston, as well as those accessing support through Community Champions, Connecters and Triage services in the Kingston Stronger Together Hub. Promote social prescription and build stronger referral routes from health and community services to education and community services.	Build the capacity and capability within the community to **support self-management, self-care**, promoting health and social prescribing community offers. Proactively support people with complex health and care needs by **bringing health and care professionals together around the individual** – through Implementation of the proactive anticipatory care (PAC) model. Roll out the proactive anticipatory care (PAC) model across all PCNs by 2022. **Support people with long-term conditions** by expanding IAPT **(psychological therapies)** and providing referrals to social prescribing support for their mental wellbeing. **Develop a model of care for people with long term conditions** that span the range from prevention through to detection, to management and optimisation of care. Promote and use **digital health promotion tools to support self-care** and manage long term conditions. Promote in-person and online **courses for people with long term conditions** i.e. face to face and online Diabetes courses and face to face and online adult education courses.	Tackle **inequalities associated with Covid-19 in adults including social inequalities such as loss of income** (i.e. caused by the impact of Covid-19) (eg. adult education courses for financial budgeting, increasing skills to gain employment, mental wellbeing etc). Coordinate work on **Covid-19 and flu vaccinations**, especially to reach adults most at risk, the vulnerable and those in the community who may experience social exclusion i.e. through outreach. **Promote adult health improvement initiatives and services** including screening opportunities, particularly to those at most risk of health inequalities. **Develop health equity partnership work** with communities where we know there are people with poorer health outcomes or have limited access to services. Including developing conversations about physical and mental wellbeing signposting to support services and language support to access services. Develop Kingston's **Black, Asian and Minority Ethnic (BAME) Mental Health Partnership** and action plan to tackle inequalities. Through early intervention, **increase referrals to healthy lifestyles support** such as stopping smoking, exercise referrals and healthy weight educational opportunities, especially for those adults who experience inequalities and are most vulnerable to poor health outcomes. Promote and support uptake of smoking cessation services, especially amongst adults with anxiety or depression where smoking rates are high[79].

Action	Action	Action
Promote in-person and online prevention courses such as the 'Healthier You' National Diabetes Prevention Programme (NDPP) for people at risk of developing Type 2 diabetes and Health and Fitness Classes which are subsidised by the government through Adult Education. Promote **lifestyles services and Adult Weight Management for adults** utilising the Public Health England grant and through links with adult education, also utilise the Adult Education Budget. Review the Thrive Kingston **mental health and wellbeing strategy**, updating action plans, in light of the findings of Better Mental Health Joint Strategic Needs Assessment and emerging Covid-19 related mental health needs. Review the gaps in existing **bereavement support services** and engage with the community to understand how to support the bereaved, and develop an appropriate response in light of these findings.	Increase the number of **people with learning disabilities and those with serious mental illness who receive health checks** (including by providing additional resources and responsibilities in primary care). As part of the Community Mental Health Transformation Programme, **develop Integrated delivery hubs, for people with serious mental illness**, which will provide a range of health and social care services as well as links to voluntary sector services to provide additional support for service users.	Support adults with learning disabilities, autism and mental health conditions who want to **take steps towards employment**. Utilise the Adult Education Budget to support this. Ensure local people have access to **information and advice about their rights and responsibilities at work**. Increase **targeted promotion of mental health support services for specific inequalities groups** for example, people living in deprived areas. Utilise creative funding opportunities such as the Adult Education Budget to support this. Provide **accessible integrated access points for all adults** to Adult Social Care, Community Housing, Health services and other relevant services, at the earliest opportunity. **Develop English language provision** alongside adult health interventions i.e. in Diaban Clinics to break down language barriers for groups that are predisposed to gestational diabetes and help tackle inequalities.

- We will take action to **improve our practice in identifying and recognising carers of all ages** so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.
- We will take action to **tackle inequalities in health and reduce disparities for those most disadvantaged of all ages** tackling wider determinants of health and targeting resources where there is a proportionate need to improve life chances.
- We will take action to **tackle obesity in all ages, enabling people to live physically active with healthy lifestyles and a healthy weight** to prevent ill-health and improve wellbeing.
- We will take action to promote the mental health and resilience of residents of all ages.

Impact	Impact	Impact
Number of health and social care professionals and volunteers trained as Connected Kingston Champions. Increased detection of people with LTCs through health checks and national screening programmes. Increased number of people at risk of LTCs accessing self-care prevention courses i.e. NDPP. The number of people referred to lifestyles services and accessing weight management support will increase. The number of people referred to lifestyles services who reduce their weight. Mental Health Strategy Action Plan refreshed. The bereaved are supported in Kingston because the gaps in bereavement support services are understood and addressed.	Number of organisations reporting they can support their users with LTC to self-care and self-manage. The number of people supported to live independently in the community will increase. Number of individuals receiving tailored support. Number of people with LTC using IAPTS services report better mental health. Reduction of people being diagnosed with a long term condition in A&E. Increase in the number of long term conditions identified. Reduction in the gap between prevalence and actual long term conditions across the borough. Number of patients with a LTC accessing social prescribing initiatives for weight management will increase. Increased number of people with diabetes meeting the 3 Treatment Targets. Digital tools available and being accessed. More people with long terms conditions are attending self management courses supporting them to manage their condition. Increased number of people with SMI who receive an annual health check. Individuals receive more holistic and timely support. Prevent exclusion for those with co-occuring conditions. Signposting through Connected Kingston and through Kingston Stronger Together's Partnership Hub. This Hub is developing approaches and pathways to work with individuals at an earlier stage to access support and advice independently.	Reduced inequalities associated with Covid-19 i.e. people are supported with financial assistance when they're required to self-isolate. Vulnerable and socially excluded groups are reached and receive Covid-19 and flu vaccines. Screening services have been taken up by all eligible patient groups including those who're most at risk. Health equity partnership work plan developed including community champions trained and facilitating screening checks in the community. Race inequalities in mental health are addressed. Increased take up of lifestyle services by disadvantaged groups. Increased numbers of smokers with anxiety or depression stop smoking. More people with learning disabilities and mental illness are taking steps to employment or are employed. More people's wellbeing is protected as they are aware of their rights and responsibilities at work. People in deprived areas and other vulnerable groups are accessing mental health support services. People receive early, timely and holistic support at the point of need. Fewer people in the housing crisis. Increase referrals to Domestic Violence (DV) Hub and MARAC (Multi Agency Risk Assessment Conference) by Mental Health service and to Mental Health Services by those attending the DV Hub. Reduced inequalities relating to language barriers and accessing services.

Age Well in Kingston 2022-2024

Whilst people are living longer, many older people are also living with a reduced quality of life due to ill health or disability or experiencing 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
Action	**Action**	**Action**
Promoting and increasing referrals to **Healthy at Home Lifestyles services** amongst older people including falls prevention. Review the community / voluntary sector, 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 2023. Effective identification, **support and management of older people with escalating risks** to enhance people's quality of life. Achieved by creating a network-based multi-disciplinary dedicated core team that works alongside primary care. Improve the provision and coordination of services to **prevent and treat falls**. Increase opportunities for older people to be **more physically active**. Promote courses for adults to **develop support networks, improve mental wellbeing, learn new skills and remain independent**. Utilise the Adult Education Budget to support this.	Review the role of community connectors/ social prescribers, the health and mental health hubs, and **utilise community hubs to build opportunities for social connections for older people**. **Increase the ways of identifying people who are lonely and supporting them to access local services**. Work with older people, particularly those who are not accessing existing services, to develop ways for them to build social connections. Analyse social care providers to understand current levels of anxiety and depression amongst clients and identify those with the highest need to focus on **promotion and implementation of Mental Health First Aid training** to Health and Social Care staff working with older people. **Promote courses for adults** to develop support networks to reduce loneliness and isolation, improve mental wellbeing, learn new skills or build on existing skills. Develop and promote a **programme for Carers which offers both respite and a chance to improve skills**. Involve **older carers** in the development of the Carers' strategy to support those older carers at risk of loneliness and social isolation. Within the context of a compassionate community model, engage with the community to understand how to **support the bereaved** and to develop an appropriate response.	Increased use and access to **integrated digital End of Life care plans** across Kingston in all care settings including acute hospital and care homes through engagement and training. Review **quality of Integrated Digital End of Life Care Plan** records, and implementation of quality standards in Kingston. Review End of Life Care and Palliative **training needs for health and social care staff and voluntary sector** in Kingston, with a view to developing a plan to address the gaps. Adoption of a **Compassionate Communities population-based approach to EOLC and bereavement** to increase identification of bereaved people and Increase of acknowledgement/ sign-posting to bereavement of support and services. Support **care homes to be more digitally integrated** across the health and social care system. Implement **clinical tools in care homes** to manage their residents safely and consistently. Increase the number of people with **dementia and their carers identified early and provided with post-diagnosis support** and ongoing advice by implementing nationally recognised Memory Services National Accreditation Programme (MSNAP) standards within our memory assessment units within 2022 and working with partners to support success. Improve services and support for people with dementia by undertaking a whole system partners review of and **implementing the Kingston Dementia Strategy**, together with developing new dementia care home facilities in the borough, primary care support and shared care protocols to enable people to be better managed in the community and reviewing our post diagnostic support offer across health and social care.

- We will take action to **improve our practice in identifying and recognising carers of all ages** so they are linked to appropriate support options, enabling carers to reduce the social, financial and health impacts they face.
- We will take action to **tackle inequalities in health and reduce disparities for those most disadvantaged of all ages** tackling wider determinants of health and targeting resources where there is a proportionate need to improve life chances.
- We will take action to **tackle obesity in all ages, enabling people to live physically active with healthy lifestyles and a healthy weight** to prevent ill-health and improve wellbeing.
- We will take action to promote the mental health and resilience of residents of all ages.

Impact	Impact	Impact
Increased access and referral rates to **healthy lifestyles services** such as exercise referral, bone health and physical activity opportunities, weight management support, smoking cessation and alcohol support. **People will be supported to live independently and in their own home** for as long as they are able to with reduction in admission to care homes and an increase in admission avoidance. **Teams will work together** within local geographical locations to provide seamless care and support to keep people within their home and reduce the risk of deteriorating health. this is called the anticipatory care model **The anticipatory care model** will effectively identify people with escalating risks; This will deliver effective support / management for people with risks to avoid further escalation and through local / accessible support people will stay healthy and independent.	More older people will access our voluntary sector support groups through **Connected Kingston**. The uptake of **Mental Health First Aid training** to Health and Social Care staff working with older people will increase. Opportunities for people in Kingston to **remain connected to others** and improve their health and wellbeing, will increase. Reduction in people who report **feeling lonely and isolated**. Older carers to be included as a group at risk of isolation in **loneliness and isolation plans**. More older people will have access to **support from bereavement services**.	Increased number of users / use of patient initiated **integrated end of life digital care plans** including use in care homes. Increase in **quality of care plans** across organisations through SWL end of life evaluation report identifying Kingston performance and Clinical quality panel initiated to review and inform improvements in EOLC. Increase the number of people with **palliative and end of care needs** identified and included on the palliative care register. Increase identification of **bereaved people** and Increase of acknowledgement/ sign-posting to bereavement of support and services. **Safe and quicker data sharing through care homes** and the health and care system using secure email addresses (NHSmail or an NHS Digital accredited email addresses). **Care homes are able to recognise the soft signs of deterioration** through RESTORE2/ NEWS2, and be able to escalate residents appropriately. Increased referrals to Alzheimer's society from health partners, social workers, social prescribers and voluntary and community sector with more people living with dementia and their carers receiving timely information. Clear actions to bridge gaps in the dementia pathway, meet demand, address barriers and ensure people receive high quality and timely care, support and advice.

Appendix: How we will measure progress

- This Health and Care Plan was signed off in January 2022 by the Health and Wellbeing Board.
- The plan is a list of actions for partners to prioritise working on, together. However, whilst excellent work is being carried out by partners, high level measures of how we demonstrate the difference we are making are yet to be decided.
- Draft metrics are being developed by Kingston's Public Health team in partnership with Health and Care Partners.
- These draft metrics and propsed outcome measures were reported to the Health and Wellbeing Board on 22.3.22.
- The intention is for a published dashboard to be made available for the public, Health and Wellbeing Board and Kingston Place Based Partnership to review progress against the actions set out within this plan.

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