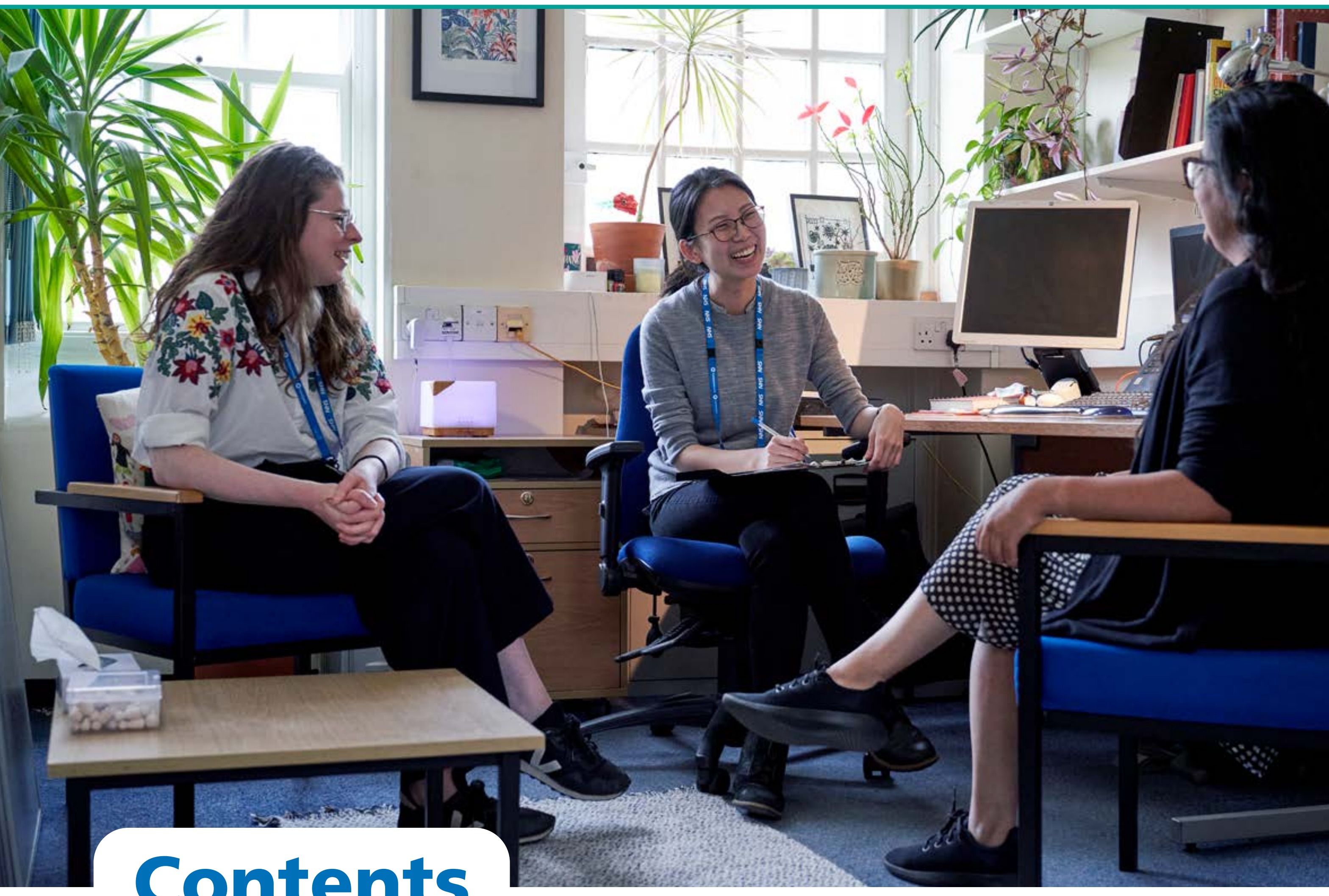
Developing our NHS Joint Forward Plan



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Foreword

Our Joint Forward Plan describes how NHS partners across South West London will work together over the next five years to meet the needs of local people. The ambitions outlined in our plan are built from our understanding of the health needs of people in South West London, the health inequalities that exist and importantly the views, experiences and concerns of our people and communities.

As the NHS in South West London, our collaborative approach has helped us maintain our position as a high performing system in London, and ensured we perform well against NHS targets and priorities, including referral to treatment times, elective care and vaccination delivery. There is no hiding from the fact that this is a challenging time for health and care services, but we are recovering well from pandemic, and we will continue to work together to improve further.

We are clear that achieving the ambitions in this plan will need us all to work together differently, as we shift our focus from treatment to prevention, support people to make healthy choices, and improve our services and the way we provide care. Our focus will be to:

- Prevent ill health and support people to self-care
- Reduce health inequalities
- Keep people well and out of hospital
- Provide the best care wherever patients are accessing our services
- Use technology to improve care
- Manage our money
- Make South West London a great place to work
- Deliver the NHS' requirements of the Integrated Care Partnership Strategy.

This Joint Forward Plan is being written in two stages. This first stage outlines our level of ambition, the context we are working in for each part of plan and the views of people and communities. The final plan, which will outline our actions to deliver our ambition and respond to the needs and views of our people and communities, will be published in June 2023. It will then be updated each year.

The last few years have shown us that when we come together, we can make real and tangible improvements to the health of local people. We look forward to achieving more together.

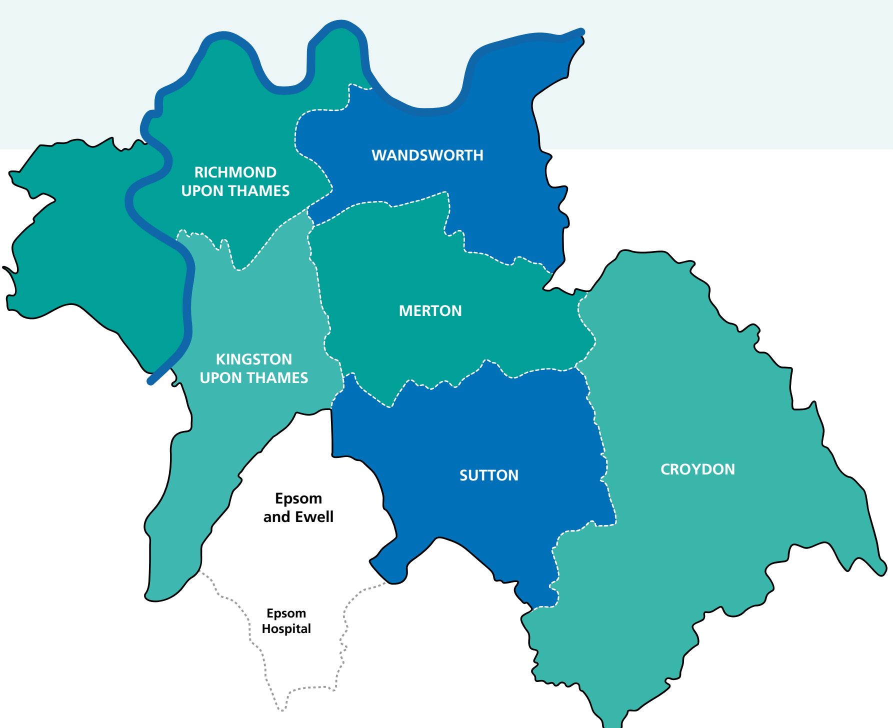
Sarah Blow
Chief Executive Officer
NHS South West London Integrated Care Board

Our ambition

The South West London Integrated Care Board (ICB) brings the NHS and partners together to improve the health of people in South West London, manage the NHS budget and arrange South West London's health services. We have four core aims, these are to:

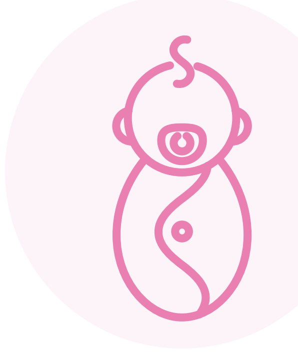
- Improve outcomes in population health and healthcare,
- Tackle inequalities in outcomes, experience and access,
- Enhance productivity and value for money, and
- Help the NHS support broader social and economic development

We work with our partners across the six boroughs of South West London:



- **Our Acute and Community Providers:** Central London community Healthcare, Croydon Health Services NHS Trust, Epsom and St Helier University Hospitals NHS Trust, Hounslow and Richmond Community Healthcare, Kingston Hospital NHS Foundation Trust, Royal Marsden Foundation Trust, St George's NHS Foundation Trust and Your Healthcare
- **Our two Mental Health Providers:** South West London and St George's Mental Health NHS Trust, South London and the Maudsley NHS Foundation Trust
- Our 39 **Primary Care Networks**
- **The GP Federations** in each of the our six boroughs
- The **London Ambulance Service**
- Our six **Local Authorities**: Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth
- Our **South West London Joint Working Group** and our six **local Healthwatches**: Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth
- Our **South West London Voluntary and Community and Social Enterprise (VCSE) Alliance** and our diverse VCSE sector organisations and community groups. Our voluntary sector infrastructure organisations, including:
  - Community Action Sutton
  - Croydon Voluntary Action, Asian Resource Centre of Croydon, Croydon Black and Ethnic Minority (BME) Forum and the Croydon Neighbourhood Care Association
  - Kingston Voluntary Action
  - Merton Connected
  - Richmond Community Voluntary Services
  - Wandsworth Care Alliance
- Our **NHS provider collaboratives**:
  - Royal Marsden Partners
  - South West London Acute Provider Collaborative
  - South London Mental Health Provider Collaborative

Our ambition is for people in our boroughs to



Start well

Live well

Age well

Our goal over the next five years is to enable South West Londoners to Start Well, Live Well and Age Well. Our ambition is to make real and tangible improvements in health and care for local people. To do this we need to be clear about where to focus our collective action, this is the purpose of this Joint Forward Plan.

To ensure that our actions are targeted to the right areas we have assessed the health needs of the people in South West London. This can be found in chapter one.

As we look ahead to the next five years, we are facing a number of challenges:

1. Recovering services from the pandemic
2. Reducing health inequalities
3. Increasing demand for services
4. Meeting the growing and changing needs of patients
5. Tackling our system wide workforce challenges
6. Managing our financial pressures
7. Improving our productivity and efficiency
8. Improving our performance against some of the NHS targets

We know that to meet these challenges we will need to work together differently, ensuing that we make the best use of our resources, do more together to keep people healthy and prevent ill health, support people to self-care and tackle the health inequalities that exist in our boroughs. This Joint Forward plan outlines how we will continue to work together to do this over the next five years.

Part One: About South West London

Understanding health need in South West London

We know that many factors influence the health of people and communities. There is a complex interplay between a persons individual characteristics and genetics, their lifestyle, and the physical, social, and economic environment in which they live. Whether people are healthy or not, is determined by their circumstances and environment. The 'wider determinants of health' such as where we live, our environment, our income and education level, and our relationships with friends and family all have considerable impacts on health.

Our health behaviours and lifestyles are also important drivers of health outcomes. This includes smoking, alcohol consumption, diet, and exercise. Genetic inheritance plays a part in determining lifespan, healthiness, and the likelihood of developing certain illnesses. Access to and use of services that prevent and treat disease also influences our health.

Many of the underlying causes of poor health and wellbeing can be prevented. To improve the health and wellbeing of people in South West London, we will ensure that our five-year plan not only includes treating people who are unwell, but also works with our partners and communities to improve physical and mental health and wellbeing and prevent ill health.

We have assessed the needs of our population. We will describe South West London as a whole; however, we are aware that averages can mask inequalities between and within our six boroughs. Health and care plans for our six boroughs are therefore developed to address local needs – health and care plans can be found in Part 5, working together at place.

Understanding our population demographics

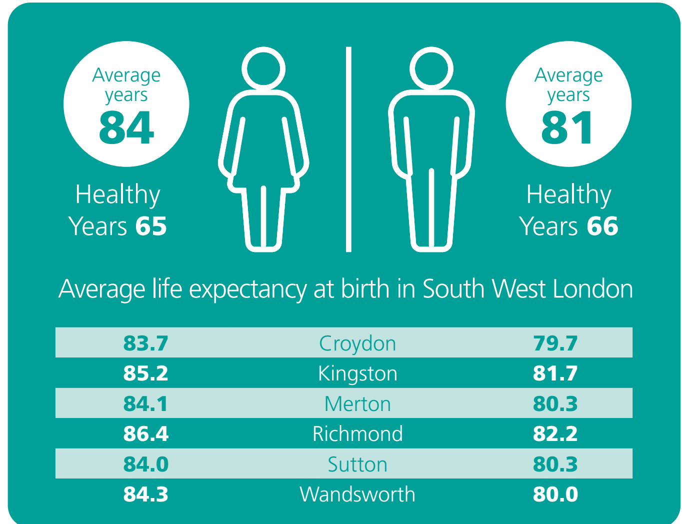
1.5 million people live in South West London. 100,000 more people are living in our boroughs now than in 2011 and we are expecting our population to grow by an additional 30,000 people in the next 10 years.

Our current population is slightly younger compared to the average for England. The average age of our population has increased by one-three years since 2011 and it is projected that we will have about 30,000 less children and young people, about 4,000 more working age people, and around 58,000 more older adults by 2033.

Predicted percentage change in each age group, by borough, between 2023 and 2033

	Age 0-14	Age 15-64	Age 65+
Croydon	-10.1%	-1.3%	30.3%
Kingston	-12.4%	1.7%	24.8%
Merton	-12.7%	-0.8%	24.3%
Richmond	-13.8%	-0.7%	28.2%
Sutton	-10.0%	1.8%	21.1%
Wandsworth	-7.0%	2.1%	29.6%

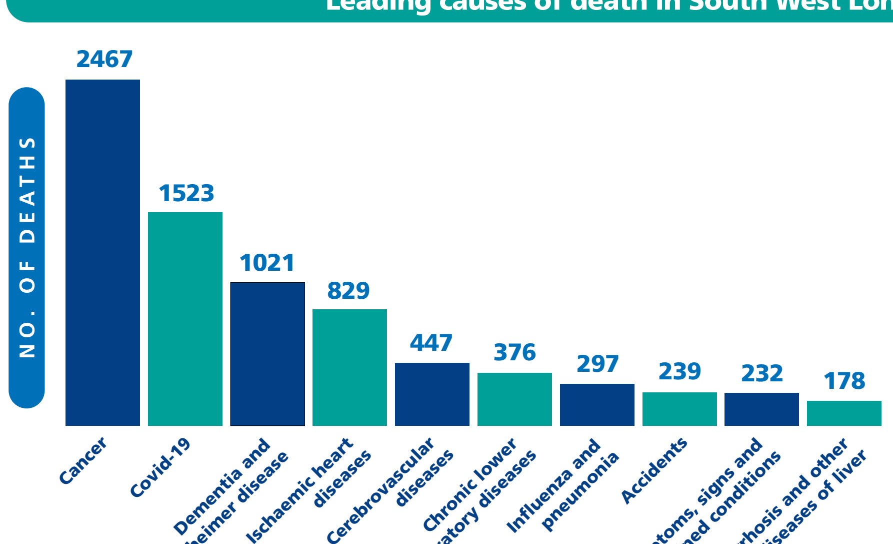
The average life expectancy in South West London is 84 years for women and 81 years for men. Following nearly 20 years of improvement in life expectancy, the Covid-19 pandemic had a significant negative impact on the life expectancy of our residents, with a fall of between one and three years, depending on where you live.



83.7	Croydon	79.7
85.2	Kingston	81.7
84.1	Merton	80.3
86.4	Richmond	82.2
84.0	Sutton	80.3
84.3	Wandsworth	80.0

We know which conditions cause the highest number of deaths in our population.

Leading causes of death in South West London 2021



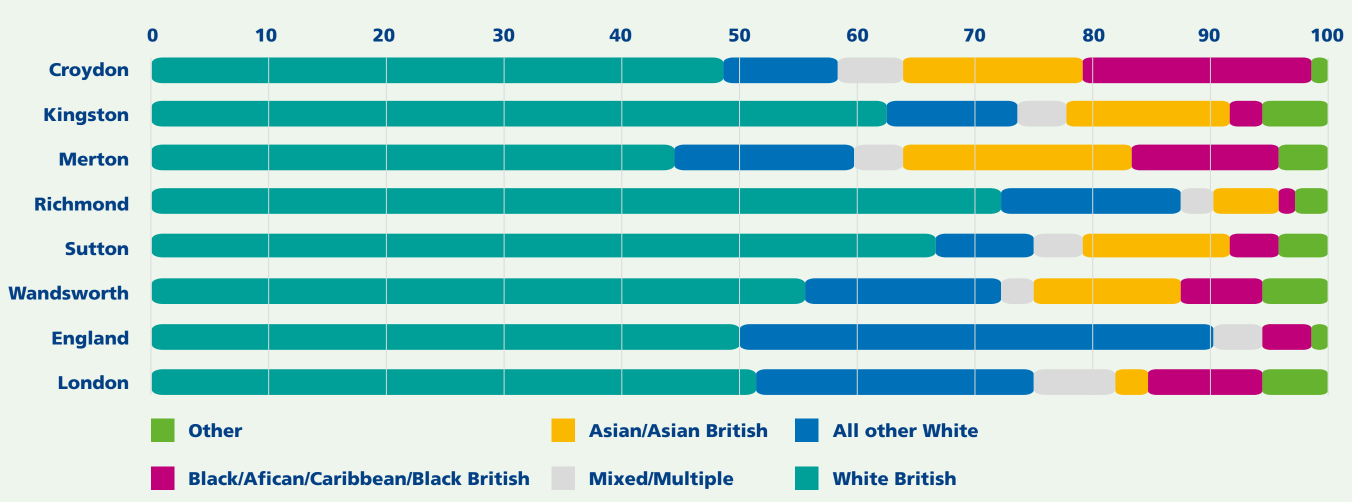
Ischaemic heart disease was one of the leading cause of death for our residents in 2020/21[1]. It is the single most common cause of premature death in the UK. It cannot be cured but treatment can help manage the symptoms and reduce the chances of problems such as heart attacks. 1.9% of our adult population are known to have coronary heart disease and there were 829 deaths from ischaemic heart disease in 2021.

Our aim is to improve healthy life expectancy by at least five years by 2035. This means increasing the average number of years that an individual is expected to live in good health. The healthy life expectancy of our population is better than the London and national average but varies depending on where you live and your gender. Healthy life expectancy for males is generally similar to London averages apart from Richmond and Kingston which show higher healthy life expectancies. On average across South West London, men live one more year in good health than women do, but this ranges from 63.2 years in good health in Croydon to 70.2 years in Merton. Healthy life expectancies vary for females, although they are generally higher than London averages. The healthy life expectancy of women ranges from 62.4 years in Croydon to 70.1 years in Wandsworth. Richmond displays an almost 10 years higher life expectancy for females compared to London averages, Croydon however has dropped below London.

The average English indices of multiple deprivation (IMD) score for South West London is 15.9 which means we are less deprived than the average for both London and England, however there is significant variation between our places. 50% of our most deprived residents live in Croydon, 22% in Wandsworth, 11% in Merton and in Sutton, compared to 4% in Richmond and 2% in Kingston.

1. Excluding Covid-19 deaths).

When we look at ethnicity of people in South West London we find:

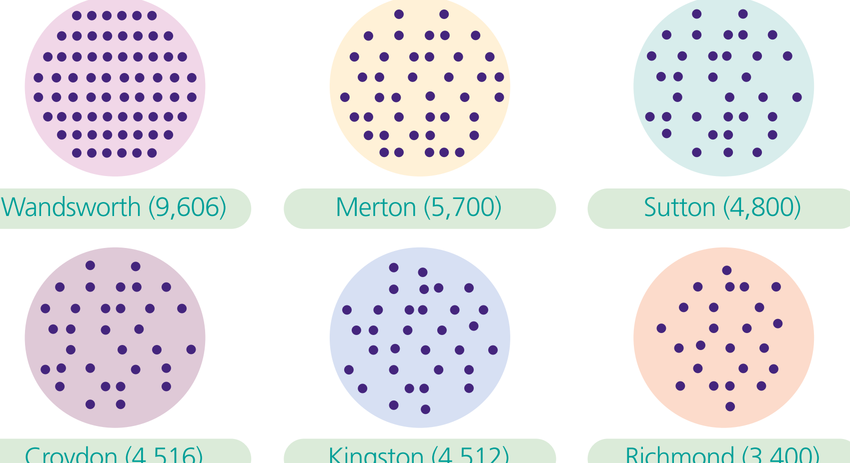


Ethnic diversity across our boroughs varies. When compared to London's 32 boroughs we find (from most diverse to least diverse):

- 12th Croydon
- 19th Sutton
- 22nd Merton
- 29th Kingston
- 30th Wandsworth
- 32nd Richmond

2021 Population density, residents per km²

South West London is an urban area with significantly higher population density than the national average. This is true across London, and we see significant variation between our boroughs.



The wider determinants of health

Our opportunity for good health starts long before when we might need health care, and so the responsibility for the health of the public extends beyond the health and social care system to the circumstances in which people are born, grow, live, work and age. We have analysed our wider determinants of health and a summary of these are given below as at 2021/22 (unless stated otherwise) which is the most recent data available.

Education and skills

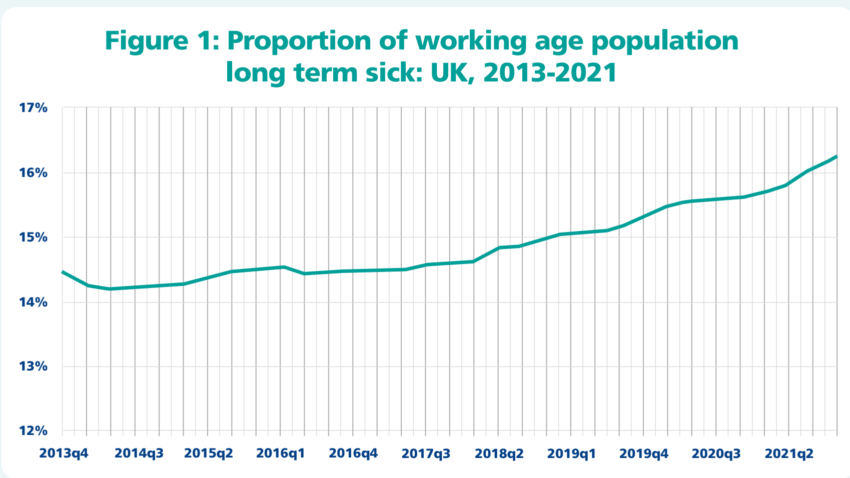
- School readiness at the end of Reception is better than the national average but has decreased across South West London by nearly 5% since the Covid-19 pandemic.
- In 2018/19, children with a free school meal status were less likely to achieve a good level of development at the end of Reception than those without. A similar pattern has been seen with children achieving the expected level in the phonics screening check in Year 1.
- 3.6% of young people aged 16 and 17 years are not in education, employment, or training, an improvement over the last five years.

Good work

- In 2023, 4.6% of our population are unemployed, slightly more than the national average.
- The number of people claiming out of work benefits is decreasing, but in January 2023 was still 57% higher than pre-pandemic, an additional 13,000 people. This is slightly higher than the national picture of 56.9% more claiming out of work benefits in January 2023 than 2019.
- The chart below displays the growing proportion of long-term sick in the UK population since 2013. The increasing prevalence of ill health has a significant impact on the NHS as well as on the wider society as people with ill health leave the workforce early. This has a significantly higher impact on those living in areas of high deprivation and in certain ethnicities living in England.

Money and resources

- Average weekly pay in 2022 for our residents was higher than the national average but 15% of our resident's jobs were paying below the London living wage of £11.95 per hour.
- In 2022, people living in Wandsworth had the fourth and Richmond the seventh highest median full-time gross weekly pay in the UK. However, inflation has been rising faster than average weekly pay in South West London for several years.
- 38,000 (1 in 8) children in South West London live in relative low-income families.
- 62,000 (1 in 10) households were in fuel poverty even before the recent increases in energy bills. Nationally, average household energy bills have risen from c.£750 per year in 2021 to c.£3500 per year.



Source: Health Foundation (2022)

Our surroundings

- Air pollution in South West London is worse than the national average but better than the average for London.
- The proportion of deaths attributable to air pollution is worse than the national average but better than the London average.
- The Office of National Statistics (ONS) data tells us that our residents have poorer access to private and public green space and are less likely to use outdoor space for exercise than people who live elsewhere in the country.
- Although crime deprivation scores improved between 2015 and 2019, meaning the risk of personal and material victimisation at local level is less, the number of violent offences, sexual offences, and domestic abuse incidents and crimes have been increasing in South West London in the last five years.
- Around 1 in 3 adults in South West London do less than 30 minutes of exercise per week.

Housing

- Affordability of home ownership has worsened since 2002. On average, housing for our residents is nearly 50% less affordable than the average for London.
- 11.2% of households are overcrowded in South West London, which is slightly better than the average for London of 15.7%. Household overcrowding is worse for our residents than it is nationally, although it has improved in the last 10 years. We do have significant variation between our places. The proportion of households with overcrowding in Croydon (13.4%) is nearly double that in Richmond (7.0%).
- Over 6,000 households in South West London are owed a duty under the Homeless Reduction Act, which means they are eligible for help either to prevent a household becoming homeless or help for households who are already homeless to secure settled accommodation.
- Nearly 7,000 households in South West London are in temporary accommodation.

Food, diet and weight

- Obesity rates of our residents double between reception and Year 6 (from 18% to 35%), and then double again by adulthood.

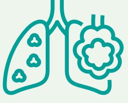
Family, friends, and communities

- During the Covid-19 pandemic, on average more people in South West London reported feeling lonely compared to the national average.

Challenges across the life course

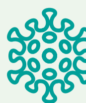
Our health behaviours and lifestyles are thought to be the second most important driver of health outcomes. This includes smoking, alcohol consumption, diet, and exercise. Although the challenges vary for each age group, we have found some common themes emerging from our health needs assessment. These are:

- **Healthy lifestyles:** Smoking, alcohol, high body mass index, high fasting blood glucose, and hypertension are the leading contributors to disease burden in our residents.



- **Long term conditions:** Ischaemic heart disease, stroke, chronic obstructive pulmonary disease, diabetes, and musculoskeletal conditions are the top contributors to burden of disease and mortality in our residents.

- **Mental health:** More than 1 in 10 South West London residents have a mental health condition.



- **Cancer, screening and vaccinations:** Coverage in our population is frequently lower than recommended targets.[2]

2 Data Sources: PHE Fingertips Public Health Data, ONS Census 2021, SWL Health Insights Platform, NHS Model System Insights, London Mental Health Benchmarking Network

Start well

In 2021 there were over 18,000 live births in South West London and about a fifth of our population were aged under 16. Comparing indicators with national averages, the health and wellbeing of children in South West London is mixed. Apart from Croydon, all boroughs perform better than or equal to the national and regional average in terms of babies born at term with low birth weight. Low birthweight is an enduring aspect of childhood morbidity, a major factor in infant mortality and has serious consequences for health in later life. Breastfeeding initiation in South West London is better than the national average, and better than or equal to the regional average in all places apart from Sutton. Increases in breastfeeding are expected to reduce illness in young children. In the following areas, outcomes for our children are worse compared to national or regional averages.

Healthy lifestyles

Indicators of general health: Infant mortality is an indicator of the general health of an entire population. Infant mortality rates are lower than the national average in all six boroughs.

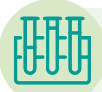
Obesity: Nearly 1 in every 5 children in Reception are overweight or obese. This almost doubles by Year 6. Nationally, there is a pattern of younger generations are becoming obese at earlier ages and staying obese for longer[3].

Alcohol: Our children and young people are more likely to be admitted to hospital due to alcohol than if they lived elsewhere in London. In the year to October 2022, nearly 250 children and young people were receiving treatment from community-based services for substance misuse (including alcohol).

Oral Health: Dental decay has similar prevalence in South West London as the rest of London at 12.6%. This is higher than the national average of 10.7%, less than half of children received NHS dental care last year and we have a higher rate of hospital admissions for dental caries in the 0-5 age group at 278 per 100,000, compared to the national average of 220.8 per 100,000.

Mental health

Each year around 16,000 under 18s receive community NHS funded mental health treatment in South West London. This is 4.5% of the children and young people (CYP) population, which is above the London average of 4.1%.



Cancer, screening and vaccinations

Our childhood vaccination coverage is below the recommended level of 95% to achieve population protection for almost all childhood vaccinations, in all boroughs. Coverage varies from 80-90% coverage in routine vaccines given to one-and two-year-olds to 70-80% measles, mumps and rubella uptake in five-year-olds. Over the last ten years, uptake of childhood vaccinations has been declining in South West London. Vaccine coverage is closely correlated with levels of disease.

Supporting carers and inclusion health groups

Children and young people with caring responsibilities are more likely to report worse health outcomes for themselves than those who don't provide care, as they have less individual time. National data suggests that 1 in 4 young carers feel lonely, and young carers are three times more likely to report a long-term mental health condition than non-carers of the same age.

3 Johnson W, Li L, Kuh D, Hardy R (2015) How Has the Age-Related Process of Overweight or Obesity Development Changed over Time? Coordinated Analyses of Individual Participant Data from Five United Kingdom Birth Cohorts. PLoS Med 12(5)

Live well

About two thirds of our population are 16 to 64 years old. The health of our working age population in South West London is mixed when compared to national averages.

Healthy lifestyles

Smoking, high body mass index (BMI), high fasting blood glucose, high blood pressure, and alcohol use are the leading causes of disease in South West London.

Smoking: Our adult residents are less likely to smoke compared to the rest of England, however smoking prevalence in patients with long term mental health conditions is approximately double that of patients without.

Obesity: Over half of our adult population are either overweight or obese and rates vary significantly between and within our places (from 45.5% in Richmond to 62.8% in Sutton).

High blood glucose: 4% of adults in South West London have high blood glucose and so are at increased risk of developing type 2 diabetes or other cardiovascular conditions.

High blood pressure: 10% of our adults are known to have high blood pressure, which is better than the national average.

Alcohol: The rate of alcohol related mortality is below the London and national averages but varies between our places (ranging from 21.5 per 100,000 in Richmond to 40.4 in Merton).

Long term conditions

Overall, disease prevalence is lower than national levels except for the prevalence of serious mental illness, but still nearly a third of our resident population have at least one long-term condition. The following five conditions have the biggest impact on our residents' lives.

Ischaemic heart disease: 1.9% of our adult population are known to have coronary heart disease and there were 829 deaths from ischaemic heart diseases in 2021.

Diabetes: 5.9% of our population are diagnosed with diabetes (either type 1 or type 2). In terms of clinical prevalence of diabetes, South West London has one of the lowest prevalence rates in the country with 5.9% compared to London's 6.7% and national's 10%.

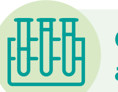
Chronic obstructive pulmonary disease (COPD): 1% of our adult population are known to have COPD and there were 375 deaths from chronic lower respiratory diseases in 2021. The COPD population in South West London is older (74% are age over 65), from White ethnic background (86%) and have more comorbidities than the general population.

Lung cancer: Between 2015 and 2019, there were fewer lung cancer cases in our population compared to the rest of England, but this varies between boroughs. In Wandsworth, the incidence of lung cancer is higher than the national average. Over the last five years, the rate of people being referred urgently for lung cancer was lower than the national average. There were 442 deaths from lung cancer in South West London in 2021. Smoking is a major risk factor for lung cancer, 13.7% of adults in South West London are smokers known to their GP.

Low back pain: Prevalence of musculoskeletal problems in 2020/21 was lower than the national and regional average, but with variation between our places.

Mental health, learning disability and autism

More than 1 in 10 of our residents are living with a mental health condition, including severe mental illness and depression. 68,500 people use our mental health, learning disability and autism services. Adult mental health admissions were below the London regional average, however admissions for intentional self-harm were higher.



Cancer, screening and vaccinations

2.7% of our adult population have been diagnosed with cancer and there are around 8,500 new cancer diagnoses in South West London every year. The three most common cancers in our population are skin, urological, and breast. Our population with cancer are more likely to be white, aged over 50, and resident in our least deprived areas. Cancer was the leading cause of mortality in South West causing 2,500 deaths London in 2020/21.

Supporting carers and inclusion health groups

7% of people living in South West London are known to provide some form of unpaid care. Evidence suggests that health professionals only identify 1 in every 10 carers, so the number of our residents providing unpaid care is likely to be much higher. This is important because unpaid carers are more than twice as likely to have poor health and caring can have a negative impact on the carer's physical and mental health as well as education and employment.

Age well

Long term conditions

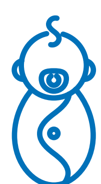
Dementia: The dementia diagnosis rate in South West London is higher than the London average. Last year waiting times for memory services in South West London varied between Trusts with the waiting time at South London and Maudsley NHS trust is three times longer than at South West London St George's mental health NHS Trust.

Frailty: Falls are an indicator of frailty and general health in the older population. Emergency hospital admissions due to falls are higher in South West London than the London and national average. Our residents aged over 75 are more likely to stay in hospital for 21 days or longer than people who live in other parts of the country.

Cancer, screening and vaccinations: Breast cancer screening uptake is lower now than it was 10 years ago. 5% less breast cancers are detected at stage 1 or 2 than peer systems across the country. The percentage of patients who are seen within two weeks of an urgent GP referral and who receive the first definitive treatment within 31 days of diagnosis and decision to treat are below national targets.

Bowel cancer screening coverage has increased in the last five years and at 59.6% is just below the national average of 59.9% and the national target of 60% uptake. This equates to 375 people aged 60-74 years who are eligible but not participating in screening.

Uptake of both the pneumococcal (PPV) and annual 'flu vaccine was below the national average in 2021/22 but slightly above the London average.



Start well

Pre Birth

Fewer pregnant women smoke

Birth

18,000 live births in 2021.

169 infant deaths

463 babies with low birth weight at term

More babies whose first feed is breast milk

The number of infants having a 12 month review is falling

Early Years

Immunisation coverage is below recommended levels

More hospital admissions with dental decay

School Years

18.7% of children in reception are overweight or obese

35.5% of children in Year 6 are overweight or obese

Over 21,000 children and young people use mental health, learning disability and autism services

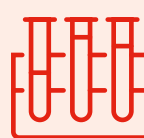
685 hospital admissions as a result of self harm

Over 60 hospital admissions each year as a result of alcohol

Older Children

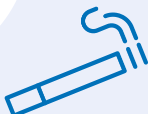
3.6% not in employment education or training

Births to mothers under 18 years old are falling



New sexually transmitted infection diagnoses are higher than the national average

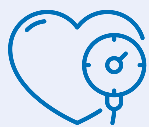
Live well



13.7% of adults are current smokers

50% of adults are overweight or obese

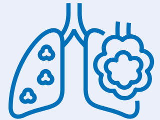
4% at risk of developing diabetes



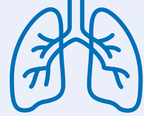
10% have high blood pressure

375 deaths from alcohol related conditions in 2020

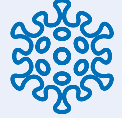
1.9% have coronary heart disease



1% have COPD



376 deaths from chromic lower respiratory diseases in 2021



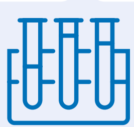
Lung cancer is less common

Musculoskeletal problems are less common

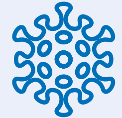
More than 1 in 10 have a mental health condition

68,500 people use mental health, learning disability and autism services

1,500 hospital admissions as a result of self harm in 2021/22



2.7% diagnosed with cancer



2,500 deaths due to cancer in 2021

7.13% of the population provide unpaid care

Working Age

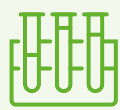
Age well

10,000 people are diagnosed with dementia

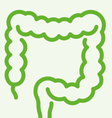
4 to 9 weeks wait for memory services

4,000 emergency hospital admissions due to falls

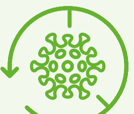
More people were lonely during the pandemic



Breast cancer screening uptake is decreasing



Bowel cancer screening uptake is below the national target



Fewer patients are seen within 2 weeks of urgent GP referral for cancer

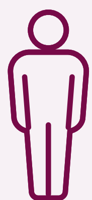
Fewer patients start treatment within 31 days of a cancer diagnosis and decision to treat

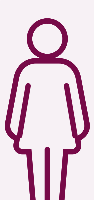
Flu vaccine uptake is lower than the national average

Pneumococcal Polysaccharide vaccine uptake is lower than the national average

Older Adults

Average male life expectancy is 81 years





Average female life expectancy is 84 years

End of Life

How we have engaged our people and communities in developing our Joint Forward Plan

This section describes our approach to working collaboratively with people and communities on the engagement of our Joint Forward Plan. Listening to peoples' views, concerns and experiences and working closely with our six Healthwatches and vibrant voluntary, community and social enterprise sector is essential if we are to meet the current and future health and care needs of our local people in South West London and deliver high quality and responsive services.

People and communities: views and concerns

High level analysis and themes from nearly 180 engagement reports.

HEALTH IMPACT OF COST OF LIVING CRISIS

- Increasing concern from our local residents
- Worries about paying bills, heating their homes and feeding their families, having a negative impact on people's mental health
- People are less able to make healthier lifestyle choices or heat their homes which may worsen existing health conditions
- Lack of awareness about sources of available support

REDUCING HEALTH INEQUALITIES

- Need to address disparities in health outcomes for different groups, for example mental health outcomes for Black and minority ethnic patients
- Need for culturally sensitive services and culturally appropriate support and information
- More understanding needed to respond to the needs of neurodiverse patients, people with a learning disability, autism spectrum disorders or dementia

LOCAL EMPLOYMENT

- People would like the NHS and Local Authorities to support for local economies, including local businesses and town centres
- Increase in Living Wage accreditation to prevent low income and insecure jobs creating stress and anxiety
- More employment support and targeted communications needed for young people, and for carers and people with a learning disability who want to work

BETTER SUPPORT FOR PEOPLE WITH DEMENTIA

- Variability of support services across SWL including respite care and day care
- Access to face-to-face support if needed for people with dementia
- Better information about service provision, with help to navigate services and non-digital access options

SUPPORT FOR CARERS

- Carers' voices need to be elevated and need for carers to be considered as essential part of support and decision making
- Improved recognition of carers to ensure they have the support they need, including young carers
- Better understanding of caring as a social determinant of health, including impacts on carers own mental health, wellbeing and social isolation
- Improved information and support, making sure carers are not digitally excluded

GREEN AND ENVIRONMENTAL CONCERNS

- Access to clean, green space important for health and wellbeing
- A reduction in traffic viewed as the main way to improve air quality
- Encouraging walking and cycling to support people to live healthy lifestyles

VOLUNTARY AND COMMUNITY SECTOR CAPACITY

- Voluntary and community sector are feeling under pressure due to increased demand
- Important to hear from small & large organisations
- Broader representation is needed

GPs AND DENTISTRY

- Availability of appointments, waiting times, desire for face-to-face as well as virtual consultations
- Variation in access across and within boroughs
- Variability in the availability of interpreter services for non-English speakers

What we have done so far

Earlier this year, we asked all of our South West London health and care partners to share all of their existing insight and engagement reports developed over the last 18 months.

We reviewed nearly 180 reports from our health and care partners including Healthwatch, the voluntary and community sector, NHS Trusts, local authorities and our Place-based engagement teams.

These 180 reports include the views and experiences of thousands of our local residents, from a cross section of our local communities. They tell us what local people feel about a broad range of health and care services and issues.

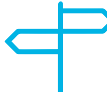
Using all of this community insight from across our partners we carried out an in-depth analysis of what people have told us to inform our Joint Forward Plan.

What we have heard from people and communities

This diagram shows a high-level summary of the themes that have emerged from reviewing the 180 reports of local people and communities views what we have heard.

REFERRALS TO NHS SERVICES

- Concern and frustration about longer waiting times for most NHS services e.g. primary care, mental health, urgent and emergency care services.
- Improved communication about waiting times and status of referrals
- More patient-centred pathways and improved coordination and continuity of care between GPs, diagnostics and NHS teams



COMMUNICATION, NAVIGATION AND SIGNPOSTING

- Patients have a range of communication needs, it would help if they were asked for their preferred communication method and this shared across their care
- Information materials need to be in accessible formats, including for people with a learning disability, non-English readers and people with sight loss
- Improved signposting for services and clear navigation
- A need for information to support people manage their own health and well-being, with a contact for questions to help navigate services where necessary
- Missing letters and not keeping patients informed about delays and changes to appointments

TRUST IN PUBLIC SERVICES

- Lack of trust In public sector organisations and professionals amongst some communities
- Trust issues higher in areas of inequalities and those from Black, Asian and Minority Ethnic backgrounds
- Based on experiences of discrimination people have had previously

DIGITAL SERVICES - OPPORTUNITIES AND CHALLENGES

- Shift to digital services has left some population groups facing digital exclusion
- Need multiple points of access and to retain options for face to face contact
- Data sharing creates opportunity for greater coordination between services on the care pathway
- Self-help opportunities through single point of access information hubs and condition-specific apps
- Digital exclusion impacting older people, people with physical, sensory or learning disabilities and carers

SOCIAL ISOLATION

- Social isolation impacting on mental and physical health, particularly for older people, people with a learning disability and carers
- Exacerbated by a shift to digital services and the cost-of-living crisis

PREVENTION AND SELF-CARE

- Immunisation and vaccination - motivators and barriers vary between communities, the offer needs to be tailored
- Time and cost viewed as barriers to healthier living by many
- Need for Improved and accessible information available to help people manage their own conditions
- Peer group and community support highly valued

MENTAL HEALTH SERVICES

- Long waiting times suggest the need for more interim support and virtual rooms required to fill gaps while waiting for treatment
- Desire for more peer group and community-based support services
- Culturally competent services or community-based services needed to improve outcomes and reduce stigma
- Older people's mental health problems not being well enough identified and addressed

You can read our full analysis and a list of all the 180 insight and engagement reports on our website HERE.

As well as this overview, in each care setting section we have summarised the views and concerns of people and communities on the main themes heard from our engagement and how this insight is influencing our progress and planning for our local ambitions.

In South West London, we work hard to make sure we have inclusive ways of reaching and listening to our people and communities, specifically people with poor health and the greatest needs to understand how to improve their access and experience of services and support their health and wellbeing. In our engagement we make sure we are seeking diverse views from our health inclusion groups, protected characteristics and people who live in our most deprived communities. Our work to reduce health inequalities runs throughout our Joint Forward Plan but a specific focus to understand and hear from a diverse range of voices can be found in the Health Inequalities chapter.

Our analysis of the scope, breadth and depth of these reports will also help us set our engagement priorities for the year ahead.

We would like to take this opportunity to thanks all our partners for their hard work in delivering this engagement work with local people and communities, and for also sharing their findings and reports with us. By collating and analysing these reports we can really see the breadth and reach of our partnership across South West London, and we can help make sure that the views of local people are influencing not only local plans, but also our strategic system wide Joint Forward Plan.

The table below shows the number of reports that have engagement insight or findings for each focus area of our Joint Forward Plan. Each links to the high-level themes for each area, the full high-level analysis and references:

Focus area	Insight and feedback reports from people and communities	High level themes
Reducing health inequalities	Insight reports that include learning for reducing health inequalities are listed on pages 6 to 14 of our engagement analysis report	Page 27 of the Joint Forward Plan
Preventing ill-health and long term conditions	Insight reports that include learning for preventing ill-health are listed on pages 15 to 21 of our engagement analysis report	Page 30 and 67 of the Joint Forward Plan
Acute care	Insight reports that include learning for acute care are listed in a report from South West London Healthwatch Patient experience in acute care trusts - findings for inclusion in the 2023-2028 NHS South West London	Page 41 of the Joint Forward Plan
Community care	Insight reports that include learning for community care are listed on pages 28 to 33 of our engagement analysis report	Page 41 of the Joint Forward Plan
Mental health	Insight reports that include learning for mental health are listed on pages 34 to 41 of our engagement analysis report	Page 46 of the Joint Forward Plan
Primary care	Insight reports that include learning for primary care are listed on pages 22 to 27 of our engagement analysis report	Page 51 of the Joint Forward Plan
Cancer	Insight reports that include learning for cancer are listed on pages 45 to 51 of our engagement analysis report	Page 56 of the Joint Forward Plan
Diagnostics	Insight reports that include learning for diagnostics are listed on pages 54 to 55 of our engagement analysis report	Page 59 of the Joint Forward Plan
Maternity	Insight reports that include learning for maternity are listed on pages 52 to 53 of our engagement analysis report	Page 62 of the Joint Forward Plan
Urgent and emergency care	Insight reports that include learning for urgent and emergency care are listed on pages 47 to 51 of our engagement analysis report	Page 70 of the Joint Forward Plan
Workforce	Insight reports that include learning for workforce are listed on pages 56 to 59 of our engagement analysis report	Page 80 of the Joint Forward Plan
Our green plan	Insight reports that include learning for our green plan are listed on pages 60 to 62 of our engagement analysis report Joint Forward Plan - insight from people and communities - NHS South West London Integrated Care Board (icb.nhs.uk)	Page 82 of the Joint Forward Plan
Digital	Insight reports that include learning for digital are listed on pages 63 to 69 of our engagement analysis report Joint Forward Plan - insight from people and communities - NHS South West London Integrated Care Board (icb.nhs.uk)	Page 87 of the Joint Forward Plan

As you will read in each of the care setting sections, what people and communities have told us has directly influenced our ambitions and will be at the centre of the plans we develop in the coming months. We will build on the innovative ways our partners undertake engagement across the system, including our six Healthwatches and voluntary, community and social enterprise, VCSE, sector partners, to make sure we capture a broad range of views and experiences to help further influence our plans and service delivery.

South West London people and communities strategy

Our people and communities strategy supports us to put people and communities are at the heart of everything we do. We aim to make sure that the voice of people and communities is central to all levels of our work, reduce health inequalities by better understanding local needs through inclusive engagement approaches, planning our engagement early and investing in community-led engagement.

Our agreed 10 principles for engagement

We engaged on these 10 principles form with our partners, stakeholders and communities as part of our engagement on our people and communities strategy. They set out how we work with people and communities across our integrated care system. NHS South West London people and communities engagement strategy – NHS South West London Integrated Care Board (icb.nhs.uk)

Put voices of people at the centre of decision-making and governance

Start engagement early when developing plans

Understand community's needs, experiences and aspirations

Build relationships with excluded groups, especially those affected by inequalities

Work with Healthwatch and VCSE sector as key partners

Provide clear and accessible public information about vision and plans

Use community development approaches that empower people

Use co-production, insight and engagement

Tackle system priorities in partnership with people and communities

Learn from what works and build on the assets of all ICS partners

What we have learned about engagement

During the pandemic and the Covid-19 vaccination programme, we worked with our community partners, local authorities and voluntary sector far more closely than ever before. We have learnt and built on these experiences and changed the way we work with local people, communities and our excluded groups especially those affected by inequalities.
We reviewed and discussed our approach with our partners and communities and describe our updated and responsive approach in this diagram.

BE CREATIVE

Use local champions

Use creative methods to extend reach particularly to communities experiencing heath inequalities and poorer health outcomes e.g. work with community champions, influencers and faith leaders, use films, media and social media

BE RESOURCEFUL

Use partners' networks

Continue close partnership working with LA and NHS - share resources and contacts - coordinate not duplicate to maximise each

BE INCLUSIVE

Create maximum impact

Co-design messages/adapt and iterate with local people to have maximum impact

BE CONNECTED

Find community leaders

Work with trusted leaders to speak with local people and communities

BE PROACTIVE

Make the first move

Go to local communities - rather than expecting them to come to you - provide translations and interpretors

BE REPRESENTATIVE

Reflect the population

Co-deliver engagement sessions with clinicians that reflect local populations

BE PURPOSEFUL

Join forces

Build collaborative and resilient network of communications and engagement professionals to delivery common goals

BE OPEN

Listen and understand

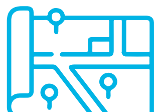
Develop ongoing conversations and sustainable relationships and build on those established relationships

BE COLLABORATIVE

Work with VCSEs

Work closely with and invest in the VCSE sector to strengthen their capacity and extend our reach

BE BOLD



Go beyond traditional boundaries

Work across borough boundaries to engage with particular communities

BE PROUD

Reflect and share

Celebrate success and feedback - show the impact of everyone's contributions

BE INFORMED

Gather data and insight

Use population health data and insight to inform, adapt and shape our approach

BE EQUITABLE

Inclusive and innovative ways of reaching and listening to our diverse people and communities - and ways for them to get involved

BE RESPONSIVE

Community First

Be led by the community and their needs - ask and respond to how they would like to be engaged

Our plans for engaging on our Joint Forward Plan priorities

Looking at the insight we already have across our partnership, we have done a gap analysis to help us plan for our first year of delivery for our Joint Forward Plan. We will now prioritise our engagement activity using a thematic approach to reflect the settings of care in this Joint Forward Plan. We will develop a rolling plan of engagement for the coming months and years to help us listen to the views and experiences of local people and communities and make sure this impacts the way we deliver our services and ambitions outlined in this plan.

Our approach to engagement

Approach

Working collaboratively with our partners

How we engage

Working with our Healthwatches

We work closely with our six Healthwatches on key programmes of work to strengthen the views they represent in our local decision making. Our local Healthwatches have skills in researching and analysing the insight they hear from local people, and producing comprehensive reports. These reports have been invaluable in production of our Joint Forward Plan and will have impact in how services are planned over the coming months and years.

We are committed to working in partnership and working together to support our engagement approaches and insight gathering.

From this year we have funded an executive officer post for South West London Healthwatch to support our six local Healthwatches' partnership working.

Working with our voluntary, community and social enterprise (VCSE) sector

We have strong relationships with our VCSE sector and are supporting a South West London VCSE Alliance model to elevate their voice, and those communities they represent in local decision-making. VCSE organisations often work with communities that we are unable to reach or have a lack of trust with statutory organisations and through them we can make sure we have inclusive ways of reaching and listening to a diverse range of communities.

We greatly value our local voluntary sector and their ability to reach deep into local communities.

From this year we have funded a SWL VCSE director post to support the collaborative working of our six local VCSE lead organisations and to help develop our SWL VCSE alliance.

Engagement in boroughs

We have created professional communities through our communications and engagement groups in each of our six boroughs that bring together local authorities, NHS trusts, our borough engagement leads, the voluntary sector and Healthwatch. These groups help us bring together insights and coordinate our engagement activity at Place level so we can gain a more comprehensive view of the views and experiences of our local people and communities.

Our 'patient or public champions'

We work with a number of patient or public champions who are involved in our local decision-making on our committees and meetings either at the borough or South West London level. A patient or public champion is often someone with lived experience who gets involved to represent their own views, or works with local networks e.g. our Maternity Voices Partnerships to advocate and make sure their voices are heard.

Working across South West London

Our people and communities engagement assurance group for South West London works collaboratively with partners to review engagement plans and activities, with membership from across the partnership including the Integrated Care Board quality and medical directors, programme directors from acute, primary care and mental health collaboratives, Healthwatch, the voluntary and community sector and the ICS communications and engagement team.

Approach

Community-led approaches

How we engage

Outreach in our communities

We take a proactive approach to hearing from local people and communities by attending local community events, meetings and networks to bring fresh insights and make sure we are proactive in our engagement approaches in each of our six boroughs.

Working through the reach of our VCSE organisations

We value our community-led approaches that benefit from the extensive reach that our VCSE partners have with local people and communities and fund specific pieces of engagement work to support our priorities and ensure diverse voices are in everything we do.

Working with our 'champions'

We are fortunate to have a diverse range of 'champion' roles including 'health champions', 'core20 connectors' and 'digital champion volunteers'. Our champions reflect the diversity of our local population. They foster engaging and trusted relationships with their communities and support often marginalised and underserved groups and individuals, which statutory organisations struggle to engage with effectively.

We work with our 'champions' as they can help engage through their local friends, family and other networks and collect feedback about people's health and wellbeing, health-related topics or on our local services.

Community or 'peer' researchers

Working with people with lived experience and understanding of a social or geographical community to carry out research and collect insight about their peers.

Approach

Focus groups and interviews

How we engage

We ask a number of questions bringing together small groups of people to hear about health topics or from specific communities to help inform our local work and help shape local health and care services. These can be done in a group (focus group) or on a one-to-one basis.

We aim to speak to specific communities based on what our local data and insight tells us about who is or isn't accessing services, people who have poor experiences of services and those with poorer health and wellbeing – aiming to make sure we hear from people that are representative of the population in South West London.

Approach

Online engagement platform

How we engage

We use an online engagement platform to help conduct surveys to ask a number of questions to local people. The platform also makes it easier to share and learn from our insight.

We use our South West London People's Panel which is a virtual group of around 3,000 people who broadly reflect the population of South West London and who regularly respond to our surveys. We are also able to use digital marketing to target different health inequality groups or geographies most affected by any areas of service change.

We are also able to provide hard copies or translated materials for those that need them.

Part Two: Reducing health inequalities and preventing ill-health

Working together to reduce health inequalities

The King's Fund define health inequalities as "avoidable, unfair and systematic differences in health between different groups of people" which are "ultimately about differences in the status of people's health". They explain that the term is also used "to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives – both of which can contribute to their health status". Health inequalities can therefore involve differences in:

- health status, for example, life expectancy
- access to care, for example, availability of given services
- quality and experience of care, for example, levels of patient satisfaction
- behavioural risks to health, for example, smoking rates
- wider determinants of health, for example, quality of housing

The Covid-19 pandemic starkly exposed health inequalities. The impact of the pandemic on people's physical and mental health was not equal with infection and mortality rates being much higher in some groups of people.

Tackling health inequalities is a priority for the Integrated Care Board and we will work together across organisations, boroughs, provider collaboratives, neighbourhoods, and across the system to tackle health inequalities and the wider determinants of health, with the aim of ensuring that equity is a golden thread through all we do.

We are proud of the existing work that has taken place across our boroughs to tackle health inequalities. We want to build on this and spread the work that has been delivered at system, place and neighbourhood levels to continue to reduce health inequalities, this is especially important at a time where people are impacted by the current cost of living crisis and increasing fuel and food poverty.

To better understand health inequalities in South West London, we assessed our health inequalities using the Core20PLUS5 approach. Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement.

The three elements of Core20PLUS5 are described below:

- **Core20:** looks at the 20% most deprived population in South West London as the core population most impacted by health inequalities.
- **PLUS:** other marginalised population groups that are most impacted by health inequalities, for example, ethnic minority communities, people with learning disability, and other inclusion health groups.
- **5:** five clinical areas of focus for adults and children and young people

The two charts on the next page highlight the key findings of the Core20PLUS5 in South West London.

Figure 1 – South West London population

	Core 20 (339k population)	Remaining 80 (1.35m population)
Age		
Median	35	38
Healthy Life Expectancy	64	70
Life Expectancy	82	84
Ethnicity		
Asian (2 in 10 are in C20)	16%	14%
Black (4.5 in 10 are in C20)	24%	7%
Other (2 in 10 are in C20)	12%	11%
White (1.5 in 10 are in C20)	48%	68%

Borough

50% of C20 population are **Croydon** residents

40% of **Croydon** residents are in C20

In contrast only **4%** of residents in **Richmond** and **2%** in **Kingston** are in C20

Long-Term Conditions

29.5% have a long-term condition (Core 20)

28.6% have a long-term condition (Remaining 80)

For adults our analysis identified that:

- **339k** of people in South West London make up our 'Core20' population
- **50%** of our 'Core20' population lives in Croydon
- **40%** of Croydon residents are in our 'Core20' population
- People in our 'Core20' population have a six year difference in their healthy life expectancy, and a two year difference in their life expectancy
- Our 'Core20' population are disproportionately represented by those from minority ethnic backgrounds.
- **29%** of our 'Core20' population have a long-term condition

Figure 2 – Children and young people South West London population (aged 0-25yrs)

Core 20 (101k population) | **Ages 0-25** | **Remaining80** (351k population)

Age

	Core 20	Remaining80
0-5	18k	67k
6-12	29k	106k
13-18	25k	87k
19-25	28k	91k

Ethnicity

Ethnicity	Core 20	Remaining80	
Asian	16%	15%	2.4 in 10 are in C20
Black	25%	8%	5 in 10 are in C20
Other	20%	19%	2 in 10 are in C20
White	39%	58%	1.6 in 10 are in C20

Borough

52% of C20 population are **Croydon** residents

44% of **Croydon** residents are in C20

2% In contrast only **2%** of residents in **Richmond** and **2%** in **Kingston** are in C20

For children and young people our analysis identified that:

- There are approximately **450,000** children and young people aged 0-25 years in South West London, of which **101,000** live in our 'Core20' population.
- **52%** of children and young people who are in our 'Core20' population are living in Croydon
- **44%** of Croydon's children and young people are in our 'Core20' population
- Our 'Core20' population are disproportionately represented by those from minority ethnic backgrounds.

Our analysis identified five clinical areas of focus which require accelerated improvement for adults and children and young people. These are:

Five Key clinical areas identified for adults:

1. Maternity:

Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.

3. Chronic respiratory disease

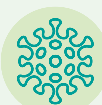
A clear focus on chronic obstructive pulmonary disease (COPD) driving up uptake of Covid-19, 'flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

5. Hypertension

Case-finding and optimal management and lipid optimal management: To allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

2. Severe mental illness (SMI)

Ensuring annual health checks for 60% of those living with SMI (bringing SMI health checks in line with the success seen in learning disabilities).



4. Early cancer diagnosis

75% of cases diagnosed at stage 1 or 2 by 2028.

Five Key clinical areas identified for Children and Young People

1. Asthma

Address over reliance on reliver medications and decrease the number of asthma attacks.

2. Diabetes

Increase access to realtime continuous glucose monitors and insulin pumps in the most deprived quintiles and from ethnic minority backgrounds and increase proportion of children and young people with type 2 diabetes receiving annual checks.

3. Epilepsy

Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.

4. Oral health

Address the backlog for tooth extractions in hospital for under 10s.

5. Mental health

Improve access rates to children and young people's mental health services for 0–17-year-olds for certain ethnic groups, age, gender and deprivation.

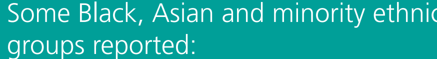
These findings inform our shared vision as we continue to work with our local partners to tackle health and care inequalities.

People and communities tell us

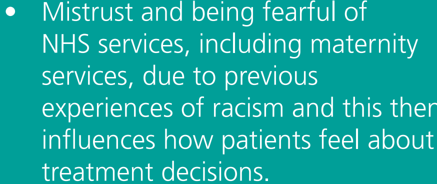
Our communities who experience health inequalities including lower-income groups, people from Black Asian and minority ethnic groups, people with learning disabilities, older people, people with mental health issues, neurodivergent people, people with dementia, carers, people who identify as LGBTQIA+ tell us:

People are more likely to face more barriers to leading a healthy lifestyle, using NHS services, and accessing prevention services like screening/diagnostic appointments. For example, food and fuel poverty, transport costs, loneliness and isolation, digital exclusion, language and translation barriers, poor experience of services due to prejudice or lack of understanding from NHS staff. People often need some specialised or tailored support that isn't always provided or available.

This can mean reliance on family members either to accompany people to appointments to translate and support, or to help with digital interactions. This isn't always appropriate.



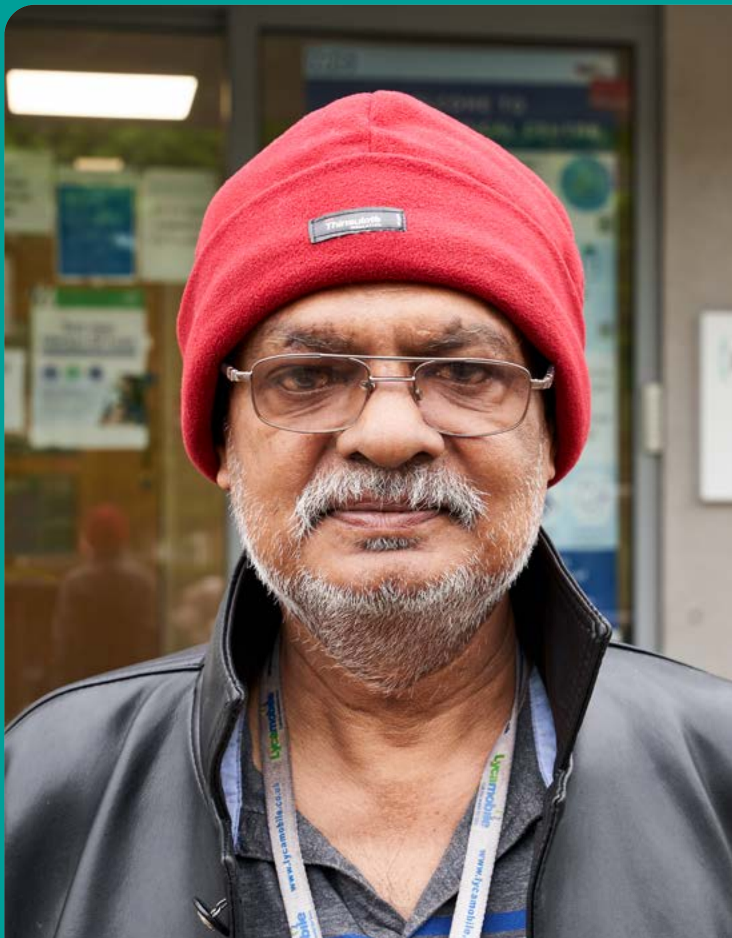
Some Black, Asian and minority ethnic groups reported:



- Mistrust and being fearful of NHS services, including maternity services, due to previous experiences of racism and this then influences how patients feel about treatment decisions.
- Having to be assertive and persistent to be believed by NHS staff, with some saying they felt frustration about concerns, symptoms or expressions of choice being dismissed, leading to multiple visits and delays before referral.

Symptoms of ill health especially mental ill health, can often be overlooked in older people

Some NHS staff don't use inclusive language and sometimes don't use culturally competent language, and can make assumptions about the causes of illness e.g., 'hard to reach' or 'disadvantaged', or language when trans-women attending prostate appointments, or assumptions about the causes of health problems being attributed to sexuality.



Our ambitions

We want to see health inequalities faced by people living in South West London eliminated and for everyone to have equal access to the same quality of physical and mental healthcare.

The diagram below outlines our five focus areas to improve outcomes for our local people.

Develop a shared vision and strategic delivery plan: aligning with local strategies, and the Mayor of London's health inequalities strategy. This will be embedded by our Core20PLUS5 approach for adults and children and young people.

Anchor institutions: Over the next five years, we will tackle and reduce socio-economic inequalities through the development of our health and care anchor institutions and delivery of actions to create opportunities to support those impacted by the cost-of-living crisis.

Equality, diversity, and inclusion of our workforce supported by an anti-racism framework: to improve equality, diversity, and inclusion for our people with an aim to develop, promote and improve access to senior positions for Black, Asian and minority ethnic staff. The system will work towards becoming an anti-racist system by implementing an anti-racist framework.

Data intelligence and innovation: Over the next five years, we will use population health data to ensure we are informed by need, variation, and population health outcomes to ensure we target resources action where they are needed most. We will ensure data supports the measuring of outcomes and impact, and that it informs the continuous improvement of the quality of our services. We will look at innovative ways to tackle health inequalities and address population health needs, working closely with local partners such as the Health Innovation Network.

Strengthen community engagement: strengthening and enabling the role of our communities through utilising co-production approaches with people with lived experience. Our voluntary, community and social enterprise organisations will be at the heart of this. We will continue to implement the Core20PLUS connectors programme applying the asset-based community development model.

To achieve our ambition, we will:

- Deliver the Integrated Care Board health inequalities strategic delivery plan
- Deliver an anti-racism framework
- Improve outcomes for our children and young people, and adults in the Core20PLUS population across the five clinical areas.
- Develop a system-wide equity outcomes dashboard
- Improve outcomes for those living with mental health conditions, learning disabilities and autism.
- Improve data coding of protected characteristics
- Develop our priority actions as anchor institutions and strengthen communities
- Level-up initiatives to reduce deprivation
- Improve rates of our Black and ethnic minority staff in senior leadership positions
- Support elective recovery to ensure inequalities are addressed – focusing on waiting lists.

Working together to prevent ill health

We want to support people in South West London to live long and healthy lives. Many of the health needs outlined in part one of our Joint Forward Plan are preventable and therefore we need to focus our efforts on those. We know that our behaviours affect our health, with some behaviours like smoking and high alcohol consumption putting us at greater risk of ill health whilst other protective factors, such as having a balanced diet, exercising and vaccinations, can reduce or prevent illnesses.

SMOKING

Smoking remains the single biggest cause of preventable illness and death in England. In South West London in 2021, 13.7% of adults in South West London are smokers known to their GP.

Smoking is a major risk factor for lung cancer. Over the last five years, the rate of people being referred urgently for lung cancer in South West London was lower than the national average.

ALCOHOL

The rate of alcohol related mortality is below the London and national averages but varies between our places (ranging from 21.5 per 100,000 in Richmond to 40.4 in Merton).

ADULT IMMUNISATIONS

In 2022/23, 66% of eligible South West London residents (age five and older) had at least one dose of Covid-19 vaccine and 70.5% of over 65s had their ‘flu vaccine.

TYPE TWO DIABETES

5.9% of our population have been diagnosed with diabetes (either type 1 or type 2), with an estimated 38,000 people living with type 2 diabetes who are yet to be diagnosed.

CORONARY HEART DISEASE

1.9% of our adult population are known to have coronary heart disease and there were 829 Deaths from ischaemic heart diseases in 2021.

CHILDHOOD IMMUNISATIONS

Our childhood vaccination coverage is below the recommended level of 95% for almost all childhood vaccinations, in all boroughs. Coverage varies from 80-90%.

OBESITY

Nearly 1 in every 5 children in Reception are overweight or obese. Obesity rates double between reception and Year 6 (from 18% to 35%), and then double again by adulthood.

HYPERTENSION

Clinical prevalence of hypertension in South West London according to GP registers is 10.64% (lower than national rate of 13.97%).

80% of patients over the age of 45 have had a blood pressure reading in the last five years. There is evidence that the remaining 20% are those who are most likely at risk of hypertension and work is underway to reach them.

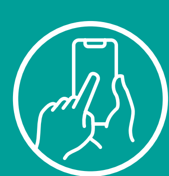
People and communities tell us

Vaccinations and immunisations: Barriers can be summarised as concerns about side effects, fear of needles, theories about people needing to develop ‘natural immunity’ or already having ‘immunity’, a lack of understanding about the risks associated with the disease that immunisation would prevent, and logistical difficulties of booking an appointment. Motivators were around people protecting themselves and their families, fear of the diseases themselves, especially when there was a perception that the disease was spreading, their duty to wider society particularly vulnerable people, and peace of mind.

Community opportunities and barriers to healthier living:

- People felt they could improve their health by changing eating habits, less alcohol and smoking, taking more gentle exercise, spending more time with family/ friends and in outdoors in nature
- Barriers to maintaining health included time pressure, debts/ finance not being able to afford healthy food and fuel, a lack of understanding about the risks of unhealthy lifestyles and the support available, air quality/ pollution, a lack of energy, a stressful life, poor habits and cravings, and social pressure being the challenges.
- In one study, a quarter of people from Black, Asian minority ethnic groups, including a third of people describing themselves as Asian, disproportionately referenced ‘cost’ as a barrier to adopting a healthier diet
- Social networks and family can influence a person to adopt healthier lifestyle behaviours, as well as trusted advice and information from a healthcare professional.
- People said advice and information need to be improved and easily accessible, and in different languages.
- Preventing disease, healthy ageing, maintaining or improving health and improving appearance were frequently mentioned as reasons why respondents would consider making lifestyle changes.

To improve health and increase prevention activity: people favoured group community activities and learning at affordable prices, peer support, mentors, and coaches. Improved and clear information for people and their carers was seen as key for people from these groups and conditions: diabetes, pregnancy, long-covid, dementia, people who are bereaved. Some people also felt alone and unsupported in managing their long-term condition.



Some people were supportive of specific self-help digital apps: such pregnancy related apps to help people through their maternity journey, ‘Car Find’ to help people living with dementia to locate their parked cars, ‘Brain in Hand’ and ‘AutonoMe’ apps for people with learning disabilities, a pelvic health app and an emotional wellbeing app for teenage and young adult cancer patients. Caveats included participants needing to own smartphones and concerns some people could be digitally excluded or need a technology package to match their needs.

The valuable role of the voluntary and community sector in providing support services for people with a long-term condition, offering activities through social prescribing and developing trusted relationship with vulnerable communities is prevalent in all the feedback from communities.

Our ambition

We want to support people in South West London to live longer, healthier lives. We want to move away from reactive disease-specific treatment to proactive personalised wellness, so that by 2035 we have improved healthy life expectancy by at least five years.

Our ambition can be achieved through prevention of the main risk factors: blood pressure, obesity, smoking status, alcohol intake and mental health (King's Fund, 2018). To do this, we will:

- Help people to stop smoking - embedding smoking cessation throughout all South West London trusts (inpatients and maternity services); support high risk patients to quit smoking.
- Work with community pharmacies to provide early detection and prevention services such as blood pressure checks, staying fit during winter (Winterfit), 'flu vaccines and smoking cessation services.
- Increase our rates of vaccination and screening. We will work ICB partners, UK Health Security Agency and NHS England on improving uptake of immunisation rates so that we exceed current national levels and protect people from infectious diseases.
- Help people to have a healthy diet and lifestyle, including signposting people to information and education, proving access to digital self-management tools and/or local services.
- Build an understanding of the impact our lifestyle behaviours have on our health – including developing a South West London prevention portal for patients and staff to better understand their condition and access local prevention offerings.
- Do more to support patients with diabetes - Increasing referrals into the national diabetes prevention programme and into diabetes structured education, and will continue to support diabetes remission through low calorie diet interventions.
- Work with community partners to identify and train accredited health coaches based in areas of high health risk to co-produce community-based and community-led health awareness, health detection, and health promotion events and services. So far this programme has provided over 1500 health and well-being checks to people not accessing primary care.
- Do more to support patients at risk cardiovascular disease, piloting a national-first cardiovascular disease (CVD) prevention programme with 700 patients in 2023.
- Increase support for people to stay well with remote health monitoring – for example, using technology, education, and self-management to support increased assessments, monitoring and patient self-management, e.g. patients monitoring their blood pressure at home, access to walk-in blood pressure machines in GP practices.
- Introduce a national-first South West London digital self-management programme to support clinicians in our clinical networks and patients to co-produce digital self-management modules for patients with common chronic conditions.
- Support automation of behavioural science-based nudges to support and empower patients to better manage their condition, including attending annual assessments and reviews.
- Work in partnership with the Integrated Care Partnership and our local authority public health teams on the development and expansion of services available across South West London, such as smoking cessation services and NHS digital weight management.

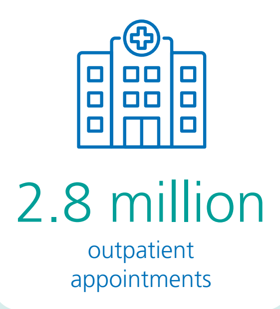
Part Three: Settings of care and collaboratives

Acute care and our acute provider collaborative

Acute care within our acute providers in South West London is comprised of planned or elective care, urgent and emergency care, cancer and maternity services. We have four acute trusts in South West London delivering NHS services for the population. These are:

- Croydon Health Services NHS Trust
- Kingston Hospital NHS Foundation Trust
- Epsom and St Helier University Hospitals NHS Trust
- St George's University Hospitals NHS Foundation Trust

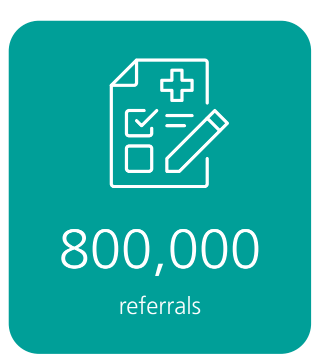
A picture of acute care in South West London



2.8 million outpatient appointments

645,000 people attend accident and emergency

160,000 operations including day cases



800,000 referrals

Almost **no patients are waiting over 78 weeks** for treatment

Over 26,000 people employed by South West London's acute service providers.

£1.9 billion spent on care provided by our acute hospitals

Our acute hospitals are facing increases in demand for care as our population gets older, people are living longer often with multiple conditions and the services recover from delays in planned care due to the pandemic.

Planned waiting lists and hospital attendances are increasing.

CQC:

- Croydon Health Services NHS Trust and St Georges University Foundation Trusts rated as "requiring improvement"
- Epsom and St Helier University Hospital Trusts rated as "good"
- Kingston Hospital NHS Foundation Trust rated as "outstanding".

One of the key focusses of all trusts is to make sure we continually improve the productivity and efficiency of the services we provide so that we can gain better value from NHS resources. Areas such as maximising the efficiency of our theatres and reducing 'do not attend' and 'new to follow up' ratios in outpatients are a particular focus.

Many services in South West London are delivered in modern, purpose-built accommodation whilst other areas are in need of substantial capital investment to improve the quality of environment in which care is taking place. We are planning investments in infrastructure to meet the needs of patients in the future. New community diagnostic centres in Kington and Croydon will be developed, surgical and intensive care facilities in Kingston and Croydon Hospitals will be built and plans for additional capacity for intensive care and a renal wing at St George's Hospital are underway. In addition, a brand-new specialist emergency care hospital (SECH) in Sutton, with redevelopments also on the Epsom and St Helier sites as part of the 'building your future hospitals' programme, are planned.

South West London acute trusts employ over 26,000 people to deliver health and care services. Ensuring we are a great place to work, and that each person employed within our organisations can reach their potential is a priority for all trusts. Hospitals have workforce challenges similar to those faced at a national level and are working together to develop and support the current workforce and seek new opportunities to grow the workforce for the future.

Planned care is a particular focus for trusts in South West London as we

recover the backlog of care built up since the pandemic. Planned Care is treatment that people decide to have to help manage a health problem, rather than emergency treatment for an urgent medical condition, or following a serious accident for example. Appointments and treatments, including surgery are pre-arranged and planned in advance.

Trusts in South West London have been working together to reduce the number of patients waiting over 78 weeks for routine treatment. Hospital referral rates have increased by above 2019/20 levels due to suppressed demand during Covid-19. However, by the end of March 2023, almost no patients will wait over 78 weeks for treatment.

Our plans are to increase activity above 2019/20 levels to reduce the number of long waiters further to an ambition of no patients waiting over 65 weeks by March 2024 and over 52 weeks by March 2025, and it improve and streamline our pathways to fast-track care.

People and communities tell us

Across all of our hospital trusts, most of our patients were highly satisfied with staff's communication, professionalism and care.

Patients feel that they are treated with dignity and respect. Patients rate our hospitals particularly highly for providing private space and privacy for examinations and doctors including patients in the conversation when they are spoke about their care in their presence.

Patients sometimes described feeling lonely while in hospital. Some South West London trusts are addressing this through volunteer programmes that provide companionship and processes that allow inpatients to send letters to loved ones.

All four South West London hospital trusts scored an average of 8.0 or higher[4], indicating excellent care, on their assessment and management of pain. However, Trusts continue to receive complaints about pain management. As an example of good practice, Kingston Hospital has launched an initiative to improve pain identification and management among patients with dementia, recognising that these patients are not always able to express their pain.

South West London patients said they were moderately satisfied for the length of time they had been on a waiting list before being admitted to hospital and for waiting for a bed on a ward after arriving at hospital. Patients raised concerns about waiting times, particularly for a referral or to schedule an outpatient appointment, specifically for people living with diabetes and those with sight loss.

Patients, their carers and hospital staff are concerned about the process for discharging inpatients from hospital into them home or community care. These concerns focussed on when patients were discharged from hospital, with some feeling that they were being sent home before they were clinically ready and others complaining about delays in them being able to return home. Patients and their carers are also concerned about having the right level of support and care when they leave hospital, for example, carers often report they aren't given enough information or training to administer care at home and most patients say they hadn't received clear instructions about how to take medications prescribed whilst in hospital. Process for people living with dementia were of particular concern.

4. 2021 National Inpatient Survey

Our South West London acute provider collaborative (APC)

Four acute hospital trusts came together in 2017 to form a South West London Acute Provider Collaborative (St George's, Epsom & St Helier, Kingston and Croydon). The trusts also work together as part of Royal Marsden Partners, West London Cancer Alliance, to improve cancer services and outcomes in South West London.

The focus of the APC is to improve the quality of services and clinical outcomes for local people across our six boroughs. An essential priority for the collaborative is to improve planned care within hospitals. The APC aims to make the most effective use of their collective resources and improve efficiency and quality, so that patients are seen in the right setting at the right time. The trusts are working with our partners at local level and at a system level to integrate health and care services.

Our acute provider collaborative has the following aims:

- Collaboration to improve clinical outcomes, inequalities and unwarranted variation for patients,
- Improve workforce health and wellbeing, whilst making South West London the best place to work,
- Deliver improved performance in quality, efficiency, and national standards,
- Deliver value for money to our populations and sustainability of our trusts, and
- Use innovation and research to improve productivity.

A core part of the APC's work is supporting clinical networks in specialist areas such as cardiology, dermatology, urology, and gynaecology. These are groups of primary and secondary care clinicians with an ambition to deliver improved clinical and quality outcomes, address health inequalities and reduce unwarranted variation across acute services. These networks of clinicians play a vital role in sharing and learning best practice and bringing new innovations in care for patients into South West London.

Our ambition for our acute provider collaborative

Hospitals have collaborated to develop an elective strategy, which outlines how we will work together to deliver improved planned care for our patients. The elective strategy was developed to continue to improve services, building on the great work that has taken place to date. The principles of the vision are to:

- Remain a leading system for elective care in the NHS.
- Address health inequalities specifically on equity of access.
- Develop a more permanent shared specialist workforce, and a sustainable workforce plan.
- Reduce variation in clinical outcomes
- Reduce costs or achieve more with the same resources in all areas by improving the productivity, quality and efficiency and sharing data to drive improvement.

Remain a leading system for elective care in the NHS

We will remain a leading system for planned care in the NHS. We recognise there is more to do to continue to reduce long waiters and achieve our ambition of no patient waiting over 65 weeks by March 2024 and over 52 weeks by March 2025. To do this, we will:

- Ensure timely access and reduce waiting times for our patients. We will continue our approach for mutual aid across the acute hospitals where surges in demand have been identified at a specific hospital.
- Continue to expand the criteria accepted in our surgical hubs so that we can optimise patient throughput, supporting a reduction in waiting times.
- Ensure there is a common understanding of demand across the system and that capacity is shared across our acute hospitals to reduce any variation in waiting times dependant in which hospital patients are treated.
- Learn from each other to improve our efficiency and quality of care to reduce unwarranted variation in practice.

Address health inequalities specifically on equity of access

We will:

- Understand the impact access to services currently has on our population and we will ensure that we are working with our place-based teams to improve this for our patients. Recent analysis in multiple outpatient attendances, monitoring appointments where patients did not attend and waiting lists, have provided us with specific areas of focus where there is variation between population groups.
- Work to identify greater support for groups in need in areas such as neurosciences, gynaecology, and urology. In addition, we will work to have single points of access across South West London in certain specialities by combining waiting lists across trusts. This will improve access to health care by equalising waiting times across our acute hospitals
- Deliver improvement in our community models that will allow people to be treated in different ways or prevent them from becoming ill and needing treatment.

- Implement new models of care that are standardised across South West London so that patients receive consistent care and practice. We will use data to drive how we will continuously improve the service provision for our patients, optimising standardised digital solutions across South West London.
- Utilising our clinical networks, continue to deliver pathway changes from primary care through to specialist services, using diagnostics at the beginning of clinical pathways to reduce avoidable referrals into our acute hospitals.

Develop a more permanent shared specialist workforce, and a sustainable workforce plan

We understand that there is increasing pressures on workforce availability within our acute sector. We have committed to creating a sustainable workforce plan, with a shared understanding of the requirements. We will grow and share workforce together, whilst also exploring the creation of new roles, new ways of working and embracing technological solutions aligned to our ambition to implement new models of care.

Building upon the collaboration our acute hospitals have already undertaken with our shared recruitment hub service, we will expand the remit to support the approach in our shared workforce plan.

Reduce variation in clinical outcomes

We will continue to ensure we continue to learn best practices to improve clinical outcomes and any variations there may be across South West London. We will use the 'getting it right first time', (GIRFT), national metrics to benchmark how we perform in delivering care to our patients as a focus for improvement.

We will continue to improve our 'right procedure right place' programme to ensure that we are delivering care in the most appropriate setting whether that is outpatient, day-case or inpatient care. We aim to optimise patient outcomes and reliance on hospital services post any planned procedure.

Reduce costs or achieve more with the same resources in all areas by improving the productivity, quality and efficiency, sharing data to drive improvement.

As the NHS face significant financial challenges for the future, our acute hospitals recognise the need to maximise delivery of performance to ensure that we remain at the forefront of productivity, quality, and efficiency. Our acute provider collaborative is implementing this at a system level so that all operate within a shared model.

The NHS has ambitious targets in the levels of activity it needs to deliver, therefore, efficiency is a priority in aiding services to recover after the pandemic. We will explore structural changes across service areas to optimise capacity, transformation, and maximise efficiency to ensure delivery of national targets. We will continue to deliver high performance in quality, performance, and efficiency, delivering against national outpatient and theatre utilisation priorities.

Transforming our outpatient services

Improving the patients experience of outpatient care is a key priority for the APC. We want to give more control to our patients by transforming the way we deliver outpatient services. Whilst we recognise the needs of our population will differ, we are committed to providing patients with the flexibility to choose the way their care is managed where appropriate, including advice and guidance for GPs, virtual, telephone and face-to-face appointments.

We will have a shared approach to outpatients transformation so that there is a consistent and familiar approach for patients, regardless of which hospital they are attending.

We will continue to reduce follow up appointments, empowering patients to be able to self-monitor where clinically appropriate, and book appointments based on their clinical needs.

Our Acute Hospitals

Croydon Health Services NHS Trust

Croydon Health Services (CHS) is part of the One Croydon Alliance. Croydon Health services includes Croydon University Hospitals which is the main provider of acute hospitals and community services for the population of Croydon. The alliance was formed by six health and care organisations to deliver integration and transformation. Our ambition has been to deliver services that are high quality, safe, integrated, and sustainable, and focused on the achievement of better outcomes.

Ambition

Working together we want to improve the health and wellbeing of people in Croydon by joining up the care and support available in our community. As one of six members of the One Croydon Alliance since 2017, CHS has long been part of an evolving place-based system. Our ambition is to deliver more preventative and proactive care, unlock the power of communities by making the most of communities' assets and skills and put services back into the heart of the community. Through the South West London Acute Provider Collaborative, we are also increasing our productivity and efficiency, through shared services and clinical networks.

All aspects of Croydon's clinical services are of vital importance to local people and are described in the clinical strategy. In respect of acute services, we remain committed to maintaining the following six previously agreed services as part of Croydon's acute hospital portfolio:

- Emergency department (24-hour A&E)
- Acute medicine
- Inpatient paediatrics
- Consultant-led maternity services
- Acute surgery
- Intensive care

Our five-year objectives

The following five-year objectives summarise our ambitions for each of the themes within the clinical strategy. Collectively they will improve outcomes, prevention, and proactive care, unlock the power of communities, and put services back into the heart of the community.

- **Urgent and Emergency Care**

Manage demand for urgent and emergency care and shift more care closer to home. Maintain our acute bed base and reduce occupancy to 92%.

- **Planned Care**

Optimise outpatient processes, reducing DNAs and improving patient experience. Expand virtual clinics and reduce unnecessary follow ups. Accelerate transformation of elective care to reach 130% of 2019/20 activity. Increase capacity through two new community diagnostics centres, whilst reducing unwarranted demand.

- **Maternity**

Improve ante-natal health and maternity experience and reduce low-birth weight babies (impacting on still births and neo-natal deaths) to below the England average for both our Core20 and general population.

- **Children and young people**

Place a greater focus on children's services, adopting a system approach to integrate care, reduce inequalities, improve waiting times and outcomes.

- **Workforce**

Continue to transform and integrate our workforce, enabling the adoption of flexible and agile working. Reduce vacancies and turnover across Croydon through multidisciplinary strategic workforce planning. Support and develop a resilient workforce in primary care and a compassionate, collaborative culture in CHS.

- **Digital**

Enable transformation by optimising existing digital tools and adopting proven new technologies including AI and robotics, whilst reducing digital exclusion.

- **Estates**

Optimise the use of the Croydon University Hospitals site and rationalise our community estate, shifting services to the community where appropriate.

Kingston Hospital NHS Foundation Trust

Kingston Hospital NHS Foundation Trust together with our partners Hounslow and Richmond Community Healthcare NHS Trust and Your Healthcare are currently engaging with staff, partners, and the public on the development of our strategy. The final strategy, 'nurture, grow, thrive', will be published in Summer 2023. In developing this we have taken stock of where we are and are asking staff and communities, where we should go next.

We have a number of key challenges that we will seek to address in our strategy these include:

- The current model of health and care being unsustainable, with overall demand and complexity increasing each year.
- The local population is predicted to grow by 14.2% over the next 10 years, leading to increased activity for services that are already stretched beyond capacity.
- An increase in demand for acute / urgent services reducing our capacity to provide planned care and impacting our ability to support end-to-end care of our residents.

The predicted increase in activity over 10 years is significant:

- A&E activity: up by 17,250 contacts
- Community nursing contacts: up by 29,831
- Day cases / electives: up by 3,630
- Non-electives: up by 7,124
- Outpatient activity: up by 61,017
- As demand increases so does cost

There is therefore an impetus to act quickly and change the way we work. Our new strategy seeks to address these issues creating a sustainable roadmap that will allow our people, our services, and our places to thrive.

Ambition

As we look to the future, it is clear that the current situation is unsustainable, and that a more proactive and preventive approach to health and care is needed – one that focuses on addressing the root causes of ill health, reducing health inequalities in our populations, while ensuring that services are sustainable and available to those who need them, at the right time and place. Our ambition is for our places, our services, and our people to thrive.

In our places, we will work with our partners to ensure that our services are designed and delivered in a way that responds to the needs of our local populations. We need to understand population health data and commit to work outside of our organisational boundaries and work at neighbourhood level to 'wrap' care around the holistic needs of individuals. Our thriving places strategy will complement the ICS priorities for 'place', embracing the core philosophy of integrated teams, with all health and care services built around the local geography of need.

In terms of our services, we will build upon our reputation for excellence in care, providing sustainable seven-day services with a model that works for patients and staff. We will also work to become known as a "specialist" in the generalist aspects of community care.

Our strategy will describe how we will begin by creating the right environment for our people so they can deliver the high-quality care that meets the expectations of local people, and nationally set standards. This will mean adapting the workforce, so we can recruit and retain the people we will need in the years ahead, to deliver changing services.

Our commitment to the greener NHS strategy will also be outlined in our strategy, as ill our desire to be recognised as exemplar organisations focusing on the prevention of ill health and addressing the health inequalities in the populations that we serve. In order to deliver on our strategy, we will place quality improvement at the heart of everything we do, so we remain as great places in which to work and to receive care.

We will continue to develop our strategy over the coming months and further detail will be reflected in the final version of the Joint Forward Plan.

St George's, Epsom and St Helier Hospitals Group (GESH)

St George's, Epsom and St Helier Hospitals (GESH) provide local health services for the people of Surrey Downs, Sutton, Merton and Wandsworth, and is a major tertiary centre for South West London and Surrey.

Ambition

Our vision for the next five years is to offer outstanding care, together. We will collaborate and work in partnership to meet the needs of our patients. Our vision is that by 2028 GESH will be a driving force behind the most integrated local system in the NHS – working with GPs, local government and community partners to keep people well in the community and avoid trips to hospital, integrating services across the GESH Group, collaborating with other hospitals in South West London on shared services, elective recovery and financial sustainability, and working through regional networks to integrate our tertiary services with primary and secondary care. This ambition is underpinned by a number of key priorities which describe what we aspire to achieve over the next five years;

1. Right care, right place, right time

By 2028, waiting times for our services will be amongst the best in the NHS, and we will have an outstanding safety culture, delivering lower-than-expected mortality rates and a reduction in avoidable harm. We will also be improving outcomes and patient experience and working with our partners to tackle health inequalities in our communities.

2. Affordable services, fit for the future

We will make our services sustainable for future generations. By 2028, we will have taken the difficult action required to break even each year financially. We will have reduced our carbon footprint and be on our way to net zero by 2040. We will have modernised key parts of our estate and made major strides in adopting digital technology. And we will be a thriving centre for research and innovation, playing our part in the development of tomorrow's healthcare.

3. Empowered, engaged staff

We know we must deliver improvements in quality of care whilst taking difficult decisions to make our services sustainable for the long term, we will need to make best use of our greatest asset – our highly skilled, committed workforce. Our vision is that by 2028 GESH will be amongst the top five acute trusts in London for staff engagement. This will involve getting the basics right for our employees, putting staff experience and wellbeing at the heart of all we do, fostering an inclusive culture that embeds our values developing tomorrow's workforce, and supporting our staff to work differently.

4. Collaboration and partnership

We will also play a leading role in integrating services around the needs of our patients. Our vision is that by 2028 GESH will be a driving force behind the most integrated health and care system in the NHS, and will be recognised as a national exemplar for integrated working – working with GPs, local government and community partners to keep people well in the community and avoid unnecessary trips to hospital, integrating services across the GESH Group, collaborating with other hospitals in South West London on shared services, elective recovery and financial sustainability, and working through regional networks to integrate our tertiary services with primary and secondary care.

Moving to action

Building your future hospitals programme: Following public consultation, a proposal to build a brand-new specialist emergency care hospital (SECH) in Sutton has been agreed, bringing together core major acute services for Epsom and St Helier's most unwell patients and those who need more specialist care on a single site, whilst care continues in our existing, refurbished hospitals at Epsom and St Helier for the majority of services. This is a once-in-a-lifetime opportunity to truly transform services, patient experience and patient outcomes, and to put services on a more financially sustainable footing. It represents the biggest investment in healthcare in the region for a generation.

Workforce: We have an opportunity to empower and equip our staff to work differently. Our 17,000 staff, with their skill and dedication to patient care, are our greatest asset.

Digital technology: Digital technology is transforming a wide range of industries, including healthcare. Some of the digital advances we are starting to pursue, such as a shared system for electronic patient records across St George's and Epsom and St Helier, could lead to major benefits for our patients and staff.

Collaboration: there is huge opportunity to improve care for our patients and value for taxpayers by delivering more integrated services:

- With partners in our local communities: hospitals, GPs, community services, social care and the voluntary sector collaborating to keep their local populations healthy
- Across our group: Building on years of collaboration in a range of fields, Epsom, St Helier and St George's have come together as a Group, under a single management team.
- With other hospitals: across the country, 'provider collaboratives' are expected to play an increasingly important role in the NHS.

Community care

Community services play a key role in keeping people well, treating and managing acute illness and long-term conditions and supporting people to live in their own homes. Community services covers a wide and diverse range of interventions and are delivered in a wide range of settings, including in people's homes. Community services are used by all age groups and can provide short-term support and care, such as health visits after a baby is born, to long-term support for people living with frailty, long-term or chronic conditions, as well as supporting people who are near the end of their life. Community physical health services play a crucial role in the delivery of good health care, providing vital support to people with long-term conditions and underpinning patient flow from the acute systems.

A picture of community care in South West London:

Different provider types providing community services including standalone NHS community services, integrated acute and community services and a community interest company.

There are five major providers for community services in South West London. These are: Your Health Care which provides services in Kingston, Central London Healthcare, CLCH, provides services in Merton and Wandsworth, Hounslow and Richmond Community Healthcare, HRCH, provides services in Richmond, Croydon Health Services are integrated with the acute provider Croydon University Hospital, and services in Sutton are provided by Sutton Health and Care Integrated Provider, which is hosted by Epsom & St Helier Trust.

CQC ratings for our community services are all rated as 'good', with the exception of Croydon Health Services, which is rated as 'requires improvement'.

£231m

is currently invested in community services

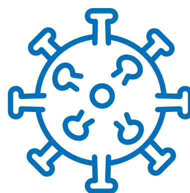
Workforce is a key challenge across community services addressing this challenge, including recruitment and retention, of staff in an innovative way is a priority.

294,000 referrals were made in 2022 with the highest number of referrals to district nursing (59k) and musculoskeletal services (57k).

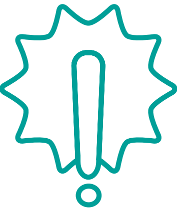
Demand is increasing due to:

- **Our growing and ageing population**, inevitably increasing the number of people needing NHS care and the intensity of support they require.
- **Unmet health needs,** growing visibility and concern about areas of long standing need exacerbated by delays in treatment due to Covid-19.
- **Greater number of people living with long-term conditions**

In 2022, 225k people had multiple contacts resulting in a total of 1.4 million contacts.



The pandemic, the cost-of-living crisis, together with people living longer with multiple long-term conditions, including dementia, has increased demand for support.



Innovative services such as falls pickup, urgent community response, virtual wards, long covid, have been established in response to national needs and increased demand.

All six of our places have seen their over 65s population increase between 2011 and 2021. In ten years' time, we expect about 58,000 more older adults will live in South West London. An older a person is, the more likely they are to suffer from chronic conditions such as dementia, diabetes, and arthritis.

People and communities tell us

Patient satisfaction is very positive for NHS community services– for example, Central London Community Healthcare[5] providers report that their key patient satisfaction indicators are overwhelmingly positive, with nearly 100% respondents saying they were treated with respect and dignity and 98% rating their overall experience as good or very good.

People want to be able to live independently and be supported to do so. Most people supported the 'home first' approach but felt additional wrap-around support was often needed.

Most people who left hospital to a 'rehabilitation bed' rather than their own home, did so because they did not want to be a burden on their family or were worried they did not have enough space for equipment at home.

People said services in the community needed to be more joined-up, communication between services needed to be better, and they wanted more of a role for the voluntary sector services. We need to do more to 'bridge the gap' between hospital and home.

We could better support vulnerable communities and people who experience health inequalities if services were located close where these communities live and work.

Unpaid carers are a huge asset to NHS services but often find it difficult to get information on support and services, including financial information. Carers also need support with their own physical and mental health and well-being, particularly young carers.

The voluntary and community sector in South West London were recognised as highly valuable for health and wellbeing, providing a wealth of community services and support, particularly for people with long term conditions. People felt this should be expanded and that we should invest in smaller voluntary, community and social enterprise organisations as well as the larger more well-established organisations.

5. CLCH (2023) A summary of key activities relating to patient experience and patient public engagement from CLCH services

Our ambition

We want to support people to stay well, live independently and only go to hospital when they absolutely have to. When they need care out of hospital, we want people to be supported by integrated community services who, by working in partnership with health, social care and voluntary sector providers, support to come home from hospital, address long standing inequalities, prevent ill-health, and tackle the wider determinants of health and wellbeing.

We are committed to developing community care across South West London and over the next five years we will:

- Work with partners and patients to develop a core model for community services for each place. This model will build on the transformation work that is already being progressed and will be supported by a common set of outcomes. This work will also identify how we can better integrate our services to maximise the efficient use of resources and improve productivity.
- Use population health data to ensure that our community services meet the needs of the most vulnerable people in our population.
- Increase equity of access, experience and outcomes by reducing unwarranted variation and ensuring a fair and sustainable allocation of resources.
- Prioritise prevention and early support as we know this promotes good recovery and reduces the impact of ill-health.
- Design a new model for community health workforce, including voluntary and community sector and peer support to tackle recruitment and retention issues.
- Co-produce service developments with patients and residents in South West London, putting partnership with those who use services and those in our communities at the heart of everything we do.
- Reduce waiting times and ensuring people are cared for in their home or preferred environment wherever possible.
- Think differently about how we commission and deliver community services in healthcare and consider how we use other enablers such as better care fund contracts, section 75 arrangements, local authority services and other non-statutory services to deliver our priorities in an integrated way.

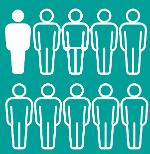
Mental health, learning disability and autism

Mental health services are provided by a variety of organisations, including two large NHS mental health trusts, primary care and several smaller, voluntary sector or local authority-led organisations. Our main mental health service providers are:

- South West London and St George's NHS Mental Health Trust (SWLSTG)
- South London and Maudsley NHS Foundation Trust (SLAM)

In line with national data people in South West London experience the following:

At least **one in four** people will experience a mental health problem at some point in their life with **one in six adults** has a mental health problem at any one time.



More than **1 in 10** of our residents are living with a mental health condition, including severe mental illness and depression.

Half of those with lifetime mental health problems first experience symptoms by the age of 14 and three-quarters before their mid-20s.

Life expectancy of people with a serious mental illness is **15-20 years shorte**r than for those without.

Mental ill health represents up to **23%** of the total burden of ill health in the UK – the largest single cause of disability.

Estimates have suggested that the cost of treating mental health problems could double over the next 20 years.

More than £2 billion is spent annually on social care for people with mental health problems with **nearly 11%** of England's annual secondary care health budget is spent on mental health.

In South West London

£300 million

is spent each year providing mental health services to our South West London residents.

Around **50,000** people in South West London access mental health services each year.

Clear links between physical and mental health for example people with chronic health conditions have a higher risk of developing mental health disorders.

Each year around **16,000** under 18s receive community NHS funded mental health treatment in South West London. This is **4.5%** of the children and young people population, which is above the London average of **4.1%**

215 children and young people were admitted to hospital in 2022 for mental health conditions.

Self-harm is increasing

Children and young people in South West London have a high level of need for mental health support. A higher proportion of under-18s access NHS community mental health services compared to other London ICBs and there are high numbers of hospital admissions for self-harm (Data source: Public Health England Fingertips). Demand is also increasing and at a faster rate than population growth.

There are **123,997** people in South West London with a diagnosis of depression recorded on GP practice registers, accounting for 9.1% of the population, above the London average of 8.7%.

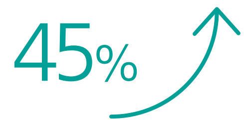
Higher prevalence of dementia than the London average

Higher suicide rate compared to London.

Sutton, Richmond, and Kingston have the highest rates of suicide of the South West London boroughs (11, 10 and 9 per 100,000 population respectively). These rates are above the London average (8 per 100,000 population)

(Data source: Public Health England).

Overall service demand for adult mental health services has increased by around **12%** from 2018 to 2021.



IAPT referrals across South West London increased by **45%** from 2018 to 2021.

Our children and young people population the demand is **increasing at a faster rate** than population growth. CYP population was projected to grow by 2% from 2018 to 2021 but overall service demand has increased by around 11%.

Total referrals and patient contacts for adults and children within secondary care mental health have increased between 2018 –2021.

% Change (2018-2021)	South West London and St Georges mental health	South London and Maudsley
Referrals	+14%	+10%
Patient contacts	+6%	+30%

There are some mental health conditions in evidence in South West London that can be in part linked to our demographic variation. Croydon has a higher prevalence of severe mental illness (SMI), such as bipolar disorder, schizophrenia and other psychoses, than other South West London boroughs due to the younger age of the population and higher rates of deprivation

The prevalence of serious mental illness (SMI) in South West London is 1.0% which is slightly below the London average of 1.1%

(Data source: QOF)

Evidence for prevention, early intervention and public mental health initiatives is developing, and there are opportunities to consider support for mental health differently. However, this will require us to reconsider how we use our resources and invest in longer term prevention as opposed to crisis and acute care.

The Covid-19 pandemic adversely impacted on people's mental health. Post-pandemic increases in referrals, complexity and severity have increased the challenges our services face. In addition, newer presentations are being seen in some cohorts, for example, mental health related school avoidance in children and young people.

In addition to Covid pressures, the cost-of-living crisis and the increased level of support required for people with complex needs have increased pressure within mental health pathways.

Workforce also remains a key challenge across South West London and beyond. New initiatives to increase recruitment and retention of staff are being developed.

People and communities tell us

The significant increase in demand for mental health services for children and young people, as well as adults, has meant concern from communities about much longer waiting times, and the need for some support while people are waiting for their first appointment.

Services, organisations, and communities should work together to support people and manage demand on NHS services, for example, local authorities and schools for young people, more support from primary care, more peer support, and the voluntary sector to have better links into NHS services.

We need to do more to reduce the stigma of using mental health services as there is a lack of awareness among many communities about the challenges faced by people with mental health issues, as well as people just not knowing where they can go for help. This is particularly the case for many vulnerable groups.

Loneliness and isolation, the cost-of-living crisis and digital exclusion are major issues that make local people's mental health much worse.

Local people are keen on the development of different kinds of services in the community like drop-in centres, 24/7 crisis cafés, and community activities.

Concerns about a lack of specialist support from NHS staff for people with specific illnesses and lack of understanding about service users from particular backgrounds for example, dementia, perinatal mental health, people from Black, Asian and minority ethnic backgrounds, carers, people with neurodiversity, LGBTQ+ people, migrants and refugees.

Our ambition

We believe that everyone has a right to good mental health. We want South West London to be the best place to live for emotional wellbeing. A place where mental health services are accessible and meet the needs of the local population and no person feels that taking their own life is their only option and where people with serious mental illness have the same life expectancy as the general population. A place where everyone has access to early support for their emotional wellbeing and mental health, where health inequalities are eradicated and where our services work seamlessly together so that support and care are provided in the most appropriate setting.

To achieve these ambitions over the next five years for both children and young people and adults we will:

- Improve recovery rates and quality of life for serious mental illness and mild to moderate mental health conditions.
- Improve levels of access to services across different communities and reduced restrictive practices of all types.
- Reduce suicide and self-harm rates.
- Reduce rates of detention for men from black ethnic backgrounds.
- Increase understanding of mental health issues and wellbeing amongst communities.

In order to achieve this, we need to change the way that we design, fund and deliver mental health services and the way that we collectively think about, talk about and support strong our mental health across and within our communities.

Learning Disability and Autism

There are approximately 18,000 people living in South West London with a learning disability and/or are autistic. This number is expected to grow to approximately 20,000 people by 2030. The population group is very diverse with a spectrum of needs and the needs of autistic people are different to the needs of people with a learning disability.

Nationally published data shows that:

- People with a learning disability are least likely to have a cancer screen (nationally 52.5% of people with a learning disability have had a breast cancer screen compared to 68% of the general population
- 37.5% of people were classified as obese compared to 29.9% of the general population
- People with a learning disability are 8.4 times more likely to have a serious mental health illness than those without.

Research has shown that on average, people with a learning disability and autistic people die earlier than the general public, and do not receive the same quality of care as people without a learning disability or who are not autistic. Disproportionately higher numbers of children and adults with a learning disability and autism enter the criminal justice system.

Our ambition

In line with the NHS Long Term Plan our ambition for people with a learning disability and/or autism is to:

- Reduce avoidable and preventable admission to mental health inpatient beds. At the end of December 2022 35 people were in an inpatient bed with seven children and young people and 28 adults
- Reduce mortality and preventable deaths. Nationally on average, the life expectancy of women with a learning disability is **18 years shorter** than for women in the general population and 14 years shorter than for men with a learning disability than for men in the general population
- Improve the health and wellbeing of people with learning disability and/or autism.
- Improve autism diagnostic assessment and support by reducing current waiting times and improving pre and post diagnostic support
- Improve quality of inpatient care by ensuring 100% of patient care plan reviews are completed within the national targets, restrict the use of seclusion and reduce length of stays.

Working together to improve care – collaboratives

The Health and Care Act 2022 established a duty for collaborative delivery. The key pillars of system, places, and provider collaboratives offer opportunities to improve mental and physical health care and reduce fragmentation and gaps in existing pathways:

In addition to the six places (Croydon, Kingston, Merton, Richmond, Sutton & Wandsworth) and individual organisations, South West London includes three provider collaboratives: Acute, Mental Health and Cancer.

Provider collaboratives involve two or more NHS providers working at scale to tackle key challenges and deliver benefits including[6]:

- Reducing unwarranted variation and inequality in health outcomes, access to services and experience.
- Improving resilience by, for example, providing mutual aid.
- Ensuring that specialisation and consolidation occur where this will provide better outcomes and value.

Our mental health provider collaborative

In South West London, our mental health provider collaborative is part of the existing South London Mental Health and Community Partnership (SLP) which is a well-established partnership between South West London and St George's Mental Health NHS Trust (SWLSTG), South London and Maudsley NHS Foundation Trust (SLaM) and Oxleas NHS Foundation Trust. Formed in 2017 and the trusts have around 12,000 staff between them working across a population of 3.6 million, spanning two ICSs and 12 London boroughs.

SLP is focused on developing standardisation for mental health service areas and pathways over our six boroughs and our two main NHS providers. It also brings together clinical leaders to drive service developments and ensure involvement and co-production from service users and communities in pathway design, delivery, and evaluation.

Examples of areas of success include:

66% reduction in forensic readmissions.

93% fewer children and young people placed out of area.

Introduction of a crisis line supporting both adults and children.

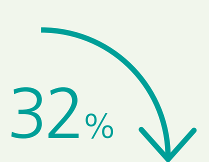
A pilot run by SWLSTG has informed the NHS111 Press 2 model to be implemented in 23/24. This will enable people ringing NHS 111 for mental health support will be able to speak directly to a mental health professional.

Delegation of the ICB mental health placement budget have 136 SWL patients have been supported to step down to less restrictive settings and a reduction length of stay has reduced from in independent sector providers to an average of 11 months within NHS rehab inpatient wards.

Introduction of a Nurse Development Programme which is growing the number of Band 5 community mental health nurses, developing leadership skills training for Band 6 and advancing careers at Band 7 and above.

6. Working Together at Scale: Guidance on Provider Collaboratives (NHSEI Aug 2021) Each ICS can apply flexibility and develop provider collaboratives to suit their needs, however, all NHS trusts are expected to part of at least one provider collaborative arrangement. Provider collaboratives have a range of aims, ambitions and leadership models – all of which respond to the challenges and opportunities they seek to address, the landscape they work within and existing and evolving partnership approaches.

Impact of transformation at scale – overall SLP highlights Better local services, value and outcomes for south London patients



32%

32% reduction in South London children and young people's use of mental health hospital beds

36%
Fewer forensic patients out of area

66%
reduction in readmissions

1000+ new complex care patient assessments

100+ stepped down to less restrictive environment

Targeted investment in South London-wide and new trust services

New care models savings reinvested local services

Covid response across system; leading post-pandemic **prevention strategy** with local authorities and VCSE

SLP has a clear vision of:

- Right care, right time, right place – for each patient as an individual
- Mental health services working together efficiently to deliver seamless, patient-centred pathways.

The trusts collaborate in a variety of informal and formal ways, including through lead provider collaborative models for key service areas with delegated commissioning responsibilities and budgets across secure care, CAMHS Tier 4, Adult Eating Disorders and Complex Care. Transformational benefits have been delivered in each area including reduction of out of area placements, reduced length of stay in inpatient wards, reduction in restrictive practices and financial efficiencies leading to reinvestment of funds in broader pathway elements.

The South West London MHPC will:

- Improve access, experience, and outcomes to address health inequalities in line with CORE20PLUS5
- Improve efficiency (of delivery and pathways and use of resources)
- Reduce cost pressures
- Enable resource redistribution/ reinvestment

To deliver the following outcomes:

- Improved equality and equity of mental health care
- Increased in care delivered close to home and in the least restrictive settings
- Measurement of clinical outcomes as standard and improved recovery/ maintenance of wellbeing
- Increased positive feedback around access and wellbeing
- Improved operational flow – improved ease of referral, reduced waiting times (all services), reduced DToCs, reduced admission and readmission rates
- Improved efficiency – reduced hand offs between providers, improved productivity within services, reinvestment of savings within prevention/ early intervention/ low tier services, consolidation of contracting and management approaches reducing management time/ roles required.

The ambitions for the collaborative are driven by specific elements of South West London mental health strategy, such as inequalities and timely access. In 2023/24 further service areas will be considered through the development of specific cases for change which define the issues, challenges and opportunities and consider whether the provider collaborative working is a good fit for resolution. Cases for change for adult eating disorders, CAMHS, community adult services and acute, crisis and urgent care will be developed.

Primary care

Primary care, including general practice, is an essential element of a high-quality and cost-effective health system. For most people, it is the typical entry point into health services. However, we know that primary care is experiencing many challenges such as demand and capacity and a changing workforce, as well as changing patient needs.

A picture of primary care in South West London:

173
GP Practices

39
Primary care networks

6 General practice federations. Our federations work together through the South West London Federation Alliance.

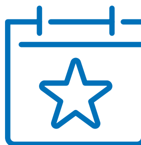
Funding

£271m delegated general practice primary care budgets

£127.9m
The allocation for Pharmaceutical, general optometry and dental (POD) services in South West London

163 (93%)
of practices have a CQC rating of 'good' or 'outstanding'.

12
practices are subject to 'requires improvement' or 'inadequate' ratings and are receiving support from local teams to help respond to their challenges.



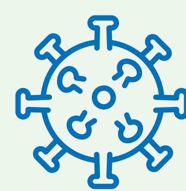
South West London's general practices provided in excess of 7.95 million primary care appointments in 2022.

Percentage of face-to-face appointments increased from 52% to over 67% in 2022.

Primary care networks are providing over 6,500 appointments per week under the new Enhanced Access Service, 6.30pm-8pm weekdays and 9am-5pm Saturdays. Some PCNs are also providing appointments outside of these hours in-line with patient need, such as commuter and paediatric clinics.

Our GP patient survey results are amongst the best in the country with high levels of satisfaction in primary care including:

- Ease of getting through by phone
- Satisfaction with appointment times
- Overall experience



Covid-19 changed the way we access primary care, accelerating the use of telephone and online consultations and appointments, electronic prescribing and online health advice

3117

whole time equivalent (WTE) staff employed by South West London's General Practices

977

GP WTE employed with 201 of GPs aged over 55 years.

Workforce shortage for clinical roles and some professions with an ageing workforce, such as the high proportion of nurses aged over 55 (45%). There are 72 fellows, across 41 different surgeries, benefiting from participating in the successful salaried portfolio innovation (SPIN) fellowships programme, for newly qualified GPs and nurses.

Significant increase in clinical roles beyond GPs and Nurses such as pharmacists, paramedics and physiotherapists, through our additional roles reimbursement scheme (ARRS) programme - We have employed **590** full time equivalent, FTE, ARRS roles compared to **560** FTE in September 2022. PCN intended recruitment plans for 2023/24 will increase these roles to 681 FTE.

Pharmaceutical optometry and dental services in South West London

From the 1 April 2023, South West London ICB will take responsibility for NHS pharmacy, optometry and dental (POD) services currently commissioned by NHS England. We have agreed a London operating model and have put in place a London POD hub hosted by North East London ICB and governed by a pan London oversight group. In 2022/23, the financial allocation for these services for South West London ICB is £127.9m.

The delegation of these functions will enable us to integrate POD functions, join up pathways of care and manage local population health needs better, tackling inequalities and promoting continuity of care. Pharmacy, optometry and dental services are key components of general health and wellbeing, with deep rooted connections to prevention, primary care and community services. There will be a period of embedding the new arrangements in 2023/24,

Our priorities for pharmacy, optometry and dentistry services are to:

- Strengthen links with integrated neighbourhood teams, primary care networks, population health management and public health.
- Fully align and localise approaches, advice and communications relating to staying well, through all primary care providers, particularly promoting the wider services offered by community pharmacies.
- Use data and intelligence to develop local initiatives to improve patient access and experience.
- Embed professional and clinical POD leadership
- Establish local services to support partner collaboration across health, social care and public health to help address health inequalities and support more joined-up working.

People and communities tell us

GPs

- GPs were highly valued by local people, however access was an issue mentioned across a range of engagements. A lack of access to GP appointments, could sometimes mean residents avoided contacting the GP, and either looking elsewhere for example by going to A&E, or not seeking further support.
- Many people would like to see an increase in appointments, with some people preferring face to face appointments, to video or telephone appointments.
- Some people had concerns about the sorts of appointments available being appropriate for specific groups. For example, older people preferred face to face appointments and there is a need for longer appointments to explain complex issues. Different groups of patients may need different appointment types, for example for people living with dementia, Asylum seekers, refugees, carers, homeless, vulnerable, mentally and physically disabled and other marginalised groups such as patients who are autistic. Patients with language barriers also needed longer GP appointments and reported not always getting these.
- Most people wanted to be seen at their own practice but many were willing to travel to another GP practice if they could get an appointment sooner.
- There were some concerns about inconsistencies between GP surgeries on the way conditions were treated. Some participants felt that they knew more about their condition than their GP. Some felt that GP support post hospital discharge is not always adequate.
- Reports that Black women felt that GPs did not listen when they go with symptoms, leading to multiple visits and delays before referral.
- There is a need to ensure interpreting and translation services are provided when required. Some people found it embarrassing to have their family members translate for them.
- Carers valued interactions with the GP of the person they cared for. For most of the carers' engaged, they would have valued the GPs checking-in with carers about how they were doing following hospital discharge of the person they cared for.
- Some people reported the need for better communication and coordination along their treatment journey, including communication between GP practice and diagnostics teams.

Dentists

- Local people highly value dentists but reported variable access and residents unable to locate or register with an NHS dentist.
- People had difficulty getting an appointment and challenges in getting emergency appointments.
- Dentists needed better information about their services, with some saying websites needed to be improved and updated.

Pharmacists

- For some groups of patients' pharmacists are very important for information and advice, for example Gypsy, Roma and traveller communities reported using local pharmacies a great deal. Some people with diabetes said pharmacists were helpful, but sometimes gave inconsistent advice on medication and dosage.
- People can be put off visiting a pharmacy due to busy queues, poor previous experience and not being able to talk in private. People said they were more likely to visit a pharmacy if they were assured about the pharmacist's qualifications, services offered and opening times.
- Privacy is also important. People might be discussing sensitive health issues or requesting emergency contraception. Assurance about confidentiality and spaces for private conversations were important to people.

Our ambition

We want people in South West London to access primary care in the way that suits them best so that they can get the information, care, and support they need quickly. We want fully digitalised and connected primary care which eradicates clinical variation, improves health outcomes, and looks proactively at the needs of patients so that we improve the continuity of care for those who need it and keep people healthier for longer.

We are committed to primary care being the foundation of local care and we will achieve this over the next five years by:

- Ensuring that general practice is **accessible** to routine and urgent need through a variety of channels, as well as increasing access and face to face appointments for different levels of need, enabling patients to access the right clinical support.
- Working to **prevent ill health** including the development of a directory of South West London prevention services particularly around smoking, immunisations, and long-term condition self-management (including digital apps).
- **Targeting health need** identified through our joint strategic needs assessments and Core20PLUS5 analysis.
- **Developing PCNs and integrated neighbourhood teams** to deliver a range of co-ordinated and timely services at the right scale, for example, with practices, PCNs, and boroughs.
- Further **developing integrated neighbourhood services** that extend beyond traditional physical and mental health services to include social care, **voluntary sector, self-management, and prevention support** so that people can live their healthiest life and be independent for as long as possible
- Develop a **risk stratification** tool to identify and prioritise people who may benefit from a proactive care offer and integrate relevant data and services to ensure a holistic view of the support and care is provided to people.
- Targeting **health improvement**:
  - Although we have successfully achieved 75% learning disability (LD) health checks throughout 2022/23, we want everyone with a learning disability to have proactive primary care
  - We will focus on areas such as dementia diagnosis, exceeding the national target of 66.7% and will roll out a new primary care specification to increase access to serious mental illness health checks
- Further developing our primary care **estate, digital initiatives, and IT infrastructure** to ensure our practices have the tools and environment to improve and develop
- **Recruiting and retaining** GP, nursing, and other clinical and non-clinical skilled staff. Ultimately, we want to have a primary care workforce that:
  - Is broader in terms of roles and skills,
  - Is recognised and valued,
  - Is supported to train and develop,
  - Enjoys fulfilling work that provides opportunities for development and career progression,
  - Is here to stay, now, in five years, ten years and beyond.
- Supporting **partnership working** across Southwest London's health and care services and provide a strong primary care voice.
- Developing our primary care estate so that it is fit for the future and has the biggest impact on health inequalities and services.

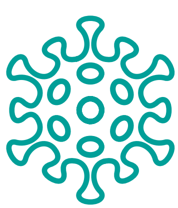
Part Four: Spotlights on areas of care

Spotlight on cancer

Cancer is the leading cause of death across South West London and we know that as our population gets older, the chances of people getting cancer at some point in their lifetime increases. We also know that the more cancers we are able to diagnose early, the more people will survive to live with and beyond cancer.

Tackling the causes and consequences of cancer is a key priority in South West London. And the NHS Long Term Plan highlights that despite the progress made in cancer survival over the last two decades, we can do more to diagnose cancer earlier. We also know that deprivation and other societal factors affects the changes of a person having their cancer diagnosed early, and we need to do more to eliminate these differences.

More than **52,000** people are living with or beyond cancer in South West London



One in every two people will get cancer in their lifetime

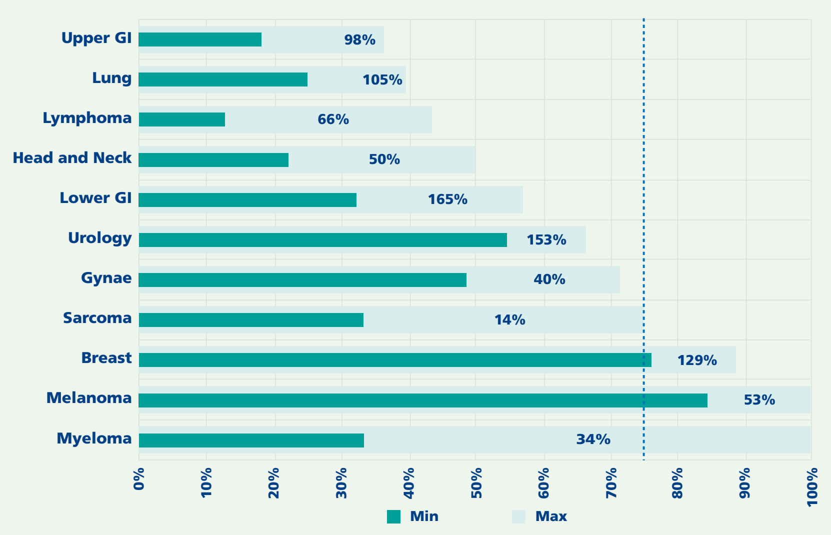
Nearly **40%** of all cancers are preventable, and a consequence of lifestyle factors such as smoking and obesity

tackling the causes of these preventable cancers also helps us to reduce other chronic health conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and heart disease.

58%

of cancers are diagnosed at stage one or two in South West London against a national target of 75%

Variation between top and lowest borough for the proportion of staged patients diagnosed in 2018 early (stage 1 or 2) in South West London by tumour type and how many extra patients would be diagnosed early if this variation was reduced



The percentage of early cancer diagnoses vary across our boroughs from 61% in Sutton to 56% in Merton. We have a way to go to make sure that 75% of all cancers are diagnosed early.

2020/21 incidence of cancer by borough[1]

Borough	2020/21 Incidence per 100,000
Sutton	429
Richmond	394
Kingston	364
Croydon	358
Merton	343
Wandsworth	261

Table 1: cancer deaths by age group as a percentage of all deaths (all boroughs) South West London: 2021

	South West London					
Cause of Death	Sum of 0-24	Sum of 25-39	Sum of 40-59	Sum of 60-74	Sum of 75+	Sum of Total
LC02 Cancer (malignant neoplasms)	0%	48%	49%	47%	22%	30%

People in South West London generally respond well to the three national cancer screening programmes that cover cervical, bowel and breast. Over the next three years a new screening programme for lung cancer will be rolled out and we will work hard to reach all parts of our community. We know that screening saves lives, and although we have a relatively high uptake of screening, inequalities remain. For instance, if you live in one of the most deprived areas in South West London, you are 17% less likely to have had bowel screening. Understanding more about the people who are less likely to have screening is a key priority for us, aligning with both the cancer ambition of early diagnosis and the core20PLUS5 framework.

Typically, cancers are categorised into stages with stage 1 being a small cancer that has not spread up to stage 4 where the cancer has spread in the body. People who are diagnosed early, at stages 1 and 2, have the best chance of being cured and the best change of long-term survival. The more cancer diagnoses we can make early, the better for our population and our communities.

To achieve the scale and pace of transformation we need, we work with our partners through our cancer alliance, Royal Marsden Partners. Royal Marsden Partners is part of the Royal Marsden Hospital and is dedicated to improving cancer services. By working closely with our partners in primary care, place, acute hospitals and community services, we will drive innovation and best practice so that we have the best chance of meeting these goals for our communities.

People and communities tell us

People in South West London report a positive experience of cancer services, and high levels of confidence in the NHS teams looking after them.

Patients had positive experiences of the speed of access to diagnostic tests, and the way they were given their diagnosis.

There is some inequity in experience across the cancer pathway for some groups, specifically those from our most deprived communities, and those who identify as Black or Asian or as LGBTQI+ or with a pre-existing long-term condition.

People said we needed more culturally specific support groups for Black men with cancer and to encourage more open discussion about cancer in local communities.

Some people said being seen by a Black clinician would reduce concerns about racial bias.

More needed to be done to encourage people with a learning disability to take up breast cancer screening.

People wanted more emotional support in the community after their cancer diagnosis.

There was sometimes a lack of awareness of about different cancers, and a need to reduce taboos and shift perceptions with local people and communities.

People wanted credible advice from trusted NHS sources about cancer, and to feel empowered to ask questions about treatment.

Patients' were sometimes not aware of the different therapy and supportive care services that were available to them while having cancer treatment.

Teenagers and young people with cancer valued access to a digital app to support their emotional wellbeing.

Our ambition

Our mission is to save more lives in South West London, through earlier diagnosis and reducing inequalities across the cancer pathways. And for anyone that might have cancer, we want to make sure that we act quickly so that no one has to wait more than a month to receive that diagnosis, and no more than a further month to start their treatment.

We know that to do this we need to focus on understanding where variation exists, act on variation in partnership with our communities and place-based teams, continue to improve the cancer diagnostic and care pathways and embrace new approaches to early diagnosis.

Our strategic ambitions are to:

Diagnose people earlier and faster, and improve survival.

- Improving the early diagnosis rate by 4% by 2025.

Remove variation and optimise care.

- Tackling the variation in early diagnosis across South West London, so that 940 more people have their cancer diagnosed early over the next three years.
- Targeting people with the highest need and tackling inequality.
- Adopting innovations that improve cancer care and outcomes.

Improve patient experience and quality of life

- Improving access to care and ensuring it is personalised and holistic.

To achieve our ambition, the following strategic delivery programmes have been developed through careful analysis of the data and consultation with our patient advisory group:

- Reducing variation in screening programmes and increasing uptake
- Working with places and primary care networks to diagnose cancer earlier
- Improving diagnostic and treatment pathways, and
- Personalised, holistic care.

These programmes will be underpinned by our cross-cutting priorities of:

- Addressing cancer inequalities, and
- Innovation, spread and adoption.

In addition, focus and attention will be on recovering services following the Covid-19 pandemic.

Recovering services following the Covid-19 pandemic

Reducing variation in screening programmes and increasing uptake

Working with Places and PCNs to diagnose cancer earlier

Improving diagnostic and treatment pathways

Personalised holistic care

Two of the programmes are cross cutting across all of our work

Addressing cancer inequalities

Innovation, spread and adoption

Reducing variation in screening programmes & increasing uptake

We will deliver new types of screening, which identify tumours at an earlier stage, which will include:

- Targeted lung health checks across South West London, starting with the geographical wards with the highest smoking rates by the end of 23/24.
- Genetic testing for all new colorectal and endometrial cancers to identify those with a higher family risk of cancer.
- Management of people at high risk of liver and pancreatic cancer.
- Support clinical testing for new ways of diagnosing cancer with just a blood test.
- Test and implement new methods of screening people with Barrett's oesophagus using 'cytosponge' at Croydon University, St Georges & Epsom St Helier hospitals.
- Reduce variation in existing cancer screening programmes, such as bowel, cervical and breast screening, working with place.
- Reduce inequality by developing clear population health dashboards to understand more about our screening uptake in real time to allow rapid interventions.

Working with places & primary care networks to diagnose cancer earlier

At place: We will engage our populations, particularly those less likely to come forward with cancer symptoms, to develop interventions which reduce this issue

In primary care: We will reduce differences in early-stage diagnosis by working in the areas with less cancers diagnosed and treated through the urgent cancer pathway.

We will continue to embed urgent cancer referral guidance, ensuring faecal immunochemical testing (FIT) in primary care reaches the threshold of 80% compliance. We will also further develop our cancer population health approach to generate actionable insights by GP practice, age, sex, ethnicity, and deprivation.

Improving diagnostic & treatment pathways

We will continue to support trusts in South West London to diagnose and treat patients diagnoses with cancer, within 62 days

We will meet the national faster diagnosis target, achieving 75% of people informed of their cancer diagnosis by 28 days following their referral. This will include:

- Breast pain pathway: we will create a new service for people who have breast pain, based in the community with expert assessment teams.
- Urology pathway: we will ensure that there are more nurse-led diagnostic and imaging capacity available.
- Lung cancer diagnostic pathway: we will improve the speed of diagnosis, and make sure specialist diagnostics, such as positron emission topography (PET) and endobronchial ultrasound (EBUS) are available locally.

We will ensure all patients with a sign or symptom of cancer have a clear diagnostic pathway into secondary care. This will include continuing to increase the volume of patients referred to 'vague symptom' clinics, to meet the target of 4% of cancer referrals.

In addition, we will ensure all trusts record cancer staging and everyone gets the most appropriate treatment through clinical pathway groups, such as through chemotherapy and radiotherapy networks.

Personalised holistic care

We will demonstrate that all patients across South West London are offered a consistent personalised care through a holistic needs assessment, personalised care and support planning, and receive an end of treatment summary.

We will refresh patient-initiated follow-up pathways for priority tumour types, ensuring this is fully operational in breast, colorectal, prostate and endometrial cancer pathways.

We will also develop a patient and public involvement programme, involving patients and public in the codesign, oversight and scrutiny of our cancer programmes. This will include the co-design of an innovative, whole-system approach for cancer prehabilitation and rehabilitation. It will utilise best practice in order to establish a sustainable funding model.

Spotlight on diagnostics

Most people will have a diagnostic test in their lives – whether that is a blood test in primary care to find out cholesterol or sugar levels; an x-ray to check for a fracture, or something more invasive like endoscopy or a biopsy to help diagnose a cancer.

It is vital that patients get the rights tests at the right time so that the right clinical care is provided.

As we continue to learn about illness and diseases, and the number of people with one or more health conditions increase, the number and type of diagnostic tests we need to do also increases. By 2026, we predict that we will be doing 40% more diagnostic tests than we do today.

We have a range of challenges that we need to work on in the coming years. These include:

- Increasing capacity in our diagnostic services to meet current and forecasted demand.
- Increasing our workforce so that we have the right staffing to keep pace with rising demand. This includes the need to increase training places available to develop our future workforce.
- We will need to review our estates and replace equipment as it increasingly ages.
- We need to fully digitalise our diagnostics services improving connectivity and interoperability across the NHS from primary to secondary and tertiary care.
- We need to identify and address population needs, health inequalities and ensure equity of access to diagnostic services. We know that if you live in a more deprived area in South West London, you are more likely than average to have complex health conditions and consequently you will need more diagnostic tests.
- We need to ensure that we organise services so that we provide the right diagnostic tests in the right places and in a way that helps to reduce health inequalities.

We will do over 62,000 echocardiograms in 2023, finally eliminating the backlogs caused by Covid-19.

What do we mean when we talk about diagnostics?

We use the term diagnostics to describe all the tests that you might have to help diagnose and manage a health condition. There are different types of diagnostics. Here are some of the most common ones:

- Pathology tests are the blood tests, analysis of body fluids or small tissue samples (called biopsies) that most people will have at some point in their lives.
- Imaging covers X-rays and things like MRI (magnetic resonance imaging), or CT (computerised tomography) scans. These are tests which help us see inside your body without actually needing to go inside it.
- Endoscopy is the group of tests where a camera goes inside your body to look inside your lungs stomach or bowels
- Echocardiography is where sound waves are used to trace how your heart is beating

People and communities tell us

Building on the London-wide patient and stakeholder engagement undertaken by NHS London, we undertook additional engagement in local boroughs as part of the development of the South West London community diagnostic centres programme.

We have undertaken a wide range of patient and stakeholder engagement utilising both locally sourced information and more extensive feedback. The key themes are:

Communication and coordination: a theme across all engagement. There was consensus amongst patients that we need to improve communication and coordination. This included communication between GP practices and diagnostics teams, diagnostics teams, and the patient, and within NHS teams, such as between diagnostics teams and specialist treatment teams. Residents would like to choose their preferred mode of communication, for example, text, email, or letter.

Responsiveness: people expressed a sense of confusion about the diagnostic pathway, unsure about what the next step in the treatment process will be, where they will be sent or feeling they were being rushed through. People would like staff to take time to explain tests and to answer questions and to be sensitive about the impact of the diagnosis.

Continuity of care: familiar processes and consistent, appropriate communication are key for people if they are to feel they are at the centre of their treatment. People with long term conditions, neurodiversity, learning difficulties and physical disabilities particularly raised the importance of continuity of care.

Patient-centred care: People wanted us to ensure that changes to diagnostic pathways were done with the patient at the centre.

Location does matter; close to home or easy to get to, but this is less of a priority than the speed of being seen and the overall experience.

Our ambition

We want to increase access to high quality, fast diagnostic services for all patients. In doing this, we want to ensure that our patients experience is improved. To do this we will:

- **Increase diagnostic service capacity.** In the next five years, we will create new diagnostics centres and invest in new equipment / rooms. At the same time, we will improve our productivity making our diagnostics services more efficient and effective.
- Work with system partners to **address health inequalities** in South West London. In doing so we will make sure that our services adapt as our population grows and changes. We will ensure that we target service developments specifically so that when we increase capacity or change pathways, we do so in such a way as to reduce inequalities, and reduce the impacts that deprivation has on people's access to care.
- **Establish imaging networks** and re-design and develop streamlined diagnostics pathways including via the community diagnostic centres. This means creating new and improved relationships between providers of diagnostic tests that help us share workforce and images more easily across South West London providers, GPs and specialised care centres. Our patient feedback tells us that timely diagnostic testing is sometimes more important than where the test takes place, so we will make sure that our pathways minimise the time to tests, allowing patients to choose to travel within South West London should they wish to.
- **Increase our diagnostics workforce** to keep pace with the expansion of services. This means we will implement our diagnostics workforce plan which includes establishing new training academies for key diagnostic modalities.
- Through a **digital transformation** in diagnostic services, improve the patient experience and operational efficiency and effectiveness.
- Develop the **diagnostics referral pathway and supporting systems** to address concerns raised by patients and their representatives to improve coordination, communication and to enhance patient experience.

The additional diagnostics capacity proposed in South West London combined with clinical pathway and digital transformation will improve clinical and patient outcomes by:

- **Reducing waiting times** for people, meaning they can start their treatment journey sooner
- **Improving access to tests** and scans, keeping up to date with changing clinical practice, delivering new diagnostic testing sites, and
- **Addressing the impacts of health inequalities** by specifically focusing on those actions which will make the most difference to our most deprived communities.

Spotlight on South West London Maternity

We are working together with women and their families to improve our maternity services, so they become safer, more personalised and family friendly. We want services where every woman has access to information to enable her to make decisions about her care and where she and her baby can access support that is centred around their individual needs and circumstances.

Over **17,000** babies each year are delivered in South West London

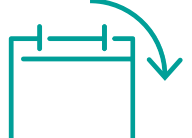
There are **four maternity units in South West London:** Croydon Health Services NHS Trust, Epsom & St Helier University Hospitals NHS Trust, Kingston Hospital NHS Foundation Trust, and St George's University Hospitals NHS Foundation Trust

Maternity services at Croydon hospital have recently been given an improved rating of "Good" for safety following an inspection by the Care Quality Commission (CQC)

As many as **20%** of women giving birth in South West London will experience mental health issues during their perinatal period (this is the period during pregnancy and up to a year after birth)

31-40 **Years**

Women giving birth more likely to be **aged 31-40** compared to other areas



Overall, in 2021/22 **maternity bookings were lower** than previous years

Births were 7% lower in 2021/22 than in 2019/20

People in Croydon borough have the **worst health outcomes in their deprived areas** including higher smoking rates and higher low term birth rate babies

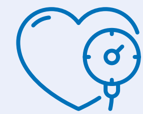
From 2015-19 the general fertility rate was **61.8 live births per 1,000 women**

Maternity Voices: Each of the hospital's maternity units have an active maternity voices partnership group (MVPs) to ensure that women's and families' voices are heard, and their requirements and suggestions acted upon. The MVPs are also involved in the design and improvement of new and existing maternity services

Partnership working: Our local maternity and neonatal system, LMNS, is a partnership of maternity and neonatal units who bring midwives, obstetricians, service users, neonatal staff, managers, commissioners, public health, educators, perinatal mental health providers and GPs together. The aim of the LMNS is to achieve improved personalised safer care, improve continuity of care, and provide accessible information to help women and their families make choices about their individual care

Challenges affecting the delivery of our maternity and neonatal care include shortages of staff, inequality of care, and access to shared patient data (electronic and paper copies)

There are **pockets of deprivation across South West London** with higher stillbirth rates in ethnic minority groups, particularly in Croydon. Women from African, Caribbean, and South Asian backgrounds experience a higher proportion of stillbirths compared to white British women



More women who are **35 years or older** are having their first baby and sometimes there is an increased risk of older women having a more complex birth, including: pregnancy-induced hypertension (high blood pressure), gestational diabetes, pre-term (early) labour and poor neonatal outcomes

The number of obese women giving birth in South West London is increasing, - associated risks for these women and babies include increased risk of severe bleeding and the likelihood of births resulting in a caesarean section

UNICEF's Baby Friendly Initiative (BFI) was developed to support maternity, health visiting, neonatal and children centre services to provide parents with the best possible care and guidance to help them to form healthy attachments with their babies to support health and development.

All our trusts have completed an assessment of current infant feeding policies and guidelines, including workforce education and training. Where improvements are required, the trusts have developed and implemented new ways of working and training to meet the requirements as set out in the programme.

Epsom & St Helier Hospital has also shown that it provides the leadership, culture and monitoring needed to maintain and progress the standards over time and has achieved the gold award, which is the highest accreditation that can be achieved.

What our patients and communities say

Maternity care in South West London is positively rated by women and their families.

People said care could be improved if women had the same midwife throughout their maternity journey. They felt this would help them to build trust and confidence in their care, and enable the midwife to get to know them and pick up on the softer signs in their physical and mental wellbeing.

Women wanted to be empowered to have more choice in their maternity care and for their choice to go beyond which hospital they would give birth in.

People told us that their safety, and the safety of their new-born was of paramount importance. They wanted high quality and consistent care throughout their pregnancy, birth, and post-birth for them as an individual.

There was a lot of support and enthusiasm for the idea of the app to support women before and after pregnancy journey.

Maternity service users from Black, Asian and minority ethnic backgrounds, and postnatal women who have significant underlying medical conditions were asked for their lived experiences. The main themes highlighted were:

- Women described raising recurrent concerns with the midwifery team and not feeling listened to or understood. Some women mistrust services, based on previous experiences of racism.
- Some women described difficult births and problems when returning home with a new baby. It was felt that early emotional or low-level mental health support could make a positive difference.
- Women described notes not being read and plans not being followed. For example, when they required additional care, there was a lack of appreciation that they were under the 'maternal medicine plan' and needed more support and advice.
- Some participants said they needed clearer and easier information about staying healthy pregnancy and birth, and wanted more support with feeding their baby.

Our ambition

We want all women to have safe maternity care which is personalised, kind, professional and family friendly; where every woman has access to so that she can make decisions about her care; and where she and her baby can access support that is centred on their individual needs and circumstances so that their whole experience is positive and memorable.

We understand that the core requirements in achieving our ambitions are:

- To always listen to women and their families
- Improve safety, outcomes, and experience
- Grow, support, and retain our workforce.

To achieve our ambition we will:

Improve choice, personalised care and continuity of carer

South West London was a pioneer for the national maternity choice and personalisation programme. As a result of this programme, we have produced a booklet "My Maternity Journey" to around 20,000 women to help them to make informed choices about the care they would like to receive throughout their maternity journey. This booklet is given to all women with their booking appointment letter.

The booklet has recently been revised to include information about continuity of carer and guidance on co-sleeping. To reach a wider range of women (such as those with learning disabilities) we are developing an animated video to explain the maternity journey, which has also been translated into the 5 most widely spoken languages in South West London.

Every woman is offered the choice of where to have her baby (place of birth), hospital, birth centre or home, and this is discussed with the woman at regular periods throughout her pregnancy. We have also increased the number of women booked onto the continuity of carer pathway. This allows women to receive care from a small team of midwives during her pregnancy, enabling her to get to know them well and form a bond of trust.

We will also focus on supporting vulnerable women and families, as well as those from the most deprived areas, and identify and support with domestic abuse or other safeguarding risks.

NHS England set a target (in 2019) that at least 20% of women should be booked onto a continuity of carer pathway. In 2019, 23% of women in South West London were booked onto the pathway. This number has continued to increase each year and in 2022 50% of women were on the pathway.

Improve safety, outcomes and experience

All our maternity units follow the 'saving babies lives care bundle' guidelines which are designed to reduce stillbirths, neonatal deaths, maternal deaths, and brain injuries by 50% by 2025, and we are on track to meet the targets for all. The guidelines focus on five elements of care:

1. Reduce smoking in pregnancy,
2. Risk-assess foetal growth restriction,
3. Raise awareness of reduced foetal movement,
4. Deliver effective foetal monitoring during labour, and
5. Reducing preterm births.

To do this, we will:

- Support women to stop smoking during pregnancy. All women will be assessed for carbon monoxide at their antenatal appointments and will be referred for specialist support if needed.
- Focus on women with a high risk of having a baby with a low birth weight by monitoring growth throughout pregnancy. Staff will be trained to detect risks at the earliest opportunity.
- Increase education to support pregnant women to detect and report when they believe foetal movement has reduced.
- Detect and manage diabetes in pregnancy. All trusts have diabetic leads within maternity teams and continuity of carer will be developed to support women with gestational and pre-existing diabetes.
- Develop pre-conception care to support women and families to plan pregnancies as safely as possible.
- Detect and manage neonatal hypoglycaemia (low blood sugar). We will ensure all maternity and neonatal staff have received training to detect, manage and escalate when a baby's blood sugar has decreased significantly (low blood sugar in neonatal babies can result in poor neurodevelopmental outcomes).
- Ensure early recognition and management of deterioration of the woman and/or baby during labour and after the birth. We will ensure all maternity and neonatal staff have appropriate skills and drills training.
- Implement a standardised risk assessment to improve foetal monitoring whilst in labour.
- Monitor to enhance prediction, prevention, and preparation for pre-term births with a goal of reducing pre-term births from 8% to 6%.

Enhance postnatal care

To enhance postnatal care, we will:

- Review breastfeeding support available to women and identify key actions to increase breastfeeding rates and we will monitor the impact on the levels of obesity in children.
- Standardise our post-natal pathways across trusts to reduce the variation in care and guidance and improve outcomes for women and families.
- Implement services to provide postnatal physiotherapy and multi-disciplinary pelvic health clinics so that women are supported to return to physical health as soon as possible after birth.
- Implement the recommendations of the national postnatal framework.
- Expand access to perinatal mental health services so that over 700 more women receive support and care over the next five years. This will include rolling out maternity outreach clinics so that women can access antenatal and perinatal mental health care in one place by 2023/24.

Support maternal medicine networks

The network was set up in South West London to ensure that women with significant medical health issues receive appropriate care and access to advice throughout their pregnancy and beyond to improve their experiences and outcomes. The network also provides support and training for staff to improve the quality of care they provide.

Enhance pre-conception care

We are reviewing our opportunities to enhance pre-conception care. In addition to improving patient outcomes, this work will help address key health inequalities, such as maternal smoking and obesity and will empower our population to make healthier choices.

We are developing care pathways for women with complex long-term conditions, such as congenital heart disease, asthma, epilepsy, thalassemia, sickle cell and type 1 diabetes, who are planning to conceive, and we will align this with the maternal medicine networks so that these women are better supported during their pregnancies.

Ensure women can make informed choices and have personalised care plans

To ensure women can make informed choices and have personalised care plans, we will:

- Continually assess the impact our animated video is having, including translated versions, and build in any improvements that may be required.
- Review and develop the standardised personal care and support plan that records conversations about choices, giving women ownership of their plan, which is reviewed at each appointment.
- Engage with seldom heard communities via our patient involvement group, maternity voices partnership, and local community organisations to further improve services for these groups.
- Feed in the experiences of women from all our communities, especially Black, Asian and minority ethnic groups into the improvement of our maternity services.

Commit to grow and support our workforce

We will work collaboratively to develop and implement a plan that improves access to high-quality maternity care for all women, regardless of their background. By doing so, we can help ensure that mothers and their babies receive the care and support they need to have a healthy and positive birth experience.

To achieve this, we are working to enhance the capacity and wellbeing of our workforce, ensuring that our healthcare professionals have the skills and tools needed to deliver high-quality, compassionate care and that South West London is a great place to work.

Improve care and clinical outcomes

To improve care and clinical outcomes we will:

- Address the main causes of perinatal mortality and morbidity for babies from lack, Asian and mixed ethnic groups, alongside babies born to women in the most deprived areas. Ensure continuity of care for women from black, Asian and minority ethnic communities and from the most deprived groups.
- Provide a translation service when needed.
- Improve the prevention, identification, and treatment of ‘mild to moderate’ pelvic floor dysfunction following birth, and ultimately reduce the number of women living with pelvic floor dysfunction postnatally and in later life.
- Improve the quality of data we collect and utilise it to provide a safer service to women and families in South West London.

Monitor and learn to improve our services

We will monitor our services in a number of ways:

- Care Quality Commission (CQC) maternity annual survey
- Ockenden, Kirkup reviews - embed recommendations across South West London services
- Service user engagement - ensuring co-production of services and programmes with service users
- Ensure roll out of ‘baby buddy’ as a source of maternity information in South West London and measure its use
- ‘Birthrate plus’ and acuity tool - assessment of midwifery staffing establishment requirement in line with NICE guidelines and management of skill mix
- Implementing a training programme to upskill maternity support workers (MSWs) in line with HEE’s competency, education and career development framework.

Spotlight on long-term conditions

Long-term conditions, or chronic diseases, are conditions for which there is currently no cure, and which are managed with drugs and other treatment, for example: diabetes, COPD, arthritis, musculoskeletal issues (MSK), mental health conditions, and cardiovascular disease (CVD), and hypertension. Supporting people with long-term conditions to live healthier, more independent lives is a key priority for the ICB.

1 in 3 people
(about 500,000)

have been diagnosed with a long-term condition in South West London

About 25% of UK adults currently live with two or more long-term conditions

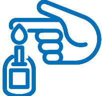
Most long-term conditions are less common in our residents compared to the rest of the country.

Out of 266k people in South West London that have either hypertension, diabetes, COPD or serious mental illness, 64 people have all four of these long-term conditions

Long-term conditions are more common in older people and more deprived people.

Pre Covid-19 in South West London:

- **161k** people had been diagnosed with hypertension
- **17k** people had been diagnosed with serious mental illness
- **19k** people had been diagnosed with chronic obstructive pulmonary disorder (COPD)
- **64k** people had been diagnosed with diabetes



There are more people with diabetes and hypertension (36k) that just diabetes (28k)

About 1/3 of people have a long-term condition that has not been diagnosed

Long-term conditions account for:

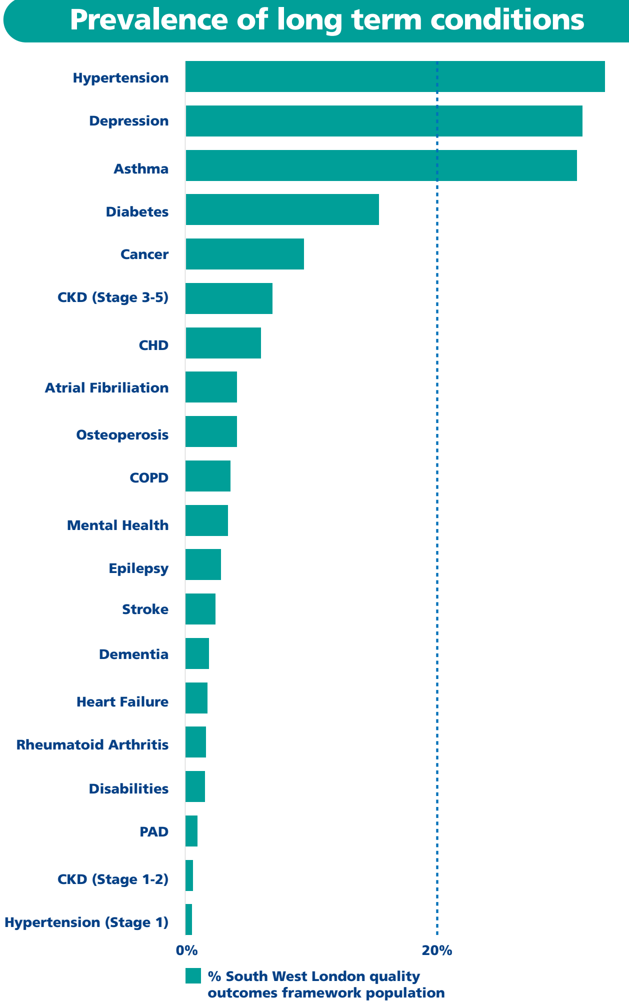
50% of all GP appointments

64% of all hospital outpatient appointments

70% of all hospital bed days

70% of health and care spend

Early detection and treatment of long term conditions reduces the risk of the condition worsening and a person needing to go to hospital.



People with a long-term condition living in deprived areas and from Black, Asian and minority ethnic communities have poorer outcomes, experience and access of health and care services, which was particularly highlighted by the Covid-19 pandemic. They use less primary care and prevention services and more emergency services. This is due to many factors: a lack of trust, a lack of appropriate education and information, lack of access, and services that are not personalised or developed for their needs. Transforming the way that we deliver services to ensure such inequalities are prevented is a priority.

Cardiovascular disease (CVD)

CVD affects the heart or blood vessels. CVD causes about 25% of deaths in the UK and costs about £7.4 billion per year. CVD is the largest cause of early death in deprived areas and the disease is more common in South Asian or African Caribbean people.

Early detection and treatment of high-risk conditions, such as hypertension (high blood pressure) and atrial fibrillation (an irregular heartbeat) are key to improving the health of people with CVD. In South West London, there are about 90,000 people with hypertension who are unaware of their condition. In addition to this, over 67,000 people with hypertension are not properly treated.

1 in 4 deaths in England are caused by CVD which equate to one death every four minutes.[6]

Respiratory diseases

Respiratory diseases, including asthma and chronic obstructive pulmonary disease (COPD), impact the lungs and cause breathing difficulties. These diseases affect one in five people and are the third biggest cause of death in England, costing the NHS about £4.9 billion. The Covid-19 pandemic had a negative impact on the identification or detection of respiratory disease,

One-third of people that go into hospital for COPD are unaware that they have the condition and are not receiving treatment.

6 Public Health England

Musculoskeletal (MSK) conditions

Musculoskeletal (MSK) conditions, such as low back pain and neck pain, is the greatest cause of disability. Over 28 million working days are lost due to MSK conditions every year in the UK and is the second largest cause of sickness absence in the UK for men and women. MSK conditions account for 30% of GP consultations in England.

Diabetes

People with diabetes, a serious condition where your blood glucose is too high, use a more healthcare services than people without diabetes. Over 73,000 people in South West London have diabetes and over 64,000 people have pre-diabetes. About one-third of South West London people with diabetes do not know that they have diabetes. The Office for Health Improvement and Disparities predicts that South West London will have a lot more diabetes patients in the future, approximately growing by 19% by 2030 and 28% by 2035. Diabetes care costs about 9-10% of the NHS budget, with 80% of this cost spent on treating unnecessary or preventable complications (Diabetes UK). Diabetes is more common in deprived areas and in South Asian or African Caribbean people.

People and communities tell us

The role of the voluntary and community sector in providing support services for people with a long-term condition, offering activities through social prescribing and developing trusted relationships with vulnerable communities is a common theme in all the feedback from communities.

To improve health and increase prevention or 'stay-well' activity (e.g., diet, exercise, lifestyle changes) people favoured group community activities and learning at affordable prices, peer support, mentors, and coaches. Improved and clear information for people and their carers was seen as key for people from these groups and conditions: diabetes, people with high cholesterol/ hypertension, long-covid, dementia, people who are bereaved.

Some people felt alone and unsupported in managing their long-term condition.

What mattered to people was staying physically and mental well, helping to maintain independence. Support that was found helpful included group activities at affordable prices, regular contact, support for carers, and help with confidence and independence at home and in the community. Some people said they favoured condition specific activities, e.g., a diabetes-specific supervised exercise class.

People said advice and information about support and activities need to be improved and easily accessible, and in different languages. For some conditions like Long Covid, people suggested online webinars with clinicians and digital information resources and local sources of peer support. Some people with long term conditions said travelling back and forth to regular and multiple appointments could be changed by online solutions.

Some people were supportive of specific self-help digital apps, such as 'Car Find' to help people living with dementia to locate their parked cars. Some concerns remained however that participants needed to own smartphones, and some people could be digitally excluded or need a technology package to match their needs.

Those on low incomes had more barriers to 'keeping-well' for example in buying healthier food, self-help equipment like blood pressure cuffs, and taking part in affordable activities.

Our ambition

We want to prevent or detect long term conditions early. If people do develop a long-term condition we want to reduce the risk of the condition worsening, and we want them to have the fewest avoidable hospitalisations and A&E attendances in the UK.

To achieve our ambition, we will shift focus from reactive disease-specific treatment to preventing sickness and proactive personalised wellness. We will be focused on the wellness of the population. We will:

- Help people to live healthier for longer, through equitable access to wellness or preventative services
- Work innovatively and collaboratively with local partners to maximise opportunities for preventing ill health, making best use of technology and community assets, and the implementation of best-practice prevention enablers.
- Use existing community networks to engage with people in high-risk, high-deprivation populations around what they require in terms of prevention, detection, and management of their long-term conditions.
- Embed the principles of personalised care in our approach to long-term conditions, ensuring:
  - Shared decision making
  - Personalised care and support planning
  - Enabling choice
  - Social prescribing and community-based support
  - Supported self-management.
- Improve equal access to quality prevention services to keep people healthier for longer. This will include education, self management, digital tools, physical activity, peer support, expert patient programmes, health coaching and other wellness services.
- Identify people with a long-term condition early
- Support patients to understand their long term condition(s) and how to manage it.
- Once identified or diagnosed with a long-term condition, deliver self-management and education programmes to help people to manage and stay healthier for longer.
- Deliver timely treatment to people for their condition, with regular check-ups to reduce the risk of needing hospital admission.
- Train proactive community healthcare teams that have the information and tools to keep patients healthy in the community. Community staff will have access to specialist support and wellness or prevention tools and services.
- Provide support and care in the community and significantly expanding patient access to group and peer support appointments.
- Build stronger relationships with local organisations in the voluntary and community sector to better support people living in high health risk.
- Build on our healthcare partnerships, such as with academics, industry partners and community pharmacy.

Spotlight on urgent and emergency care

Urgent and emergency care is the combination of GPs and other primary care services, emergency departments and ambulances, community and mental health services providing same-day or unplanned care. It accounts for more than 40% of the total spend in South West London.

Most urgent and same-day care is delivered by our GP practices and pharmacists. As our population increases, becomes older and the number of people with chronic conditions such as diabetes and heart disease rise, demand on services is increasing.

When our hospital beds are full, this affects the whole urgent and emergency care pathway for example people might have to wait a long time in an emergency department or ambulances being delayed at hospital.

In 2022, all our hospital beds have had patients in them almost all the time

Performance against the **4-hour A&E target** has been below the current 95% target throughout 2022, averaging 74%

600

On average **600 patients a month** have been seen in our 2-hour community response services in the last year. By far the majority of patients were over 65

The proportion of people waiting for a bed longer than four hours after they have been admitted to hospital ranges between

20% and 30%

34,000

There were 34,000 calls to 111 in South West London and the total volume is expected to reach around 50,000 a month by 2026

473

people in a hospital bed for longer than 21 days. This is just under one in four of our beds

400

At any one time there are around 400 people in hospital in South West London do not need to be there

In May 2022, 120 people waited longer than 12 hours for a mental health bed; and 90 of those waited longer than 24 hours

The number of people admitted to hospital urgently has exceeded our plans throughout the year. For instance, in January 2023 nearly **3000 more non-elective spells were recorded in our hospitals than we had planned**. This represents 15% more activity than expected

61,500 emergency department attendances a month. Of which 13% were admitted to hospital

700,000 primary care appointments of which 400,000 are face to face. While this represents the totality of primary care appointments, including chronic disease management, it demonstrates the level of community-based care provided. This number will reach more than 1 million per month by 2026 based on current trends

Each day on average

11%

of people in a hospital bed do not need to be there

Since 2018, urgent care in South West London has been under increasing pressure. We can see this mainly in the growth in the number of contacts that people are making with primary care and 111 services. Within our hospitals we have made significant changes to the way emergency departments (ED) work, with the introduction of comprehensive same day emergency care (SDEC)[7] services that account for around 25% of our non-elective capacity. These changes have reduced the number of patients seen in ED, but those patients that are seen in ED are sicker and need more care before they can be admitted to a bed or discharged.

The high level of pressure on the urgent care system impacts not just on patients, but also on our staff. It is vital for our population that we make sure our workforce is the right size, has the right support, skills and diversity to deliver the kind of urgent and emergency care that we need.

7. SDEC is the provision of same day care for emergency patients who would otherwise be admitted to hospital.

People and communities tell us

Praise for the care and kindness of staff in South West London Urgent and Emergency care services, particularly London ambulance staff.

There were variations in satisfaction with urgent and emergency care services for women, younger people, those from Black, Asian, and other ethnic minority backgrounds, and those with disabilities.

Some reports of reduced confidence in urgent and emergency care services, which was attributed to people's experiences of care, particularly waiting times, and the view that the NHS needed to invest in more staff. There were some concerns around staff not having the time to listen to people about their symptoms

Mental health 'crisis cafés', (Sutton as an example) reduced pressure on A&E for some service-users, who said they would otherwise have attended A&E. There was a desire to see those crisis services in the community expanded, particularly during weekends.

People valued GPs but waiting times for a GP appointment caused some people to look elsewhere for support, such as the A&E, or not to seek further support. Some people made the choice to go to A&E because they felt their injury was too serious to be seen outside of hospital, or they felt that because it was their child, they needed to be seen in hospital.

Some of the reports suggested the need for better communication and joining-up between NHS services to improve the urgent and emergency care experience, and that sharing patient-data between organisations, for example, pharmacies, GPs and GP hubs. could help this to happen.

Our ambition

Through partnerships between acute, community and mental health, primary care, social care and the voluntary sector, we want responsive urgent and emergency care services that are understood by local people and that provide more, and better, care in people's homes, gets ambulances to people more quickly when they need them, sees people faster when they go to hospital and helps people safely leave hospital having received the care they need.

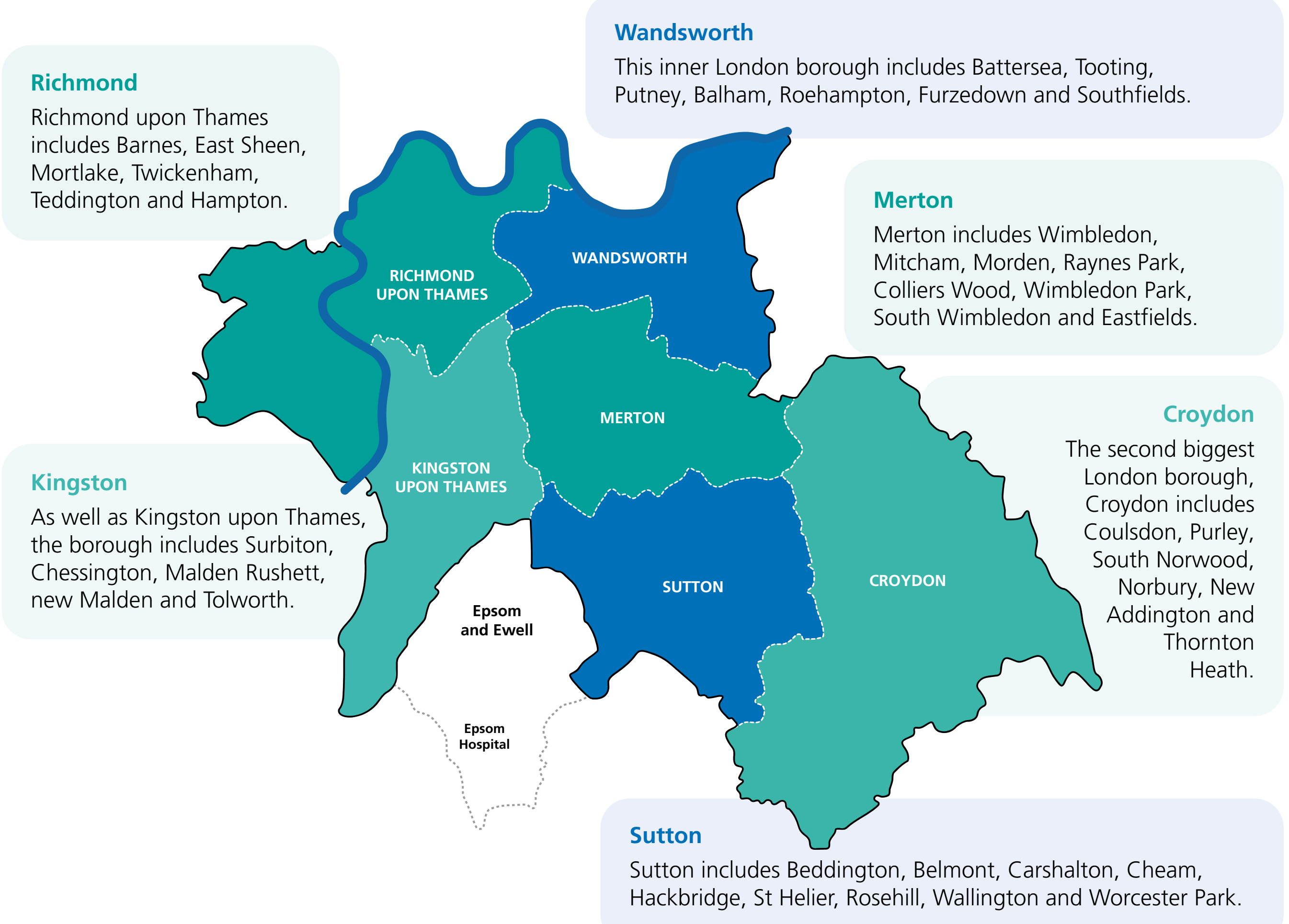
To do this we will:

- **Create a simple and accessible integrated urgent care offer, with primary care as its central pillar**
  - Building on the connection and trust between a person and their GP practice or primary care network.
  - Ensuring our 111 service works ever more closely with primary care and that the people working in primary care have the support services they need to call on, such as urgent community services, access to diagnostics or referrals into same-day emergency care services.
- **Create a single 'front door' so that patients know how to access urgent and emergency care in person, by phone and online.**
  - Making it easy for people to get the right care regardless of where they call or turn up.
  - Building and promoting the use our 111 service so that it is increasingly known and trusted and making it easier for 999 and 111 services to work together so we can use our resources wisely.
  - Increasing the number of senior clinicians working in 111 and 999 so that more people can be dealt with on the phone or by video call.
  - Using digital integration to make it easier for services such as emergency department or 111 to book an appointment in the most appropriate place based on the urgency of their condition.
- **Create a resilient and flexible urgent and emergency care workforce that are able to deliver high quality and innovative care.**
  - Completing detailed workforce planning and develop a clear plan to recruit, retain and develop staff.
  - Creating a clinical network to support our urgent and emergency care clinical leaders across South West London.
  - Developing a clearer understanding of what support people working in urgent and emergency care services need, building a health and wellbeing offer that is tailored to staff working in this high paced environment.
  - Thinking differently about how to recruit and retain staff – for instance by developing innovative training and apprenticeship programmes and implement new ways of working such as rotational staffing models.
- **Timely patient flow through the system**
  - Eliminating waiting across the system - from patients waiting for an ambulance all the way through to people waiting to go home.
  - Working with partners to create the workforce and beds in the community that mean people can go home as soon as they are ready. As part of this we will expand our virtual wards scheme, so that patients can continue to receive the nursing and clinical oversight in their own home.
  - Working with our provider community to optimise patient pathways, increasing the ability of our teams to discharge people earlier in the day and at weekends.
  - Aiming to reduce our bed occupancy to an average of 85% over the next five years.
- **Build our urgent and emergency care services with patient experience at its centre.**
  - Actively seeking out people and groups to help us design our emergency and urgent care services.
  - Bringing our patients together with our staff to help co-create pathways that make sense to our population.
  - Helping people understand urgent and emergency care services so that they can access the right care when they need it.

Part Five: Working together at place

We are clear that the key to health and care improvement lies in each of our six borough partnerships who work together to address the health and care needs of local people. Recently, local health and care partners refreshed local health and care plans to set their joint work programmes for the next two years. These local health and care plans form the foundation of our five-year South West London Joint Forward Plan.

Our local place-based partnerships bring together the NHS, local authorities, Healthwatch, voluntary and community sector organisations and local residents to work together to understand and meet local health and well-being needs. Our six places in South West London are the same borough boundaries as our six local authorities.



We want to make sure that our Joint Forward Plan takes proper account of local health and wellbeing strategies and therefore are asking each of the six health and well-being boards what they would like the joint forward plan to include from local health and well-being strategies.

Feedback from health and wellbeing boards will be summarised in this section of the final plan and we will work with chapter and place leads to reflect the requirements of the health and wellbeing boards as we develop our actions and finalise our plan in June.

Part Six: Workforce

To deliver the ambitions and actions in our Joint Forward Plan, we are critically dependant on our people and the way they work. We will need to work in a more integrated way, making sure that our people are supported to have more flexible careers, a better work-life balance, and that we have the right numbers of people with the right skills to meet the changing needs of our populations.

34,000

People are employed in the NHS in South West London. We are also supported by a large number of volunteers, voluntary sector organisations and carers

10%

of staff work in a primary care setting.

42 years

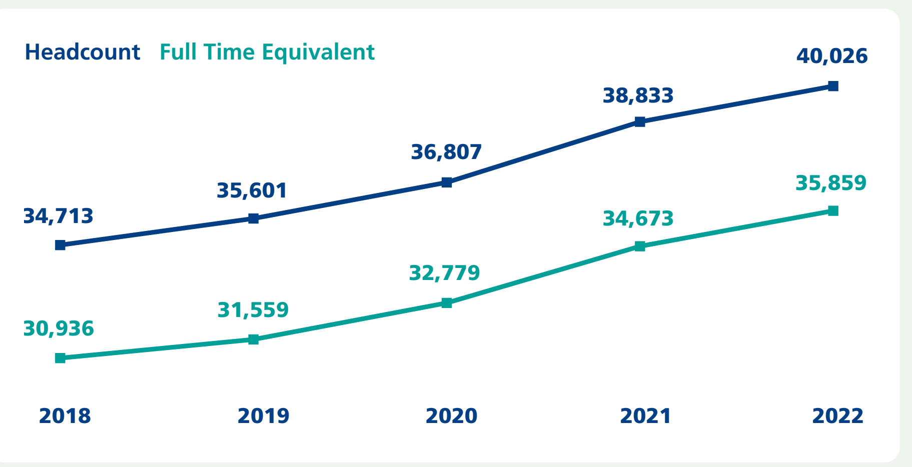
the average age of our staff.

16.3%

of our staff are over the age of 55

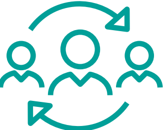
Total Workforce

This chart shows the increase in primary, secondary workforce overtime. Overall, primary and secondary care have grown by the percentages indicated



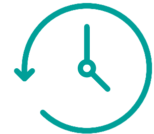
16.5%

of our staff leave South West London each year



Staff

one of the highest turnover rate is seen in those under the age of 35



6.2 years

the average length of service (less than it was in 2018) – for under 35 years it is 2.3 years

£11.7m

As large employers, we have an apprenticeship levy to spend on apprenticeship training which we do not always fully use

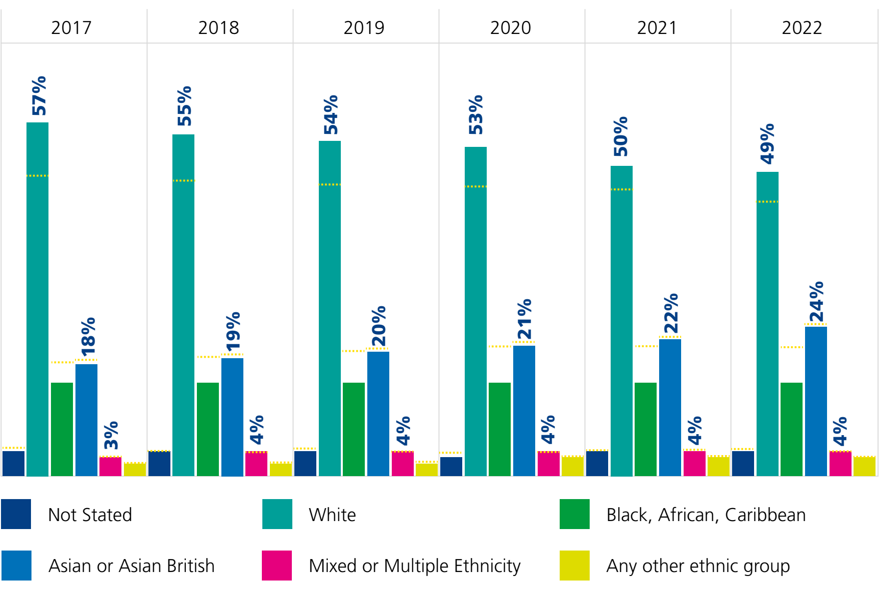
In common with the rest of the London, the following posts are the most difficult to recruit to:

- Medical specialists in emergency medicine
- Clinical radiologists
- Medical specialists in paediatrics
- Midwives
- Psychiatrists
- Occupational therapists
- Nurses across all sectors
- Physiotherapists
- Speech and language therapists
- Diagnostic radiographer

Top reasons why our staff leave South West London

- Fixed term contract ending
- Work-life balance
- Relocation
- Promotion
- Retirement

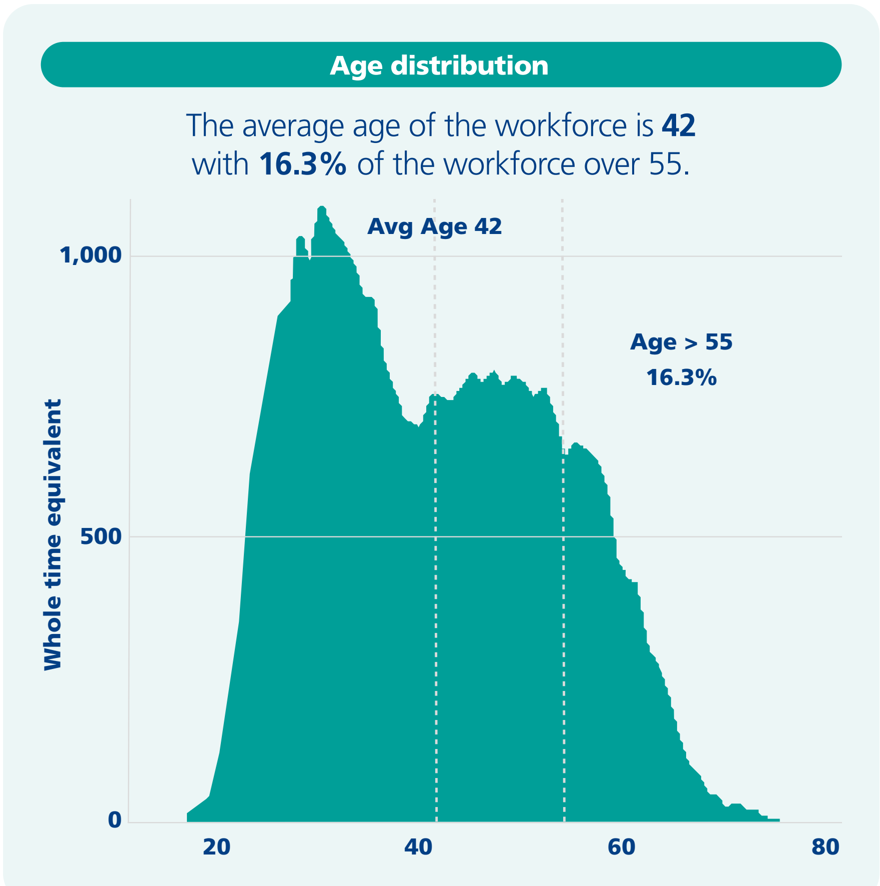
Ethnicity of our workforce over the years. Percentage split by ethnicity, by year. Dotted line shows regional average.



We have seen changes in the ethnicity of our staff over the last few years. In 2022, staff who identify as white make up 49% of our workforce (57% in 2017). Asian or Asian British staff make up 24% of our workforce, up from 18% in 2017.

Staff who identify as white make up the majority of the workforce in roles band 7 and above.

- **Band 7:** 61% • **Bands 8 A-D:** 67% • **Band 9:** 79%

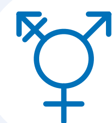


In work poverty is increasing,with more people in employment claiming universal credit

Nursing and midwifery

13%
Growth in nursing and midwifery staff since Dec 2018 up by 1,066 posts

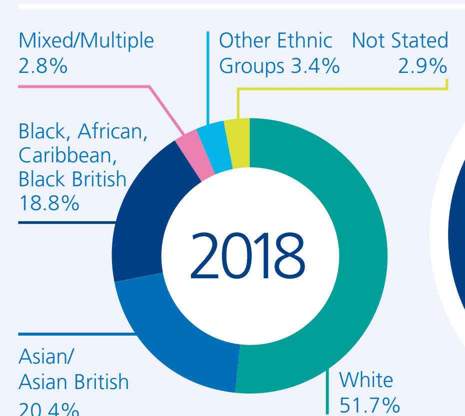
42 Years
Average age



88%
of nursing and midwifery staff are female

18.3%
Band 5s have the highest turnover

18.9%
Of nurses over the age of 55 left South West London in 2022



Ethnicity

The profile of nurses in South West London between 2018 and 2022 has changed as follows:

Mixed/Multiple 2.9%
Other Ethnic Groups 3.0%
Not Stated 2.6%
Black, African, Caribbean, Black British 21.5%
2022
Asian/ Asian British 29.7%
White 40.3%

The highest turnover in nursing and midwifery is those over 55

Allied health professionals (AHP)

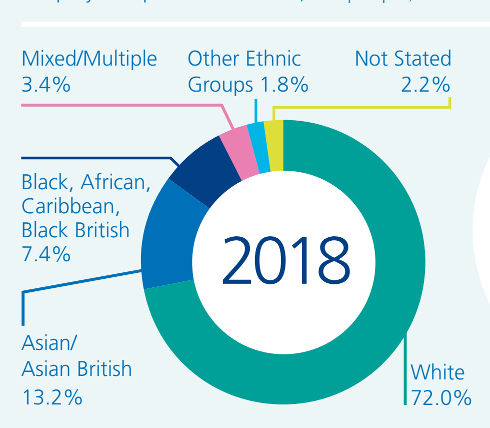
14%
Growth in Allied Health Professionals (AHP) since Dec 2018 up by 294 posts

14 **Professions**
Make up our AHP workforce and the third largest workforce in South West London (over 4,000 people) in total

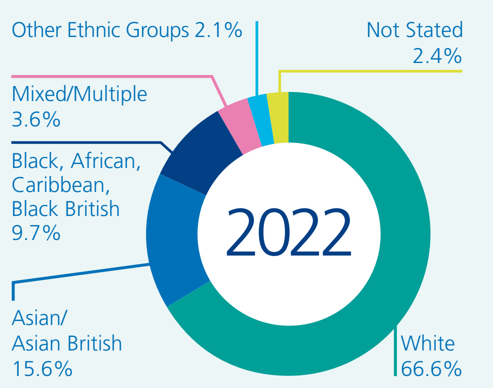
39 **Years**
Average age of AHPs with over 8% over the age of 55

80%
of South West London AHP staff are female – down from 82% in 2017

Turnover
15.4%
Physio **23.4%**
Occupational therapists **24.9%**



Ethnicity has also changed within this reference period:



Medical staff

Consultants

12% Growth in consultants since Dec 2018 to whole time equivalent 188

48 Years Average age of a consultant

54% Male

7.3% Of our consultants leave

9.7% Of medical staff over 55 years old leave

6.6% Of medical staff Under 55 years old leave

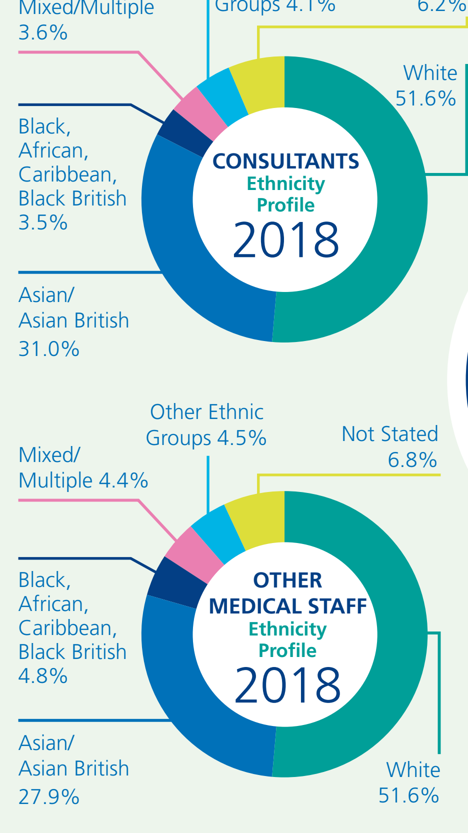
Junior doctors

16% growth In all other medical staff since Dec 2018 up by 351 posts

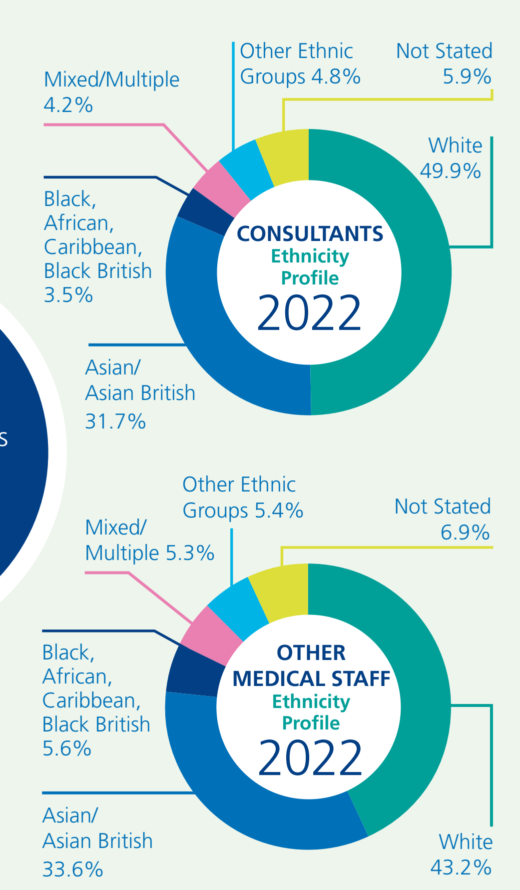
34 Years Average age of all other doctors

56% Female

Medical staff – Ethnicity



When looking at the medical workforce across South West London we find that:



General practice surgery

39
Primary care networks covering South West London

46 Years
Average age

994 GPs
Across South West London

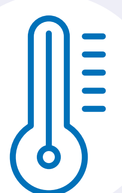
63.7%
of GPs are female

More people providing direct care

Paramedics | Pharmacies | Social Prescribers

From 180 at the end of 2019/20 to 560 by September 2023

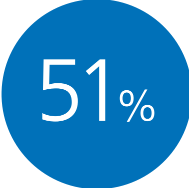
Sickness rates in South West London



Sickness in South West London trusts range from

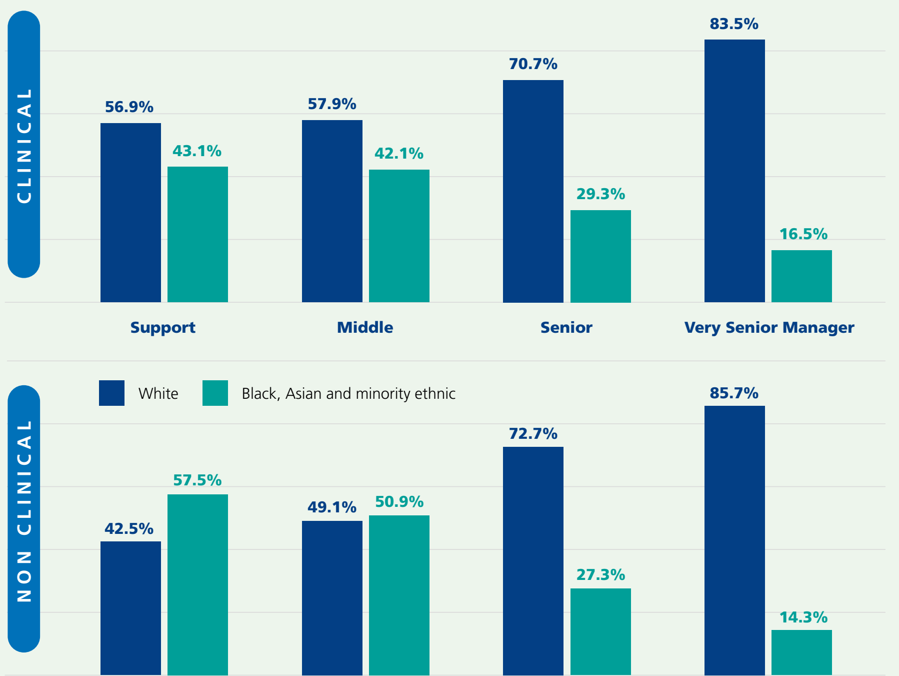
3.6% to 5.9%

Diversity and workforce race equality



Black and ethnic minority staff make up **51%** of the workforce compared with **49.9%** in London

Black and ethnic minority staff are **1.7 times** more likely to be subject to disciplinary action than white staff, a slight decrease from 1.87 previously



Black and ethnic minority staff are significantly under represented in senior leadership roles with over **80%** of very senior manager roles filled by white staff

Support (Bands 1-4),
Middle (Bands 5-7),
Senior (Bands 8a-9),
VSM (very senior managers)

Our big workforce challenges

Similar to other parts of the health and care system nationally, South West London has a number of workforce challenges, our top six are:

- **Recruitment and retention** – securing a strong supply of new people to fill our vacancies whilst retaining our experienced staff.
- **Planning our workforce of the future** – improving our data and structure for workforce planning activities. Enhancing our ability to collect, see and interrogate data. This, together with understand the changing needs our patients is required for effective workforce planning and service redesign.
- **Diversity and Equality** – We are not yet representative of the communities we serve and have issues raised through Workplace Race Equality that we need to urgently address.
- **The cost of living in London** with people choosing to leave South West London and/or the NHS to increase their salaries, or move to less expensive areas to help meet the rising cost of living.
- **Proving better care for our people** – supporting their health and wellbeing.
- **Improving morale of our people** – increasing flexible working options, supporting their recovery from the pandemic.

People and communities tell us

Patients and local people have told us:

They would like compassionate treatment from staff who care

Staff shortages and pressurized environments can often mean some staff don't have the time to listen or consider patients specific needs, or backgrounds e.g., ethnicity, people with dementia, people with mental health issues, neurodiverse people, trans people

In some communities, particularly Black, Asian and minority ethnic communities, there is mistrust and fear about using NHS services due to experiences of racism from NHS/public services from within those communities.

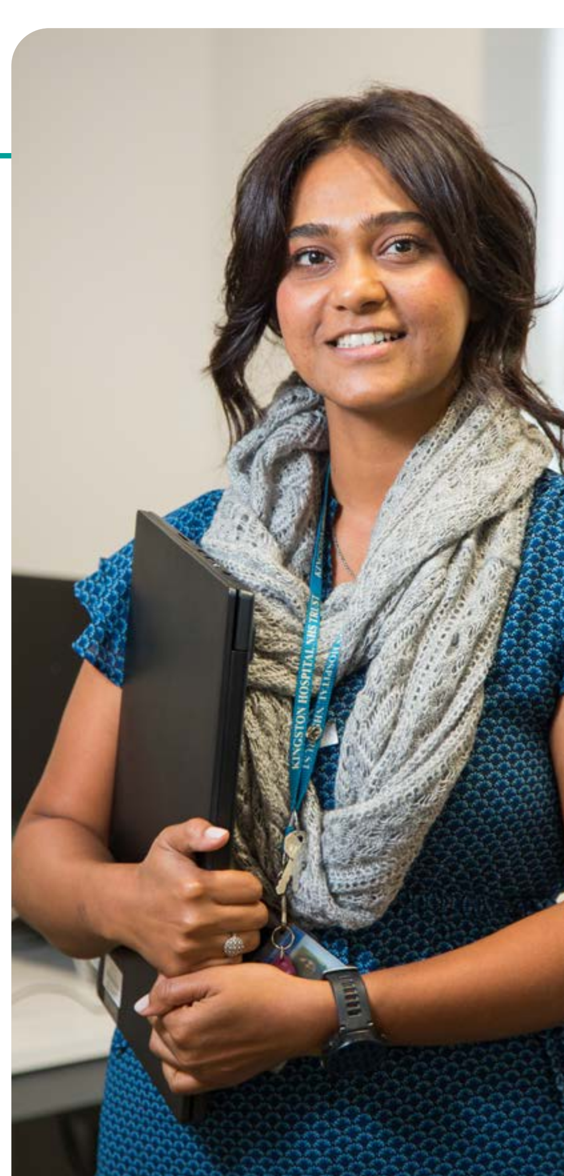
Patients with long-term conditions would like to be recognised as experts in their condition as many have lived with i llness for years. Patients are keen to be 'partners' with clinicians around their care plans and decision-making.

Our ambition

We want South West London to be a great place to work. A place where our people have fulfilling jobs which recognise their contributions. We want everyone to be supported by great managers who respect, listen and care for them so that they in turn can do their very best every day. We want to make South West London a magnet employer so that our supply outweighs our vacancies. We want to be a fair, non-discriminatory NHS that is representative of the communities we serve.

To meet this ambition, we will:

- Think differently about how we design and recruit to vacancies
- Support our people to develop so that they do not have to leave South West London to grow
- Use digital technologies to create more capacity for our people so that they have more time to care
- Create centres of excellence, supported by the latest technology to simplify and speed up what we do
- Invest in our managers so that they have the skills they need to perform at the highest standard and get the very best from their jobs
- Support staff with the cost of living including expanding our range of non-pay and other benefits
- Support the health and wellbeing of our people by continuing to develop our services and support
- Work to become fully representative of the communities we serve and help local people into employment
- Create psychological safety in all South West London NHS organisations so that people can speak up without fear so that we improve what we do



Part Seven: Our green plan

In October 2020, a new strategy, 'delivering a net zero National Health Service', was published by the greener NHS national programme. It outlines that "The climate emergency is a health emergency. Climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS'. It explains that 'the situation is getting worse, with nine out of the 10 hottest years on record occurring in the last decade and almost 900 people killed by heatwaves in England in 2019. Without accelerated action there will be increases in the intensity of heatwaves, more frequent storms and flooding, and increased spread of infectious diseases …'

It goes on to say that 'over the last 10 years, the NHS has taken notable steps to reduce its impact on climate change. As the biggest employer in this country, there is more that the NHS can do. Action must not only cut NHS emissions, currently equivalent to 4% of England's total carbon footprint, but also build adaptive capacity and resilience into the way care is provided. This action will lead to direct benefit for patients, with research suggesting that up to one-third of new asthma cases might be avoided as a result of efforts to cut emissions. This is because the drivers of climate change are also the drivers of ill health and health inequalities. For example, the combustion of fossil fuels is the primary contributor to deaths in the UK from air pollution, disproportionately affecting deprived and vulnerable communities.'

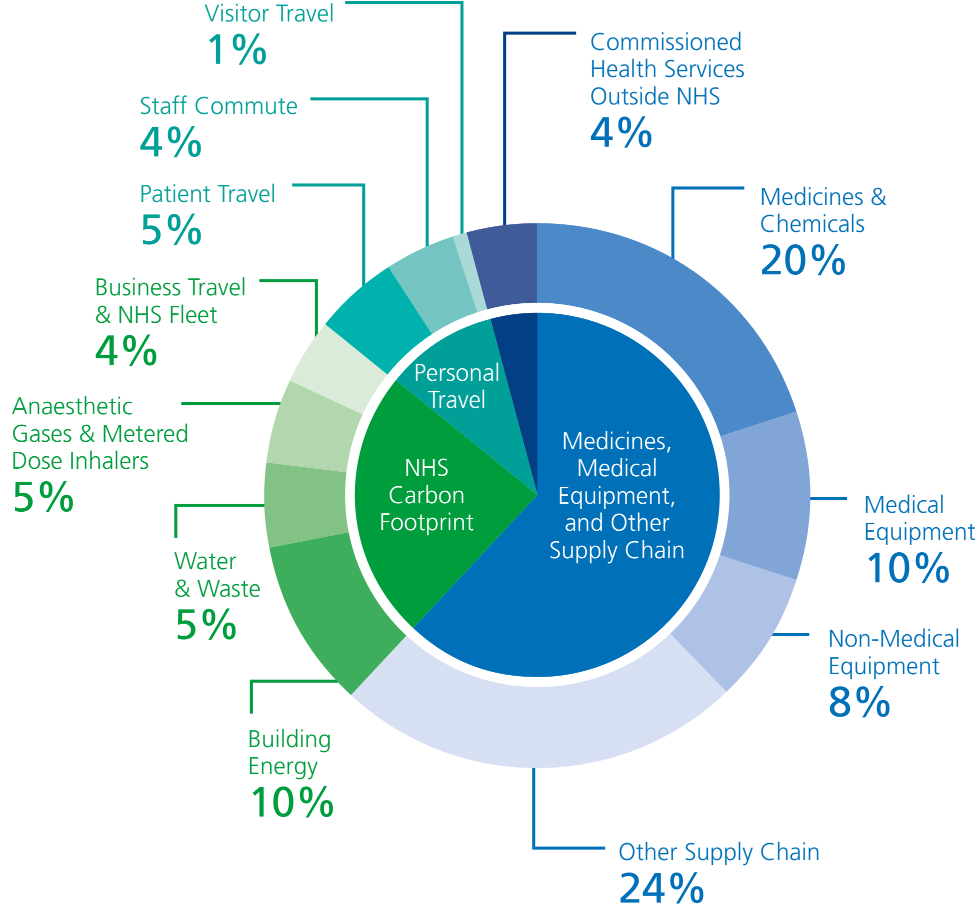


Figure above: Sources of carbon emissions by proportion of the NHS Carbon Footprint Plus

In South West London we have been working together on the green agenda for some time. Our trusts have made tremendous progress, the list below summarises some of our key achievements to date:

All trusts have **Green Plans in place** that support the NET zero strategy

All trusts well **below national desflurane reduction target**

Numerous **sustainability days and awareness campaigns successfully completed**

Surgical instrument recycling processes introduced

Electrical vehicle charger infrastructure projects implemented and underway

UK's first carbon neutral patient menu introduced by a South West London trust

Heat decarbonisation projects initiated across trusts

Switch to **renewable energy** across trust sites

Carbon neutral food suppliers introduced

Electric fleet introduced across trusts

Safe re-usable theatre equipment practices introduced

Created **green spaces** and increased plant biodiversity at trust sites

Cycle to work and active travel incentive schemes in place

Digital appointments increased, with some trusts exceeding national targets

Nitrous oxide waste reduction plans initiated with leak tests complete on all sites

All trusts now have **carbon footprint calculations**

Solar panel installations underway trust sites

MDI recycling points setup, awareness schemes initiated to switch use

All trusts have **switched to recycled paper**

LED lighting transition projects underway

People and communities tell us

Many people said that what they valued most about where they lived, were the green space and parks.

Open spaces and green parks were felt to improve mental and physical wellbeing and create spaces for communities to thrive.

Litter and antisocial behaviour were highlighted as reducing the enjoyment of these spaces.

Traffic and air pollution were key negative aspects of the local environment and seen as barriers to healthier living. Reducing traffic was seen as being the main way to improve air quality.

People said there was not enough emphasis on the role of walking and cycling as health determinants, given the positive impact on health. They felt 'active travel' has the potential to tackle obesity, increase exercise levels, reduce local air pollution, and has mental health benefits.

Our ambition

For the emissions we control directly (the NHS carbon footprint), we want to be net zero by 2040, achieving an 80% reduction during 2028 to 2032; and for the emissions we can influence (our NHS Carbon Footprint Plus), we want to be net zero by 2045, achieving an 80% reduction during 2036 to 2039. To this we will:

- **Embed sustainability into our culture:** If we are to be successful in changing our behaviours and operations sustainability needs to a part of everything that we do.
- **Make it easier for our partners to collaborate, share information and best practice:** in order to learn from and support one another in moving towards and championing our common net zero goals. We have launched a "greener South West London" digital portal to support our partners to make contact with one another and coordinate green plan activities.
- **Work across organisational boundaries:** We will increase the scope of our activities and reach out across to primary care, local authority and other partners that were not with us at the start of our journey
- **Develop leadership and staff pledges** so that we are all working to the same goals.
- **Use only recycled paper in South West London** and reduce total paper usage year-on year.
- **Create recycling points for metered-dose inhalers in all GP surgeries and community pharmacies,** and ensure guidance on appropriate inhaler usage is clear and helps reduce prescriptions for these products
- **Cut out all nitrous oxide** wastage/ leakage by 2023
- **Keep desflurane usage to below 3%** in 2022
- **Go electric for patient, inter-site and courier transport** by 2027
- **Reduce carbon emissions from buildings** by 20% by 2025

In order to achieve these priorities, we have developed our areas of focus for the next five years:

Workforce and leadership: Ensuring we engage all staff within the Integrated Care Partnership to create a 'guiding coalition' of passionate and engaged people that will help us to change the way in which we work and embed sustainability into everything we do.

Sustainable models of care: Ensuring that current and future models of care take into account their impact on people and the planet and have overall improvement of public health at their heart.

Digital transformation: Utilising technology to streamline health and care, whilst reducing its associated cost and carbon emissions.

Travel and transport: Reducing our carbon emissions from staff, patient, visitor and supplier transport.

Food and nutrition: Promoting sustainable and healthy diets and reducing food waste.

Estates and facilities: Reducing our carbon emissions from our buildings.

Supply chain and procurement: Decreasing our supply chain emissions and developing more sustainable procurement practices across the NHS in South West London.

Medicines: Reducing desflurane usage aligned to guidance and national targets, reducing nitrous oxide waste across the system, and supporting patient choice of less carbon-intensive inhalers where clinically appropriate.

Adaptation: Working together across our infrastructure and supply chains to prevent and minimise the impact of climate change on our services, patients, staff and communities.

Data: Enabling us to better understand our carbon data and track our progress.

Part Eight: Digital, data and population health management

Our digital strategy outlines how digital transformation will support improved care, efficiency, and the delivery of integrated care. This includes promoting the health and wellbeing of our population and ensuring people are able to live independently at home, for as long as possible. Our work is driven through strong leadership, robust governance, a people-centred approach, and focuses on the five priorities included within our digital 'north star'.

Our first digital priority is to establish a strong foundation of **digital infrastructure** for South West London, as the basis for our **shared care record** that provides our health and care professionals with a complete patient care history to assist better clinical decision making. Building on this structured patient data allows the creation of a **population health platform** that delivers sophisticated analytics and insights and supports increased access to data and information to enable transformation of care through a population health management (PHM) approach.

With the NHS app as the single point of access, our patients will be able to view and enter information into their care records using a **personal health care record**. This further complements the richness of the South West London shared care record and population health platform, ensuring improved care delivery and outcomes for South West London patients.

Through embracing **digital innovation**, we will ensure that we are at the forefront of digital delivery, continually improving our digital capability by making the best use of the latest technology, supplier skills and expert knowledge base.

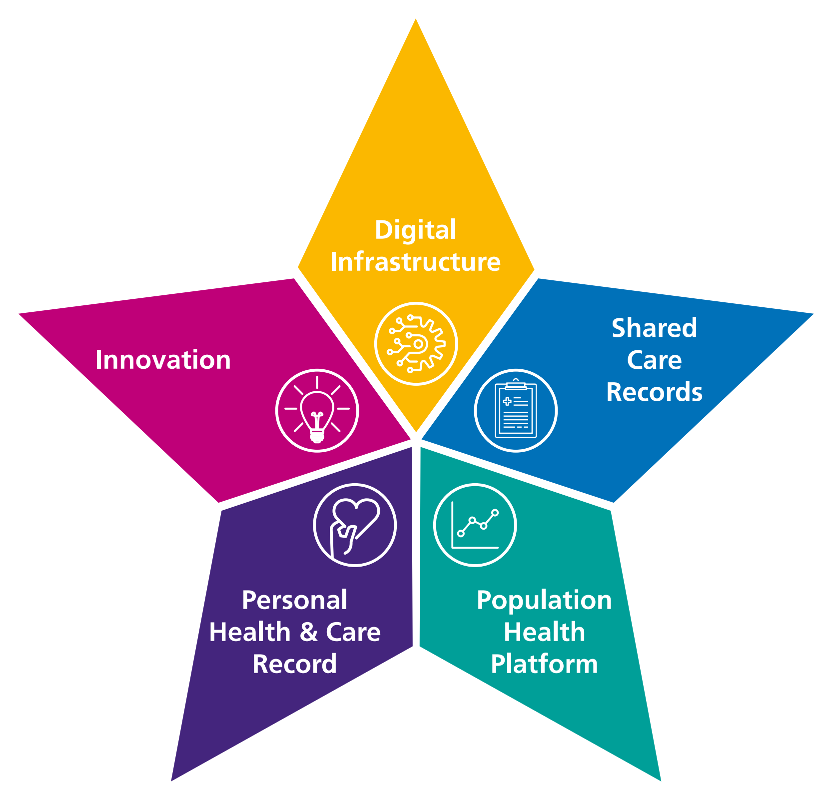


Figure 1: Our digital 'north star' encapsulating our five digital priorities

Over the last two years, South West London has invested in technology to support people in their preferred place of care. Delivering virtual care out of hospital was essential during the Covid-19 pandemic. This virtual care included delivering remote monitoring, a method to measure a person's vital signs in the comfort of their own home, as a part of the virtual ward programme. Supporting virtual care will continue to be a priority for digital services over the years ahead.

Some of our immediate priorities are:

Project ID and Title	Description
Electronic patient record levelling up (Epsom & St. Helier and SWL St Georges)	NHS England frontline digitisation funds for FY2022/23 to migrate Epsom & St. Helier onto the St. George's Cerner system.
ICS digital infrastructure maturity assessment (DMA)	Creation of a baseline for infrastructure using the infrastructure adoption model (INFRAM), supporting what good looks like, the 2023/24 planning guidance, corporate services improvement opportunities and future DMAs.
ICB digital cyber maturity assessment	Creation of a baseline for cyber to understand ICB-level risks and investment prioritisation, supporting what good looks like, the 2023/24 planning guidance, corporate services improvement opportunities and future DMAs
Electronic patient record 10-year roadmap and planning for re-procurement	Creating a forward plan for electronic patient record systems within the ICB.
ICB system intelligence and data strategy development	Creation of a system intelligence strategy and plan. Implementation of quick wins.

We recognise the need for the development of the right infrastructure to support access and use of data as well as the wider system requirements, such as workforce, finance, quality, and performance planning. This includes increasing access, use and content of health insights (a knowledge base available to our staff to access a range of data sets and analysis to support patient care).

We have created a three-year digital transformation investment plan following engagement with health and care organisations across South West London. We are now able to identify where opportunities lie for acceleration of proven technology and where we need to invest to achieve core levels of by 2025.

The creation of integrated care systems has presented an opportunity to create an aligned approach to improving population health across South West London allowing us to review our local and system priorities and to use the increasingly rich data available to target those in our communities with the greatest need using a population health management (PHM) approach.

Using population health management to improve health and care

Population health management (PHM) is a way of working to help our frontline teams understand current health and care needs and predict what local people will need in the future. It uses historical and current data to understand what factors are driving poor outcomes in different population groups. Using PHM means that we can tailor better care and support for people, design more proactive, joined-up and sustainable health and care services, which make better use of our resources, and improve health and wellbeing now as well as in the future.

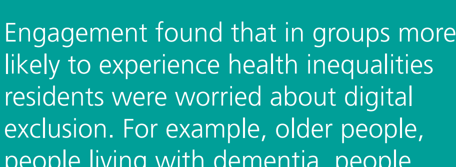
We have been building our PHM capability. In 2021 we took part in a national development programme which enabled us to set up population health management pilots locally that focused on looking at population health management data (data and intelligence). As a result of these pilots, health and care professionals were given valuable insights in a digested format and identified nearly 7,000 people, in either primary care networks or our places, by looking at and analysing the data and information available and worked with them to create and design interventions that helped improve their outcomes.

During 2022, we engaged with our partners from across South West London to listen and identify examples of good practice, valuable resources, and appetite to use PHM, capturing the variety of development needs. This included ICS partners from primary care networks (PCNs), local authority and borough partners, NHS acute and community services and provider collaboratives, and mental health trusts. This stocktake enabled us to set out the steps we need to take together to create the capability and capacity to use our collective resources more effectively, to add most value to our population and tackle inequity. Our population health management roadmap outlines the steps.

People and communities tell us

Feedback showed that digital engagement has increased following the pandemic and lockdowns. NHS and council websites were trusted sources for information. Internet use was high among many residents, with smartphones the most popular way to get online.

Across the engagement reports, digital apps, websites, online community meetings and appointments have helped to deliver health and care services. Some people were supportive of specific self-help digital apps, such pregnancy related apps to help people through their maternity journey, 'Car Find' to help people living with dementia to locate their parked cars, 'Brain in Hand' and 'AutonoMe' apps for people with learning disabilities, a pelvic health app and an emotional wellbeing app for teenage and young adult cancer patients.



Engagement found that in groups more likely to experience health inequalities residents were worried about digital exclusion. For example, older people, people living with dementia, people

with a learning disability, people with autism, people with sight loss, and people for whom English is not their first language. While younger people were usually more confident to access digital healthcare, reports found a variance in willingness, ability, and confidence to use digital services and a continuing demand for face-to-face appointments. More generally only among those aged 75 and over, does internet use start to decrease.

Digital exclusion increasingly now means social exclusion as well as difficulty accessing services. People told us that overcoming this was about more than having community spaces for support, and the training to gain skills; many people also needed financial support for IT equipment or needed a technology package to match their needs.

Engagement also highlighted the potential of improved IT to provide better continuity of care and co-ordination between services, examples of feedback are from frailty services, the London Ambulance Service, Urology pathway.

Our ambition

Digital technology is now a significant part of our everyday lives. We want to use that technology to change the way we deliver services, providing faster, safer, more convenient care and supporting patients to self-care. Through our use of technology, we want to make the jobs of our clinicians and staff easier and improve productivity and patient outcomes. Recognising that not everyone can or wants to engage with the NHS digitally, we will continue to offer a range of ways in which people can receive care and support, and interact with us. To achieve this, we will:

- Create a single. end-to-end health and care record that our staff and patients can access and use.
- Make better information available at the point of care for patients and our clinicians so that they can make more informed decisions about care.
- Give people the information and tools they need to support them to self-care, including self-care applications that interact with their health and care record, and support people to be cared for in their preferred place of care.
- Use digital transformation to support the mobility of patients and staff across multiple settings and organisations
- Continue to work with partners to improve data quality
- Promote innovation that supports patients and workforce, whilst addressing digital inequalities and exclusion by continuing to offer a range of ways in which people can receive care and support and interact with the NHS.
- Create additional workforce capacity thought the use of using digital technology
- Connect technology in people's homes and support the continued development of virtual care.
- Implement our digital investment fund
- Create a joined-up platform to enable staff to access the systems they need, wherever they are and reduce bureaucracy and frustration often felt by our frontline line staff through digitalised solutions.
- Develop a data strategy to improve how we capture and use data, moving from a reactive way of using data to a proactive one, improve analysis and insights, and create a consolidated view of data across the ICB.
- Create a system-wide intelligence hub to join up data and information more effectively, remove duplication and help deliver better patient care.
- Improve our analytical skills and capability to make better use of all the data available, using the intelligence and insight gained to improve the outcomes for patients.
- Develop our digital workforce so we have the right people with the right skills to propel digital acceleration and transformation across the system. In addition to our digital specialists, we will develop the digital capabilities and skills of all our people.
- Deliver the actions in PHM roadmap particularly those relating to data, information, and the system wide intelligence hub.

Part Nine: Quality and safety

Improving quality is about making health care safe, effective, patient-centred, timely, efficient and equitable[8]. In South West London we will work together across our organisations to deliver quality improvement, embedded in a patient safety culture, so that we improve care, avoid harm and improve the experience of those who access care.

The quality picture in South West London

Areas where we are improving

- Access – There has been an increase in the hours that childhood and adolescent mental health service (CAMHS) support is available in all emergency departments (ED) across the system. Children and young adults can now access mental health care in ED from 09:00 to 22:00 hours every day.
- Never events are below the London average and serious incidents are below average at 9% in South West London.
- Over 95% reduction in continuing healthcare overdue assessments.
- General reduction in complaints across our hospital, community, and mental health services. However, rates of patients recommending our A&E services using the family and friends test have decreased due to poor patient experience.
- Out of 173 GP practices, there are seven that are rated by the CQC as 'requires improvement'. Two of those practices were re-inspected and ratings improved to 'good'
- The majority of South West London providers are rated good by the Care Quality Commission (CQC):

Trust CQC ratings as of 2 March 2023

- Amber - requires improvement
- Green - good
- Star - Outstanding

Organisation Name	Inspection Category	Publication Date	Overall	Safe	Effective	Caring	Responsive	Well Led	Maternity	Combined quality	Use of resources
Central London Community Healthcare NHS Trust (community services)	Community Health NHS and independent	15.06.20	Green	Green	Green	Green	Green	Green			
Croydon Health Services NHS Trust	Acute Hospital NHS non Specialist	22.02.23	Amber	Amber	Amber	Amber	Amber	Amber	Green	Amber	Amber
Epsom and St Helier University Hospitals NHS Trust	Acute Hospital NHS non Specialist	19.09.19	Green	Amber	Green	Green	Green	Green	Green	Green	Green
Hounslow and Richmond Community Healthcare NHS Trust - Hounslow	Community Health NHS and Independent	19.10.18	Green	Green	Green	Green	Green	Green			
Kingston Hospital NHS Foundation Trust	Acute Hospital NHS non Specialist	14.12.22	Star	Green	Green	Star	Green	Star	Green		
South West London and St George's Mental Health NHS Trust	Acute Hospital NHS Specialist	20.12.19	Green	Green	Green	Green	Green	Green			
St George's University Hospitals NHS Foundation Trust	Acute Hospital NHS non Specialist	18.12.19	Amber	Amber	Amber	Green	Amber	Amber	Green	Amber	Amber
The Royal Marsden NHS Foundation Trust (community services)	Acute Hospital NHS Specialist	16.01.20	Star	Green	Star	Star	Star	Star			

8. The Health Foundation 'Quality improvement made simple'.

Areas where we need to improve (data as of January 2023)

- Due to paediatrician capacity in the community, this has impacted on timeliness of statutory assessments with initial health assessments for our **children looked after** dropping from 46% to 39% compared to previous year and review health assessments from 97% to 85% compared to previous year
- **Hospital related falls** across South West London increased by 2%
- **Hospital acquired infections** have increased against annual thresholds across South West London especially e-coli, (7%) and c.difficile (13.5%)

We have implemented the six principles set by the NHS. Our quality strategy outlines how we will continue to build upon them and implement our local quality priorities to continuously improve quality of care for the people of South West London.

A designated executive clinical need for quality

Population focused vision: Clear vision and credible strategy to deliver quality improvement across the ICS, to deliver care that is high-quality, personalised and equitable

Co-production with people using services, public and staff - **A defined governance and escalation process in place for quality oversight**

Clear and transparent decision-making - **An agreed way to measure quality, including safety, using key quality indicators**

Timely and transparent information sharing - A defined way to engage and share intelligence on quality, including safety - **at least quarterly and delivered through a system quality group**

Subsidiary - A defined approach for the transfer and retention of legacy organisation information on quality in accordance with the Caldicott principles

Our ambition

We want high-quality, personalised and equitable care for all, now and into the future. We want to create a culture and environment that supports the delivery of high-quality, continually improving care in which excellence in clinical care can flourish. And we want improving people's experiences to be as important as improving clinical outcomes and safety. To achieve our ambition, we will:

- **Deliver safe care and embed a learning culture:** We will put people at the heart of how we deliver care, with outcomes based on what is best for them, their families and their carers. We will continuously work to reduce risk and empower, support and enable people to make safe choices and protect them from harm, neglect, abuse and breaches of their human rights; and ensure that we learn from experience and share this across South West London. We will implement the NHS patient safety strategy across the ICB and ensure these are embedded to support safety improvement.
- **Deliver effective care:** We will provide the best quality person-centred care, so that we meet the needs of the individual as well as their family. We will focus on improving quality of life, working together collaboratively across organisational boundaries. We will offer high-quality training, routinely utilise National Institute for Health and Care Excellence (NICE) guidelines and take an evidence-based approach to everything we do. We will continuously improve the quality of our health and care based on research, evidence, NICE quality standards benchmarking and clinical audits, sharing this across South West London.
- **Provide a positive experience and outcome for our patients and our staff:** We will offer responsive and personalised health and care, that focuses on improving the quality of life and wider determinants, encompassing the start well, live well and age well model. Our care will be delivered with compassion, dignity, and mutual respect. This will be shaped by listening to and understanding what matters to people, patients, and our staff, as well as empowering people to make informed decisions and design their own care, so they are equal partners in their health and care. We will make sure that those who do not have a voice, those who are under-represented or who cannot speak for themselves are heard. In turn, this will lead to services that are coordinated, inclusive and equitable
- **Reduce health inequalities and deliver equitable care:** We will be a system that promotes and leads equity; where everybody has access to high-quality care and outcomes, and those working in health are committed to understanding and reducing variation and tackling inequalities
- **Improve our Core20PLUS5:** We will continue to improve the outcomes and experiences of our 20% most deprived population (children and young people and adults) across South West London and all six places.
- **Focus on prevention and self-care:** We will improve the health and wellbeing of local people, address inequality by tackling health problems earlier and preventing them from becoming worse. Our local authorities and Public Health are working with the NHS on a range of programmes including healthy early years, healthy childhood, sexual health, substance misuse, tobacco cessation, physical activities, health checks and community development. Improving quality of self-care and prevention services will be underpinned by how we ensure our services are sustainably resourced, with well-planned and cost-effective services. We will develop services that are based on the long term, rather than reactive, with flexibility built in.
- **Continuous quality improvement:** For us to achieve all five quality priorities, we need to build our quality improvement (QI) capability across the system. We will develop a structural approach to the delivery of quality improvement. Continuous QI will be the enabler and golden thread to everything we do as a system. We are proud that all of our South West London health organisations are delivering QI programmes, adopting a number of QI metholdogies, and making positive strides in improving patient and workforce outcomes. However, our plan is to adopt a system wide approach to Quality Management System across the ICS for system wide priorities...
- **Deliver our quality statutory duties:** We will provide positive assurance to our population that all quality, safeguarding and safety statutory duties are being met and that concerns are addressed rapidly, and improvement plans are having the desired effect and outcomes for our population and patients.

- **All Age Safeguarding:** The delivery of safeguarding duties for children and adults is one of the ICB's statutory duties, this means we will ensure oversight and assurance of the delivery of the NHS safeguarding accountability and assurance framework and continue to implement the quality escalation assurance process.
- We will improve quality of our safeguarding delivery for all clinical services that support our statutory child protection, looked after children and child death responsibilities such as child protection medical assessments, child sexual abused medical assessments, sexual health services, and psychological support services for victims and families.
- We will improve quality of our safeguarding delivery for vulnerable adults at risk and focus on transition from paediatrics to adulthood through implementation of statutory duties in partnership with local safeguarding adult boards (LSABs).
- We will have a shared vision of quality assurance– underpinned by national and local frameworks building on a proactive, responsive and dynamic process based on users' needs.
- We will make our relationships with local authorities, the local police, and our statutory partners our top priority because relationships are at the centre of how we safeguard our citizens.

Part Ten: Performance and outcomes

In South West London, we have a track record of delivering strong performance against the NHS constitutional standards, setting ambitious targets for improving the health and care for our population. We will continue this progress, as well as supporting the national ambitions, despite the challenging environment we find ourselves in following the pandemic.

We are developing our monitoring of 170 metrics from the operating plan, the NHS oversight framework, the NHS long term plan and our local priorities. Performance metrics are monitored against their planned trajectories or targets where relevant, otherwise they are tracked so that statistically significant changes can be observed and risks flagged early. This year, NHS England have asked that our plans focus on 30 of these in particular in our operating plans. These are in the areas of urgent and emergency care, community health services, primary care, elective care (including cancer and diagnostics), maternity, use of resources, workforce, mental health, learning difficulties and autism, and prevention and health inequalities.

We are doing relatively well in elective care and our treatment of long waiters

We have the fewest long waiters in London for both routine and cancer waits (London has the fewest per population nationally for both). Epsom & St Helier have the fewest patients waiting over 62 days for cancer treatment. Of all the acute trusts in London, Kingston Hospital Foundation NHS Trust has the fewest patients waiting over 52 weeks.

We are also relatively strong in dementia diagnosis; we consistently exceed the national ambition to recover the rate to 66.7%.

Our challenges are mainly around urgent and emergency care and primary care access

Although our system level A&E performance is relatively strong at three of our four acte trusts, Kingston is below the London average, mainly due to increased demand and limited alternatives to A&E. Of the London systems, South West London has been challenged with patients waiting over 12 hours from decision to admit to admission from A&E. To reduce these delays, there is heightened focus on patient flows inside and outside of hospital.

This year, diagnostic performance has been impacted by increased two-week wait referrals and greater urgent demand. Although diagnostic activity has increased, urgent and two-week wait patients are prioritised, meaning that routine patients have waited longer. There has been a particular focus to reduce the wait time to a diagnostic test, resulting in a 40% reduction in patients waiting over six weeks since September.

To address the performance areas outlined above we are taking action to:

Improve our A&E wait times

Hospitals, local boroughs and care homes are working together across South West London to improve the flow of patients through hospitals and onward to their homes or to other rehabilitation facilities. This past year, we implemented our initiatives to treat patients in their homes with 'Hospital at Home' (clinical visits) and the 2-hour urgent community response ambulance cars. We also implemented our virtual wards, enabling patients to be discharged from A&E more quickly and monitored at home. We are expecting to achieve the national target of seeing 76% of A&E patients within four hours by 2024, and plan to exceed this threshold consistently to improve our patient experience.

Right patient, right place, first time

Our trusts closely monitor the patient waiting lists and in 2023, we will implement the standardised NHS outpatient guidance for 'getting it right first time' (GIRFT) to drive improvement in waiting times, quality and outcomes. We are progressing our advice and refer initiatives, so that patients with routine conditions are managed in primary care with clinical support from hospital specialists. Our patient-initiated follow-up (PIFU) will enable patients to be seen in secondary care (hospitals) when they need it, after they have received treatment.

Improve wait times from referral to treatment

Through our hospitals and our acute provider collaborative, we are committed to continuing our reduction of overall wait times, and plan to have no patients waiting 65 or more weeks for routine treatment by March 2024. For cancer, our cancer collaborative, Royal Marsden Partners, has developed plans with our hospital trusts to deliver the diagnostic and treatment capacity needed. Royal Marsden Partners will continue to support in delivering operational solutions, as well as longer term improvement via clinical transformation. There is more information about this in our acute care and cancer chapters

Diagnose patients more quickly to help to reduce wait times

Building on our current plans, will ensure that 95% of South West London patients receive a diagnostic test within six weeks, as per the national requirement. We are developing our community diagnostic centres, which will provide quicker access to tests and greater convenience to patients. In many cases, tests will be done in a one-stop-shop setting. There is more information about this in our diagnostics chapter.

In our hospitals, we are maintaining focus on the diagnostic workforce, and are increasing diagnostic capacity via insourcing and outsourcing as needed.

Reduce unwarranted variation across the ICS

We have developed our capability to identify population groups who are not receiving treatment as quickly, or who have poorer outcomes.

For cancer, strategic plans are being formed by Royal Marsden Partners, with clinical and engagement leads in the six boroughs. We will improve our understanding of why some population groups are diagnosed or treated later and will form strategies to address those inequalities.

For routine treatment, we are working with clinical teams to understand why some groups receive treatment later than others and will continue to develop solutions collaboratively across the system for equity of access to healthcare. Through our clinical networks, our clinicians are reviewing patient treatment pathways, forming systemwide models of care to reduce variation across South West London. Our regular meetings explore opportunities of mutual aid within and outside the system for pressured specialties.

As we continue to develop our plans and ambitions for the next five years, we will also develop our system outcomes and how we will know we have achieved our aims.

Getting the primary care part right

Primary care is typically the entry point into health services and plays an important role in the health and care system. We are working to increase capacity so that people can get the care they need locally at the right time, rather than later or at A&E departments. Primary care networks (PCNs) are providing over 6,500 appointments per week under the new enhanced access service, 6.30pm-8pm weekdays and 9am-5pm Saturdays. Some PCNs are also providing appointments outside of these hours in-line with patient need, such as commuter and paediatric clinics. We are also recruiting to new roles in primary care to increase our workforce. This extra capacity will help us move toward the national ambition of ensuring that everyone who needs an appointment with their GP practice gets one within two weeks, and that those who contact their practice urgently are assessed the same or next day according to clinical need.

Ensuring patients needing mental health services have the right care at the right time in the right place

Our mental health provider collaborative, South London Partnership, are continuing their efforts to improve access to mental health support for both adults and children and young people, introducing a crisis line supporting both adults and children. South West London and St George's Mental Health Trust continues to innovate, having run a pilot that has informed the upcoming NHS111 press 2 model; people ringing NHS111 for mental health support will be able to speak directly to a mental health professional.

In line with the national ambition to achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services, South London Partnership has introduced a nurse development programme, growing the number of community mental health nurses, developing leadership skills training for middle grade nurses and advancing careers of more senior nurses.

Our adult mental health admissions were below the London average this year, and South London partnership continues to work towards eliminating inappropriate adult acute out of area placements. This year, we reduced the number of children and young people placed out of area by 93%.

South West London has exceeded the national ambition of recovering the dementia diagnosis rate to 66.7% and has plans to improve further on this position.

Looking after people with a learning disability and autistic people

Although we have successfully achieved 75% learning disability health checks throughout 2022/23, we want everyone with a learning disability to have proactive primary care. As per the national ambition, we are working to reduce reliance on inpatient care, while improving the quality of inpatient care. We will also ensure public facing London Ambulance Service staff are provided training about how to engage with and support people with learning disabilities and autism.

www.southwestlondon.icb.nhs.uk
March 2023