NHS South West London
Integrated Care Board

South West London Integrated Care Board

Supporting Information for Meeting Pack

17 May 2023
09:45 – 13:00

Wandsworth Civic Centre, Wandsworth High Street, SW18 2PU

NHS South West London
Integrated Care Board

ANNEX A

Agenda Item 04

Decisions Made in Other Meetings

Operating Plan 2023/24

NHS
South West London

2023/24 Operational Plan
SWL Integrated Care Board
4 May 2023

1. Executive Summary

This paper summarises South West London's response to the Operational Guidance, that was published by NHSE in December 2022, for activity and performance targets, finance (revenue and capital) and workforce.

These plans have been shared and discussed with the SWL Finance and Planning Committee at its April meeting and the Committee where it confirmed support for the plan, recognising financial guidance was still being confirmed with NHSE.

2. Background and approach to planning

The Operational Planning Guidance for 2023/24 and Financial Planning Guidance was released by NHSE in December 2023. This was shared with the ICB Board at its meeting in January 2023 and the main published document is accessible here NHS England » 2023/24 priorities and operational planning guidance.

The guidance sets out requirements for the NHS for the upcoming year. For 2023/24 this includes "three key tasks":

1. recover our core services and productivity, specifically to:
    - improve ambulance response and A&E waiting times
    - reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
    - make it easier for people to access primary care services, particularly general practice.
2. make progress in delivering the key ambitions in the Long Term Plan (LTP),
3. continue transforming the NHS for the future

Alongside this, systems are required to:

- recover productivity and deliver a balanced financial position
- continue to narrow health inequalities in access, outcomes and experience
- maintain quality and safety in our services, particularly in maternity services

In South West London we worked as a system to take a common approach on our planning assumptions. These included:

- Agreement to prioritise delivery of elective and cancer wait times – agreed with CEOs (Autumn 2022)
- Agreement that A&E performance will be compliant with 76% target – UEC Steering Group (January 2023)
- Agreement of principles for modelling additional activity – CEOs (March 2023)
- Agreement to model in additional MRI capacity activity in order to improve delivery of 6 week wait times for that modality - CEOs (March 2023)

- The Finance and Activity Committee agreed to take a common approach on financial planning including:
    - Delivery of a stretching but realistic CIP target of 5.5%
    - Modelling Elective Recovery trajectory (ERF) through delivery of challenging productivity gains rather than material cost increases.
- Agreement to work together under the system's established capital planning approach.

3. Governance and oversight

Plans have been developed by all of our provider organisations based on these common principles. Regular updates have been discussed on a weekly basis at the system-wide CEO meeting and SWL ICB Executives have formally met with Executive Colleagues at each provider trust twice to:

- Understand the ambitions in individual provider's plans,
- Review the development of supporting transformation plans
- To ensure that plans triangulate.

Consolidated system plans have also been shared with relevant governance groups to ensure their support. The groups comprise:

- SWL Recovery and Sustainability Board
- SWL ICB Finance and Planning Committee
- SWL Senior Management Team
- SWL Elective Board
- Diagnostics Board
- Outpatient Board
- UEC steering group (and local A&E Delivery Groups)
- Elective Recovery group
- Cancer delivery group
- Mental Health planning group
- Virtual Ward Programme Board

In line with national timescales, we submitted draft plans to NHSE at the end of February. These were updated following feedback from NHSE for a revised submission at the end of March 2023 prior to final submission on 4 May 2023. The financial position submitted on 4 May shows a system deficit of £81.6m. This compares with an expected deficit for 2022/23 of £57m.

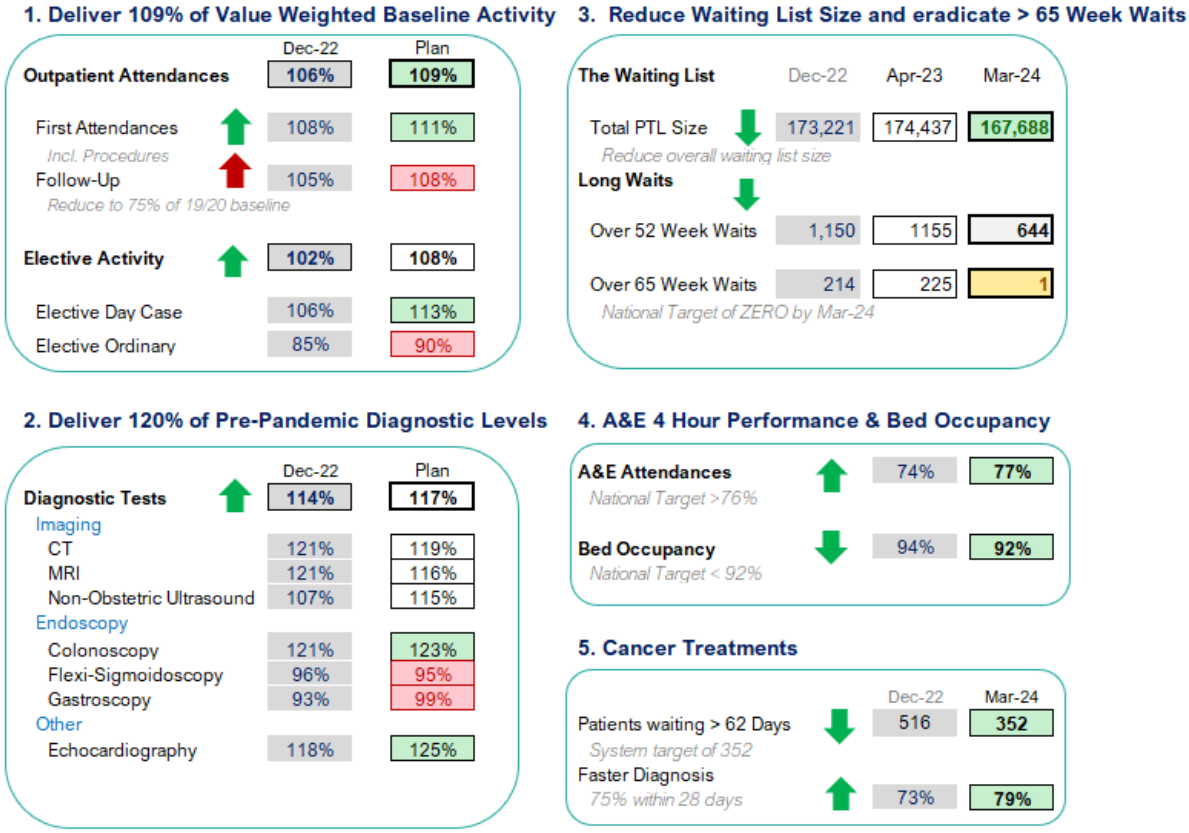
This pack presents the summary of the SWL plans focussed on the three key areas: performance, finance and workforce.

4. Activity and performance – acute providers

SWL plans set out that our system will deliver:

- Waiting times targets in line with national expectations (eliminating 65 week waits for the elective activity)
- Achievement of the Faster Diagnosis Standard and 62-day cancer targets
- Activity to achieve the Elective Recovery Fund target
- Continued progress towards the diagnostic waiting times target (which is required to be 95% by March 2025)
- Achievement of the A&E 76% target
- Bed Occupancy in line with the 92% threshold set within the guidance

A summary of activity and performance ambitions for SWL acute providers for 2023/24 is presented below. Activity and performance levels in 2022/23 are provided for context.



5. Mental health targets

The number of mental health targets that the system is required to focus on has reduced to six targets in 2023/24. South West London expects to achieve three of these and make progress against the remaining targets by Q4 2023/24.

Targets we expect to achieve are:

- **IAPT** - trajectories are currently in line with the NHSE target for SWL. This equates to 9,880 per quarter. Current activity is roughly 12.5% below this target.
- **Dementia** - plans are projected to exceed the national target (70.6% versus a target of 66.7%)
- **Community mental health access** - expected to deliver 5% year-on-year growth.

We continue to make progress on:

- **Out of area placements** – Our providers (SWLSTG and SLAM) have plans in place to deliver improvements on the current level but do not meet national requirement – there is full oversight from our provider collaborative and strategic oversight groups
- **CAMHS and perinatal services** - we are agreeing investment for CAMHS and perinatal services to deliver improvements in Q3 and Q4 however this is unlikely to enable us to deliver the target in-year. Full oversight is taking place
- There are significant challenges in achieving **Children and Young People's mental health** (CYP MH) access at both a regional and national level due to recruitment issue, however improvements are still expected.

It should be noted that workforce capacity and recruitment remain a challenge for mental health services and is a key risk to the delivery of these targets.

6. Other performance targets

Other performance targets the ICS is required to deliver include:

Learning disabilities and autism - Achieving the Annual Health Check target of 75% and reduce the number of people with Learning Disabilities and Autism who are in inpatient care to 35 (including children, adults and specialised)

Primary care - The number of GP appointments are planned to increase by 3% in 2023/24. With an increase in referrals to community pharmacist consultation service from general practice (5,400 in Q4 2023/24) and from NHS 111 (c. 3,000 in each quarter 2023/24)

Virtual wards – In line with the approved business case virtual ward capacity is planned to be increased to 425 patients with an occupancy rate of c.85%.

7. Finance

The system has developed the 2023/24 financial plan to meet the key targets in NHS planning guidance. Detailed work has been undertaken by the CFO group, with oversight from the relevant organisation Finance Committees and the SWL Financial Recovery and Sustainability Board. This plan is a £81.6m deficit but delivers the following key financial targets:

- Delivering the elective recovery fund target and ensuring receipt of associated income
- The Mental Health Investment Standard (MHIS, uplift of 6.94%)
- The system cap on agency staff expenditure.
- Adhering to the management cost cap for running the ICB

The table below shows the deficit plan by organisation.

4 May plan summary (£m)	CHS	ESH	KHT	SGH	HRCH	RMH	SWLSG	ICB	System total
I&E position	-16.4	-37.9	-16.8	-15.7	0.5	2.0	0.3	2.5	-81.6

In developing this plan the following assumptions have be used:

- **Inflation** - inflation costs assumed in line with National Cost Uplift Factor (CUF) assumptions, with any pressures over national assumptions held as risk outside the plan.

- **Covid and capacity funding** - 0.6% (Covid) and 0.9% (Capacity) uplifts assumed on all NHS contracts.
- **Cost pressures** – any investments need an identified source of funds. Other cost pressures were only included in the plan if nationally mandated or unavoidable / contracted. This equates to £20m across the system (c.0.5% of total costs).
- **Efficiency** – A 5.5% (£210m) efficiency target has been assumed.

Risks to delivery of the financial position include:

- Estimated **excess inflation** held outside the plan of £42m. This includes CHC and prescribing inflation at the ICB and non-pay contractual inflation (including energy) at the trusts.
- **Delivery of efficiencies** – current requirement of £210m. As at the end of April £25m was unidentified. The plan phasing assumes a build-up of delivery over quarter one, but the programme needs to be fully delivering by July, to ensure the required savings are achieved in year.
- **Reduction in agency** usage is a key part of the efficiency plan and needed to meet the SWL agency cap, which will be made challenging by activity surges not anticipated by the operational / activity plan. Key to achieving agency reductions will be the ability to recruit substantively in high demand clinical specialities.
- **Out of sector contract**. In 2022/23 differences in interpretation of national guidance by ICSs outside of London, resulted in less funding than expected. There is a risk this could be repeated in 2023/24 as more funds have been distributed on a population basis.
- In order to achieve the full **Elective Recovery Fund** that has been allocated to SWL, our system must achieve its Elective Recovery Target. All providers have plans that seek to achieve this target. Delivery below this is likely to result in funding being "clawed back" to NHSE.

Whilst the 2023/24 plan is a deficit the system is working together (overseen by the SWL Financial Recovery and Sustainability Board) to return the system to breakeven in 2024/25.

8. Capital

The table below shows the 2023/24 5 year NHS capital plan, in line with what has previously been agreed by the Board, included here for completeness. Year 1 of this plan was published on 21 April 2023.

		2023/24												
Organisation type	**PLAN £000**	**ICB**	**Croydon Health Services**	**Epsom and St Helier Hospitals**	**Kingston Hospital**	**St George's Hospital**	**Hounslow and Richmond**	**SWL & St George's**	**The Royal Marsden**	**TOTAL FULL YEAR PLAN**	**2024/25**	**2025/26**	**2026/27**	**2027/28**
Provider	Capital budget for NHS trusts		14,096	27,383	16,782	32,704	2,047	38,932	15,708	147,652	152,197	119,197	119,197	119,197
ICB	Capital budget for primary care maintenance and IT	2,585								2,585	2,583	2,583	2,583	2,583
Subtotal		**2,585**	**14,096**	**27,383**	**16,782**	**32,704**	**2,047**	**38,932**	**15,708**	**150,237**	**154,780**	**121,780**	**121,780**	**121,780**
Provider	National programme funding: Upgrades and New Hospitals Programme			17,128				11,100		28,228	125,721	200,363	190,882	125,567
Provider	National Programme funding: Diagnostics, electronic patient records, elective recovery		21,051	4,659	1,611	5,687		920		33,928	20,610	6,218	-	-
Total system capital plan before technical accounting items		**2,585**	**35,147**	**49,170**	**18,393**	**38,391**	**2,047**	**50,952**	**15,708**	**212,393**	**301,111**	**328,361**	**312,662**	**247,347**
Provider	Technical accounting change to lease accounting under IFRS 16		2,300	7,730	1,516	44,529	-	7,500	4,207	67,781	22,875	18,164	10,628	15,999
ICB	Technical accounting change to lease accounting under IFRS 16	6,160								6,160	15,616			
Provider	Technical accounting adjustments for Private Finance Initiative buildings				1,148	250				1,398	1,398	1,398	1,398	1,398
Total system capital plan after technical accounting items		**8,745**	**37,447**	**56,900**	**21,057**	**83,170**	**2,047**	**58,452**	**19,915**	**287,732**	**341,000**	**347,923**	**324,688**	**264,744**

9. Workforce

Systems are required to ensure that the financial value of agency usage is less than 3.7% of total pay costs. Plans for SWL set out that this expectation will be achieved in 2023/24. To achieve the agency cap, providers are planning to transfer existing bank and agency staff to substantive roles.

Providers have developed workforce plans that align with activity and financial assumptions made. SWL provider plans for 2023/24 show a small decrease in total staff in post when compared to 2022/23 plans (-514.85 WTE, -1.5%). The following tables provide further insight as to where these increases and decreases in workforce are planned, by staff type; including a breakdown of the total substantive WTE across SWL.

WTEs	Staff in post 2022/23	Plan 2023/24	% WTE Change	WTE Change	Variance %
Total Workforce (WTE)	**35,420.44**	**34,905.59**	**-1.5%**	**-514.85**	**-1.5%**
Total Substantive	30,731.84	30,686.87	-0.1%	-44.97	-0.1%
Total Bank	3,563.15	3,433.00	-3.8%	-130.15	-3.7%
Total Agency	1,125.45	785.71	-43.2%	-339.74	-30.2%

Breakdown of total substantive WTE	Staff in post 2022/23	Staff in post Proportion	Plan 2023/24	Plan Proportion	WTE change	WTE Proportion	WTE Proportion Chg %
Registered Nursing, Midwifery and Health visiting staff	9,147.77	29.8%	9,077.27	29.6%	-70.50	156.8%	127.0%
Other Scientific, Therapeutic and Technical Staff	4,441.32	14.5%	4,491.67	14.6%	50.35	-112.0%	-126.4%
Support to clinical staff	7,757.54	25.2%	7,788.75	25.4%	31.21	-69.4%	-94.6%
NHS Infrastructure Support	5,145.05	16.7%	5,087.86	16.6%	-57.19	127.2%	110.4%
Medical & Dental	4,225.86	13.8%	4,227.28	13.8%	1.42	-3.2%	-16.9%
Any Other Staff	14.30	0.0%	14.04	0.0%	-0.26	0.6%	0.5%
	30,731.84	100.0%	30,686.87	100.0%	-44.97	100.0%	

10. Productivity

We know that across the country NHS productivity has worsened since before the pandemic. Recovery of productivity is therefore a requirement for all systems in 2023/24.

Using the same calculation as NHSE we can confirm that all our providers' plans present an improvement to their underlying productivity compared to 2022/23.

11. Key risks to delivery

The system will need to manage risks to delivery of plans during the year. These include:

- Continued operational pressures (including industrial action) may impact our ability to deliver our planned elective activity through improved productivity
- Risks to achieving our financial plan (as noted in the finance section above)
- Ability to recruit and retain staff with on-going reliance on agency staff

Risks to the delivery of this plan will be managed through the Board Assurance Framework and will have oversight from the recovery and sustainability board and formal ICB governance as well as individual trust governance processes.

12. Next steps

Final plans for activity, performance, finance and workforce are required to be submitted to NHSE on 4 May 2023.

The system now needs to rapidly move from planning to systematic implementation of these challenging plans this year whilst also ensuring alignment with longer term strategies, such as the Joint Forward Plan.

NHS South West London
Integrated Care Board

ANNEX B

Agenda Item 04

Decisions Made in Other Meetings

SWL ICB Financial Plan 2023/24

SWL ICB Financial Plan 2023/24

Introduction

NHS England issued it's 2023/24 Planning Guidance in January 2023 with subsequent amendments and additions received after this date. Allocations were issued for 2023/24 and 2024/25 which confirmed the level of growth that the ICB will receive along with a £20m convergence factor adjustment (to reduce funds available back to the level assumed to be required to meet the needs of our population).

SWL ICB received an allocation of £3.05bn to commission its services which compares with a total allocation in 202022/23 of £3.06bn. It is difficult to make a direct comparison between years due to changes in the funding methodology.

This report provides an overview of the approach to creating the ICB 2023/24 financial plan, including the assumptions used, ongoing governance to manage the position in year and remaining risks

The ICB is planning for a £2.5m surplus to support the system position of a £81.6m deficit.

Allocation Overview

The ICB allocation is split into 3 areas:

- **Programme Allocation** – this is the largest allocation and is to fund the commissioning of all healthcare services. Net growth was 4.49% after a convergence factor adjustment of -0.71%.
- **Primary Care Medical Services** – this is for the commissioning of services from GP's. Net growth was 5.16% after a convergence factor of -0.4%
- **Running Cost Allocation** – this is to fund the administration of the running of the ICB and has received no uplift from 2022/23. This is in effect a reduction in our allocation due to the value of the pay award.

There are several allocations which were previously classed as non-recurrent in 2022/23 that have now been made recurrent in 2023/24. These include:

- Maternity,
- Health inequalities,
- Inflation

Further to these, non-recurrent allocations have been received for elective recovery fund (ERF), Covid, winter/virtual wards and additional discharges programmes.

Key Assumptions

2023/24 National Planning Expectations

Programme Allocation
NHS England planning assumptions have been applied in line with the table set out in ***Appendix 1***. This covers inflation, capacity and covid funding. Further to this the following national guidance/assumptions have been used:

- ERF has been distributed to acute providers in line with national guidance on a pro-rata share of their nationally calculated elective baselines.
- We are collaborating with partners across the country to agree reciprocal approaches for the application of growth into contracts.
- Mental health has been uplifted in line with the mental health investment standard.
- The national allocation for service development funding (SDF) has reduced from £96m in 2022/23 to £66m. However there are less prescriptive requirements for the reduced allocation allowing more local approaches to be taken. Given that commitments against SDF are largely on a non-recurrent basis there is minimal financial risk in this reduction.

Primary Care Medical Services
Although the Primary care medical services allocation has been confirmed we are still waiting for the finalisation of the national contract discussions that will enable us to fully allocate the expenditure budget. Within the current plan it is assumed that all costs can be covered within this allocation and if this is not the case we will need to review any areas of discretionary spend.

Running Costs Allocation
The budget is set in line with the running cost allocation of £29.5m. The ICB has been notified of management cost reductions from 2024/25 and we will work towards plans to develop them.

2023/24 Local Planning Assumption

In addition to the national planning guidance the ICB made some local decisions, as follows:

- SWL ICB would deliver at least a breakeven position in 2023/24
- The ICB has set a minimum 5.5% efficiency saving target against its influenceable spend (circa £600m) in line with its ICS partners
- The baseline for building the 2023/24 budget was the 2022/23 month 7 forecast outturn (in line with the budget setting process starting in late 2022)

SWL ICB Financial Plan

The 2023/24 detailed financial plan has been developed over the last quarter of 2022/23. This process has been led by budget holders, in line with national guidance and the local budget setting guidance issued and agreed at the ICB Senior Management Team meeting in December 2022. Updates have been provided to the Finance and Planning Committee throughout the process. On formal approval of the budgets, Budget Holders will sign to

confirm they will deliver their budgets in line with the Standing Financial Instructions and Scheme of Delegation.

The ICB plan is to spend £3.047bn against the £3.05bn allocation, creating a £2.5m surplus. The table below compares the 2023/24 planned spend to 2022/23 expenditure (excluding non-recurrent spend), with the key changes described.

Area	2023/24 £'000	2022/23 £'000	%	Key changes
Acute	1,659,095	1,600,686	3.65	There was a redistribution between ICB and specialised Commissioning allocation and changes to the ERF allocation
Mental Health	318,740	302,634	5.32	Includes Learning Disability services so the uplift is in line with national guidance
Community	240,712	224,768	7.09	Uplift reflects increase in BCF and NHS contract mandatory uplifts.
Continuing Healthcare	177,311	170,729	3.85	Uplifts applied and impact of current action plans to manage and monitor spend
Primary Care (Including Prescribing)	508,397	494,453	2.82	Uplifted in line with allocations and impact of actions to manage prescribing spending
Other Programme Services	47,494	53,706	-11.9	This is project funding which is variable year on year and remaining efficiency target that needs to identified.
Running Costs	29,531	29,356	0.60	In line with allocation
Grand Total Before SDF	**2,981,280**	**2,876,331**	**3.74**	
SDF	66,346	96,829		Funding of services in line with allocation received. There has been a reduction in the amount of SDF available in 2023/24. Although additional allocations could be received in year
Grand Total	**3,047,626**	**2,973,160**	**2.50**	

The budget can be further split by area and this detail is shown below.

SWL ICB Overall Plan by Service Area & Place

	ICB Acute Service Expenditure	ICB Mental Health Service Expenditure	ICB Community Health Service Expenditure	ICB All-age Continuing Care Service Expenditure	ICB Primary Care Service Expenditure	ICB Other Programme Service Expenditure	Total Programme	ICB Primary Medical Services Expenditure	ICB Running Costs	Total
Croydon Place	**1,200,519**	**11,657,089**	**21,808,887**	**29,804,062**	**54,139,015**	**1,951,859**	**120,561,431**	0	421,577	**120,983,008**
Kingston Place	**2,167,952**	**5,153,382**	**5,492,754**	**27,390,292**	**29,358,333**	**885,867**	**70,448,580**	0	597,780	**71,046,360**
Merton Place	**236,395**	**8,500,233**	**7,363,709**	**21,628,810**	**28,176,754**	**1,040,791**	**66,946,692**	0	0	**66,946,692**
Richmond Place	**724,562**	**6,891,424**	**2,995,663**	**29,429,225**	**26,276,443**	**962,317**	**67,279,634**	0	0	**67,279,634**
Sutton Place	**450,315**	**6,491,130**	**5,328,376**	**30,949,801**	**29,525,065**	**1,306,039**	**74,050,726**	0	774,172	**74,824,898**
Wandsworth Place	**199,735**	**11,718,976**	**39,324,519**	**36,669,621**	**48,645,953**	**5,296,191**	**141,854,995**	0	1,060,905	**142,915,900**
SWL Place	**1,654,115,623**	**268,327,594**	**158,397,968**	**1,438,905**	**13,842,497**	**36,051,085**	**2,132,173,672**	**278,433,000**	**26,676,566**	**2,437,283,238**
SDF Funding	**0**	**0**	**0**	**0**	**0**	**66,346,270**	**66,346,270**	**0**	**0**	**66,346,270**
	1,659,095,101	**318,739,828**	**240,711,876**	**177,310,716**	**229,964,060**	**113,840,419**	**2,739,662,000**	**278,433,000**	**29,531,000**	**3,047,626,000**
ALLOCATION							2,742,162,000	278,433,000	29,531,000	**3,050,126,000**
TARGET SURPLUS										**2,500,000**

Key things to note within the budget are:

- Primary Care funds are overseen at a SW London level
- Running costs allocations for Merton and Richmond are included in the Wandsworth and Kingston budget lines respectively

  The Better Care Fund has been uplifted in line with guidance (5.66%)
- The following allocations are also included under other programme services:
  - Health Inequalities - £4,318k
  - Additional discharge - £6,931k
  - Additional physical/virtual capacity funding - £19,273k

SWL ICB Efficiency Programme

In line with ICS partners the ICB set a 5.5% savings target against its influenceable spend. This equates to a £33.8m savings programme. The development of the savings programme is being overseen by representatives and budget holders from across the organisation. Saving opportunities will be assessed for any quality impact as appropriate.

The development and delivery of these savings plans will be reported monthly as part of the Finance report to ensure the Finance and Planning Committee have oversight and understand the delivery themes.

Risks

The following risks to the delivery of the plan can be summarised as:

Inflation

- Continuing healthcare prices continue to rise due to increases in the London minimum wage and general non-staffing costs such as energy. We have tried to mitigate this with a comprehensive savings programme which may keep growth flat or better, however, inflation could cut across all of this.
- Prescribing costs could continue to be impacted by increases in the no cheaper stock obtainable (NCSO) issue that affected us in 2022/23. In addition, general inflation on drugs could be higher than national planning assumptions.

Delivery of savings

- Further work is required to develop the £33.8m efficiency programme to ensure it is delivered - this will include the requirement to identify additional schemes in case any slip in year.

Elective recovery funding mechanism

- The ICB and therefore the system could lose ERF funding (clawed back) if providers are unable to deliver the required levels of activity. With current levels of industrial action leading to elective cancellations this presents a high risk to the system.

- Within the national planning guidance, it is confirmed that some support activities such as diagnostics should be funded on a cost and volume basis. To deliver the ERF target this would require a significant overperformance in these services which may not

be affordable to the ICB if the actual elective activity underperforms and funds are clawed back as a consequence – which will create an overspend for the ICB.

Conclusion

The Board are asked to:

- Note the process undertaken and that planning assumptions have been made in line with national guidance
- Approve the detailed revenue budget
- Acknowledge the risks outlined in this paper, in particular that the savings programme is still under development and that the delivery of non-recurrent efficiencies would have a financial impact in future years.

APPENDIX 1 – NATIONAL ALLOCATION GROWTH BY AREA

	2023/24	2024/25	Commentary
Cost uplift factor (excl efficiency)	2.9%	1.8%	Weighted average of the below
o/w Pay	*2.1%*	*2.1%*	*See: 2023/25 NHS Payment Scheme – a consultation notice*
o/w Drugs	*1.3%*	*0.5%*	*See: 2023/25 NHS Payment Scheme – a consultation notice*
o/w Other Operating Costs	*5.5%*	*1.3%*	*See: 2023/25 NHS Payment Scheme – a consultation notice*
o/w Capital	*4.0%*	*1.3%*	*See: 2023/25 NHS Payment Scheme – a consultation notice*
Provider efficiency factor	(1.1%)	(1.1%)	See: 2023/25 NHS Payment Scheme – a consultation notice
Future acute (incl ambulance) activity growth	2.2%	2.2%	Underlying activity growth (ambulance 2.6%, acute 2.1%). This excludes funding to support existing acute and ambulance capacity as recovery from COVID back to normal levels continue (see 'underlying capacity recovery support' below).
Acute and ambulance support to underlying capacity recovery	0.9%	0.2%	Uplift to API (acute and ambulance) contracts to support underlying capacity recovery back to normal levels. This uplift should be applied to API fixed payments with trusts prior to the adjustment to extract the elective funding ('elective adjustment'). The elective adjustment extracts the cost weighted value of the 2023/24 elective target from the fixed payment value. The application of the underlying capacity recovery funding therefore reduces the productivity gap that trusts need to close in 2023/24 and supports underlying capacity recovery.
Community activity growth	4.1%	3.1%	Activity growth, not total growth
Total MHIS growth	7.0%	3.2%	Total growth (inc inflation), including 1.7% above base growth in 2023/24
CHC	7.3%	6.2%	Total growth (inc inflation)
FNC	8.5%	8.5%	Total growth (inc inflation)
Prescribing + Excluded Drugs	2.4%	2.3%	Total growth (inc inflation)
CNST growth	9.6%	6.5%	Expected CNST growth
BCF	5.7%	5.7%	5.66% in line with mandate (excludes £0.3bn funding for discharge)
SR21 additional savings	n/a	(0.3%)	Further efficiency in 2024/25 through SR21 stretch
Base growth	**5.3%**	**3.2%**	**National average base growth applied to allocations**
Convergence	**(0.6%)**	**(1.1%)**	**Convergence applied to all commissioning streams**
Post convergence growth	**4.6%**	**2.1%**	**Base growth + convergence**
COVID	0.6%	n/a	0.6% uplift to API contracts as COVID funding moves to a pop basis (1.2% for ambulance)
Total growth incl COVID & ERF	**3.2%**	**2.1%**	**Total growth**

NHS South West London
Integrated Care Board

ANNEX C

Agenda Item 06

SWL Mental Health Strategy

NHS
South West London

DRAFT

Our Mental Health Strategy:

For everyone who lives, works or studies in South West London

Executive Summary

Mental health is of critical importance to individuals, communities and wider society and we want SWL to be the best place to live for emotional wellbeing.

Mental health is of critical importance to individuals, communities and wider society and we want SWL to be the best place to live for emotional wellbeing.

Whilst we have high quality mental health services across our six boroughs, we have many challenges to tackle. We know that our services don't always meet the needs of our local communities and we have unequal service availability, access and outcomes; rising demand, acuity and complexity; and workforce gaps.

In SWL we don't spend as much as some other areas on mental health – 10% of our NHS budget compared to nearly 14% as an average across England – and we want to address this investing more in prevention and early support and in mental health for children and young people specifically.

Our new SWL Mental Health Strategy has been developed through analysing population needs and listening to issues raised by residents, stakeholders and those with lived experience of mental health issues. This is a Strategy that focuses on prevention (from pregnancy and birth onwards for the whole life course) as much as treatment which values emotional wellbeing and community resilience. And this Strategy is for everyone who lives, works or studies in Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.

Our vision is that in SWL we want everyone to have access to the right support at the right time for their emotional wellbeing and mental health. We recognise that many influences come from wider factors such as employment, education, housing, and community and we will work in partnership with local authority colleagues to address these. Our services will work effectively together and with people who use our services as early as possible to meet needs and ensure everyone receives the support they need in the most appropriate setting.

The aims of this strategy are to:

- Prevent mental illness and provide early support for recovery as we know this promotes good recovery and reduces the burden of Ill-health.
- Increase equity of access, experience and outcomes for all SW Londoners – reducing unwarranted variation and ensuring a fair and sustainable allocation of resources.
- Better support and equip our CYP and those that support them to manage their mental health and emotional wellbeing in the future.
- Design a new model for mental health workforce including voluntary and community sector and peer support to tackle mental health recruitment and retention issues.
- Expand bio-psycho-social care to address the mortality gap and the opportunity to increase years of quality life.
- Co-produce delivery of this strategy with service users/ residents in SWL, putting partnership with those who use services and those in our communities at the heart of everything we do.

We have high aspirations for the mental health and wellbeing of our SWL residents and communities. To reflect these we have set ourselves ambitious goals over a ten year period:

By 2032/33 we will have	
Population	**Services**
• Increased equity of service access to reflect community demographics with no unwarranted variation in outcomes • Improved mental and emotional wellbeing for residents in SWL • Reduced the 'mortality gap' between those with SMI and the general population • Eliminated racial inequality around overrepresentation of black people in detention, inpatient and crisis care • Ensured no person known to mental health services presents to A&E unless for physical health issue • Eliminated restrictive practices • Zero suicide • Significantly reduced self-harm • Eliminated inpatient stays outside of SWL for SWL residents • Closed unneeded acute inpatient beds	• Fully integrated mental health care in place for people with SMI and physical health needs, social care needs (including supported living), LDA, homelessness and substance misuse • Allocated resources based on need • Redirected mental health investment with the majority of spend occurring in primary care, VCSE and community settings • Increased funding into mental health benchmarked with other areas nationally and increased the proportion of funding spent on CYP mental health specifically • Fully staffed services with new roles in our workforce and positive staff wellbeing, satisfaction and morale • Embedded research and evaluation of services, operational models and initiatives as standard practice using meaningful recovery and experience measures • Services responsive to population health needs and flexibly delivering changes

We will deliver our Strategy through work across 4 themes with specific focus and content:

1

Prevention and early support including:

a) Support for children and young people and families
b) Healthy environments
c) Mental health literacy and reducing stigma

2

Bio-psycho-social model including:

a) Physical healthcare for people with SMI
b) Neighbourhood teams & integration
c) Complex needs & co-occurring issues

3

Inequalities including

a) At risk communities
b) Unwarranted variation

4

Timely access including:

a) Least restrictive care & recovery
b) Waiting times
c) Transitions
d) Discharge

Our Strategy will link to wider SWL ICS programmes especially around workforce, population health management and digital technology.

We will deliver our work using annual plans with strategic leadership and drive through the SWL Mental Health Partnership Delivery Group which comprises clinical and non-clinical representatives from across our six places, our mental health providers and our ICB teams.

In year 1 we will focus on making improvements to children and young people's mental health and embedding transformation of community services for adults with SMI. We will support these areas of change by completing a detailed strategic review of mental health investment to date and the outcomes delivered from this, agreeing approaches to outcomes measurement and evaluation and reviewing public mental health work to identify future initiatives for deployment in SWL and ensuring mental health leadership and resourcing is in place.

We are excited about the changes that we can make in collaboration and we invite you to join us on our journey.

1. Introduction

Welcome to our new South West London Mental Health Strategy. This is for everyone who lives, works or studies in South West London. We believe everyone has the right to good mental health.

The importance of mental health

We know that poor mental health adversely affects individuals, their families and communities and wider society. The impacts of mental ill-health are wide ranging and stark: People with mental health issues are more likely to live in areas of deprivation, have lower incomes, live in less stable housing, find it harder to secure and retain employment, have fewer qualifications, have poorer physical health and die younger than the general population. And mental ill-health can affect us all – with one in four people experiencing a mental health problem of some kind every year with one in six experiencing a common mental health problem in any given week in England.

We know that there are things we can do to improve emotional wellbeing and resilience with new evidence around treatment, care and support emerging all the time. But improving mental health is not just about treatment. We need to consider wider wellbeing and social determinants of health as well as prevent mental illness developing in young people. By taking a whole population approach to mental wellbeing and encouraging access to green spaces, being physically active, making connections through communities or friends and family, we can shift the whole population towards flourishing and reduce the numbers of people experiencing troubling mental health problems[1].

We want SWL to be the best place to live for your emotional wellbeing and this is a Strategy for everyone who lives, works or studies in Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.

1. https://neweconomics.org/uploads/files/d80eba95560c09605d_uzm6b1n6a.pdf

In the years that mental health has been a national health priority we have achieved a great deal across our six boroughs through partnership working and clear ambitions, but we need to do more. Access to services and outcomes remain unequal; we know that not everyone gets the support they need. Too little resource is dedicated to early support or prevention of mental distress; some people don't receive help until they are in crisis meaning recovery is longer and more complex. Health and care organisations (including mental health services) don't always work well together making it confusing and complicated for service users. We need to change the way that we design and deliver mental health services and the way that we collectively think about, talk about and support strong mental health across and within our communities.

Our new Mental Health Strategy outlines the challenges we face in SWL, the ambitions we have for change and how we intend to go about delivering this. We are excited to begin our journey now in the spirit of partnership and collaboration as our SWL ICS embeds.

We will hold ourselves to account for clear delivery plans and annual progress and we invite you to join us because mental health is everyone's business.

2. National context

We recognise that all our local work in the NHS sits within a broader, often complex, environment. The key strategic elements relevant to mental health – including opportunities and challenges – are outlined below. Taken together with our understanding of our SWL population, this forms our case for change.

The importance of mental health

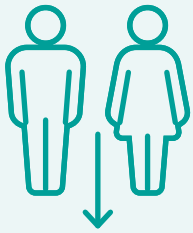
It's hard to overstate the importance of mental health for us in the 21st century. The facts speak for themselves.

From an individual perspective:

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

Nearly **one sixth** of the workforce is affected by a mental health condition.

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



The life expectancy of people with a serious mental illness is 15-20 years shorter than for those without[2].

People with mental health problems often have fewer qualifications, find it harder to both obtain and stay in work, have lower incomes, are more likely to be homeless or insecurely housed, and are more likely to live in areas of high social deprivation.

If you have a mental health issue you are more likely to have physical health problems and up to 50% of people with a severe mental illness have at least one (and often multiple) long-term physical health condition(s)[3].

At a societal level:

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

£26 billion

Mental health related absences cost UK employers an estimated £26 billion per year.

Whilst the majority of NHS spending is on physical health, estimates suggest 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. In 2003 estimates put the costs of mental health problems in England at £77 billion; in 2022 this figure was estimated at nearly £101 billion. And these figures do not include costs related any exacerbation of physical health issues, reduced performance at work, costs to housing or criminal justice sectors, suicide and self harm or alcohol substance misuse.

Despite this, we still struggle to adequately support people to recover from mental illness, to ensure people with mental health conditions play an active and valued role in society and their communities and to intervene early and prevent mental health issues occurring or reoccurring.

Our most deprived communities have the poorest mental and physical health and wellbeing.

2. Brown S, Kim M, Mitchell C, Inskip H. Twenty five year mortality of a community cohort with schizophrenia. British Journal of Psychiatry. 2010;196(2):116-21.
3. https://www.kingshealthpartners.org/our-work/mind-and-body/khp-mindbody

The strategic environment

Mental health is a national health priority in England.

Over the past 25 years mental health policy and practice have evolved significantly, growing from the *National Service Framework for Mental Health* to the first clinical guideline (for Schizophrenia) published by the National Institute of Clinical Evidence (NICE) to the mental health outcomes strategy *No Health without Mental Health* to the *Five Year Forward View for Mental Health* and most recently the *NHS Long Term Plan (LTP).* These developments have led to clear standards, national priorities and targets and additional investment.

Alongside this, awareness of mental wellbeing has grown. More parents understand emotional literacy and how they can support their children's mental wellbeing, supporting happiness and resilience. Collectively, as a society, we are more open to talking about mental health at all ages and in different groups, although, of course, there is more to do to eradicate stigma and shame which persists in many communities.

We are seeing increasing evidence for prevention and public mental health initiatives and we know that addressing the social causes of ill health such as securing good housing, employment, connecting with people, being physically active, being in nature/ accessing green spaces, learning new skills and practicing mindfulness, all positively impact on our mental health and reduce stress. Organisations have responsibilities to provide health workplaces and this can be achieved through a culture of participation, equality and fairness and developing the role of line managers. Schools can tackle mental health and wellbeing by offering support through a 'whole school approach'.

Finally, the implementation of integrated care systems with their focus on population health, inequalities, productivity and value, and broader development offers opportunities to connect mental wellbeing to our communities and to improve mental health care and reduce fragmentation and gaps in existing pathways. This will be accomplished by partners co-operating in new ways.

Current pressures

As we publish this Strategy, the NHS continues to manage the legacy and impacts of Covid-19. From a mental health perspective, around a third of adults and young people reported their mental health worsened during the pandemic[4], certain groups – young adults, women, those from ethnic minority communities and those experiencing socio-economic disadvantage – were identified as most at risk of adverse mental health outcomes[5] and new types of presentations occurred – emotionally based school avoidance in CYP for example. Current cost of living pressures have added to pressure on individuals, families and communities.

Post-pandemic increases in demand (referrals), complexity and acuity have been seen with services struggling to cope. In 2021 a record 4.3 million referrals were received for mental health in the NHS and March 2022 1.2 million people were waiting for mental health treatment. Between 2017 and 2021 Across the country there has been a rise in the percentage of children identified as having a probable mental health disorder from 11.6% in 2017 to 17.4% in 2021 – with CAMHS the fastest growing speciality. Longer waiting times lead to deterioration for many people and increase presentation into crisis and emergency services. When individuals do access care their recovery is likely to take longer and potentially require more support.

Whilst mental health has welcomed increased funding since 2015, the sector still represents a small portion of overall health funding with just 13.8% of local health spend allocated to mental health, including learning disabilities and dementia[6] in 2022/23. In addition, budget pressures in social care and increasing inflation make it challenging to meet needs.

All of these issues, alongside the wider national context, result in pressures within the NHS workforce. There are high levels of vacancies and challenges in retaining existing staff. Individuals are choosing not to work in or to leave the NHS for a variety of reasons including burnout and ill-health, lack of job satisfaction, wanting better work-life balance, wanting better rewards or opportunities. Workplace culture also plays a part with discrimination, bullying and abuse reported through the NHS Staff Survey. Whilst training, attraction and retention programmes exist rates of workforce growth are too low to meet demand for services.

We need to consider this landscape when setting our ambitions for mental health care in SWL.

4. https://www.mind.org.uk/coronavirus-we-are-here-for-you/coronavirus-research/
5. https://researchbriefings.files.parliament.uk/documents/POST-PN-0648/POST-PN-0648.pdf
6. https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/

3. The SWL landscape

It is critical that our mental health services meet the needs of our SWL population. Understanding population needs is the foundation of our Strategy.

Our mental health services

SWL is made up of the boroughs of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth and has a population of 1.5 million people.

Health and care services for our population are delivered by a broad range of partners across the SWL ICS including six local authorities, four acute trusts, mental health trusts, community physical healthcare services, social care, public health teams, the London Ambulance Service, voluntary and community sector enterprises (VCSEs), primary care (including general practice, pharmacy, dentistry and optometry) – increasingly organised into primary care networks or neighbourhood teams. Healthwatch organisations, community groups, individuals with lived experience and residents all play important roles in service review and development.

The SWL ICB spends around £300 million each year (10% of its total allocation) providing mental health services. This supports around 50,000 people from all age groups and backgrounds to access support for mild, moderate, severe and complex mental health needs within the community, as inpatients or within crisis settings.

South West London and St George's Mental Health NHS Trust (SWLSTG) and South London and Maudsley NHS Foundation Trust (SL&M) deliver the majority of our mental health services with circa 2,700 whole time equivalent staff. Outside of specific mental health provision, primary care and schools are often the first port of call for initial support for adults and children respectively.

South West London Health and Care Partnership

South West London CCG
South London Partnership
London Ambulance Service
Primary Care
Voluntary, Community and Social Enterprise

Main Mental Health Providers:

SWLSTG SLaM ELFT

Achieving for Children CANDI

Main Mental Health providers:

SWLSTG (mental health sites) – Springfield University Hospital, Wandsworth Barnes Hospital, Richmond Tolworth Hospital, Kingston Jubilee Health Centre Est, Sutton Wilson Hospital, Merton

SLaM (mental health sites) – The Maudsley Hospital, Camberwell Bethlem Hospital, Bromley Lewisham Hospital, Lewisham Lambeth Hospital, Lambeth

Our population and their needs

30% of SWL's residents are aged under 25, **57%** between 25-64 and **13%** over 65

SWL has an **older population compared to the rest of London**. Whilst the boroughs have similar age profiles to each other

Wandsworth has a high proportion of working-age adults (**63%**), **Croydon** has a high proportion of CYP (**32%**) and **Richmond** has a higher proportion of older adults (**16%**)

The ethnic background across SWL boroughs varies with Croydon being the most ethnically diverse and the SWL CYP population under the age of 25 being more diverse compared to the population of SWL as a whole. Specific communities and populations can be found across SWL.

Overall, SWL is affluent with Richmond, Kingston and Sutton the three least deprived boroughs in London. Croydon is the most deprived SWL borough remaining just above the London average. Within SWL however there are neighbourhoods with struggling with higher poverty and deprivation including new Addington, Old Coulsdon, North Croydon in Croydon; Norbiton and Berrylands in Kingston; Mitcham and Morden in Merton; Richmond Riverside and Hampton North in Richmond; Roundshaw and St Helier in Sutton; and Roehampton and Putney Vale in Wandsworth.

SWL boroughs have some of the highest employment rates in London with all boroughs meeting or exceeding the London and national average rate of people agreed 16-64 in employment. SWL boroughs also have some of the highest median

weekly earnings in London however there is significant inequality in earnings both between and within boroughs. People living in Sutton earn on average £210 less per week that people living in Wandsworth. Kingston and Wandsworth have the highest level of pay inequality, with the greatest difference in hourly pay between those earning in the top 20% compared to those in the lowest 20%. Housing affordability varies with less affordable housing compared the London average in Merton, Richmond and Wandsworth and more in Croydon, Kingston and Sutton.

Vulnerability exists across SWL in other markers as well. For example, Sutton has the highest rate of children on child protection plans compared to the London and national average. Croydon has higher rates of children looked after (CLA) compared to the London and national rate, as well as the highest absolute number of CLA and high number of unaccompanied asylum seekers.

In terms of education, children in SWL tend to perform well in school. For example, in Attainment 8 scores which measure the performance of students in their 8 best GCSE results, every SWL borough achieves a higher score than the national average. Richmond has the highest score of all London boroughs with Kingston and Sutton being third and fourth highest. When looking at the proportion of 16-17 year olds in education, employment or training, the picture is more mixed however, with Wandsworth and Croydon being below the London average.

In terms of mental health needs data show us that:

- CYP in SWL 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 ICSs.
- For CYP there are also some distinct population groups with particular needs which cross boroughs boundaries – for example CYP living in poverty or CYP at high performing schools experiencing eating disorders.
- In CLA emotional wellbeing is a cause for concern for approximately a third of children across London, rising to 37% nationally. In Richmond, Merton and Kingston this is a concern for half of all CLA.
- Across SWL, 16% of CYP have special educational needs (SEN). The number is increasing with the fastest growth in Kingston and Richmond. The proportion of pupils with SEN in SWL with a primary need for social, emotional and mental health support is above the London and national averages with highest rates in Wandsworth and Merton. Additionally, both the proportion of pupils with SEN with an autistic spectrum disorder or with a learning difficulty are both above the London and national averages.
- Self harm is a key issue. For adults Kingston, Richmond and Sutton have the three highest rates of admission for self-harm of all London boroughs and for CYP these three boroughs along with Wandsworth and Merton are in the top ten London boroughs for admission to hospital for self-harm. In Kingston, self harm admission rates for CYP and adults are twice as high as the London average.
- SWL has the lowest level of SMI in London yet there is a higher prevalence of depression in working age adults and high suicide rates compared to the London average in 5/6 SWL boroughs (excepting Wandsworth and Merton respectively). In addition, there are high levels of physical health conditions in our SMI population with over 50% of people with SMI have co-morbid diabetes. There is some variation in prevalence of mental health conditions which can in part be linked to demographic variation. For example, Croydon has a higher prevalence of SMI (e.g. bipolar disorder, psychosis) than Richmond.

- SWL has higher rates of people in treatment specialist alcohol misuse services but lower rates (excepting Sutton) for drug misuse.
- For people in contact with secondary mental health services a higher proportion live in stable and appropriate accommodation in SWL but a lower proportion are in employment compared to other London boroughs.
- For older adults, less than half of social care users aged 65 and over have as much social contact as they would like. This will add to social isolation and loneliness as factors that impact on their mental health.
- Our older adult population has a higher prevalence of dementia compared to other London ICSs.

Across both CYP and adult services demand for mental health support has increased in recent years and nationally, CAMHS is the fastest growing specialty of any across the whole NHS. This demand is being felt within SWL mental health services. Forecast population growth will impact further on this and, along with an ageing population, needs consideration when planning and delivering mental health support.

Meeting population needs

Mental health is a clear priority for SWL partners.

SWLSTG and SL&M services are rated as 'good' by the Care Quality Commission and we have established processes for seeking and responding to feedback and including those with lived experience in service improvement and transformation initiatives.

We have previously set system level ambitions for mental health and mental health is included as a priority in the local health and care plans for each of our six boroughs. We have a strong tradition of values-led collaborative working in mental health with an established partnership delivery group, transformation board and the South London Mental Health and Community Partnership (SLP) a formal collaborative between SWLSTG, SL&M and Oxleas NHS Foundation Trust which works at scale to deliver transformation and improvements to specialist mental health pathways and as well as supporting clinically driven improvements to mental health services at local system level.

Our partnership working is critical as we have clear issues to tackle.

Our greatest challenge is that service availability is not equitable. The borough you live in SWL affects the services you can access, how long you wait and the outcomes you can expect. Historic funding disparities exist between boroughs, meaning the level of resourcing (both financial investment and workforce) in each borough in not proportionate to need.

Variation continues as a key theme when we look in more detail at our mental health services:

- Both the level of access to mental health services and the amount of contact with mental health services varies for people in all age ranges across all six boroughs. For CYP, adult SMI and perinatal services the numbers of people accessing services are below expectation.
- At points of transition – moving from children's to adult services, or between different types of care – activity often reduces meaning some individuals are falling into a gap.
- Performance across national metrics is mixed. SWL has the lowest performance in London for CYP access to eating disorder services yet consistently meets recovery rate targets for IAPT and two week access targets for Early Intervention in First Episode Psychosis. Both improvements in key performance areas – e.g., carrying out physical health checks for people with SMI, and dementia diagnosis – and deteriorations – e.g., people being placed out of area for acute inpatient care – are evident over recent years.
- Use of services differs between boroughs and population groups. For example, CYP in SWL have a disproportionately high level of mental health A&E attendances compared to the general population; Croydon has the highest rate of working age adult activity taking place in crisis settings; and older adults have longer lengths of stay compared to those under 65 years of age. Admission rates to mental health inpatient wards varies and once admitted the length of stay is similarly mixed.

- Ethnic inequalities exist in service access and activity across SWL with a range of impacts seen. For example, CYP from Asian/ Asian British groups are under-represented in mental health services and CYP from minority ethnic groups have a longer length of stay when admitted. For adults, those from black population groups have more contact with secondary care mental health teams, are more likely to be admitted once seen by crisis teams and once admitted have a longer length of stay.

Alongside this variation, SWL has experienced Covid-19 impacts in line with other geographies with increased demand, acuity and complexity of need across the system presenting as increases in referrals, longer waiting times, longer lengths of stay and delayed discharges. Partners are struggling to recruit and retain staff (vacancy rates average 20%) and find suitable provision for people with complex needs.

When considering investment and taking the relative level of population need into account, SWL spends more per head of population on mental health services compared to other London areas, however, this still benchmarks low compared to areas outside of London where spend is an average of 14% of the ICB budget, compared to the 10% in SWL. For CYP mental health investment specifically the picture is more stark with SWL spending the lowest level across London.

Our starting point

The above elements, alongside the national context, form the foundation for our Strategy. This is summarised below in SWOT – strengths, weaknesses, opportunities and threats analysis.

Strengths	Weaknesses
• Effective collaborative working • High quality existing services • Rich and varied mental health provider landscape including VCSE partners including prevention initiatives within local authorities. • Strong, longstanding mental health leaders • Committed and resilient workforce • Embedded ethos of co-production and involvement	• Lower historic levels of mental health investment compared to other areas • Unwarranted variation in investment levels, access, activity, outcomes and services provided between boroughs • Clear ethnic inequalities in service access • High vacancy rates and competition for staff • Lack of provision for complex individuals
Opportunities	**Threats**
• Passion and enthusiasm for mental health amongst a range of stakeholders • Increasing evidence base of mental health prevention initiatives • New mental health environments at Springfield, Barnes and Tolworth integrated with local housing, wider services and new green space • Population health management intervention development and testing • Digital delivery of care and support • Research and education expansion • Community organisation and asset mobilisation through South London Listens • Green agenda driving sustainable models of care	• Focus on physical healthcare elective recovery effectively deprioritises mental health • Deficit financial position within the SWL ICS NHS partners • Local authority funding pressures and forecasts and s114 notice from Croydon • Continuing rises in mental health demand, acuity and complexity • Changes to policy direction and the existing political landscape • Lack of long-term workforce model

Our understanding of our challenges and our opportunities has supported us in developing our MH strategy.

4. How we developed our strategy

We developed our Strategy in three stages:

1. Assessment of population health need, strategic landscape analysis and identification of innovation.
2. Engagement with our local population (including service users and carers) and professional stakeholders with an online survey, virtual and face-to-face discussions and reflective discussion sessions.
3. Synthesis of data and information into key content.

1. Assessment of population health need, strategic landscape analysis and identification of innovation and best practice

In 2022, we reviewed quality, operational performance, workforce and finance data from our NHS mental health providers, commissioning data from our six places, local and national benchmarking data, as well as publicly available data from the Office for National Statistics, Public Health England, Local Health and Care Plans, Joint Strategic Needs Assessments and national mental health datasets. The data analysis was discussed with key health and care leads and interpretation was augmented with stakeholder workshop discussions.

This work created detailed outputs on population health needs and the strategic landscape that acted as background and context from which to develop the Strategy.

The review work also collected evidence on best practice and innovation across mental health care. This was formulated into a catalogue and available for us to consider alongside published material as we begin to consider transformational developments for SWL.

2. Public and partner engagement

We developed an extensive engagement plan to ensure we were able to hear the views of service users, their carers and families, clinicians, wider stakeholders and residents in SWL. We used both survey and discussion approaches over a number of months.

Our survey received 966 responses (mostly online but some in hard copy) and asked people about how they maintain good mental health and/or where or to whom they would turn if they started to struggle with their mental health or after a mental health crisis.

Overall, family and/ or friends were highlighted as the primary source of support for anyone struggling with mental health problems, with over 60% of respondents indicating it would be their first choice for help if they started to struggle. The same held true for maintaining good mental health and recovering after a mental health crisis. Respondents also indicated that exercise and time in nature (both 52%) or doing activities they enjoy (32%) were identified as supportive with digital tools not scoring highly.

> "In early adulthood I would rely exclusively on my friends when feeling close to a depressive period."

When people start to struggle, they turn to the NHS, with 57% of respondents indicating they have or would seek NHS support, while 28% would seek help from a charity or voluntary sector organisation. Some people do go to the private sector, with 25% saying they have or would do this.

Many respondents reported an overall positive experience with mental health care, whether that was a helpful and responsive GP in their local practice, or access to an IAPT service. However, many others highlighted problems with how our services are set up currently.

The main difficulty people reported when trying to get help was long waiting times, with 51% of respondents indicating this was the greatest barrier to seeking help.

> "The waiting time to see someone was a year. By then I found someone I pay Private which took a huge toll on my finances."

The second most highly ranked barrier was "stigma or shame" with 38% reporting this.

> "When I was first diagnosed with severe clinical depression, my feelings were belittled by my partner at the time. He said I wasn't depressed and I was making it up. However my GP took things seriously and realised just how ill I was. It was definitely people around me though that didn't understand and made me feel ashamed and useless for having these difficulties and feelings."

We need to continue to raise public mental health awareness and tackle access issues to improve mental health and wellbeing across SWL.

Our meetings and discussions provided additional feedback and asked us to consider:

- What more can be done with local authorities and education around prevention and early support for CYP around mental health?
- How can services across health, social care and the voluntary sector develop better links and reduce fragmentation to prevent escalation and reduce demand on NHS services?
- How can social prescribing and voluntary sector services support more people experiencing mental ill health?
- Can primary care offer a greater provision of mental health services?
- How can carers be more supported when caring for someone with dementia or mental ill health?

Towards the end of our engagement period we held open, virtual sessions for stakeholders to review and reflect on our vision and aims and provide additional information or views for consideration. Over 50 people attended across four reflective sessions. These sessions helped confirm we were focused on the right things and provided input to help us refine our language and the development of themes.

3. Synthesis of data and information into key content

Once we had collected all the information we drew together key commitments under our four themes and aligned outcomes to these. These describe the work that we will deliver and what we expect to achieve.

5. Vision, aims and outcomes

Vision

In SWL we want everyone to have access to the right support at the right time for their emotional wellbeing and mental health. We recognise that many influences come from wider factors such as employment, education, housing, and community and we will work in partnership with local authority colleagues to address these. Our services will work effectively together and with people who use our services as early as possible to meet needs and ensure everyone receives the support they need in the most appropriate setting.

Aims

The aims of this strategy are therefore to:

- Prevent mental illness and provide early support for recovery as we know this promotes good recovery and reduces the burden of Ill-health.
- Increase equity of access, experience and outcomes for all SW Londoners – reducing unwarranted variation and ensuring a fair and sustainable allocation of resources.
- Better support and equip our CYP and those that support them to manage their mental health and emotional wellbeing in the future.
- Design a new model for mental health workforce including voluntary and community sector and peer support to tackle mental health recruitment and retention issues.
- Expand bio-psycho-social care to address the mortality gap and the opportunity to increase years of quality life.
- Co-produce delivery of this strategy with service users/ residents in SWL, putting partnership with those who use services and those in our communities at the heart of everything we do.

Outcomes

We have high aspirations for the mental health and wellbeing of our SWL residents and communities. To reflect these we have set ourselves ambitious goals over a ten year period:

By 2032/33 we will have	
Population	**Services**
• Increased equity of service access to reflect community demographics with no unwarranted variation in outcomes • Improved mental and emotional wellbeing for residents in SWL • Reduced the 'mortality gap' between those with SMI and the general population • Eliminated racial inequality around overrepresentation of black people in detention, inpatient and crisis care • Ensured no person known to mental health services presents to A&E unless for physical health issue • Eliminated restrictive practices • Zero suicide • Significantly reduced self-harm • Eliminated inpatient stays outside of SWL for SWL residents • Closed unneeded acute inpatient beds	• Fully integrated mental health care in place for people with SMI and physical health needs, social care needs (including supported living), LDA, homelessness and substance misuse • Allocated resources based on need • Redirected mental health investment with the majority of spend occurring in primary care, VCSE and community settings • Increased funding into mental health benchmarked with other areas nationally and increased the overall proportion of funding directed to CYP mental health specifically • Fully staffed services with new roles in our workforce and positive staff wellbeing, satisfaction and morale • Embedded research and evaluation of services, operational models and initiatives as standard practice using meaningful recovery and experience measures • Services responsive to population health needs and flexibly delivering changes

Due to their scale and their nature, we expect that these goals will take longer than the life of this five-year strategy to deliver. We have therefore included more specific outcomes for each of our themes which can be found in the following sections. During the first 6 months of our Strategy we will work with people with lived experience to set targets for delivery.

Themes

We will deliver our Strategy through work across 4 themes with specific focus and content:

1

Prevention and early support including:

a) Support for children and young people and families
b) Healthy environments
c) Mental health literacy and reducing stigma

2

Bio-psycho-social model including:

a) Physical healthcare for people with SMI and mental health support for people with physical health care conditions
b) Neighbourhood teams & integration
c) Complex needs & co-occurring issues

3

Inequalities including

a) At risk communities
b) Unwarranted variation

4

Timely access including:

a) Least restrictive care & recovery
b) Waiting times
c) Transitions
d) Discharge

The detail of the themes are outlined in the following specific sections.

6. Theme 1: Prevention and early support

Including:

- Support for children and young people and families
- Healthy environments
- Mental health literacy and reducing stigma

What we know

Early support for mental wellbeing is vital. Evidence shows that when we support people to focus on better mental wellbeing fewer people struggle with mental health problems or they're better able to cope with existing conditions.

Supporting people to maintain good mental health is about understanding what helps to keep us balanced and able to cope with struggles and manage our emotions. Issues such a poverty, homelessness, unemployment and discrimination impact are detrimental to our wellbeing. Things such as connecting with other people, being physically active, being in nature/ access to green spaces and learning new skills are proven to improve self-esteem and self-confidence, help people develop a sense of purpose or belonging and reduce stress.

Preventing mental health problems also benefits physical health outcomes and ensures people can live well and maintain a healthy lifestyle. Embedding prevention and early support initiatives in communities can destigmatise mental illness and support the

development of positive beliefs around mental wellbeing and mental health literacy. Connecting these approaches into our buildings and organisations supports us to build health environments and support work on the wider determinants of health.

Whilst prevention and early support is beneficial for all, research demonstrates that around 75% of all mental health problems develop by 24 years of age. In addition, the first 1,001 days (including pregnancy) are critical for a child's life in terms of both physical and emotional wellbeing. Stress and adverse childhood experiences in this period can have lifelong impacts. If we are serious about improving mental health of our population over time, we must focus on preventing children and young people developing mental health issues including supporting parents during pregnancy and onwards.

Demand for CYP mental health services from has increased significantly during and following the Covid pandemic. The rise in the percentage of children identified as having a probable mental health disorder noted in the strategic landscape section above represents a 50% increase – a shift so considerable it requires national, regional and local attention. The position is similar across SWL where referral numbers have significantly increased alongside the acuity and complexity of the people needing support.

What people told us

Prevention and early support were key issues highlighted in our survey and through discussions with service users, carers, clinicians and partners.

We heard that people want the prevention and early support agenda around mental ill-health to have the same focus as that around physical ill-health. There are many examples of initiatives to support improved physical health across the life span and mental health needs to do the same.

"Make promotion of good mental health (and prevention of mental ill health) an equal basis to physical health"

"Low cost or free physical activity, plenty of green spaces, free activities for low-income people."

People are more open to discussing mental health now, which is a positive change. Stigma and shame still exist, though, and we heard suggestions to improve information and advice in the community where people go every day, not just through health services or the voluntary sector.

"Provide easily accessible information both online and via health & Wellbeing Hubs or through key community points of access e.g. Faith groups, Barbers, Shopping Malls etc"

CYPs mental health was a priority across many groups that we spoke with. People recognise that supporting CYP early can prevent mental ill health later, and one of the ways to do this is by supporting parents to have good mental health.

"More support for parents and prospective parents - adverse childhood experiences correlate with poor mental health (as well as physical health, social and occupational outcomes)."

To support CYP to develop and maintain good mental health, it's clear that prevention needs to start early and be accessed in the places CYP are, which is primarily education, but also social services.

"More prevention and early support in CYP mental health to better link Local Authority services and education."

"Focus on people long before they need mental health services and work with schools etc to start a lifelong journey in good mental health."

What we need to do

- Increase the availability of evidence-based prevention and early support initiatives and increase funding into these areas year-on-year.
- Develop an approach to public mental health drawing on work underway at national level and drawing on expertise in our local authority public health teams.
- Develop an "assets based" approach to promoting mental health and wellbeing working with communities and non-health organisations as full partners.
- Continue to work in conjunction with South London Listens (a partnership between the NHS, Local Authority and VCSE) to develop and deliver community defined change around mental health.
- Train and develop colleagues working outside of mental health to identify mental distress early and provide effective input and signposting.
- Expand Mental Health First Aid Training across SWL and promote best practice approaches.
- Work with partners to further develop a co-ordinated approach to suicide prevention.
- Build upon the success of social prescribing and join up the offer across SWL to provide consistent and effective non-clinical support to develop and maintain mental wellbeing.
- Expand the availability of parenting programmes, perinatal mental health services and early years support for families in partnership with local authorities in particular for vulnerable parents.
- Increase the proportion of funding that is used for CYP mental health recognising that tackling issues earlier prevents mental health ill health in adulthood.
- Deliver focused prevention work for cohorts of CYP known to be at higher risk of developing mental health issues.
- Move away from the tiered system of service access for CYP and families and implement a needs based framework removing gaps and simplifying provision.
- Ensure the best range of digital support options and that these are regularly reviewed and updated and uptake monitored.
- Continue to develop the 'whole school approach' with ongoing investment into schools Mental Health Support Teams.
- Develop, support and deliver mental health promotion programmes in line with the evidence outlined in the prevention concordat for mental health.
- Through place-based partnerships, work to address social and economic factors that have an adverse effect on mental wellbeing.

Outcomes we expect to deliver

- Increased the range of prevention, early support and advice services available
- Increased understanding of mental health issues and wellbeing amongst key communities
- Developed community led and assets based models for delivery
- Improved mental health, wellbeing and support to carers
- Implemented effective parenting, early years and education programmes
- Trained residents, VCSE partners, wider health, education and care professionals and employers in mental health support
- Improved recovery rates and quality of life for people with mental health issues
- Reduced suicide and self-harm rates
- Increased investment in and level of services provided to CYP and families
- Improved system collaboration around population-wide prevention and early intervention
- Implemented measurement of outcomes, population wellbeing and services

7. Theme 2: Bio-psycho-social model

Including:

- Physical healthcare for people with SMI and mental health support for people with physical health care conditions
- Neighbourhood teams & integration
- Complex needs & co-occurring issues

What we know

Having a serious mental illness can adversely impact on an individual's physical health. This is related to a number of factors including medication impacts, wider determinants of health and lifestyle factors such as being more likely to live in unsettled accommodation or smoking or alcohol use and challenges in managing an existing long term condition such as diabetes, COPD or cardiovascular disease. Whilst there are initiatives to support people with SMI to access an annual physical health check, the levels of uptake are low and the support available to improve their physical health lower still.

The integration of health and care services has been a long-held ambition. We know that our services are fragmented and vary by borough. We also know that our services don't always talk to each other or to other services or agencies supporting the same person. Our statutory services also don't always provide wholly person-centred care and people can feel 'done to' rather than involved in their care. We know there are a range of different therapies, interventions and support that we could deliver but we don't always have the space, time, or resource to offer them. We have a good offer of voluntary sector support across our geography but, again, it varies by borough and offer

or level of support making it even more complicated to know that support exists and how to access it. The implementation of our SWL ICS, the examples of integration emerging at different levels, across England, offers a platform to make change happen.

People don't always present with 'simple' issues for resolution; many people experience challenging situations and some people will have complex needs or range of issues they need support with such as substance misuse, ADHD, learning disability and autism or dementia. At present our pathways and care packages do not always support people to recover or to live as independently as possible. Sometimes support breaks down leading to crisis or placement far from home. Tailored and specific care pathways and packages are needed and these can only be developed and delivered through partnership working.

What people have told us

Through our engagement work people told us that they want a model that joins up physical and mental health and is person-centred:

"A focus on physical and mental health together. Any new diagnosis of a long-term condition should also include an offer of mental health support."

"Listen to them and what they need. Everyone is different and a 'one type fits all approach' might not be right."

People also talked about wanting local access with better support in primary care and suggested how we could work better together across services, including primary care or the voluntary sector.

"Create multi-agency pathways with lots of different entry points to encourage the idea that there is not just one doorway to support and advice that can help."

"Skill up GPs to be able to deal more with MH issues confidently such that patients get very early primary intervention."

"Placing mental health workers in General Practice."

People told us how valuable peer support or voluntary sector services were to them. Including wider partners in integrated teams would be positively received.

"More support for people around housing, benefits. People within teams who are specialists in these areas so that the support is more holistic."

"I was lucky enough to get a peer support worker. We worked together for approximately two years and she came up with some really helpful coping strategies, shared ideas and she gave me hope."

"MIND and Samaritans were fantastic."

What we need to do

- Establish a comprehensive approach to physical healthcare for people with SMI detailing expectations, support available and roles of different professionals.
- Ensure that physical health checks for people with SMI are carried out and results are acted upon with brief interventions, signposting or referrals as appropriate.
- Revise training curricula for all health and care professionals to include a mandatory set of competencies around understanding/ recognising, communicating and signposting to psycho-social support.
- Ensure that mental health support is available to those with physical health conditions working with primary care and acute partners (including the SWL Acute Provider Collaborative) to build this into physical health pathways.
- Facilitate the creation of successful partnerships and shared learning with NHS, local authority, primary care, education, police and voluntary sector partners.
- Embed mental health into emerging neighbourhood teams and primary care networks – developing multi-disciplinary team working and shared population health approaches and supporting the SWL Primary Care Strategy.

- Promote the co-ordination of care around an individual's needs in a seamless way, embedding this as a core principle in any redesign or transformation.
- Develop coherent and responsive pathways involving specialist, community and VCSE services, and peer support, for people with co-occurring physical and mental health issues and ensure that health and local authority services work jointly together as needed (for those with substance misuse issues for example).
- Pool system expertise to develop an inclusive, recovery focused model of care and commissioning approach for people with complex mental health needs recognising and tackling funding and provision challenges.

Outcomes we expect to deliver

- Improved health outcomes for people with SMI with physical health conditions.
- Integrated mental health care with primary care, social care and education partners.
- Reduced services user experiences of services feeling fragmented or disconnected and needing to tell their stories multiple times.
- Included VCSE partners and peer support in mental health pathways.
- Made services easier to navigate and more joined up.
- Improved independence and recovery for people with complex mental health needs.
- Developed a sustainable model with clear pathways for those complex needs provision including rough sleepers, co-occurring substance misuse, learning disabilities and autism.

8. Theme 3: Inequalities

Including: • At risk communities • Unwarranted variation

What we know

Understanding the population and their needs is crucial in designing and delivering inclusive and effective services. Health inequalities – unfair and avoidable differences in health across the population, and between different groups within society – impact on how long people are likely to live, the health conditions they may experience and the care that is available to them. We can tackle health inequalities but this requires dedicated and structural approaches and partnership working to impact on the wider determinants of health.

The Core20PLUS5 model is a national initiative aimed at supporting ICSs to drive action around health inequalities. recognising and understanding health inequalities. It was developed for adults but has now been adapted for CYP. Core20 refers to the most deprived 20% of the national population, PLUS refers to additional population groups identified for health inclusion at local level (such as people from BAME communities, those experiencing homelessness or people LDA or multiple health conditions) and 5 refers to clinical focus areas which require accelerated improvement (SMI is one of these 5 for adults and mental health more broadly is one of the 5 for CYP).

As has been described earlier in this Strategy the SWL population is diverse and varied. Across our six boroughs we have deprived communities, a range of educational attainment and employment levels, ethnically diverse communities, some high levels of children looked after and CYP with additional needs, and a people from all protected characteristic population groups as defined under the Equalities Act 2010. We also know that people from black ethnic backgrounds are more likely to be detained under the Mental Health Act and experience inpatient and crisis services. We have made commitments to anti-racism but we need to make this real.

In addition, our mental health services are not all designed to meet a standard set of expectations or to address population needs, there are different expectations and processes that people need to navigate and there is unwarranted variation in quality, outcomes nad experience. We want to transform our services to ensure equity across SWL.

What people have told us

A range of people participated in our survey and discussions, however, we recognise that some voices are still heard less frequently and we have more work to do to reach people in all our communities.

We heard that people from some communities experience shame or stigma in trying to access services. This is a barrier before they even reach a service and then they face all of the other issues identified in our discussions: long waiting times, inflexible support, not being listened to, etc. There were suggestions around doing more specific work around those from ethnic minorities.

"Design a specific peer support group for BAME as they may feel more comfortable disclosing early symptoms to someone who they can ethnically identify with."

"Keep on talking about mental health - making people aware that mental health does not choose class, colour, wealth, age or ability/disability. Everyone can and is affected by it."

What we need to do

- Develop a co-production approach to working with communities, residents, service users, carers and wider stakeholders bringing lived experience and seldom heard voices to the fore.
- Further develop our understanding of the SWL population through work with public health teams and in conjunction with the SWL ICP Strategy.
- Provide more support into groups that analysis shows to be overrepresented in terms fo those detained under the Mental Health Act or underrepresented in early access to mental health services.
- Use a community outreach model to engage with communities in partnership with local voluntary sector partners.
- Develop a health inequalities work programme in line with national, regional and local approaches and CORE20PLUS5.
- Identify communities and population cohorts most at risk of mental ill health ((for example, children looked after) and use a population health management approach to design and implement interventions to maximise emotional wellbeing and develop resilience.
- Build upon the existing Ethnicity in Mental Health Improvement Project (EMHIP) to share learning across all six SWL boroughs and in relation to other cohorts.
- Tackle racism and discrimination and deliver our anti-racism framework.
- Annually allocate recurrent investment to tackles health inequalities around mental health.
- Review care models and performance by service area and implement a consistent core offer to reduce unwarranted variation in service availability, quality of care and outcomes.

- Move resources, with appropriate consultation, planning and impact assessment, between boroughs and service areas to ensure equitable provision based on population health needs (both in terms of burden of mental ill health and wider socio-economic factors).
- Work closely with places and neighbourhood teams to tailor core offers to be culturally sensitive and acceptable.
- Proactively look outside of SWL and identify learning, evidence and best practice around communities at risk, health inequalities and unwarranted variation

Outcomes we expect to deliver

- Increased levels of community participation in mental health programmes and projects.
- Improved levels of access to mental health services for people from across underrepresented communities.
- Services provided closer to communities we serve with more care and treatment delivered by people from these communities.
- Positive recruitment and career development initiatives for people from local communities.
- Improved outcomes for people from at risk communities.
- Reduced rates of detention generally and the disproportionate use of detention for people from black ethnic backgrounds.
- Improved experience and mental health, wellbeing and support for carers.
- Redistributed resources to reflect population needs.

9. Theme 4: Timely access

Including:

- Least restrictive care & recovery
- Waiting times
- Transitions
- Discharge

What we know

Delivering the right care and support as early as possible improves and shorten people's recovery journey. When people deteriorate significantly or experience a crisis they are more likely to need intensive interventions and inpatient care. To keep people safe in these circumstances increased restrictive practices may be required – such as detention under the Mental Health Act, seclusion, increased observations, physical or pharmacological restraint – all of which can negatively impact on an individual's experience and dignity and can imping on people's human rights. In developing community based and early support services, and reviewing our crisis and inpatient services, we aim to reduce restrictive practices.

Once people are unwell and need support, whether it be a physical or mental health issue, they want to access that support quickly. We have waiting time targets for all elements of NHS care specifically to ensure that people do not endure unduly long waits for support. Mental health is no different to physical health in the evidence that providing specific interventions or therapies in a timely manner supports a better chance of recovery and reduced likelihood of further deterioration, however, mental health waits do not attract the same attention or scrutiny as those for physical health services.

Waiting times for mental health services have increased since the pandemic, owing primarily to increased demand (numbers) but also the acuity and complexity of those presenting for help.

Often, there are not enough clinicians to enable services to provide safe care to the numbers presenting and, thus, a waiting list develops. While it is not always harmful for someone to wait for a service, the waiting times seen in mental health are too long and in some areas impact on wider elements of life – CYP waiting for mental health support may struggle school or have reduced educational attainment. Our mental health services are struggling to reduce waits without any additional support. We want to tackle waiting times and improve access to care, including offering additional support available when waits occur.

Sometimes people need support from a number of different types of services or they may need to move services at specific points – such as CYP moving into adult services. Poorly managed 'transitions' can mean people fall into gaps between teams or deteriorate as new services don't understand their needs. In addition, if people are discharged from services too early or without adequate support they can experience a relapse or needing to re-engage with services in an unplanned way. We have high quality mental health services in SWL but their organisation and operational processes are not always as clear and simple as they could be; we want to improve this.

What people have told us

People told us that the number one barrier to accessing services was waiting times. We heard this through meetings and through the survey results. Interestingly, people said they could accept waiting for certain services but that they wanted to have some sort of support or check-in while they waited.

"Provide mental health treatment promptly. Waiting months or years for mental health treatment is not acceptable."

"Quicker access to services or some form of monitoring regularly whilst on waiting lists."

Generally, people were positive about the services they received and how quickly they were assessed, especially in IAPT or CAMHS, but then having to wait for treatment without any additional support means many people suffered more than they had to. Some people suggested signposting to other services, providing peer support or a plan of action for the person while they wait for their treatment.

"Have support available e.g. peer groups or education groups for person and carers during the waiting time between asking for help and seeing specialist services so that there is not a complete vacuum of support during this period."

Discharge (from inpatient or community services) and the support following it also came up for those that had been in services. It's clear that people can feel "lost" following discharge and it can be difficult to re-integrate into the community and the period following discharge from inpatient services is known to be a time of heightened risk of suicide. We also need to recognise the importance of relationships in mental health care and feeling of loss when relationships with teams or services. Some suggestions included regular check-ins or ongoing community support. They want to be able to get back in easily if they relapse or have issues post-discharge.

"More support for those that have been discharged so that they do not relapse. I personally believe that the door should be left open and at the point of discharge the service user informed that if things get worse then you know where we are and if you need help then contact us."

What we need to do

- Increase investment in community services to maximise opportunities for close to home, least restrictive care available.
- Ensure all partners are signed up to principles of delivering least restrictive care and have clear processes in place around care planning, crisis management, goal setting and risk management to facilitate this.
- Share learning and innovation around least restrictive practice and implement new models in support of this approach.
- Reduce waiting times for access to services and starting treatment through pathway improvements and optimised referral processes, and by reviewing and potentially revising service availability in terms of population need.
- Provide consistently clear and early information on waiting times and provide access to self-help resources or support from wider partners including VCSE whilst people wait.
- Make it easier for people to navigate services and know where to access support with a dynamic and maintained directory and map of SWL mental health services.
- Better support people to move between services and ensure transitions are proactively managed to avoid people falling through the gaps.
- Reduce hand offs and interfaces between teams within and between organisations creating integrated ways of working and seamless pathways.
- Promote a positive experience of, and clear expectations around, discharge – as a part of their recovery journey – from an early point in a person's care experience.
- Improve step down approaches enabling people to return to services as needed at their own initiative therefore avoiding deterioration or crisis and reducing unnecessary administrative processes around referrals and assessments.
- Increase continuity of care by stabilising and developing the mental health workforce.
- Increase peer support for more positive step down, transition and discharge experiences.

Outcomes we expect to deliver

- Reduced restrictive practices of all types
- Reduced presentations to A&E for people known to mental health services except for physical health issues
- Eradicated out of area placements for acute mental health provision
- Reduced waiting times for services
- Improved positive feedback around transitions and discharges from services
- Increased peer support levels available across all boroughs
- Improved workforce retention, satisfaction, wellbeing and morale
- Standardised models of care with consistently high performance across a range of indicators

10. Enabling programmes

As well as developing key activities and priorities within mental health, the delivery of the Strategy will be made possible by working with colleagues across the SWL ICS on a number of enabling programmes. We will ensure that there is a strong mental health presence within these workstreams.

1. Population Health Management

Population Health Management (PHM) offers opportunities to understand needs of specific population groups and communities and to develop focused interventions to address these.

Within SWL mental health is represented within PHM Programme Board but as yet there is no defined or dedicated work in this area.

We will develop an appropriate approach and bring together experts in this areas. We will work with colleagues from informatics teams to review data and address gaps. We will learn from the successful pilots of PHM at place and primary care network level. We will deploy this approach to ensure we develop services to respond to current needs, not historic service models, and increasingly focus earlier in the patient pathway to ensure people are supported more in the community. This will further help to support prevention and reduce health inequalities.

2. Workforce

Sustained workforce challenges is arguably the greatest pressure the NHS has to tackle. In line with the national and regional picture, SWL has high vacancy levels in some services, high turnover and difficulties recruiting to some roles. Both SWLSTG and SL&M have flexible working models in place which will continue to develop to respond to changes in employment expectations post-pandemic. In addition, we have begun to include new and extended roles in our services models and to develop new career pathways. We offer training and preceptorship opportunities but as anchor institutions and with our partners in South London Listens, the SWL ICB, SWLSTG and SL&M, can do more to support people in our communities to consider and enter a career in mental health.

We support the wider ICP strategy first year focus on workforce and will support the SWL People Board and broader initiatives. Workforce elements will form a core part of the Strategy annual delivery plan.

3. Digital

This Strategy recognises the increasing role digital technology plays in healthcare. We believe that digital tools such as internet resources, mobile apps, online services and video consultations can augment traditional service delivery and access to support.

We already have a solid foundation of digital delivery which was extended during the pandemic. For example, video consultations remain are an option for service users and we have commissioned platforms such as Kooth (the online mental health resource for CYP).

We will better co-ordinate digital initiatives across the ICS to ensure a joined-up approach. We will continue to develop links with London wide initiatives such as the Good Thinking resource. We will work with the Health Innovation Network to identify and review opportunities for further innovation and technology use. We will monitor usage and outcomes from digital resources and continue to develop new approaches and ensure that all digital elements are reviewed and approved to ensure quality standards are met. We also recognise that digital exclusion exists and we will work to ensure people who want to access digital resources have opportunities to do so. We will work with the SWL Digital Programme to support the delivery of the Digital Strategy and Programme.

In addition we will work with wider partners around the Primary Care Strategy and the delivery of the SWL ICB Joint Forward Plan.

11. Implementing our Strategy

We want to thank everyone who has been involved in developing our Strategy. We know that we are only at the beginning of the journey and that co-producing and delivering the changes that have agreed will need energy, commitment and partnership working.

Our delivery structure

In SWL we are developing an integrated approach to mental health meaning that we will have a strong collaborative structure to support the delivery of the Strategy.

The SWL MH Partnership Delivery Group (PDG) will oversee the implementation of the Strategy and provide updates to the SWL ICB and ICP. This group is chaired by the SWL ICB Partner Member for Mental Health and brings together SWL ICB officers, all 6 SWL places, the two main mental health providers (SWLSTG and South London and Maudsley NHS Foundation Trust – SL&M) and the SLP. The PDG sub-groups will focus on key service areas – such as CYP MH, provide technical input – around planning or finances, or lead on development areas – including inequalities and population health management approaches.

A small group of senior leaders will take overall responsibility for the Strategy delivery, setting the annual plan, involving stakeholders and monitoring and reporting on progress.

The two main mental health providers in SWL – SWLSTG and SL&M – will come together in a SWL Mental Health Provider Collaborative structure under the existing South London Mental Health and Community Partnership (SLP) to set common standards and models of care, transform existing provision and effectively connect specialist and local services.

Each place will support the delivery of the Strategy locally through mental health partnership boards and nominated leaders, tailoring work relevant to local communities and challenges.

Measuring success and progress

Critical to success is having clear plans. We will develop an annual delivery plan as part of the standard planning cycle. This plan will detail the priority areas, milestones and outputs expected. It will be signed off by the PDG. The plan will identify and confirm funding and wider resources required for delivery.

Our planning and our work will be transparent and clear for all to understand.

Quarterly updates on the annual plan will be made to the PDG and onwards to the SWL ICB Board 6-monthly. Metrics will be agreed to measure progress towards expected outcomes. We will develop 'return on investment' approaches to help understand the impact of investment decisions and we will evaluate and assess changes we make. Impact assessments will be undertaken before changes are made.

Year 1 focus

In our first year – 2023/24 – we will focus on two key areas for delivery of improvements:

1. Going further and faster for CYP making improvements around support available for CYP and families whilst waiting, support available in schools and transitions to adult or wider services.
2. Embedding transformation of community transformation for adults with SMI.

We will also set up our delivery structures and carry out a number of pieces of enabling work to help us work together across the system.

This will include:

1. Ensuring our governance structures are in place to support delivery.
2. Completing a detailed strategic review of mental health investment to date and the outcomes delivered from this to form the basis of a longer term model aimed at allocating resources based on need.
3. Agreeing approaches to outcomes measurement and evaluation (including setting targets for delivery with people with lived experience and understanding our baseline data) and reviewing public mental health work to identify future initiatives for deployment in SWL.
4. Confirming mental health leadership and resourcing is in place.

12. Glossary

Term	Definition
SWL	South West London – geographic area formed of the six boroughs of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.
ICS	Integrated Care System – a partnership of organisations that come together to plan and deliver joined up health and care services to improve the lives of people in their area. They will be responsible for how health and care is planned, paid for and delivered. An ICS has four key purposes: 1. improving outcomes in population health and healthcare 2. tackling inequalities in outcomes, experience and access 3. enhancing productivity and value for money 4. supporting broader social and economic development
ICB	Integrated Care Board which is the statutory NHS body within an ICS that decides how the NHS budget for their area is spent and develop a plan to improve people's health, deliver higher quality care, and better value for money, and
ICP	Integrated Care Partnership which brings the NHS together with other key partners, like local authorities, to develop a strategy to enable the Integrated Care System to improve health and wellbeing in its area

www.southwestlondon.icb.nhs.uk

May 2023

NHS South West London
Integrated Care Board

ANNEX D

Agenda Item 06

SWL Mental Health Strategy

2023/24 (year 1) delivery plan

SWL MH Strategy – 2023/24 (year 1) delivery plan

Our year 1 delivery plan focuses on two core improvement areas and enabling work. Significant enabling work is required in year 1 to set up for success. From year 2 onwards delivery will shift to being focused on outcomes and improvement at clinical, service and population levels.

Objective	**Milestones**	**Outcomes**	**Strategy theme mapping**[1]			
			PES	BPS	I	TA
Core areas						
1. To better support CYP and their families and improve available mental health offers.	• Review SWL MH provision for CYP and families and identify gaps (Q2) • Implement extended perinatal services (Q3) • Implement additional support services for CYP and families whilst waiting for CAMHS (Q3) • Implement revised communication protocols between CAMHS and wider partners (inc schools) (Q3) • Optimise referrals from primary care increasing non-CAMHS signposting (Q3) • Improve pathways within key CAMHS service areas – neurodevelopmental, eating disorders – to reduce waits (Q4) • Agree investment areas and service expansion for 2024/25 (Q4)	• Access rates improved • Waiting times reduced • Increased support and signposting available • Increased proportion of funding allocated to CYP MH				
2. To transform SMI models for adults across SWL embedding new community models and evolving crisis support improving access, experience and outcomes.	• Set up SWL group to share learning and develop core SMI adult model/ standards (Q1) • Increase VCSE provision and peer support in adult SMI services (Q2) • Pilot SWLSTG rapid and enhanced community response to support system flow (Q2) and expand if successful (Q4)	• Flow metrics improved (out of area placements, length of stay) • Holistic care planning in place • Access rates improved				

[1] PES – Prevention and Early Support; BPS – Bio-psycho-social; I – Inequalities; TA – Timely Access

	• Delivery 100 day discharge challenge work (Q3) • Implement changes to crisis pathway under NHS 111 (Q3) • Enhance MH input into place neighbourhood teams structures (Q3) • Implement holistic care planning as move away from Care Programme Approach (Q3) • Confirm core offer for all 6 SWL boroughs (Q3) • Roll out community SMI model into all SWL boroughs (Q4) • Agree SMI 2024/25 plans (Q4)	• SMI health checks increased • Standardised care model developed				
Enabling work						
3. To develop a future investment model based on need and delivery to date.	• Agree strategic financial and delivery review scope and begin work in all partners – managed via SWL MH PDG (Q1) • Review return on investment (RoI) models and agree approach to MH for SWL (Q2) • Complete strategic financial and delivery review and develop recommendations on funding allocation for 2024/25 (Q2) • Review MH funding allocation models – SWL and external – and develop and discuss options for SWL change (Q3) and agree through place, provider and ICB structures (Q4) • Agree 2024/25 funding allocations through planning round (Q4)	• Clear view on funding use and delivery to date • Ability to demonstrate RoI for MH funding • Revised funding model				
4. To define the approach to public mental health,	• Review RCPsych work on public mental health interventions and approaches and identify all local initiatives (Q1)	• SWL MH prevention and early support programmes increased.				

	prevention and early support.	• Develop collaborative view of interventions for SWL with clear funding and implementation plans and feed into 2024/25 planning round (Q3)					
5.	To shift towards outcomes-based commissioning and delivery.	• Review current outcome measure and data collection within commissioned services, and set against national expectations (Q2) • Agree standard outcome measurement for common service areas with providers and people who use our services (Q3) and implement these along with revised data collection (Q4) • Develop framework for service review and evaluation (Q3) and agree cycle of reviews to support Strategy delivery (Q4) • Integrate shift to outcomes measurement into 2024/25 contracting (Q4)	• Outcome measures in place for services. • Data being collected to support measurement of change over time.				
6.	To confirm governance, resourcing and leadership structures to ensure successful delivery of the Strategy.	• Core strategy delivery group in place with nominated leads and workplans for all objectives; Strategy stakeholder (inc service users and carers) steering group in place to support wider input and review (Q1) • Existing ICB MH groups refreshed and supporting Strategy delivery; place alignment to plans completed (Q2) • Future MH leadership and resourcing proposed (Q3) and confirmed (Q4) • Roles, duties and functions of SWL MH PDG and SWL MHPC confirmed and in place and any agreed business cases for MHPC delegation agreed (Q4) • Year 2+ Strategy delivery plans confirmed (Q4)	• Governance, leadership and delivery resourcing in place. • Responsibilities and roles confirmed.				

NHS South West London
Integrated Care Board

ANNEX E

Agenda Item 07

SWL Primary Care Strategy Update

Appendices

NHS
South West London

Primary Care Strategy Update

Appendices

May 2023

Prevention

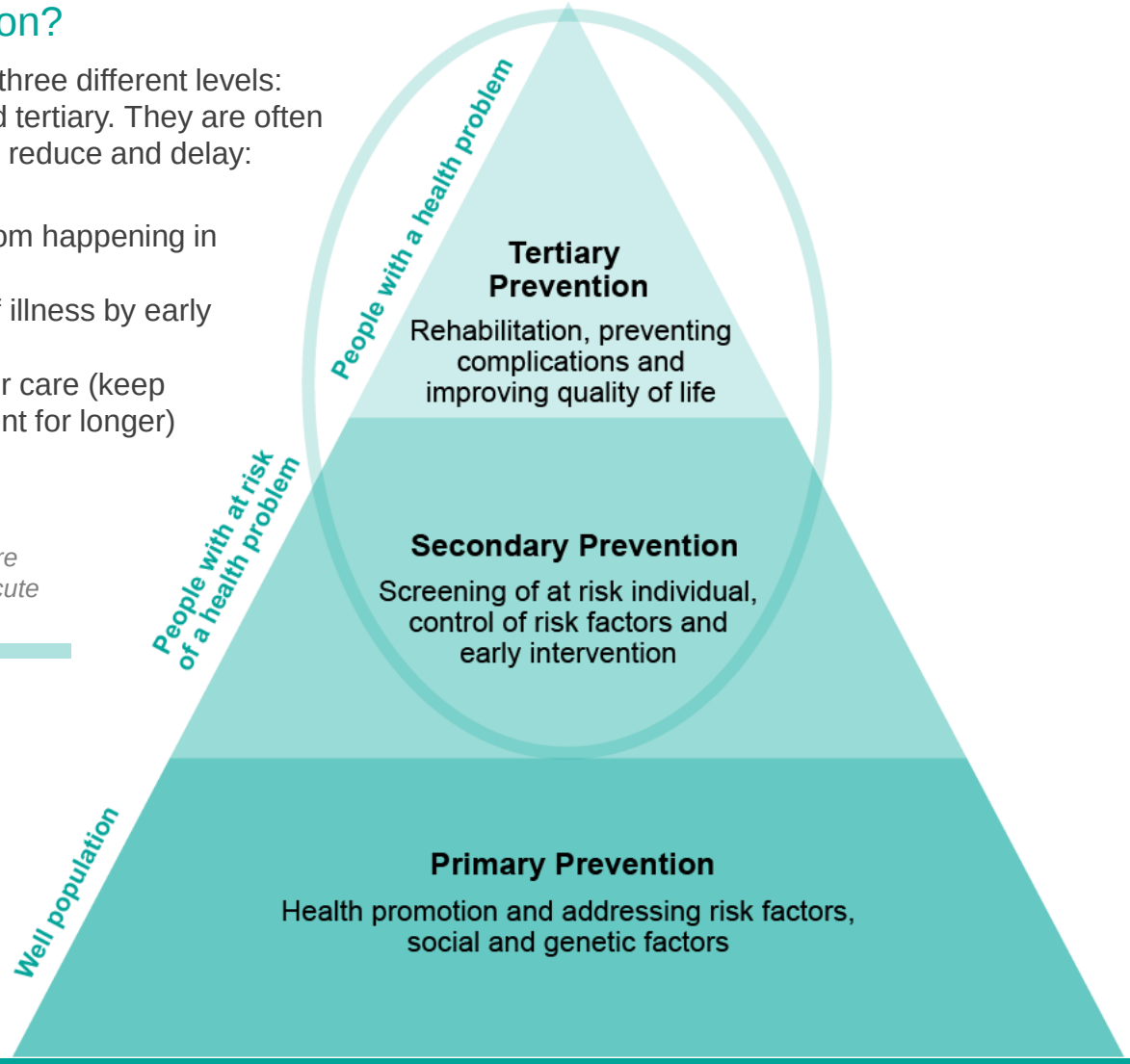
Context

What is prevention?

Prevention consists of three different levels: primary, secondary and tertiary. They are often referred to as: prevent, reduce and delay:

1. **Prevent** illness from happening in the first place
2. **Reduce** impact of illness by early detection
3. **Delay** the need for care (keep people independent for longer)

Focus areas for primary care support the avoidance of acute and A&E attendances



Building on our achievements

Immunisation

- 3.5 million Covid-19 vaccines delivered to 1.2m people across South West London (as at October 2022)
- PCNs and community pharmacies have delivered the majority of these vaccines across multiple locations including in every care home
- Throughout the Covid-19 vaccination programme SWL has exceeded the London average for uptake across the majority of cohort groups
- South West London continues to perform well for flu vaccine uptake. It has the highest uptake percentage in London overall and across all but one cohort group

Respiratory

- Spirometry is used in primary care to improve diagnosis and monitoring of lung conditions
- Fractional Exhaled Nitric Oxide (FeNO) devices are being used to support improved detection and management of asthma

Self management

- Digital self-management system now in place for musculoskeletal and pelvic health modules; acute waiting list, CVD and respiratory modules are in co-production. These will signpost to local prevention offerings. Access is via self-referral, GP, Community, Trust, A&E, and soon pharmacies
- More than 90% of GP practices have implemented digital self-management to 22,000 patients
- National digital exemplar; digital exclusion pioneer

Supporting self management

Current number of users	**22,040 prescribed** **11,672 registered** (51% activation)
Reduction of first-time appointments	**2,292**
Reduction of repeat appointments	**4,553**
Cost savings on prescriptions	**£518,215**
Reduction of physio referrals	**881**

Next steps

Our role is to support the implementation of key prevention enablers so that GPs and their teams have the tools needed to help patients manage their condition better to prevent unnecessary worsening of conditions

Mapping

- Map all prevention services and primary care prevention enablers
- Identify and agree the model of care
- Identify required enablers
- Identify where support is required
- Identify where numerous conditions can overlap - for example CVD, diabetes, chronic kidney disease, fatty liver
- Identify where work can be done at scale – for example by using automation software so patients get called back for a follow-up at the right time

Prioritise and implement

- Prioritise key enablers and the support required
- Provide hands-on support to practices including identifying the cohorts of patients for specific diseases
- Where required, design and test new approaches – for example, communications, interventions, workforce and so on to understand what works best for different patient cohorts

How we will measure our progress

Prevention

- % of diagnosed offered available prevention
- % started
- % completed; health outcomes – for example, diabetes patients referred to NHS digital weight mgmt., >80%

Early detection

- Find 80% of expected long-term conditions prevalence (85% for Atrial Fibrilation)

Digital self-management (including MSK)

- % of diagnosed offered SWL digital self-mgmt
- % activated

Optimisation

- % Patients have had annual assessments and review
- Blood pressure: 80% treated to NICE target
- Cholesterol: 60% aged 25-84 years with a CVD risk score >20% on statin
- Atrial Fibrilation: 90% at high risk of stroke receiving anti-coagulant
- Diabetes: 85% meeting 8 Care Processes
- Respiratory: % Asthma and COPD patients have annual review and care plan

Looking to the next 5 years

Helping people live well for longer

Working with local authority public health colleagues and across the ICS

Contribute to a healthy lifestyles prevention pathway

- Health checks
- Weight management
- Smoking
- Alcohol
- Exercise
- Social prescribing

Support the prevention and early diagnosis of chronic conditions

- Management of diabetes
- Screening
- Support with mental health at earliest possible stage
- Digital self-management

Develop staff into preventionists

- Develop infection preventionists
- Make every contact count
- Think compassionately
- Motivational interviewing
- Health promotion

Develop health maintenance approaches

- Use personalised care to support patient groups, for example immunocompromised, long term conditions
- Support self-care

Prevent communicable diseases

- Improve immunisation uptake
- Developing our response to outbreaks and incidents
- Further development of antibiotic stewardship

Improve the health and wellbeing of our population

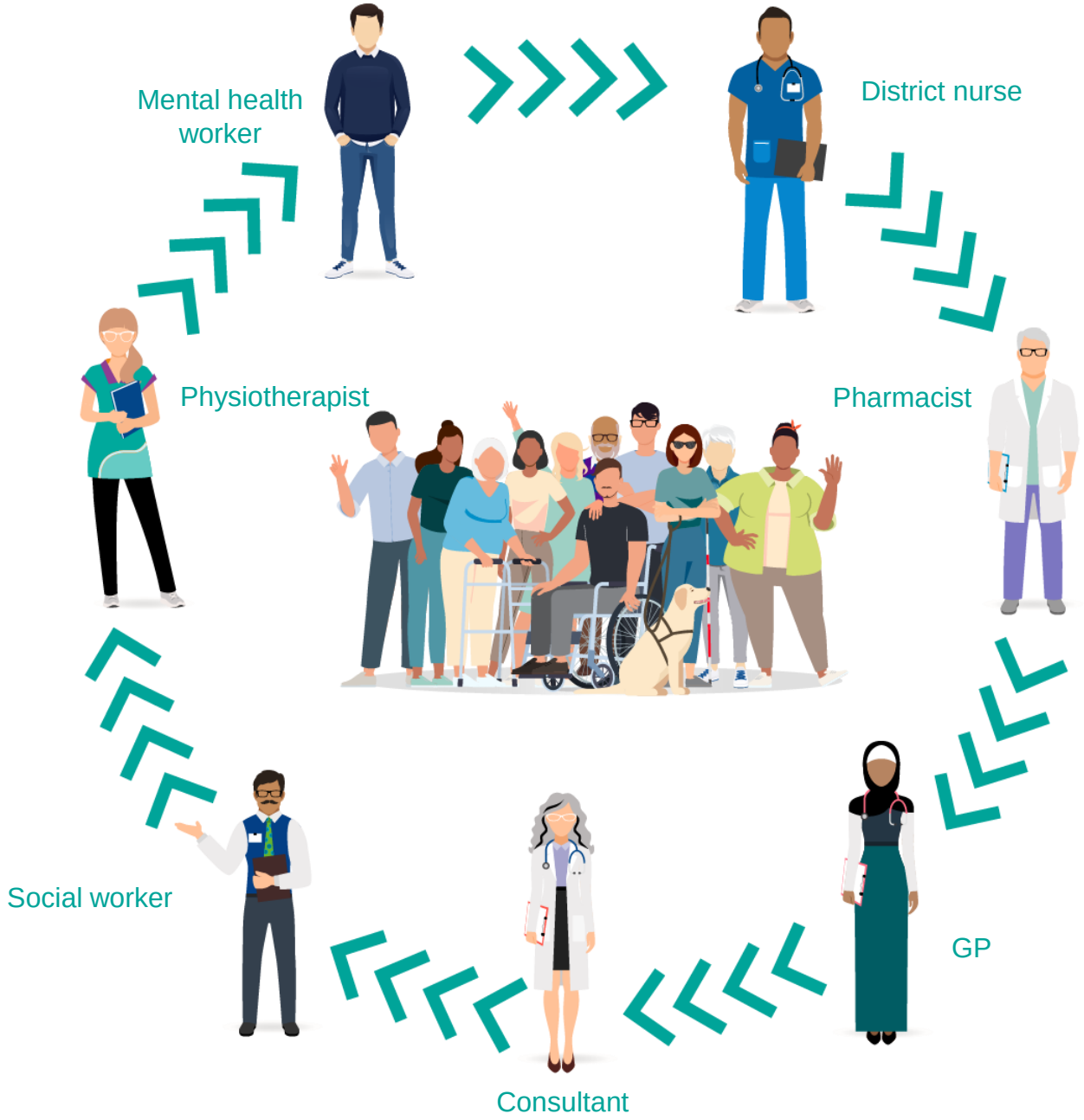
Integrated neighbourhood teams

What is an integrated neighbourhood team (INT)?

Integrated neighbourhood teams are fundamental building blocks of integrated care systems. These teams will be dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

The intention is to bring together all providers within a PCN's geographical area to work seamlessly to support that local population's needs.

It means aligning the clinical and operational workforces of community health providers with neighbourhood areas or 'footprints' and working alongside dedicated, named specialist teams from acute and mental health trusts, particularly community mental health teams. **It will bring together previously siloed teams and professionals doing things differently and improving patient care and outcomes.**



Understanding Core20Plus5

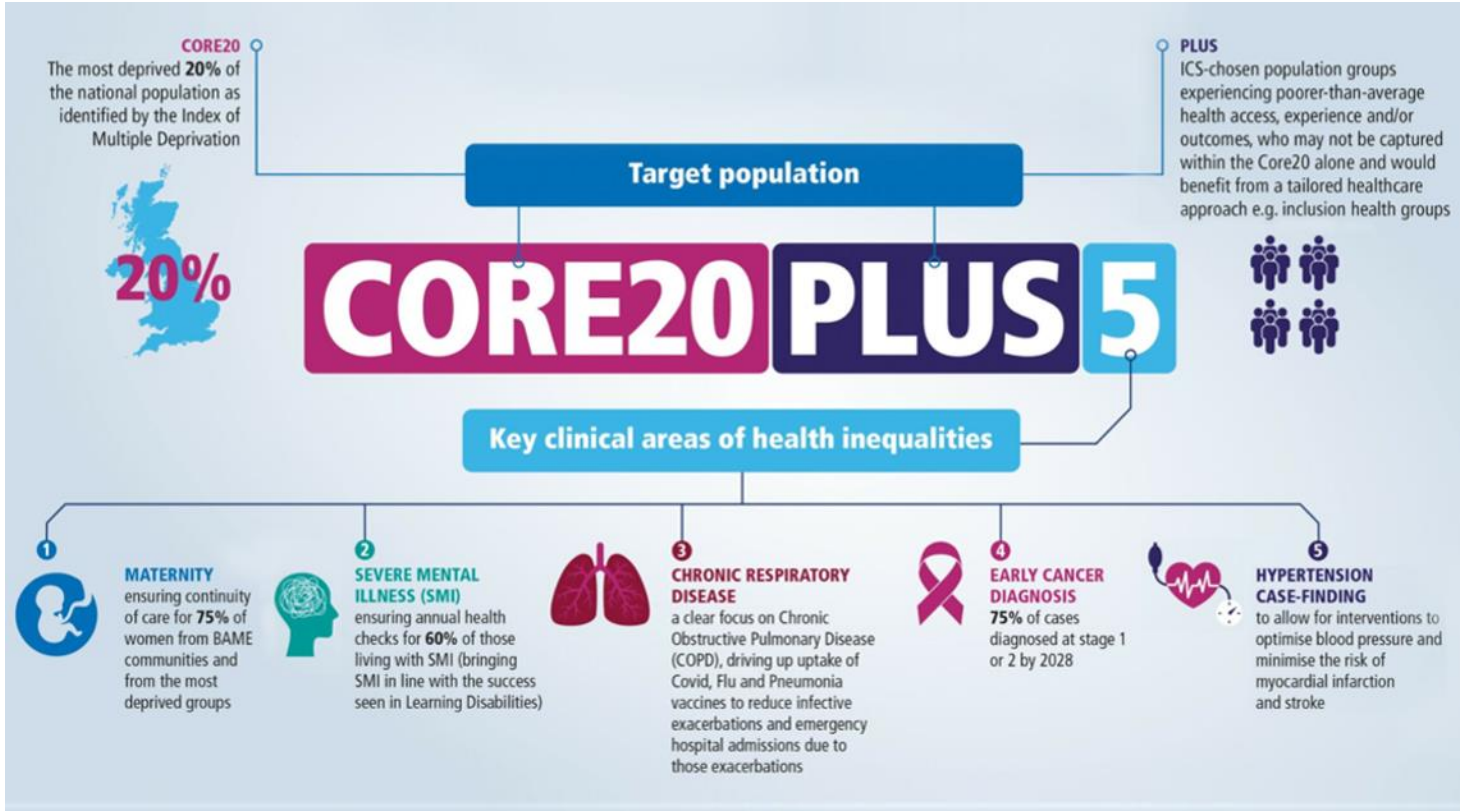
Core20PLUS5 is an approach designed to support integrated care systems to focus on improving wellbeing and outcomes for populations that are experiencing the worst health.

Core 20 describes the most deprived 20% of the national population as identified by the national index of multiple deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health – income deprivation, employment deprivation, education, skills and training deprivation, health deprivation and disability, crime, barriers to housing and services, living environment deprivation.

As well as, or ‘plus’, the Core 20 populations, integrated care systems also identify the local population groups that are experiencing poorer than average health access, experiences and outcomes. For example ethnic minority communities; inclusion health groups; people who are autistic or experiencing learning disabilities; communities with pockets of deprivation among relative affluence; people with multi-morbidities; and protected characteristic groups

It then concentrates on the five clinical areas prioritised in the NHS long term plan: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, hypertension.

Core20PLUS5 was introduced by NHS England in 2021



Operating model for Integrated Neighbourhood Teams

The proactive care model has six core components

1 Case identification

Patients are digitally identified and clinically validated

Using data-driven approaches to identify patients most likely to benefit from proactive care

2 Holistic assessment

Identifies the health, social and self care needs of the patient (and carer)

Identifying the health, social and self-care needs of an individual which impact their wellbeing.

3 Personalised care and support planning

Cohesive and comprehensive plans developed with patients and wider stakeholders involved

Empowering and enabling patients to take an active role in making decisions about their care.

4 Multidisciplinary working

Multidisciplinary team (MDT) meetings review progress and make recommendations

Develop MDTs that review, recommend and deliver care.

5 Coordinated care

One named coordinator assigned per patient

Working with patients to support them to understand recommendations and coordinate their care through a single point of contact.

6 Interventions and support

Tailored to the patients needs and preferences

Implement support that is tailored to the patient's needs and preferences.

Next steps

Proactive care workstreams

Business intelligence and data developments

- An initial SWL Proactive Care Dashboard outlining the priority cohorts has been developed to support colleagues to better plan their local models of care
- Develop a risk stratification tool to give clinicians better opportunities to identify and prioritise people who may benefit from a proactive care offer

Communication and engagement

- Plan communication and engagement activities that support boroughs to raise awareness and increase understanding of the benefits of proactive care
- Support the inclusion of the patient voice within the local models of care by continually adapting the models based on feedback
- Develop and support the digital inclusion element of proactive care

Health inequalities

- Ongoing equality impact needs assessment (EHIA) to explore the likely impact on people who have been identified as requiring proactive care
- Use the EHIA to inform requirements for local models of care to better support people with protected characteristics, Core20Plus and vulnerable groups

Universal care plan (UCP)

- “What happens to me is just as important as what’s the matter with me”
- Across London, the aim is to develop a personalised care and support plan that all individuals can access, for example paramedics to help deliver the most appropriate care

Operating model development

- Clinical leads group overseeing the development of models in all boroughs
- Develop local workforce models and training requirements to support implementation
- Continually adapt and revise based on outcomes data and patient and carer feedback (and staff feedback)

Looking to the next 5 years

The proactive care models of care in SWL will deliver:

Reduction in the use of unplanned care services such as A&E, early examples from Kingston & Richmond show a 40% reduction

Reduced health inequalities by improving access, experience and outcomes in line with Core20PLUS5 priorities

Improved patient experience by ensuring patients with multiple long-term conditions receive integrated health and care at home for a better better quality of life

Improved staff retention and satisfaction, through opportunities for development, multidisciplinary working and effective co-ordination

A health and care workforce that collaborates to support people to stay independent and healthier for longer

For each of the above, detailed data sets are being developed so quantifiable metrics will be recorded

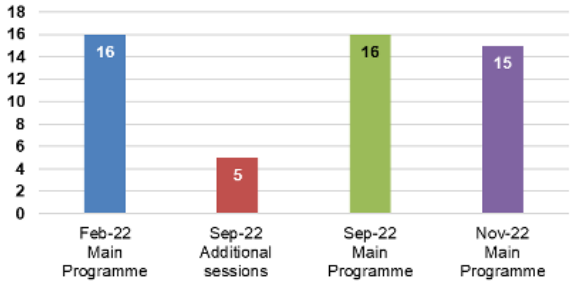
Building on our achievements

Accelerated Access Improvement Programme (AIP)

Practices are actively signing up to the 20-week programme. Outcomes from practices that completed the Feb-22 programme include:

- Better availability and access to appointments
- Clinical and administrative time used more effectively by improving practice processes
- Staff provided with further skills and knowledge to help manage change and quality improvements
- Better system for managing prescriptions; safer.

Number of NHSE Accelerated AIP participating practices



Positive GP survey results relating to access

SWL have achieved results above the national average for the past 4 years for:

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

Extended access wrap-around service

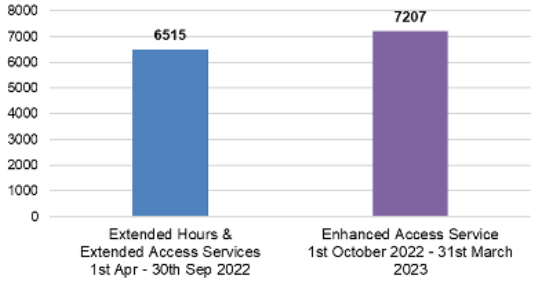
In place from 1 Oct 2022 to 31 Mar 2023, it covers the hours when core general practice and the enhanced access service are closed (5pm-8pm Sat and 8am-8pm, Sunday and bank holidays).

Access to primary care available 7 days per week, supporting NHS 111 and the wider system with patient redirection and ensuring patients receive the right care at the right time and place

New PCN Enhanced Access Service

Live from 1st October 2022, the service offers capacity than the services previously in place (i.e Extended Access and Extended Hours services). Some PCNs are also offering appointments outside of the Network Standard Hours (6.30pm-8pm Mon-Fri and 9am-5pm Sat) in-line with patient need, such as; early morning commuter clinics and afternoon paediatric clinics.

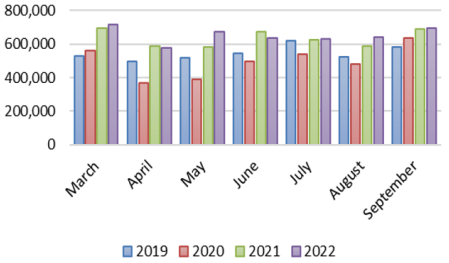
Extended Access and Extended Hours Service comparison



Note: This graph is based on 15min appts; from 1st October the appointment slot length will vary depending on the type of service as appointments will be delivered by the full multidisciplinary team, rather than only GPs and nurses.

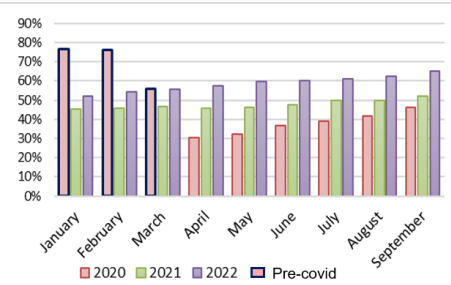
General practice appointments have increased compared to the same month in previous years including pre-covid

General practice appointment data comparison by year



Face to face consultations in general practice are increasing. Over 50% of appointments were delivered face-to-face in 2022.

General practice appointment data comparison by year: face-to-face consultations



Next steps

Continue to improve patient experience and satisfaction

- Regular monitoring of the Enhanced Access Service including patient feedback to ensure the service continues to meet patient need and demand, or if there are any concerns and/or adjustments required.
- Encourage practices and PCNs to sign-up to the NHSE Accelerated Access Improvement Programme and other opportunities to reflect on practice processes and make improvements to support practice efficiency and patient satisfaction.
- Improving patient access and optimising practice/PCN processes through the use of digital systems.

Ensure consistent information is available to staff and patients

- Ensure practice teams are aware of local services and where to access information.
- Consistent communications on telephone answer messaging, practice websites, posters and video information in waiting rooms.
- Practice websites kept up-to-date and easy to navigate to help patients get to the right place for their care.
- Local Directory of Service (DoS) is kept up-to-date with services and opening times to ensure NHS 111 and London Ambulance Service are aware of available appointments.

Improve data quality and processes

- Coding and mapping (CAM) facilitators have worked with each practice to analyse, diagnose and facilitate how appointments should be mapped and coded to ensure accurate reporting in-line with Nation Slot Categorisation. NHS Digital release practice-level GPAD data each month and this continues to be review and support provided to practices. The next phase of this work is to support PCNs with Enhanced Access Service appointments.
- Ensure all services are visible on the local DoS and are enabled for direct booking to support the redirection of patients from NHS 111
- Review IT systems that are in place across South West London to identify gaps and where improvements are required

Review of demand and capacity

- PCNs to use demand and capacity tools to improve insight at practice and PCN levels to ensure workforce planning is optimal.
- Practices and PCNs are supported to plan appropriately for same day and routine care including management of long term conditions
- Identify the reasons for over or under use of services to inform and agree next steps
- Seamless integration with NHS 111 to improve patient experience

Looking to the next 5 years

Patient experience and satisfaction

- Reduced variation in access across South West London so all patients can access the care they require
- The right balance of care to support individual patient needs – for example, continuity of care for patients with long term conditions and timely care for those with episodic or same-day needs
- Patients have access to a range of appointments (in person or remote) to meet their needs and service locations are convenient if a face-to-face consultation is required

Information flows

- Practice teams consistently signpost and make best use of other services such as the community pharmacy consultation scheme which has seen over 5400 patients accessing care quicker than otherwise would have happened in just the last 3 months
- Patients know how to access the most appropriate service to ensure they receive the right care at the right time
- Local Directory of Service holds up-to-date information regarding services and opening times enabling seamless links to NHS 111 and LAS for patient redirection

Data quality and processes

- Accurate reporting of primary care activity to help better plan services
- Seamless links to NHS 111 and other services
- Streamlined IT to access notes, refer onwards and request tests so clinicians are able to help the patient there and then without needing further appointments

Demand and capacity

- Workforce is available to respond to demand
- Contingency plans are in place for unpredictable events
- Neighbouring practices collaborate and share workforces to support resilience eg sickness issues in one practice

Additional roles reimbursement scheme (ARRS) for PCNs

ARRS provides funding from NHS England for 17 different types of roles in PCNs including:

- Clinical pharmacist and pharmacy technicians
- First contact paramedic
- First contact physiotherapist
- Mental health worker
- Social prescribing link worker

There are over 560 whole time equivalent (WTE) ARRS roles already in place in SWL.

Since 2021, there has been a large increase in recruitment and claims for these roles (329 in August 2021 to 560 in September 2022).

South West London has the largest ARRS workforce in London relative to its population.

Challenges

National workforce shortage and staff burnout

There is a workforce shortage for clinical roles all across the UK. In South West London, there are some professions with an ageing workforce, such as the high proportion of nurses aged over 55.

We know we need to:

- Use a diverse skillset as part of integrated neighbourhood teams to deliver effective services
- Maximise recruitment through ARRS, and other routes, as well as retaining staff
- Attract more staff into primary care jobs, for example by SWL Training Hubs attending careers events and using the International GP Recruitment Programme
- Widen the flexible staff pool to increase capacity and create a new offer for local GPs wanting to work flexibly
- Expand the flexible pool to include other clinical and non-clinical staff groups

Staff wellbeing and addressing equality, diversity and inclusion

We are focused on making South West London's primary care a desirable place to work – where it is inclusive and supportive, and there are opportunities to grow and develop.

We will:

- Support the Pan London Discrimination and Racism Survey in Primary Care as part of the Workforce Race Equality Standard (WRES) and commit to embedding the recommendations into the South West London WRES.
- Ensure we have multi-professional leadership networks and Freedom to Speak Up Guardians.
- Commit to staff wellbeing by building on examples such as the SWL health and wellbeing pilot, Mindfulness for Life and Wellbeing webinar series.

Staff capacity

Understanding staff capacity in primary care is important. It shapes how investment, training and resources are directed across the primary care workforce.

It is a contractual requirement for practices and PCNs to provide workforce data to the National Workforce Reporting Service (NWRS). This is crucial data for understanding changing capacity across the primary care workforce.

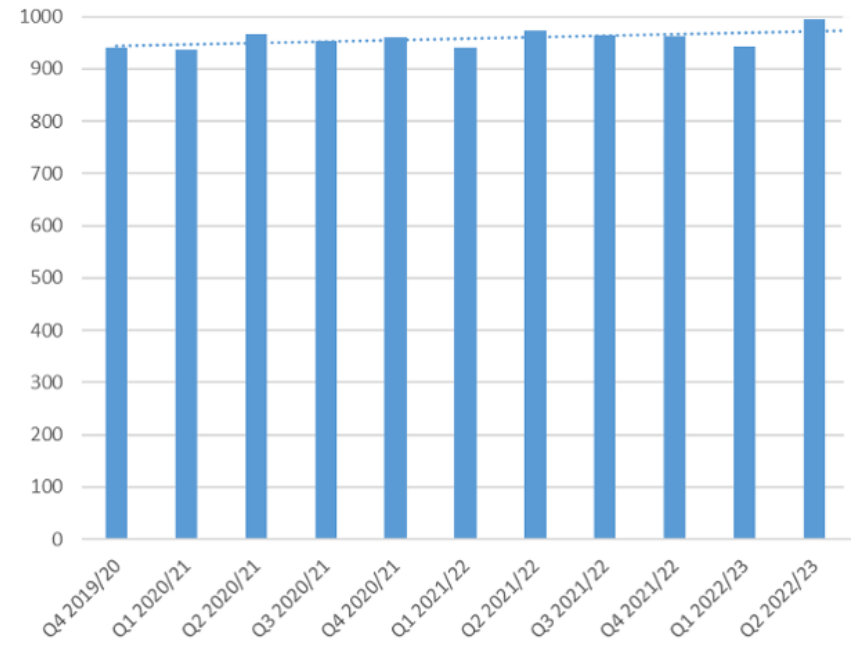
GPs

- GP full time equivalent (FTE) roles in SWL peaked in quarter 2 of 2022/23 at 994. By 2025 the trajectory is to maintain the GP FTE at 995 or above.
- Recruitment and retention plans for next three years have strong emphasis on GP's as priority.

Direct patient care roles

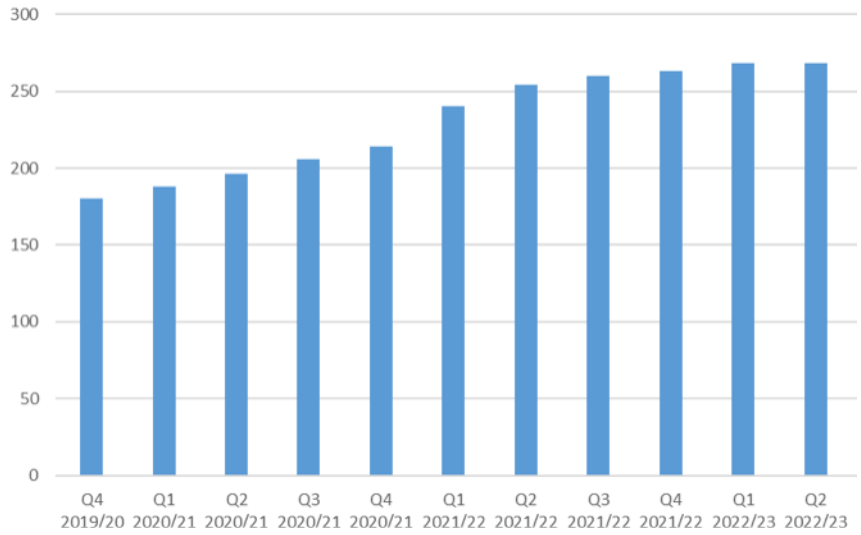
- The FTE for direct patient care roles has continued to grow to 280, from only 180 at the end of 2019/20.
- Recruitment and retention plans will continue to focus on attracting, embedding and retaining these roles.

GP Full time equivalent by quarter – National reporting system at September 2022



Other (i.e. not including GPs / nurses and ARRS staff) direct patient care roles (such as Health Care Assistants, Phlebotomists, other general practice allied health professionals)

Full time equivalent by quarter



Building on our achievements

Fellowships

There are 74 fellows, across 41 different surgeries, benefiting from participating in the successful Salaried Portfolio Innovation fellowships programme for newly qualified GPs and nurses. This gives them experience and skills by working with other settings and professionals that they otherwise wouldn't benefit from

Largest ARRS workforce in London

The ARRS workforce has increased from 329 in August 2021 to 561 in September 2022. This is testament to PCN efforts in recruiting and retaining staff

Mentors

There are 29 GP mentors in place across South West London with 64 matched mentees. The mentoring scheme was well received and had significant positive feedback in helping newly qualified clinicians benefit from the experience of the mentors

> "The best single thing I have done as a GP in the last 5 years
>
> **– Participant in the mentor programme**

System development funding

A host of schemes has been delivered across South West London. These schemes are focused on retaining and developing staff. Successful programmes include:

- 50 staff from nursing, pharmacy and paramedic backgrounds have been funded to complete non-medical or independent prescribing courses
- Admin and clerical courses supporting practices with developing their receptionist and other administrative staff skills
- 575 GPs have accessed continuing professional development opportunities provided by their training hub (of which each borough has one)

South West London Training Hub

Health Education England (HEE) has completed their training hub procurement and the SWL Training Hub has been established from January 2023. This will provide practices, PCNs and the wider primary care workforce with a way to develop training programmes and analyse training needs. It builds on the success of the six borough training hubs that have been in place for some time (and they will continue)

Next steps

Recruitment

- Data-led workforce planning to understand the workforce profile (including ageing workforce) and developing plans in response
- Maximising GP nursing and GP recruitment, as well as ARRS roles (including the new GP assistant and digital transformation roles)
- Widening participation project; recruiting from a wider pool within communities
  - Mayor of London Academies Programme helps Londoners to access jobs and skills opportunities
  - Step into work programme to help design a process to help people enter into employment
  - Jobs that Care, which goes into education institutions within South West London to raise awareness of roles within the NHS
- Utilising supply routes such as Training Nursing Associates/Nursing Associate ARRS roles
- Return to Practice – embedding opportunities for working flexible and new ways of working
- Making SWL an attractive place for clinicians entering the workforce: ongoing fellowships scheme for GPs and nurses
- ARRS workforce planning and Training Hubs to support PCNs to understand their workforce, how it can be maximised, and support them to recruit to new roles
- Training hubs to support practices and PCNs to consider how to attract staff and act as supportive employers

Retention

- Develop plans with training hubs including voluntary and community providers to support retention, reduce burnout of wider primary care workforce and benefit from their strengths within local communities
- Work with PCNs to develop a better understanding of ARRS roles so that staff are valued and properly embedded in the workforce – via appropriate supervision, learning and development and career opportunities
- Work towards embedding the HEE WRES Gold Standards Framework and embed the recommendations of the Pan London Discrimination and Racism Survey in Primary Care
- Full roll out of annual NHS England budgets, to include:
  1. Continuing professional development opportunities for GPs
  2. Admin and clerical training to support the wider practice team
  3. Skills development in particular areas such as end of life, learning disabilities and mental health
  4. Training for non-medical prescribers to allow them to develop prescribing capability
  5. Fellowship and mentoring schemes

Looking to the next 5 years

Recruitment

- More GPs, practice nurses and ARRS roles:
  - At least 650 ARRS FTE/WTE
  - 995 or more GPs (FTE)
  - 280 or more GP nurses (FTE)
- Recruited more newly qualified GPs and GP nurses to address an ageing workforce and future shortages.
- Collaborative workforce planning is ensuring decisions are data driven.
- PCNs and practices offering attractive terms and conditions – such as flexible working and necessary IT solutions, plus competitive employment packages.
- More staff recruited from SWL communities, reflective of the populations that they serve.

Retention

- South West London is an attractive place to work, where primary care staff want to stay, as measured by surveys.
- SWL Training Hub provides continuous training and development
- Practices and PCNs are supportive employers that invest in training and support their staff
- Courses and rotational posts offering staff opportunities to develop skills
- Other skilled roles are helping reduce GP workload and burnout
- ARRS roles are fully embedded and utilised
- Working environments reflect best practice (for EDI and WRES).
- Voluntary and community organisations are part of the primary care team, providing additional skills and knowledge

Communication and engagement

- Patients can access information about the wide range of roles that support them in primary care, which in turn can be accessed through digital and other forms
- There is a patient and public community that understands, supports and uses the wide range of dynamic primary care roles beyond GPs

Training hubs

- SWL's Training Hub, supported by borough Training Hubs, will be fully embedded as an enabler for primary care workforce needs in SWL.
- PCNs and practices can access a full suite of advice and support to understand and plan for its workforce
- PCNs and practices will be supported by the training hub to review the effectiveness of their teams and make adjustments accordingly.
- Primary care staff can access a wide variety of training, development and recruitment opportunities that match their needs – facilitated by training hubs

Building on our achievements

Successes and achievements

- Successful procurement and implementation of three online consultation solutions (AccuRx, eConsult and Sensely-Ask First). Online consultations transform access for patients and practices:
  - Patients submit requests to the GP practice online, such as repeat prescription requests
  - Shorter call queuing times by directing many patients to online methods
  - Ensures patients are booked with the right professional based on their symptoms and needs
- Four e-hub PCN sites are up and running, with practices sharing demand for online consultations, telephony solutions and back office functions which mean that more patients get the advice and care they need
- A demand and capacity optimisation tool (Edenbridge Apex) has been implemented across 70 practices – supporting practices to understand their population health needs and adjust their workforce capacity accordingly
- Website optimisation proceeding for practices to provide a consistent and best-practice website offer across SWL
- Telephony solutions have been developed to support winter and bank holiday access so patients call their practice rather than 111
- Group video consultations initiated to support multidisciplinary working.

Two-way SMS messaging and Video Consultation solution procured so practices and patients can communicate directly to each other.

Procurement and roll out of a solution for managing the vaccination booking programme (Accubook)

Challenges

The Covid-19 pandemic disrupted many projects across PCNs and practices.

- Digital maturity – practices are at varying degrees of maturity within their PCNs, often those who are more advanced seem to be thriving over the others
- Applications/software – there are many various applications and software solutions across practices and we need to provide a more streamlined offer to practices for ease of use

> “It is vital that primary care is supported to implement digital tools that help GPs better communicate with their patients”

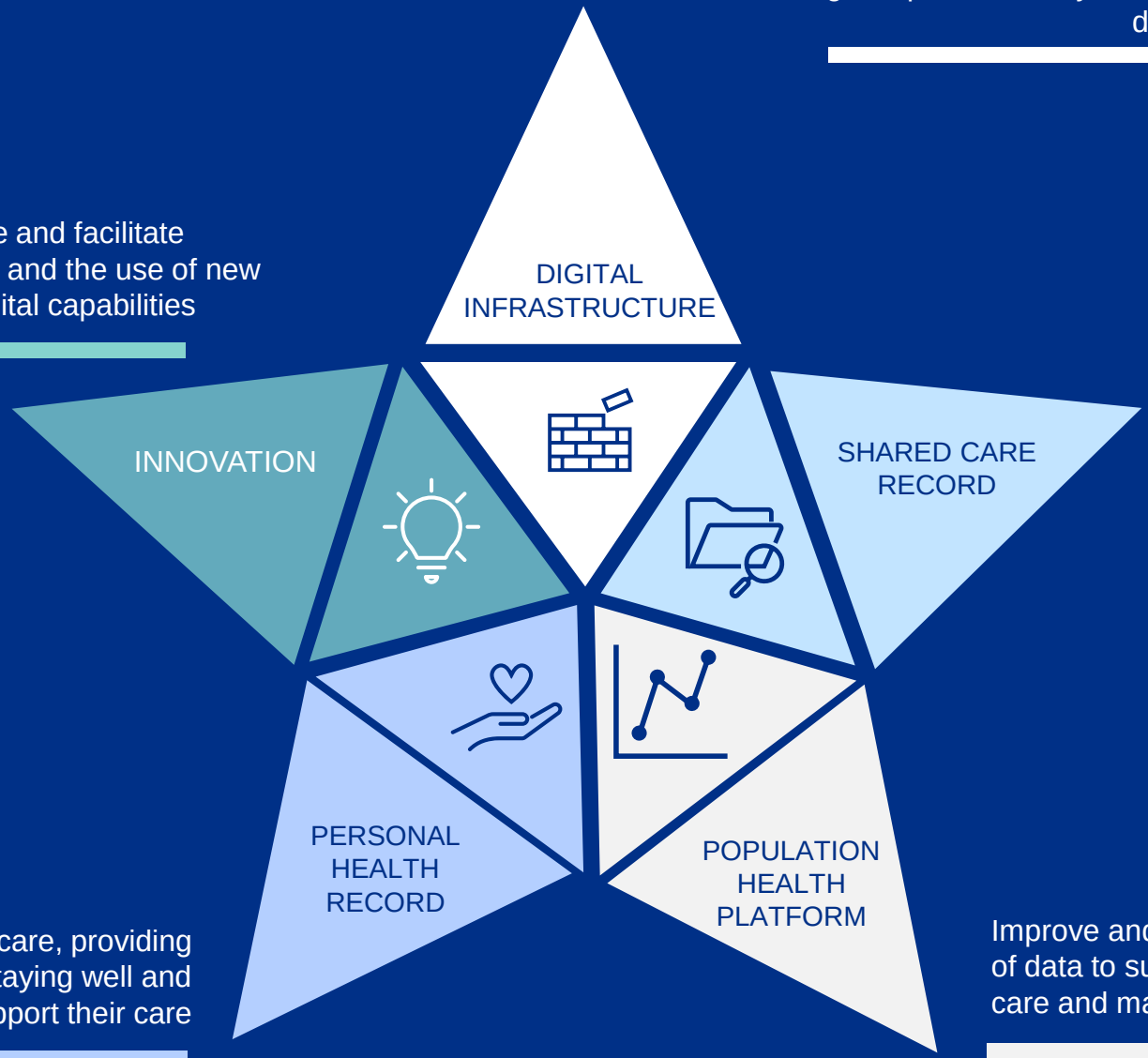
– Dr Nicola Jones

SWL Primary Care Clinical Lead

Create a robust and secure hardware platform for use across South West London, ensuring comprehensive cyber security, system and data availability, data quality and appropriate guidance

Encourage and facilitate innovation and the use of new secure digital capabilities

Provide clinicians with a real-time and complete patient clinical record at the point of care



Support patients to self-care, providing personalised advice on staying well and information to support their care

Improve and expand the use of data to support proactive care and manage capacity

Next steps

PCN digital development

- Continue working with PCNs to explore innovative ways to improve digital maturity and collaborative working to manage demand and improve patient pathways
- Support PCNs to collaborate across their INT
- Using practice, PCN and population health management data, continue to identify opportunities to improve access, pathways and use of clinical skill mix
- Work with PCNs and the SWL training hub to identify and support digital champions across each PCN that will help increase overall take up digital tools

Resilience

- Work with practices, PCNs, and the wider system, to identify opportunities to utilise the range of administration and clinical skills across PCNs, for example cloud-based telephony allows people to answer the same phone system regardless of where they physically happen to be
- Further support the use of ARRS roles to triage treatment and advice from the right clinician first time at PCN level

Improving digital access

- Improve patient access by supporting PCNs to optimise processes for more online consultation (when appropriate) to improve referral to the right clinician first time
- Further improve on the good utilisation of the NHS mobile app across primary care so that 65% of the population are using it
- Develop clear support and guidance for practices to optimise their website design
- Support practices and PCNs to manage access to prospective patient records in a safe and robust way so that patients are can access more information of their records by November 2023

Change management

- Continue providing robust, hands-on change management support across each borough including the ongoing development of clinical digital champions
- Develop communication and marketing skills to support reviews, enhance practice websites and social media, and improve communication between practice and patients
- Facilitate networking for sharing best practice, lessons learned and developing system-wide working relationships

Looking to the next 5 years

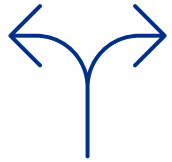
Patients will have

Seamless access to online and video consultation appointment booking and health records via a single entry point utilising the NHS App

An equitable offer and experience of primary care services

Rapid access to a wider range of appointments

Our practices and PCNs will have



Streamlined access and reduced appointment wastage using online triage

Better understanding of their population health needs and services planed and delivered according to need

Sharing and joining up of back office functions to improve resilience across practices and PCNs where desired

Increased digital maturity and optimising online presence

Opportunities to work at scale across PCNs utilising cloud based telephony

Next steps

Office 365 for the NHS (N365)

Implement modern Microsoft tools in all SWL GP practices to support collaboration, enable digital transformation, strengthen security controls and enable new ways of working

- Following a successful pilot, roll out across all SWL GP sites is planned to complete by 2025
- GPs will have access to a suite of Microsoft collaboration tools with data migrated to the N365 cloud

Corporate Wifi

Wifi will be provided to all SWL GP sites providing full GP site coverage and seamless roaming across SWL sites

- Following a successful pilot, roll out across all SWL sites is planned in 23/24
- GPs will be able to work across SWL sites accessing a single network and data hosted on the N365 cloud

Managed print

Review printing requirements across SWL to a managed print contract that would enable GPs to work across SWL and print at any site

- A pilot was conducted and an audit has since taken place to understand printing needs
- A specification has been prepared in collaboration with ICS partners interested in joining a service
- Market testing and an options appraisal will be prepared

ICS collaboration

ICS partners are collaborative on the new SWL IT service and will explore further opportunities to strengthen and create resilience and value for money through further opportunities

- Continue collaborating on network, infrastructure and cyber services
- Build on the collaboration of contracts for the Help Desk platform and telephony solution
- Assess further opportunities

Funding

Office 365 for the NHS (N365)	Corporate Wifi	Managed print	ICS collaboration
Funding to be identified from within available resources	Roll-out in progress	Funding to be identified from within available resources	Funding to be identified from within available resources

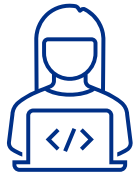
Looking to the next 5 years – providing GPs and PCNs with the IT they need to do their job

Unnecessary manual intervention, variation and duplication has reduced

What works well is being shared and implemented across all boroughs

Continuing to maximise opportunities for external investment, optimising existing funding and providing options for practices and PCNs to add more services using their own investment

Care and service able to be provided in the most appropriate setting by providing flexible access to technology



Continued investment in equipment ensuring necessary standards and, provide the right service to enable users to work effectively to deliver safe care

Improved performance and value for money for stakeholders by collaborating across the ICS

Next steps

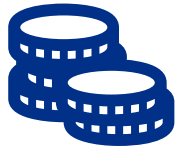
PCN Estates Strategy Development

Key activities in the programme support strategic priority planning and decision making to improve the use of primary care estate space, including:

- Produce baseline data packs for each PCN
- Complete space utilisation studies at the 214 primary Care sites in South West London
- Produce PCN estates strategies that are aligned to PCN clinical strategies

Surveys of condition and utilisation

- Survey South West London practices across two phases
- Survey insights will support practices and the ICB with strategic planning to optimise the current GP estate and provide further evidence to support business cases as funding becomes available



London Improvement Grant (LIG) 2022/23

- LIG funding is provided for GPs to undertake small improvements and essential compliance works
- The grant covers 66% of the cost of the works and practices provide the rest
- In 22/23 year 54 practices applied for funding and the process for 23/24 has recently commenced
- The final list of approved schemes will be shared as soon as it has been agreed by NHS England London