NHS
South West London

# Our five-year plan for the NHS in South West London

## A joint forward plan 2023 – 2028

# Contents





# Foreword

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

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

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

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

This Joint Forward Plan outlines our level of ambition, the context we are working in for each part of plan, the views of people and communities, the actions we will take to deliver our priorities, and our critical finance, workforce and digital enablers. We will review our plan annually.

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

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

**Mike Bell**
Chair
NHS South West London Integrated Care Board

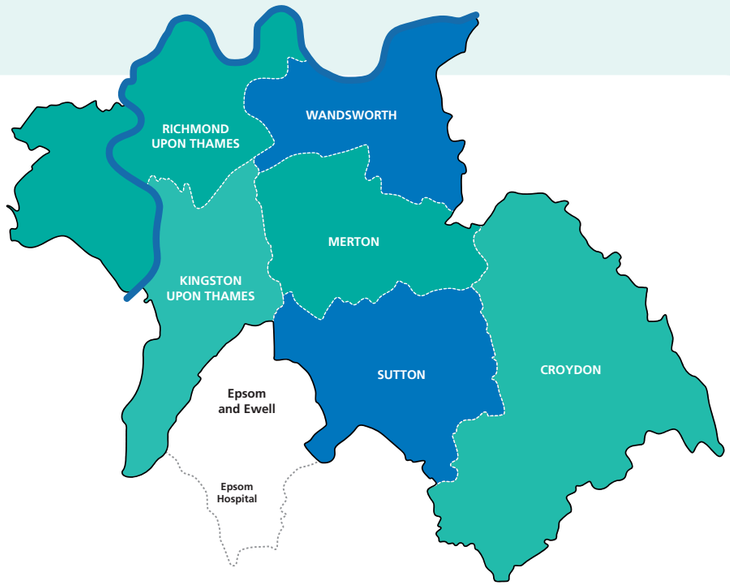
June 2023

# Our ambition

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

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

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




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



**Our ambition is for people in our boroughs to**

Start well

Live well

Age well

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

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

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

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

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

# Part One: About South West London

## Understanding health needs in South West London

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

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

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

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

## Understanding our population demographics

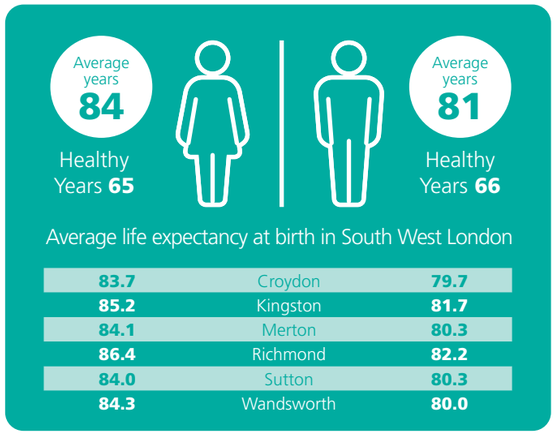
1.5 million people live in South West London. 100,000 more people are living in our boroughs now than in 2011 and we are expecting our population to grow by an additional 30,000 people in the next 10 years.

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

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

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

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

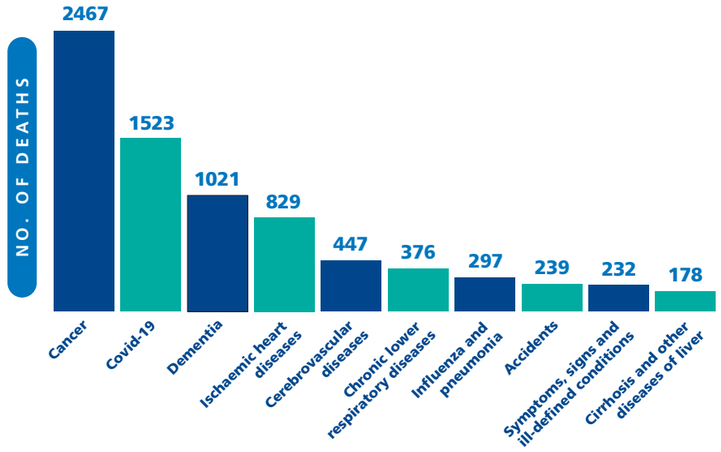



Average life expectancy at birth in South West London

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

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

**Leading causes of death in South West London 2021**




Although cancer is the biggest cause of death in South West London, ischaemic heart disease was one of the leading causes of death for our residents in 2020/21[1]. It is the single most common cause of premature death in the UK. Once diagnosed, treatment can help manage the symptoms and reduce the chances of problems such as heart attacks. 1.9% of our adult population are known to have coronary heart disease and there were 829 deaths from ischaemic heart disease in 2021.

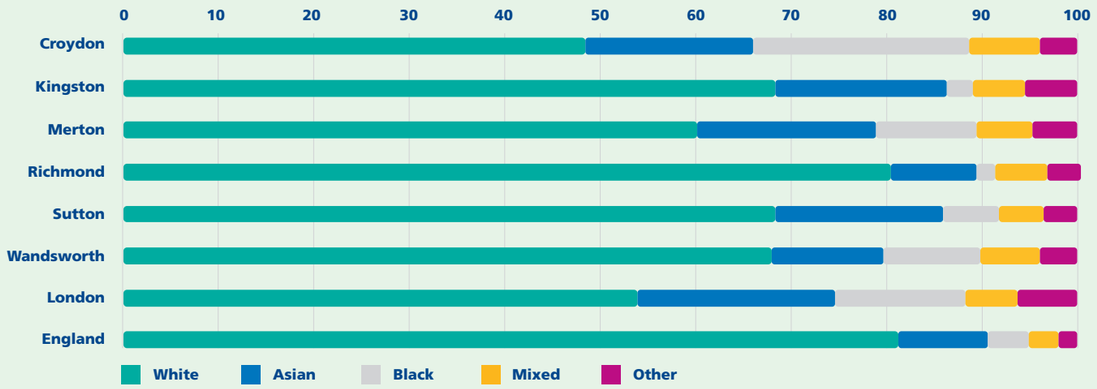
Our aim is to improve healthy life expectancy by at least five years by 2035. This means increasing the average number of years that an individual is expected to live in good health. The healthy life expectancy of our population is better than the London and national average but varies depending on where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

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

1. Excluding Covid-19 deaths.

The economic and cultural diversity of our population is changing and is projected to change even more with the continuing migration of populations to outer London areas. When measuring deprivation as a percentage of households with one or more elements of deprivation, such as employment, education, health & disability and housing, outer London (including South West London) is becoming more deprived than inner London. South West London also has high costs of housing which lowers income, and these costs are not reflected in the current indices of deprivation. This understates the true levels of poverty within the ICS.[2]

**Population by ethnic group**

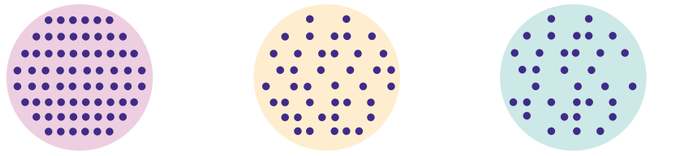



Ethnic diversity across our boroughs varies. When compared to London's 32 boroughs we find (from most diverse to least diverse):

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

**2021 population density, residents per km²**

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




2. Demographic, social, and economic change, London councils.



# The wider determinants of health

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

## Education and skills

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

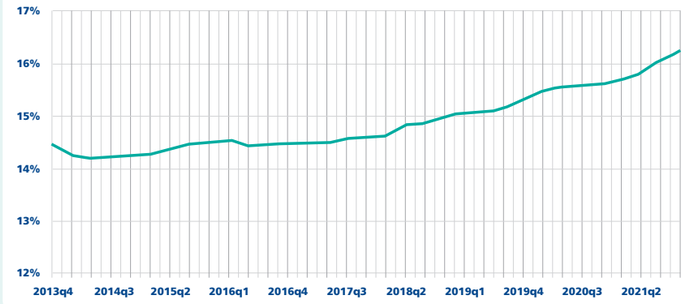
## Employment

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

## Money and resources

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

**Figure 1: Proportion of working age population long term sick: UK, 2013-2021**




*Source: Health Foundation (2022)*

### Our surroundings

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

### Housing

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

### Food, diet and weight

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

### Family, friends, and communities

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

## Challenges across the life course

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

- **Healthy lifestyles:** Smoking, alcohol consumption, healthy eating, physical activity and hypertension are the leading contributors to disease burden in our residents.
- **Long term conditions:** Ischaemic heart disease, stroke, chronic obstructive pulmonary disease, diabetes, and musculoskeletal conditions are the top contributors to burden of disease and mortality in our residents.
- **Mental health:** At least one in four people will experience a mental health problem at some point in their life with one in six adults has a mental health problem at any one time.
- **Cancer, screening and vaccinations:** Coverage in our population is frequently lower than recommended targets.[3] Cancer is the leading cause of death in South West London.

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



## Start well

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

### Healthy lifestyles

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

**Obesity:** Nearly 1 in every 5 children in Reception are overweight or obese. This almost doubles by Year 6. Nationally, there is a pattern of younger generations are becoming obese at earlier ages and staying obese for longer[4].

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

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

### Mental health

Each year around 16,000 under 18s receive community NHS funded mental health treatment in South West London. This is 4.5% of the children and young people (CYP) population, which is above the London average of 4.1%. Kingston (518), Richmond (368) and Sutton (304) have some of the highest hospital admission rates (per 100,000 population aged 10-24, 2020/21) for self-harm in London (213).

According to the research by the National Confidential Inquiry (2010-20), there were an average of 656 deaths per year due to suicide in the UK for those aged under 25 with an average of 104 per year for those under the age of 18. In South West London in the last year (April 22-March 23), we have seen two suicides in those under 18 and five in those aged between 18-25.

### Cancer, screening and vaccinations

Similar to the rest of London, our childhood vaccination coverage is below the recommended level of 95% to achieve population protection for almost all childhood vaccinations, in all boroughs. Uptake for the routine vaccines given to one to two year olds ranges from 80% to 90% across the boroughs and drops to 70-80% for the preschool booster and second dose of measles, mumps and rubella for 5 year olds

High immunisation coverage is correlated with low levels of disease.

### Supporting carers and inclusion health groups

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

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

# Live well

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

### Healthy lifestyles

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

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

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

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

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

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

### Long term conditions

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

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

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

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

**Lung cancer:** Between 2015 and 2019, there were fewer lung cancer cases in our population compared to the rest of England, but this varies between boroughs. In Wandsworth, the incidence of lung cancer is higher than the national average.

Over the last five years, the rate of people being referred urgently for lung cancer was lower than the national average. There were 442 deaths from lung cancer in South West London in 2021. Smoking is a major risk factor for lung cancer, 13.7% of adults in South West London are smokers known to their GP.

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

### Mental health, learning disability, and autism

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

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

### Cancer, screening and vaccinations

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

Cancer was the leading cause of mortality in South West causing 2,500 deaths London in 2020/21. Improvements in cancer diagnosis and treatments are contributing to people living with and beyond cancer. Nationally, Macmillan Cancer Support estimate nearly three million people are living with and beyond cancer, and they estimate that this will rise to over four million people by 2030.

### Supporting carers and inclusion health groups

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

# Age well

### Long term conditions

**Dementia:** The dementia diagnosis rate in South West London is higher than the London average. Last year waiting times for memory services in South West London varied between trusts.

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

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

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

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

## Start well

### Pre Birth

Fewer pregnant women smoke in South West London

### Birth

17,000 live births in 2021.

463 babies with low birth weight at term

More babies whose first feed is breast milk

The number of infants having a 12 month review is falling

### Early Years

Immunisation coverage is below recommended levels

More hospital admissions with dental decay

### School Years

18.7% of children in reception are overweight or obese

35.5% of children in Year 6 are overweight or obese

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

685 hospital admissions as a result of self harm

Over 60 hospital admissions each year as a result of alcohol

### Older Children and young adults

3.6% of 16/17 year olds not in employment education or training

Births to mothers under 18 years old are falling

New sexually transmitted infection diagnoses are higher than the national average for under 25 year olds

## Live well

### Working Age

13.7% of adults are current smokers

50% of adults are overweight or obese

4% at risk of developing diabetes

10% have high blood pressure

375 deaths from alcohol related conditions in 2020

1.9% have coronary heart disease

1% have COPD

376 deaths from chromic lower respiratory diseases in 2021

Lung cancer is less common

Musculoskeletal problems are less common

More than 1 in 10 have a mental health condition

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

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

2.7% diagnosed with cancer

2,500 deaths due to cancer in 2021

7.13% of the population provide unpaid care

## Age well

### Older Adults

10,000 people are diagnosed with dementia

4 to 9 weeks wait for memory services

4,000 emergency hospital admissions due to falls

More people were lonely during the pandemic

Breast cancer screening uptake is decreasing

Bowel cancer screening uptake is below the national target

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

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

Flu vaccine uptake is lower than the national average

Pneumococcal Polysaccharide vaccine uptake is lower than the national average

### End of Life

Average male life expectancy is 81 years

Average female life expectancy is 84 years

# How we have engaged people and communities in the development of our Joint Forward Plan

This section describes the engagement with people and communities that has informed this Joint Forward Plan. We also describe the way we work collaboratively with our six Healthwatches, our voluntary, community and social enterprise (VCSE) sector, as well as more broadly with the people and communities across our six places in south west London.

This diagram shows a high-level picture of the stages for engagement for this Joint Forward Plan:

**Engagement Phase 1**
January and February 2023

- **Advice** from our Healthwatch and VCSE leaders on engagement approach
- **Analysis of 180 engagement reports** collected from across our six places and partner organisations
- **Views of people and communities summary for each setting of care – to inform the 'ambition' set for each chapter**
- **Gap analysis** on where we needed more insight for the next phase

**March 2023**

- **'Developing our Joint Forward Plan'** published for feedback in March 2023


- **6 partner responses** to 'Developing our Joint Forward Plan'
- **599** responses to our **online survey**
- **7 focus groups**
- **131 one-to-one conversations**
- **5 outreach events**
- **'Views of people and communities' – updated each setting of care chapter to inform and influence plans to actions**

**Engagement Phase 2**
April and May 2023

**June 2023 onwards**

- NHS South West London Joint Forward Plan for 2023 to 2028 published in June 2023
- Ongoing engagement with people and communities in delivery of the Joint Forward Plan, with advice and collaboration from our Healthwatch and VCSE leaders


## The first phase of our engagement

In January 2023, we asked our South West London health and care partners to share their existing insight and engagement reports relating to health and care services covering the previous 18 months. We reviewed 180 reports from partners including many from Healthwatch, but also the voluntary and community sector, our NHS trusts, the six local authorities and our NHS place-based engagement teams. The views and experiences of thousands of residents, from a cross-section of our local communities told us what local people feel about a broad range of health and care services and issues.

We carried out an in-depth analysis to inform our Joint Forward Plan. You can read the full analysis and report on our website here.

We cut the data and analysis by 'setting of care' so that this insight could influence the ambition within each chapter section such as mental health, acute care and cancer care.

### Gap analysis of insight, equality, and inclusion

We conducted a gap analysis to focus the next phase of our engagement activity to make sure the ambitions and plans outlined in our Joint Forward Plan were considered in terms of equality and inclusion. We heard views from across a diverse range of local people and communities.

We continue to work hard to find inclusive ways of reaching and listening to people, specifically those with poor health and the greatest needs, so we can better understand how to improve their access and experience of services and support their health and wellbeing.

We seek diverse views from our health inclusion groups, protected characteristics and people who live in our most deprived communities. Our work to reduce health inequalities runs throughout our Joint Forward Plan, and a specific focus on hearing from a diverse range of voices can be found in the Health Inequalities chapter.

We considered key populations groups, geographies, and care settings areas to prioritise where to undertake our engagement during April and May 2023. Our gap analysis meant that we prioritised the following areas and worked with local partners, particularly the community and voluntary sector who supported us to attend existing forums and advertise open focus groups. The areas of focus included:

- Urgent and emergency care
- Primary care with a specific focus on prevention
- Long term conditions
- Children and young people
- Mental health – specifically hearing from Autistic people and people with a learning disability
- People who identify as LGBTQIA+.

## The second phase of our engagement

Since publishing 'Developing our Joint Forward Plan' in March 2023, we have carried out engagement to seek feedback from our partners, and local communities on this first draft of the plan that covered the context, our ambitions and our summary of what we have heard from local people.

We prioritised our activity to reflect the 'settings of care' sections within this Joint Forward Plan, using a range of approaches including:

- **Partner views** – asking partner organisations and their leaders to share their views on our published document
- **Survey** – hearing from people who live, work or study in South West London, for example from communities, frontline staff and students
- **Focus groups** – led in partnership with trusted community and voluntary sector organisations and aimed at specific population groups, for example with refugee and asylum seekers in Mitcham Library and adults with learning disabilities in a community centre in Kingston
- **One-to-one conversations** with people who need additional support, for example parents and carers at a Croydon Babyzone drop-in event
- **Outreach engagement** and discussions at existing community events and forums, for example secondary school young people at a Beautiful Minds school event in Twickenham

### Partner views

We asked our partners from across South West London to respond to our 'Developing our Joint Forward Plan' document. We received responses from:

- Our six South West London Healthwatches
- Our six Local Authorities
- St George's University Hospitals NHS Foundation Trust
- Leader of Sutton Council
- RM Partners cancer alliance
- GESH – St George's, Epsom and St Helier Hospital Group
- South West London & St George's Mental Health Trust

We have used these partner views to make amendments to our ambitions and actions.

### Survey

We offered an incentive prize draw to encourage people to get involved and give us their time and views. We shared the survey with:

- **The South West London people's panel** – a group of over 3,000 local people from across our six boroughs who are regularly invited to take part in surveys or join a focus group
- **Health and care staff** from across the partnership, including those who work for NHS trusts, our six local authorities and GP practices across our boroughs

- **Our NHS South West London social media** channels including Facebook, Instagram, Nextdoor and Twitter. We also asked our partners to share it through their social media channels
- **Our website** www.southwestlondon.icb.nhs.uk
- **Healthwatch and voluntary and community sector** partner channels

In total, we received 599 responses to our Joint Forward Plan online survey.

**Focus groups, one to one conversations and outreach engagement**

We carried out targeted engagement with groups identified through our gap analysis. During April and May 2023 we have engaged with 12 local groups, including: refugees and asylum seekers in Mitcham, parents and carers at Croydon Babyzone, Sutton Seniors, LGBTQIA+ group for south west London, Beautiful Minds in Twickenham for secondary school children, Searchlight Community Centre in Kingston, the Roehampton Champions network, BME Mental Health Forum in Balham, the Ethnic Minority centre in Merton, the Young at Heart Croydon BME Forum and the St George's Patient Involvement Forum.

A full list of our local engagement events during April and May 2023 is listed on our website here.

To support some of our conversations we also developed an easy read version of the Joint Forward Plan. You can read this here.


### A short film to share the views of local people and communities

During a number of our Joint Forward Plan engagement events we asked local people to share their views on camera. We have put these views together into a short film that we played at the beginning of our Action Workshop for the South West London Integrated Care Partnership. You can view this short film summary of local views here


## Engaging with parents at Croydon Babyzone

In May 2023, we joined a drop in play space for 0 – 5-year-olds in Croydon to capture the views of the parents of young children on local health services.

Alongside familiar soft play toys and games, children are given the opportunity to join child friendly first aid classes, a sensory room, and have an introduction to oral hygiene. The 200 parents in attendance were given the opportunity to talk with NHS staff, take part in a survey and share their experiences of NHS services.

Vicentia, mum to a 9-month-old boy said: "I enjoy coming here each week to meet other mums, but today has been great. It's been nice to share my thoughts and to feel heard."

Read more about engagement in Croydon at Planning the way forward with communities across Croydon - South West London ICS

### The outcome of our engagement in phase 1 and phase 2 - people and communities views

The outcome of our 180 reports analysis, and feedback from partner views, surveys, focus groups, one-to-one conversations and outreach engagement events is summarised in this diagram below. You can read the full report on our website here.

## People and communities: views and concerns

**High level analysis and themes from nearly 180 engagement reports.**

### HEALTH IMPACT OF COST OF LIVING CRISIS

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

### REDUCING HEALTH INEQUALITIES

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

### LOCAL EMPLOYMENT

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

### BETTER SUPPORT FOR PEOPLE WITH DEMENTIA

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

### SUPPORT FOR CARERS

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

### GREEN AND ENVIRONMENTAL CONCERNS

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

### VOLUNTARY AND COMMUNITY SECTOR CAPACITY

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

### GPs AND DENTISTRY

- Availability of appointments, waiting times, desire for face-to-face as well as virtual consultations
- Variation in access across and within boroughs
- Variability in the availability of interpreter services for non-English speakers
- Some GP appointment systems make it harder for some people to book, for example QR codes increase digital exclusion, telephone booking harder people with hearing difficulties
- Appreciation for pharmacists with most people seeing them as a trustworthy source of information


### NHS SERVICES AND REFERRALS

- Concern and frustration about longer waiting times for most NHS services e.g. primary care, mental health, urgent and emergency care services.
- Improved communication about waiting times and status of referrals
- More consistent and timely feedback of diagnostic results, which are often sent via GPs
- Many new parents felt there is a lack of aftercare/ postnatal support
- More patient-centred pathways and improved coordination and continuity of care between GPs, diagnostics and NHS teams

### COMMUNICATION, NAVIGATION AND SIGNPOSTING

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

### TRUST IN PUBLIC SERVICES

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

### DIGITAL SERVICES - OPPORTUNITIES AND CHALLENGES

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

### SOCIAL ISOLATION

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

### PREVENTION AND SELF-CARE

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

### MENTAL HEALTH SERVICES

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

As you will read in each of the 'setting of care' chapters, the views of people and communities has directly influenced our ambitions and will be at the centre of the action plans as we deliver them going forward.

We would like to thank all our partners for sharing their insight and engagement work and for supporting us in delivering this deeper engagement work in phase two. Particularly our local Healthwatches and Voluntary sector leaders. By working together, we can clearly see the breadth and reach of our partnership across South West London. This work will make sure the views of local people are influencing not only local plans, but also our system-wide Joint Forward Plan for south west London going forward. We will be sharing this full insight report with our partners and networks across South West London.

## Our ongoing commitment to engaging with people and communities as we deliver the Joint Forward Plan

### What we will do

The Joint Forward Plan covers the next five years, we will continue to engage as we deliver this plan and it will be reviewed each year. We will develop a rolling-plan of engagement to feed in the views and experiences of local people and communities and make sure this impacts the way we deliver the ambitions outlined in this plan.

In the short term, this will include making sure that everyone we have heard from understands how their voice has been listened to, and has influenced this plan.

In the longer term, this will include:

- A themed engagement forward plan to inform our plan's delivery with partners support and informed by our equality impact assessments.
- Take advice from and work collaboratively with our Healthwatches and voluntary, community and social enterprise organisations to maximise the opportunity to reach deep into communities and influence the planning and delivery of services.
- Regular cross-checking of what we hear from our people and communities is feeding in to our plans and delivery and we will produce an annual update on progress including a 'you said, we did' section in March 2024.
- Join up our engagement on this plan alongside our integrated care partnership priorities and strategy.

### How we will work – our 10 agreed principles and using what we have learned

To reduce health inequalities, we need a better understanding of local needs. We can achieve this through inclusive engagement approaches, planning our engagement early and investing in community-led engagement. We iterated these 10 principles with our partners, stakeholders and communities as part of our work to agree our people and communities' strategy for the South West London Integrated Care Board. They set out how we work with people and communities.


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


We will use this learning, coupled with the delivery of our people and communities' strategy for South West London to continue this work we have started in developing our Joint Forward Plan for south west London.

# Part Two: Reducing health inequalities and preventing ill-health

## Working together to reduce health inequalities

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

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

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

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

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

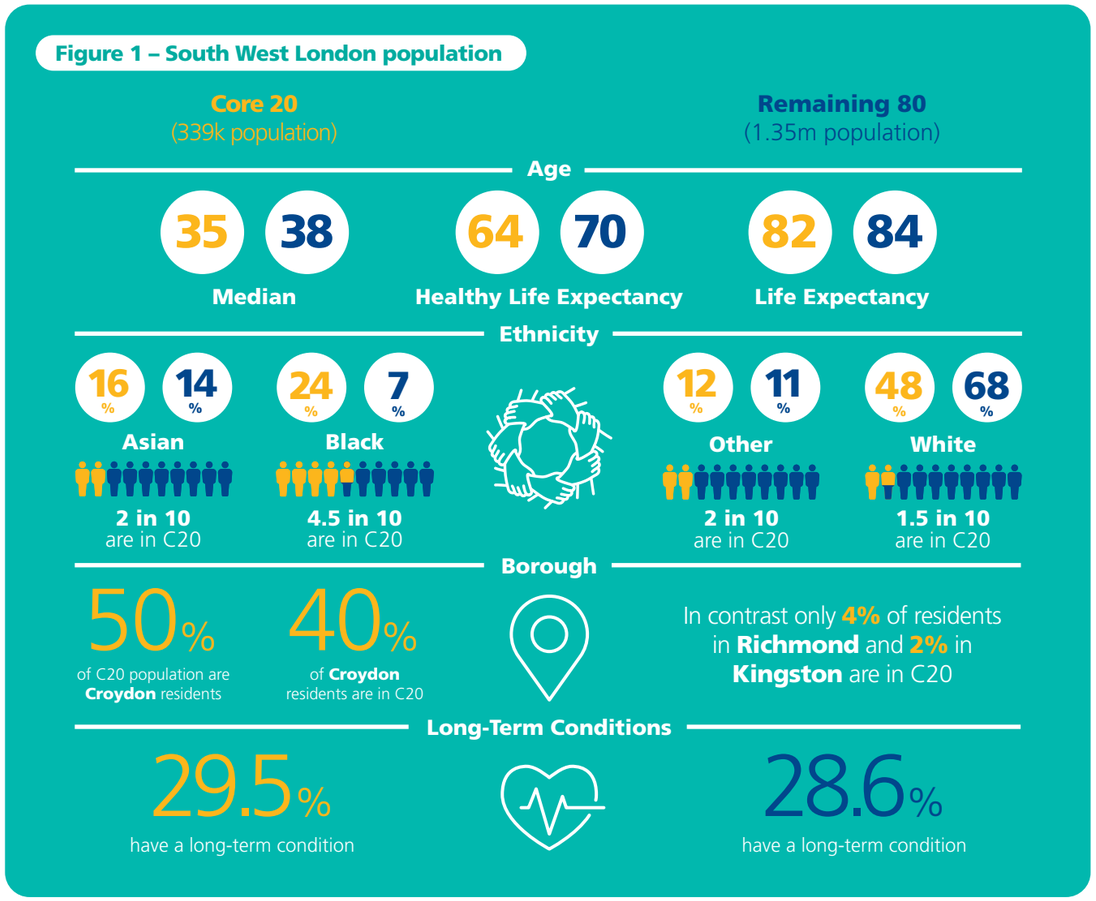
To better understand health inequalities in South West London, we assessed our health inequalities using the Core20PLUS5 approach. Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities. The approach defines a target population cohort and identifies '5' focus clinical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

The three elements of Core20PLUS5 are described below:

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

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

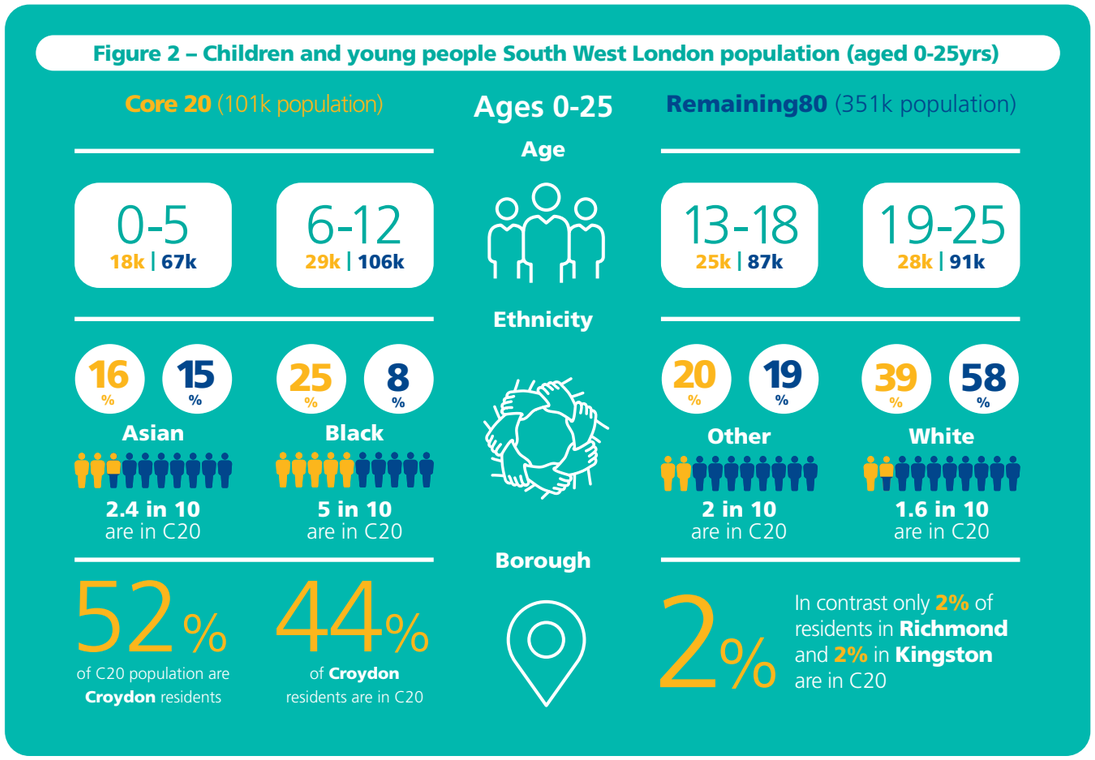
**Figure 1 – South West London population**




**For adults our analysis identified that:**

- **339,000** people in South West London make up our 'Core20' population
- **50%** of our 'Core20' population lives in Croydon
- **40%** of Croydon residents are in our 'Core20' population
- People in our 'Core20' population have a six year difference in their healthy life expectancy, and a two year difference in their life expectancy
- Our 'Core20' population are disproportionately represented by those from Black, Asian and minority ethnic backgrounds
- **29.5%** of our 'Core20' population have a diagnosed long-term condition

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




### For children and young people our analysis identified that:

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



The five clinical areas of focus which require accelerated improvement for adults and children and young people, as identified by the national core20PLUS5 analysis, are:

## Five key clinical areas identified for adults:

### 1. Maternity

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

### 2. Severe mental illness (SMI)

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

### 3. Chronic respiratory disease

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

### 4. Early cancer diagnosis

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

### 5. Hypertension

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

## Five key clinical areas identified for children and young people

### 1. Asthma

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

### 2. Diabetes

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

### 3. Epilepsy

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

### 4. Oral health

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

### 5. Mental health

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

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

## People and communities tell us

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

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

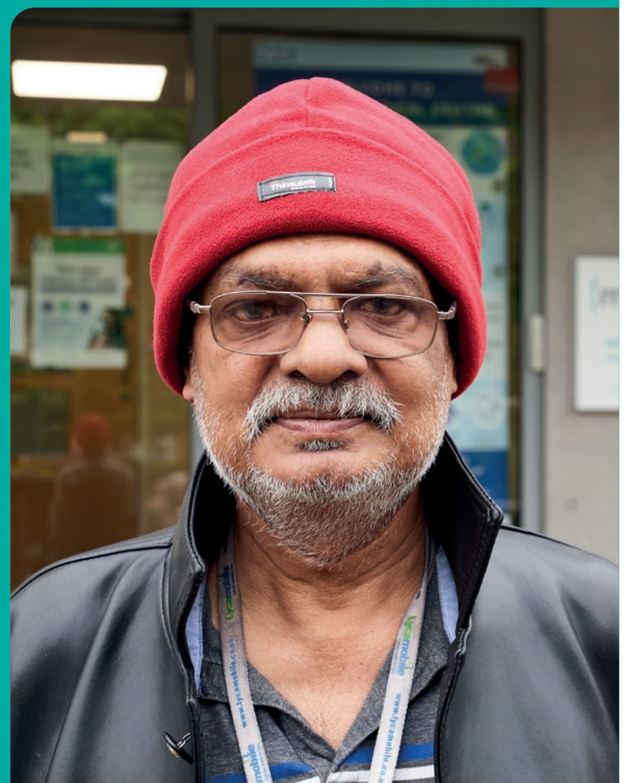
This can mean reliance on family members either to accompany people to appointments to translate and support, or to help with digital interactions. This isn't always appropriate.

Some Black, Asian and minority ethnic groups reported:

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

Symptoms of ill health especially mental ill health, can often be overlooked in older people. They can also feel they are not always listened to or taken seriously.

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





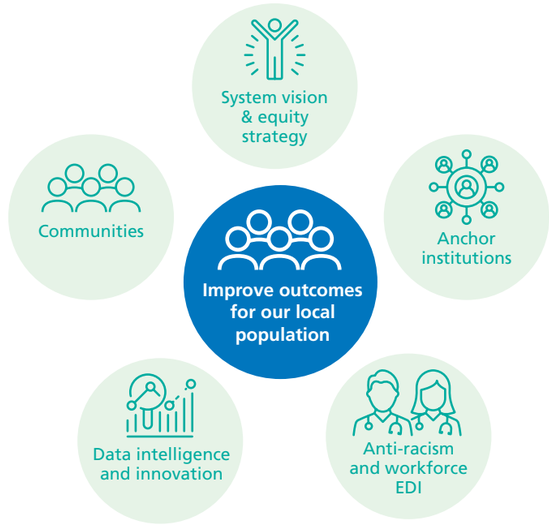
## Our ambitions

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

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

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

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




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

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

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

# Our focus and actions

### Improving outcomes for our children and young people, and adults in the Core20PLUS5 population

**To do this we will:**

- In 2023/24, deliver and evaluate the targeted and focused interventions for our core20 PLUS groups and populations with a focus on:
  - Core20PLUS community connectors.
  - Improving outcomes for black and ethnic minority communities through an anti-racism framework.
  - Tackling prescription poverty for our care leavers.
  - Improving 'flu vaccinations for our homeless communities and other inclusion health groups.
  - Improving children and young people's oral health.
  - Learning disabilities community connectors.
  - The ethnicity and mental health project.
  - Developing the health equity fellowship for our workforce and partners.
- Evaluate the impact of funded projects and programmes. This will include exploring engagement opportunities with research networks where there is alignment particularly around long-term conditions and prevention, through an equity lens (by 2026).
- Deliver the Innovation for Healthcare Inequalities Programme in collaboration with the Health Innovation Network, focusing on respiratory and maternity in Croydon as the borough with the highest Core20 population in South West London (by 2026).
- Improve outcomes for those living with learning disabilities and/or autism who have a mental health condition by focusing on early and preventative community-based services, particularly to help reduce inappropriate detentions under the Mental Health Act 1983 (by 2026).

### Developing our health inequalities strategic delivery plan

We will deliver a strategic delivery plan, building on the national and local priorities to reduce health inequalities.

**To do this we will:**

- Engage and work with system partners and communities on the priorities for South West London and set out a three-to-five-year delivery plan (by 2024).
- Launch and publish the plan, learning what has been achieved, and what more we must do to reduce health inequalities (by 2024/25).
- From 2025/26 onwards, we will review progress on delivery of the priorities for South West London, continue to map good practice, and use data and intelligence to measure impact of the delivery plan.

### Developing our anchor institutions to tackle socio-economic inequalities

**To do this we will**

- Work collaboratively with health colleagues to collectively ensure we pay the London Living Wage and develop and implement local schemes to support with the cost of living.
- Review the work of our anchor institutes and develop the next phase of the action plan (by 2024).
- Work with London health and care partners to review the recommendations and actions from the Cost of Living Evidence Report by the Institute for Health Equity, commissioned by the Greater London Authority, and agree South West London-wide action.
- Improve employment opportunities through the Core20PLUS Community Connectors programme to help improve health outcomes of the most deprived and marginalised groups in South West London.

### Developing our anti-racism framework to address racial inequalities

**To do this we will;**

- Implement race and ethnicity analytics initiatives to collate data and information on racial bias and awareness in the workplace, setting a benchmark for annual review. Recommendations and actions that come from the questionnaire data will inform the development of framework (in 2023/24).
- Developing expected outcomes as part of our equity dashboard, co-produced with communities, that enable measurement of racial equity.
- By 2026, continue to work with voluntary, community and social enterprise, organisations to engage communities impacted by racial health inequities using co-production to support improvement and better outcomes.

### Using data, intelligence, and population health management to improve outcomes and tackle inequalities for our population

**To do this we will:**

- Develop a system-wide equity dashboard to inform outcomes and improvements for our population (by 2029).
- Use a population health management approach to identify those with the greatest need, and tailor better care and support for them. We will use insights gained from population health management to inform proactive, joined-up and sustainable health and care services (by 2029).
- Improve digital inclusivity, particularly amongst marginalised communities to help with management of long-term conditions (by 2029).
- Utilise data to continue implementing our elective recovery programme in an inclusive way that does not exacerbate health inequalities (by 2029).
- Assess the impact of our local population who may not be accessing physical and mental health services (by 2029).
- Learn from best practice on approaches that improve data coding of protected characteristics (by 2029).

### Strengthening our community engagement

**To do this we will:**

- Deliver the Core20PLUS Connectors programme working with participating VSCE organisations to improve access, experience, and outcomes for our communities within our CORE20 areas (by 2026).
- Develop a community of practice and a CORE20 toolkit as an opportunity for connectors to share and scale best practice (by 2026).
- Work with the Core20PLUS clinical ambassador to provide clinical leadership in respect of health inequalities and population health improvement (by 2026).

### Delivering South West London's statutory equality duties

We will deliver our statutory duties for equality and inequalities as outlined in the Equality Act 2010 and the Health and Social Care Act 2022. Such duties include:

- Publishing equality information and objectives for the Public Sector Equality Duty.
- The annual equality delivery system reporting.
- Developing equality impact assessments and utilising the findings to improve health and care.

### Our work in focus – Core20PLUS Connectors

We have been awarded funding as part of a national NHS programme called Core20PLUS Connectors. The programme aims to improve outcomes for our children, young people and adults in the 20% most deprived communities. Around 340,000 people live in the areas in South West London where there are higher numbers of people and families with lower incomes than elsewhere in our boroughs.

The programme focuses on five areas of health – maternity care, severe mental illness, respiratory disease, cancer and cardio-vascular disease. You can read about how these priority areas have been identified and the health inequalities associated with them, on the NHS England website.

A key element of the project is recruiting 'community connectors' to support individuals, families and communities to achieve better health and connect people with local services and support.

The 'connectors' work with other community champions and uses asset-based community development (ABCD) methodology to work with the strengths of local communities to put in place what local people need. Croydon Voluntary Action leads on our ABCD training for all partners in our Integrated Care System which further shows the commitment to working with our local VCSE and their expertise in this area.


For example, community connectors recruited in Sutton have supported with an initiative to hold wellbeing events with residents of the Roundshaw Estate. By having the connectors front and centre at the events, people were more open to listen to information being shared because we were working so closely with trusted and familiar faces.

# Working together to prevent ill health

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

### Smoking

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

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

### Alcohol

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

### Adult immunisations

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

### Type two diabetes

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

### Coronary heart disease

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

### Childhood immunisations

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

### Obesity

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

### Hypertension

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

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



# People and communities tell us

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

**Community opportunities and barriers to healthier living:**

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

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

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

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

## Our ambition

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

We will work together across local authorities, voluntary sector, and communities, to co-design a system focused on the wellness of the population that also tackles health inequalities. Prevention cuts across all work programmes and projects within this Joint Forward Plan.

We aim to deliver the following ambitions jointly with our partners over the next five years:


## Our focus and actions

### Deepening our understanding of our population and health inequalities

**To do this we will:**

- Develop and deliver South West London data and digital strategies. This will include tackling digital exclusion and building on what our communities' requirements are for digital self-care apps (by 2023/24).
- Develop a health intelligence platform and health inequalities framework so that we can better understand our population's health and better measure the impact we are making. This health intelligence platform will enable more cross system working between local authorities and NHS and lead to more detailed Joint Strategic Needs Assessments and other community health analyses (by 2024/25).
- Improve access to epidemiological data so we can better understand the risk factors, service utilisation and outcomes of the Integrated Care System population and in comparison, to the national profiles.
- Use Core20Plus5 and other sources to identify and eliminate health inequalities in South West London and ensure that everyone has equal access to the same quality of physical and mental healthcare. Our detailed actions can be found in the health inequalities chapter of this plan.

### Developing a healthy lifestyles prevention pathway across South West London

**To do this we will:**

- Rollout a smoking cessation offer to every smoker or tobacco user across all Southwest London hospitals, maternity services, and mental health trusts (in 2023/24).
- Work with our communities to help them to understand and adopt healthier lifestyles and in 2023/24 develop a healthy weight programme across South West London that will help provide affordable options and support to all.
- Build on the successful 'WinterFit' intervention in pharmacies (a 15-minute conversation with over 65s advising them about the support they could access to stay fit and healthy over the winter period), and work with community pharmacies to better integrate them with our work in personalised care (social prescribing) (in 2023/24).
- Ensure that physical activity is routinely encouraged and supported throughout healthcare consultations in 2024/25, so that by 2025/26 physical activity interventions will have been embedded in hospitals ('active hospitals') and in primary care ('active practices').
- Further progress our work with communities to better understand how they want to improve their health and access prevention activities so that people across South West London have access to clear health information and are supported to manage their long-term conditions.

### Protecting South West London population from communicable diseases and environmental threats

**To do this we will:**

- Develop and embed a South West London immunisation strategy and action plans to improve uptake of childhood immunisations, school age vaccinations and adult vaccinations and to improve system response to outbreaks (in 2023/24).
- Act on feedback from people and communities to give them the right information, in the right format to make informed decisions about vaccinations.
- Work jointly with Greater London Authority on their plans to have London zero-carbon (by 2030).
- Work with partners to help make South West London greener and help reduce the impact climate change is having on the social and environmental determinants of health (from 2024/25).
- Strengthen our approach and response to outbreaks of infection and environmental threats with other ICS partners, including building upon the learning from Covid-19 especially around infection prevention and control (in 2023/24).

### Increasing support for the prevention and early diagnosis of chronic conditions

**To do this we will:**

- Increase use of NHS health checks, community health and well-being checks and case finding in community pharmacy and other outreach services to identify people with high-risk conditions including hypertension(by 2023/24).
- Identify low uptake of cancer screening programmes and work with NHS England to increase uptake and coverage to over 70% (by 2024/25).
- Develop digital support to help people navigate what is available to support them when diagnosed with a long-term condition (in 2023/24).
- Using South West London Innovation funding, utilise social engine marketing to divert people to the right advice and care in South West London (in 2023/24).
- Make available digital care pathways to support all South West London residents through their personal healthcare journeys (by 2026/27).
- As outlined in the chapter on long term conditions, we will embed secondary prevention (i.e. helping to reduce impact of an illness through enabling people access early detection).

### Our work in focus – Prevention decathlon

In South West London we have developed a series of prevention programmes under the banner of Prevention Decathlon, an innovative education programme designed to help people with a high risk of developing long-term health conditions, like diabetes and cardiovascular disease, better manage their health conditions.

The programme consists of structured health and wellbeing education sessions, physical activity classes, mobile phone app games and connecting participants to support in their local community. The programme will support 1,000 people over two years to better manage their health.

The Prevention Decathon boasts a 92% completion rate, for all participants who start the programme. Participants lose an average of 3kg and a proven average 45% increase in physical activity levels, therefore attendees are reducing their risk of developing a long-term condition.

We work alongside the Wandsworth Community Empowerment Network to deliver the programme. We have also been awarded funding via a Small Business Research Initiative to develop and deliver a national first cardiovascular disease prevention programme to support people at risk of developing cardiovascular disease.

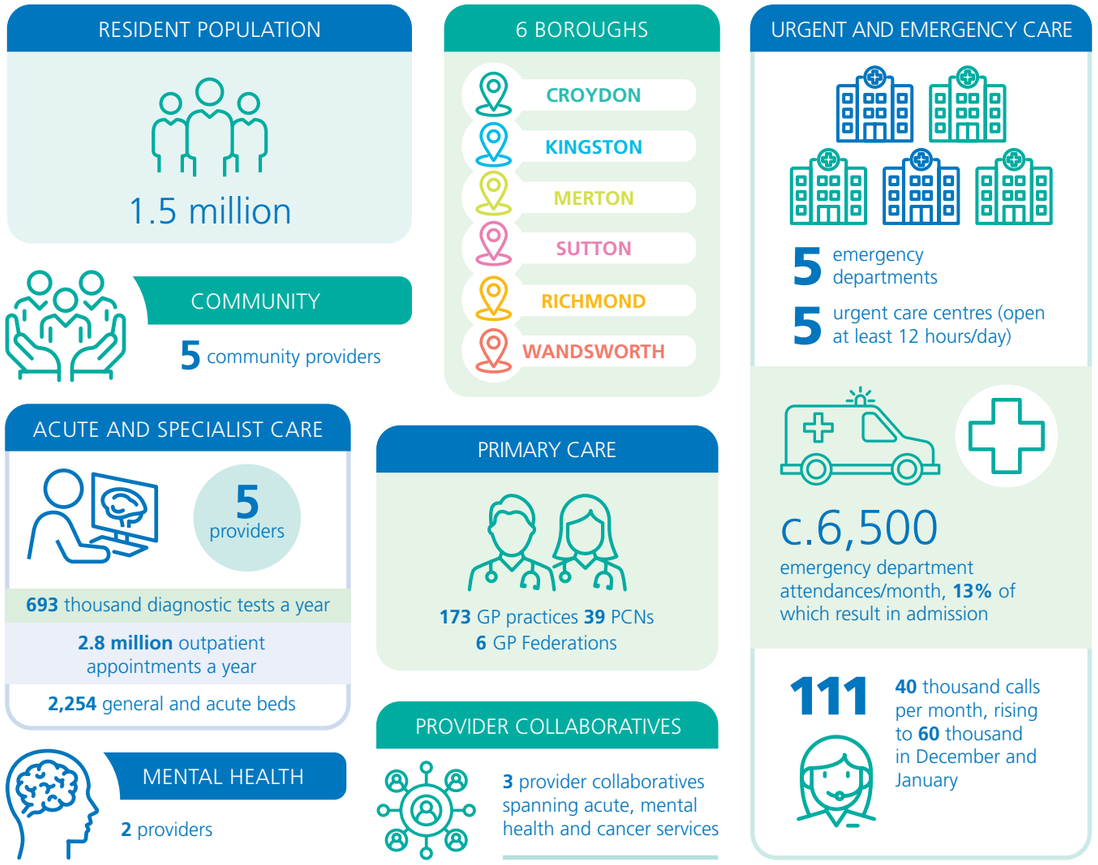
Read more about our prevention decathlons at https://www.southwestlondonics.org.uk/our-work/personalised-care/long-term-conditions/prevention-decathlon/

# Part Three: Developing the NHS in South West London

People in South West London are supported by dedicated staff and organisations to start well, live well, and age well. The early chapters of this five-year plan show us that the needs and expectations of people in South West London are changing, and our services and care will therefore need to continually develop to meet these.

This section outlines our priorities for developing services and care over the next five years. Clinicians and professionals across our system have shaped how we will enhance care in South West London. Each of that chapters that follow outline our ambition, the views of our people and communities and our priority actions.

## A picture of care in South West London






## Acute care and our acute provider collaborative

Acute care provides time sensitive and rapid interventions to people in areas such as planned or elective care, urgent and emergency care, cancer, and maternity services. Services include preventative care, diagnostics, outpatients, day-case and inpatient treatment as well as rehabilitative care. Services are delivered mainly in hospital settings but also in the community and in people's home. There are four trusts in South West London delivering acute NHS services for the population. These are:

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

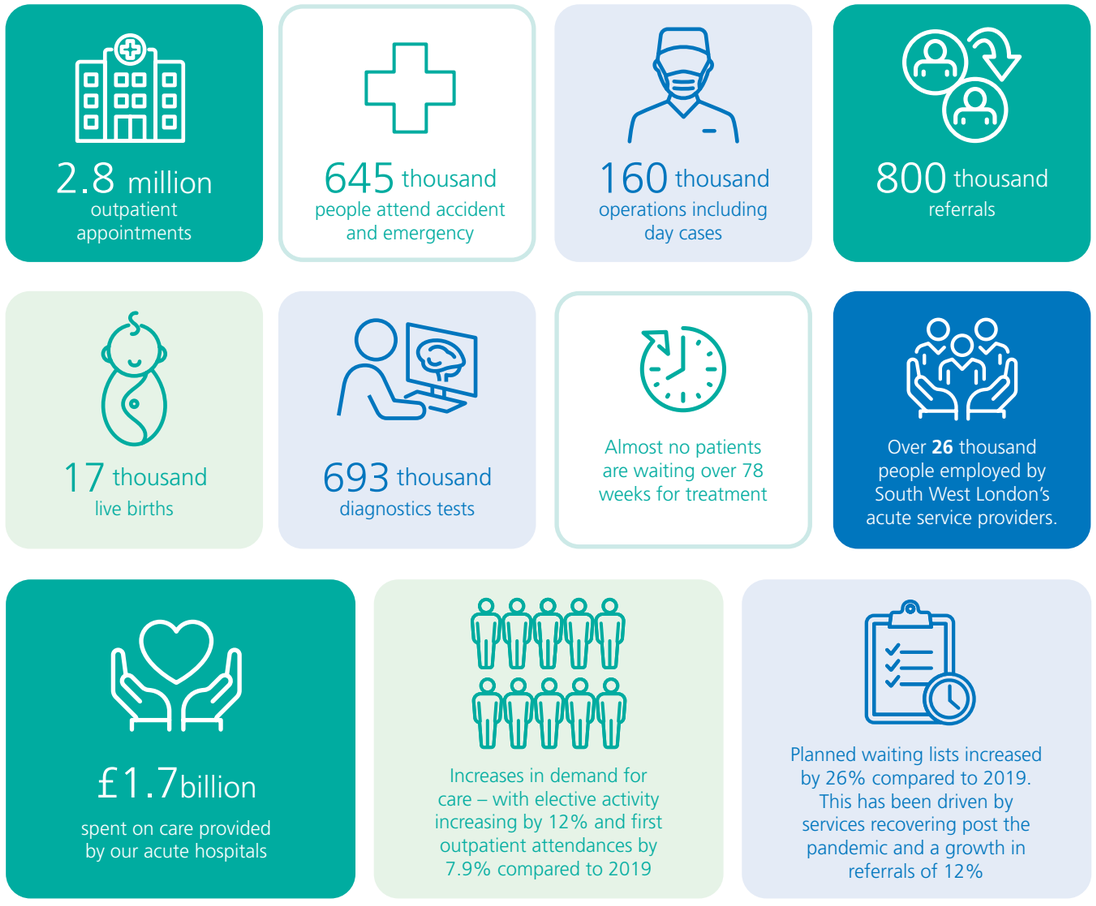
In addition, Royal Marsden NHS Foundation Trust provides specialist cancer services on behalf of the wider population of London and the South East.

St George's Hospital provides specialist clinical services for the people of South West London and the wider geographies of Surrey and Sussex in areas such as neurosurgery, hyper acute stroke care, paediatric medicine, trauma, and cardiac surgery. This constitutes around 50% of their services.

Epsom and St Helier University Hospitals NHS Trusts and St George's University Hospitals NHS Foundation Trusts, whilst separate Trusts, have formed as a hospital group.

Increasingly, NHS trusts are developing as integrated organisations managing acute and community services together to improve continuity for patients.

## A picture of acute care in South West London



The people of South West London access many of their NHS services through local hospitals and community centres. Hospitals are in the heart of our communities delivering diagnostic, outpatient and treatment services through referrals from community care and general practitioners or self-presentation in areas such as accident and emergency. Our acute services work in close partnership with the wider NHS to ensure patients are treated in appropriate settings. Increasingly acute and community services are being managed together in areas such as children's services, frail elderly care, and the management of long-term conditions so that continuity of care for patients can be enhanced. This is the case for Epsom, Croydon and Kingston which are integrated acute and community Trusts.

Whilst many services are delivered in hospital settings, the rise of technology and the importance of giving patients both choice of setting and control over their own healthcare journey will see an increase in care taking place through virtual and telephone appointments as well as treatment within community diagnostic centres and GP surgeries outside of hospital.

There are a number of priorities for acute services over the next five years:

### Delivering safe, effective, quality care

Hospital trusts will continue to ensure quality, safeguarding, infection prevention and control and safety statutory duties are being met, with any concerns being addressed rapidly leading to improved outcomes for patients. Creating a culture that enables staff to feel safe and to be able to challenge situations without repercussions are core elements of hospital trust plans.

### Managing a rise in demand for care

Hospital trusts receive over 800,000 referrals a year, an 12% increase since 2019. In order to meet this demand, the acute sector is seeing and treating more patients each year. We are investing in more diagnostic capacity by opening new community diagnostics centres and changing pathways to ensure the diagnostics tests are brought to the beginning of the pathway, allowing for patients care to be directed to the most appropriate setting. There is a focus on providing advice and guidance service to primary care, ensuring that specialist input is given to prevent unnecessary visits to hospital for patients. Work is underway to improve the accessibility of preventative services to keep people healthier for longer, specifically for patients with long term conditions. Helping through education, digital tools, coaching and peer support to help patients to self-manage their conditions.

### Managing emergency and urgent care demand

In January 2023, South West London hospitals saw 3,000 more emergency patients admitted to hospital than planned, a 15% increase. This high pressure on our emergency services impacts on longer waits in accident & emergency (A&E) for patients. 74% of patients were seen in under four hours in A&E in 2022 compared to a target of 95%. This can also impact on trust's ability to treat elective patients due to emergency pressures on beds and intensive care. Acute services are working with partners to improve the flow of patients through hospital from ambulance conveyance, initial assessment, and diagnosis in A&E through to safe and timely discharge when patients are ready to go home.

### Recovering backlogs in care

Waiting lists have grown by 26% since 2019 due to the backlogs created by the pandemic and as a result patients are unfortunately waiting longer for routine treatment. A combination of mutual aid between hospitals, new pathways of care and additional capacity is working to reduce long waiters down to a target of no patients waiting over 52 weeks by April 2025.

### Reducing health inequalities

There are differences in the care people receive across South West London in terms of access and the quality and experience of care. Acute services are working in areas such as maternity services and elective care to reduce these disparities. As an example, in Croydon, the HEARD (health equity and racial disparity) campaign in maternity aims to highlight and reduce the impact of some issues that may potentially contribute to increased risk, as well as improve experiences and health outcomes for the Black, Asian and minority ethnic pregnant women and families who access our maternity services.

### Supporting the workforce

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

### Investing in infrastructure

Some services in South West London are delivered in modern, purpose-built accommodation whilst other areas are in need of substantial capital investment, such as at St Helier Hospital, where more than 90% of the estate predates the NHS itself and is not fit for modern healthcare. South West London will see investments in infrastructure over the next few years in areas such as new community diagnostic centres in Kington and Croydon and a new hospital build in Sutton, as well as significant improvements at St Helier Hospital, to support improvements in our infrastructure.

### Enhancing digital and innovation

Our trusts will continue to invest in digital tools and innovation to support improved care, efficiency, and the delivery of integrated care. Trusts will make the best use of the latest technology, supplier skills and expert knowledge base to increasingly put patients in control of their healthcare journey and support swifter diagnosis and treatment.

### Delivering financial sustainability

Our trusts will contribute to recovering the current financial deficit in South West London by supporting a financial plan developed by all partners. Trusts will be working together to reduce excess costs, identify opportunities to collaborate on corporate and clinical services where this drives efficiencies and work with partners to improve the health and well-being of the population to reduce the demand on acute care.

## People and communities tell us

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

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

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

All four South West London acute care trusts scored an average of 8.0 or higher[5] (indicating excellent care) on their assessment and management of pain. However, trusts continue to receive complaints about pain management. As an example of good practice, Kingston Hospital has launched an initiative to improve pain identification and management among patients with dementia, recognising that these patients are not always able to express their pain.

South West London patients indicated moderate satisfaction for the length of time being on a waiting list before admission to hospital and for waiting for a bed on a ward after arriving at hospital. Patient concerns about wait times, particularly for a referral or to schedule an outpatient appointment, were raised, specifically for some people living with diabetes and those with sight loss.

The hospital discharge process does not always meet the needs of patients and their carers. Carers often report they are not equipped with the information needed to provide adequate support for the person they care for when they return home from hospital. Discharge processes for people living with dementia were cited as particularly poor, including a lack of clarity of instructions around taking medications and inviting patients to submit feedback about the quality of their care.

5 2021 National Inpatient Survey

# Our ambition

We want to deliver outstanding acute care and services that meet the needs and expectations of local people and improves their outcomes, access, and experience. We want to work with partners to improve the health and wellbeing of local people, reduce health inequalities and increase preventative care. We want to ensure the sustainability of services into the future, building and empowering our people and investing in modern estate and digital tools to support improved care.

# Our focus and actions

### Improving patient outcomes, access, and experience

**To do this we will:**

- Deliver care with compassion, dignity, and mutual respect. This will be shaped by listening to and understanding what matters to people, patients, and our staff, as well as empowering people to make informed decisions and design their own care, so they are equal partners in their health and care.
- Improve the experience patients have of our care from 2023. Our areas of focus include:
  - Improving the hospital environment.
  - Focusing on safety, quality, and experience of care for inpatients including ward accreditation schemes.
  - Improving the amount of time it takes to respond to complaints.
  - Improving experiences of patients and their carers when they are discharged from acute hospitals, providing them with better education and resources to feel supported.
- Improve choice, personalised care and continuity of carer for maternity services improving safety, outcomes, and experience by 2028 (for more information on our plans for maternity please see our chapter on maternity).
- Reducing waiting across the system from patients waiting for an ambulance all the way through to people waiting to go home from hospital (from 2023).
- Ensure timely access and reduce waiting times so that no patient is waiting over 52 weeks for treatment. We will continue to work together across our hospitals to provide mutual aid where surges in demand have been identified at a specific hospital (by April 2025).
- Focus on transforming outpatients by:
  - Investing in digital technology so patients have control over their outpatient journey and can manage outpatients on-line (by 2025).
  - Reducing unnecessary visits to hospital through patients initiating follow up appointments where it is safe to do so.
  - Expand work with GPs on advice and guidance to gain swift support for patients without the need for a specialist hospital visit.

### Increasing preventative care and providing right care in the right place

**To do this we will:**

- Transform our community models in areas such as diabetes, cardiology, and rheumatology so that people can be treated in different ways or prevent them from becoming ill and needing treatment (by 2028). For more information on our plans for community please see our community care and long term conditions.
- Work in a more integrated way with our place-based partners ensuring that care is provided in the right place at the right time, tailored to the clinical needs of patients (by 2026).
- Utilising our clinical networks, continue to deliver pathway changes from primary care through to specialist services, using diagnostics at the beginning of clinical pathways to reduce avoidable referrals into our acute hospitals in 2023/24.
- Use our healthcare expertise to support people to make healthy lifestyle choices to reduce the number of people who are suffering with long term conditions (by 2028).

### Addressing health inequalities and ensuring there are no barriers in patients accessing acute hospital services

**To do this we will:**

- Ensure that as we reduce waiting lists, we do so inclusively so no part of the population or particular group is disadvantaged from 2023.
- Ensure our digital strategy increases inclusivity and options for patients, reducing any digital exclusion (by 2028).
- Work to have single points of access across South West London in certain speciality services in 2023/24. This will improve access to health care by equalising waiting times across our acute hospitals.

### Ensuring financial sustainability of our services now and in the future

**To do this we will:**

- Contribute to recovering the deficit position within South West London health economy (by March 2025).
- Maximise delivery of performance to ensure that we remain at the forefront of productivity, quality, and efficiency especially in areas such as theatres and outpatients.
- Explore further areas of collaboration where there is merit in doing so especially in corporate services such as estates, digital and human resources commencing 2023.

### Building and empowering our workforce to support their health and wellbeing and supporting them to reach their potential

**To do this we will:**

- Share workforce, whilst also exploring the creation of new roles, new ways of working and embracing technological solutions aligned to our ambition to implement new models of care.
- Create a realistic sustainable workforce plan targeting areas of national staff shortages and hard to recruit roles.
- Adopt flexible and agile working to support the resilience of fragile services and the needs of our staff.
- Focus on being the best place to work providing health and well-being support and development opportunities for all so everyone can reach their potential.
- Build upon the collaboration our acute hospitals have already undertaken with our shared recruitment hub service, and expand the remit to include services such as occupational health.

### Investing in infrastructure to ensure modern welcoming environments with which to deliver care

**To do this we will:**

- Build a brand-new specialist emergency care hospital at Sutton and also significantly improve Epsom and St Helier hospitals (where 85% of patients will still be seen and treated) to address the long-standing patient care, workforce, estates and financial challenges at Epsom and St Helier. The specialist emergency care hospital will bring together six major services: accident & emergency, critical care, acute medicine, emergency surgery, inpatient paediatrics, and births in hospital, ensuring expertise, experience and resource will be in one place 24/7. The development is part of the government's new hospital programme and is due to be completed in 2027 at the earliest.
- Invest in community diagnostic centres in Queen Mary's Roehampton, Kingston, and Croydon to support faster access to diagnostic tests (by 2024).
- Enhance surgical capacity at Kingston and Croydon and upgrade intensive care units in St George's, Kingston, and Croydon (by 2025).
- Bring St Helier and St George's renal specialist care together in a single new unit at the St George's Hospital site built in 2026.
- Continue to invest in digital tools and technologies, improving flexibility in the way patients can manage their care (by 2028).
- Continue to use annual capital funds to upgrade and extend facilities on all hospital sites and reduce backlog maintenance (by 2028).

# How we collaborate – Our Acute Provider Collaborative

Our four acute hospital trusts (Croydon, Epsom & St Helier, Kingston, and St George's) came together in 2017 to form the South West London Acute Provider Collaborative. The four acute hospitals collaborate in areas where working together gives more system benefit than working individually. The trusts also work together with Royal Marsden Partners, West London Cancer Alliance, to improve cancer services and outcomes in South West London.

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

Our acute provider collaborative has the following aims:

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

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

The APC is focused on improving the delivery of elective, outpatients, and diagnostic services across the acute hospitals, whilst also working to optimise further collaborative opportunities in corporate functions. To date our collaboration has seen the set-up of formal partnerships with the South West London Elective Orthopaedic Centre, South West London Pathology Network, South West London Procurement Partnership, and the South West London Recruitment Hub.

# Cancer

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

Tackling the causes and consequences of cancer is a key priority in South West London. As our population gets older, the likelihood of being diagnosed with cancer increases. Significant improvements have been made in diagnosis and treatments of cancer in the last thirty years, which help people survive longer, with better quality of life. As a result, over 50,000 people in South West London are living with or beyond cancer. Nevertheless, cancer remains the most common cause of death in adults over the age of 25 years old, and as a result cancer is a significant focus locally and nationally.

The NHS Long Term Plan (2019) highlights that despite the progress made in cancer survival over the last two decades, we can do more to improve survival through diagnosing cancer earlier, when the cancer is easiest to treat, and reducing variation. We also know that deprivation and other societal factors affects the chances of a person having their cancer diagnosed early, and we need to do more to eliminate these differences.

To implement our ambitions for cancer, South West London is supported by Royal Marsden Partners. Royal Marsden Partners is one of 21 cancer alliances nationally and covers both North West London and South West London geographies, working across hospitals, boroughs, and GP surgeries, as well commissioners of screening, local, and specialist services to deliver the NHS Long Term Plan. Royal Marsden Partners is well established as a provider collaborative and brings clinical, change management and operational expertise to transform cancer pathways.

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

**One in every two** people will get cancer in their lifetime

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

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

58%

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

**2020/21 incidence of cancer by borough[6]**

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

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

| | South West London | | | | | |
|---|---|---|---|---|---|---|
| Age range | 0-24 | 25-39 | 40-59 | 60-74 | 75+ | Total |
| cause of death: cancer (malignant neoplasms) | 0% | 48% | 49% | 47% | 22% | 30% |

## People and communities tell us

What our population told us about their experience:

### Earlier and faster diagnosis

- Patients have positive experiences of the speed of access to diagnostic tests, and the way they are given their diagnosis.
- More needs to be done to encourage people with a learning disability to take up breast cancer screening.
- People want credible advice from trusted NHS sources about cancer, and to feel empowered to ask questions about treatment.

### Treatment and living with and beyond cancer

- People in South West London report a positive experience of cancer services, and high levels of confidence in the NHS teams looking after them.
- People want more emotional support in the community after their cancer diagnosis.
- Patients are sometimes not aware of the different therapy and supportive care services that are available to them while having cancer treatment.

### Inequality

- Those who identify as Black or Asian, with an existing long-term condition or from the LGBTQI+ community are less likely to come forward with cancer symptoms within 3 months. and have highlighted inequity across the cancer pathway (NCPES data 2021).
- People have said we need more culturally specific support groups for Black men with cancer and to encourage more open discussion about cancer in local communities.
- There is sometimes a lack of awareness of about different cancers, and a need to reduce taboos and shift perceptions with local people and communities.
- Teenagers and young people with cancer value access to a digital app to support their emotional wellbeing.

# Our ambition

We want to save more lives in South West London, through earlier diagnosis and reducing inequalities across cancer pathways. For those people with symptoms suggestive of cancer, we want to make sure that we act quickly so that no one has to wait more than 28 days to receive their diagnosis, and no more than a further month to start their treatment.

# Our focus and actions

We know that to achieve our ambition we need to focus on understanding where variation exists, act to reduce variation in partnership with our communities and place-based teams, continue to improve the cancer diagnostic and care pathways and embrace new approaches to early diagnosis. We also need to work closely with local people and communities to ensure that services are accessible to all.

To deliver our ambition we have three overarching priorities:

### To diagnose people earlier, faster and improve survival

Improve the early diagnosis rate by 4% by 2025, with a further step change expected through new diagnostic approaches, which are being trialed across the UK and internationally.

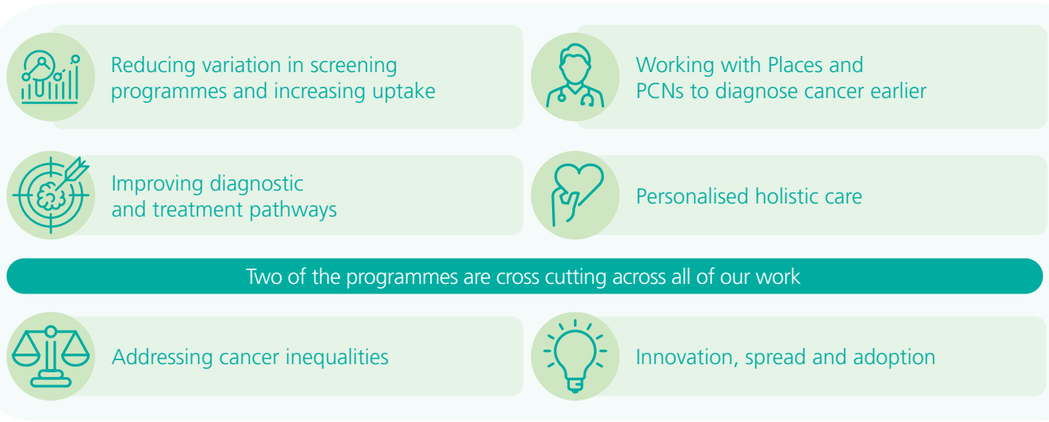
### To remove variation and optimise care

Tackle the variation in early diagnosis across South West London to ensure that 75% of people receive an early cancer diagnosis, particularly focusing on those with the highest need.

### To improve patient experience and quality of life

Improve access to care that is personalised and holistic.

To address these priorities, we have developed six strategic delivery programmes:




### Reducing variation in screening programmes & increasing uptake

**To do this we will**

- Deliver new types of screening to identify tumours at an earlier stage. This will include inviting all those eligible for a targeted lung health check by 2026/7, starting in areas with the highest deprivation and smoking rates.
- Improve our ability to identify communities that are not engaging in screening programmes, by tracking demographic characteristics against cancer staging data, and use this information to develop targeted engagement with communities.
- Work with partners to remove inequalities in the uptake of national cancer screening programmes by population group, focussing on bowel cancer screening in men, and on cervical cancer screening with women under 30.

### Working with places & primary care networks to diagnose cancer earlier

**To do this we will**

- Proactively engage with those less likely to come forward with cancer symptoms and develop interventions that give people the confidence to speak to their GP about their symptoms so that we can diagnose cancer earlier.
- Reduce variation in early-stage diagnosis by working with primary care partners in the parts of South West London where fewer cancers are diagnosed and treated through the urgent cancer pathway.
- Embed cancer referral guidance, specifically ensuring that 80% of patients urgently referred for a lower gastrointestinal cancer investigation have had Faecal Immunochemical Testing (FIT) in primary care by the end of 2023/24.
- We will further develop our cancer population health approach, creating insights that we can develop into action plans by GP practice, age, sex, ethnicity, and deprivation.

### Improving diagnostic & treatment pathways

**To do this we will**

- Work with trusts in South West London to improve cancer patient pathways so that we consistently treat patients with cancer within 62 days of urgent referral, and are consistently meeting this standard by the end of September 2024.
- We will create a new community-based expert assessment service for people who have breast pain, by the third quarter in 2023/24.
- We will increase the level of nurse-led diagnostic and imaging capacity available for suspected urology cancers.
- We will improve the speed of diagnosis for lung cancer, working towards the national optimum pathway of 49 days from urgent referral to treatment over the next 18 months.
- Increase the number of patients who are referred to 'vague symptom' clinics, creating resilient and sustainable non-specific rapid diagnostic clinics across South West London by the end of 2023/24.

### Personalised holistic care

**To do this we will:**

- Ensure that all patients across South West London are offered a consistent approach to personalised care, have the right support in place to manage their condition and aftercare, and that they receive an end of treatment summary.
- Refresh patient-initiated follow-up pathways for priority tumour types, ensuring this is fully operational in breast, colorectal, prostate, and endometrial cancer pathways.
- Develop a patient and public involvement programme, involving patients and public in the co-design, oversight, and scrutiny of our cancer programmes. This will include the co-design of an innovative, whole-system approach for cancer prehabilitation and rehabilitation.

### Addressing cancer inequalities

**To do this we will:**

- Ensure all our programmes are designed with an inequalities first approach.
- Deliver a comprehensive population health approach that supports reduction of inequality.

### Accelerating innovation, spread and adoption

**To do this we will**

- Ensure as new cancer detection approaches become established, we embrace innovation to:
  - Implement new types of screening programmes to support those with individualised risk of certain cancers.
  - Implement less invasive tests for cancer for those with symptoms.
- Ensure genetic testing for all new colorectal and endometrial cancers to identify those with a higher family risk of cancer.
- Test and implement new methods of screening people with Barrett's oesophagus using 'cytosponge'.

## Our work in focus – Increasing cancer screening uptake in the Black community

Early detection of cancer is one of the best ways for lowering cancer-related deaths, but research shows that there are large disparities between ethnic groups when it comes to screening uptake.

There are many reasons why some people may not take up screening, from difficulty attending appointments, unawareness about its importance to fear of the potential result. A recent study* found that Black people are 38% less likely than White people to be diagnosed with cancer via screening in England, highlighting the need for more targeted efforts to reduce any barriers to access and increase cancer screening levels amongst ethnic minority groups.

To address this, a partnership between Croydon BME forum, The Asian Resource Centre of Croydon and RM Partners launched the Cancer Awareness Programme for residents in March 2022.

**The programme aims to:**

1. inform and educate residents about cancer and the importance of cancer screening
2. increase uptake of cancer screening and reduce health inequalities within the Black community
3. create a trusted and safe environment for residents to engage with health professionals

Through free coffee mornings, focus groups and virtual workshops hosted by trusted clinicians including breast surgeons and GPs, Croydon BME Forum firstly sets out to understand people's attitudes towards screening. Using this local knowledge, workshops are then created to respond to queries and provide accurate and culturally sensitive information in a relaxed environment.

To date the programme has engaged over 1,300 individuals and highlights have included:

- 34 awareness talks covering cervical, breast, prostate and bowel screenings.
- 10 events co-hosted locations include churches, GPs, hospital, hairdresser, food and health store locations.
- 60 partnerships formed to support the project.




# Children and young people

**332 thousand** children and young people aged 0-18 years in South West London

**Mixed demographics across our boroughs, characterised by some areas of high affluence and areas that have some of the poorest communities, with high levels of multiple deprivation.**

**Obesity** – prevalence of obesity across our boroughs at year 6 is below the London (23.7%) and England (21%) average, with the exception of Croydon (25.1%).

Obesity in all boroughs is higher in our deprived areas, The average weight of a child is increasing between reception and year 6.

**Oral health** - Merton is higher than national average for dental decay in five-year-olds, 27.7% compared to the national 23% (Public Health England (PHE), 2019).

In 2022, 21.3% of five-year-olds in South West London have experience of dental decay, compared to a London average of 25.8% (London dental public health team, NHS England)

c.**40 thousand** children with special educational needs and disabilities (SEND), the largest areas of need are autism, speech, language and communication needs, and social, emotional, and mental health needs.

On average, 30% of children across South West London are not achieving a good level of development and consequently are not school ready. The highest foundation stage profile attainment gap is in Croydon where 33% of children do not achieve this target.

The measles, mumps and rubella, MMR, immunisation rate across South West London continues to be lower than the England average (85%) for two doses by age five years. With the exception of Croydon, which is lower than both England and London. All of our places are higher than the London average.

187,186[7] emergency department attendances for children 0-18 years. The 0-5 age group had the most overall attendances across South West London (94,914) and within that age group the highest proportion presented at Croydon Health Services NHS Trust (32,878).

16,123
children in South West London have a recorded asthma diagnosis.

In 2021, 45% of children and young people who were looked after in England had emotional and mental health problems. This compares to a rate of 10% among 5- to 15-year-old children in the general population. these statistics are reflective of our population in South West London.

7 Between March 2022 and February 2023

## People and communities tell us

We understand from engagement with our children and young people, and their parents and carers, that there are gaps in the support available and services provided. They told us that:

- There are increasing levels of mental health issues in children and young people, with long waiting times for treatments.
- There are sometimes long waits and delays to access support, especially around targeted children and adolescent mental health (CAMHS) services.
- There are some differences in the willingness of parents to vaccinate their children against flu, Covid-19, MMR and polio. For example, whilst some parents had concerns about the Covid-19 vaccination for children, most parents understood the severity of polio and were willing to vaccinate their children against it.
- Children and young people felt a lot of their life experiences happen online with social media making their mental health needs worse.
- There are sometimes long waits for diagnosis and children and young people would like more support whilst waiting.
- It is sometimes difficult to access therapies, particularly speech and language therapy and occupational therapy.
- It is sometimes difficult to understand what services and support are available to children and young people.
- It is felt that there is a lack of appropriate support for children and young people with complex and long-term needs, especially autism spectrum disorder (ASD) and learning disabilities (LD).

## Our ambition

We want our children and young people to have the best start in life, a good education, enabling them to live well, flourish and achieve their full potential.

We want to support parent and carers, at local early years settings and schools, tackling inequalities and raising education attainment. We want children to be safe, their needs and aspirations recognised and achieved, with support where required to develop independence and preparation for adulthood.

## Our focus and actions

### Reducing rates of childhood obesity

**To do this we will:**

- Work closely with public health and community leads through our existing workstreams and projects to ensure our interventions are based on the needs of the population (by 2025/26).
- Use population health management data to support children and their families to make informed choices about their diet and physical activity levels (by 2025/26).

### Improving oral health for children

**To do this we will:**

- Address the wider determinants of health through supporting parents and children to adopt healthy lifestyles and diet which will support a good level oral health (by 2025/26).
- Develop a consistent approach to early identification and intervention for oral health related to diabetes and co-morbidities (by 2025/26).

### Enhancing the quality and consistency of care for children with asthma

**To do this we will:**

- Agree a standard asthma care plan and digital platform for children and young people across South West London (by 2024/25).
- Continue to examine asthma data for South West London population and use the data to improve the management of asthma, reduce the need for secondary care and target resource to vulnerable populations (by 2024/25).
- Monitor the use of asthma bags as a proxy indicator to emergency department avoided attendance on an ongoing basis.
- Pilot an air quality/air pollution project that is co-produced with primary school children (by 2024/25).

### Supporting children and young people with special educational needs and disability (SEND) to be more independent

**To do this, we will:**

- Ensure co-production, including designing education health and care plans with parents, carers and/or young people, is embedded within all SEND (by 2025/26).
- Develop an Integrated Care System data dashboard on SEND to support an accurate, shared understanding of the needs of children and young people in our boroughs. This will support us to develop services to meet the needs and aspirations of children and young people (by 2025/26).
- Work collaboratively to improve transition pathways between children and adult health services for those for whom we maintain a statutory responsibility.
- Support designated clinical and medical officers at place to develop consistency of practice across South West London for children and young people with SEND and improve access to therapies for children and young people with SEND (by 2025/26).

### Improving our screening and immunisation rates

**To do this we will:**

- Develop targeted education and communication programmes starting from pre-conception and throughout the maternity journey (by 2023/24).
- Enhance joined up working between primary care, midwifery, and health visiting teams, particularly for parts of our population with low immunisation rates to increase immunisation uptake.
- Work with primary care to ensure that families can access immunisations at times that are convenient to them (by 2023/24).
- Monitor the uptake of the MMR vaccination on an ongoing basis. This data will be used to develop a best practice that makes every contact count.
- Develop an all-age immunisation strategy to increase vaccination up take (by 2023/2024).

### Improving school readiness

**To do this we will:**

- Work with our early years partners to ensure that as many children as possible take up a free targeted (two-year-old) or universal (three and four) early education place (by 2023/24).
- Work with our early years partners to ensure that parents and children engage with the health visiting two and a half-year-olds developmental check to help check progress against milestones at an early stage (2023/24).
- Work across the system to enrich language and communication support for all children (by 2023/24).
- Ensure follow up support for those children requiring additional assessments following two and a half-year checks, for example, speech and language therapy, neurodisability and parenting support services, so that child is fully assessed to support readiness for school (by 2023/24).
- Use foundation stage profile, FSP, as an indicator of school readiness and to provide predictive analysis of cohorts that are more susceptible to poor results so that the right support and interventions are put in place.

### Reducing health inequalities for children and young people

- To do this we will tackle difference in health and care outcomes, recognising that minority groups face greater inequality. We will have a focused and sustained progression and programmes of work to support the core20PLUS5 children, ensuring we have targeted community-based and community facing service that is inclusive from the point of access.

# Community care

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

**A picture of community care in South West London:**

There are different ways in which community services are provided in South West London, including standalone NHS community services, integrated acute and community services and a community interest company.

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

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

£231 million

is currently invested in community services

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

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

**Demand is increasing due to:**

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

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

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

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

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

## People and communities tell us

Patient satisfaction is very positive for NHS community services, for example, Central London Community Healthcare[8] providers report that their key patient satisfaction indicators are overwhelmingly positive, with nearly 100% respondents saying they were treated with respect and dignity and 98% rating their overall experience as good or very good.

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

Some people who left hospital to a 'rehabilitation bed' felt it helped with their recovery. People said that a lack of space for equipment in their own home was the main reason for preferring to be in a rehabilitation bed.

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

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

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

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

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

# Our ambition

We want to support people in South West London to stay well and live independently; supported by integrated, multidisciplinary health, social care and voluntary sector teams providing care and support close to, or in, their home, who work across organisational boundaries to provide the very best personalised care.

# Our focus and actions

### Creating a new model of care in the community

**To do this we will:**

- Review how we commission and deliver community services and how we use enablers such as better care fund contracts, sections 75 arrangements, local authority services and other non-statutory services to deliver our priorities in a more integrated way (by 2023/24).
- Identify the priority population segments, such as long-term conditions requiring specialist support, for example, cardiovascular disease, neuro rehabilitation, musculoskeletal input and define a new model of care that describes how services will develop to support peoples changing needs (by 2023/24).
- Identify the priority population groups, such as end of life care, falls, and frailty, and implement models of care that describe how services will develop and be provided to support peoples changing needs in accordance with national guidance (by 2023/24/25).
- Work with stakeholders including patients and carers to scope services across South West London to create a single framework for the delivery of community services focussed on preventative, proactive and reactive responses (by 2023/24).
- Work with colleagues in primary care to develop community services around primary care networks or neighbourhoods to improve access, outcomes and address local health inequalities (by 2024/25).
- Promote the principle of 'home first' across the acute and community setting, shifting the focus to providing patients with support at home or intermediate care, and from treatment in hospital to treatment in the community. This will include creating clear escalation pathways into step up bedded capacity as alternatives to admissions into acute units (by 2024/25).
- Deliver an at-scale and transformative model of care in the community that changes both how we plan services and care for people in the community (by 2025/26).
- Reduce waiting times in community services and ensure people are cared for in their own homes, care homes, or preferred environment wherever possible (by 2026/27).
- Increase the take up of the pro-active care model, particularly for those who are frail, across South West London (2023/24/25).

### Supporting urgent care needs and people returning home from hospital

**To do this we will:**

- Create intermediate care bed capacity that helps prevent unnecessary admissions to hospital and enables earlier discharges, thereby ensuring people can recover at home wherever possible for as long as possible (by 2025/26).
- Work collaboratively with partners to develop and deliver a core hospital discharge model to support earlier discharges and people to stay well and maximise their independence following a hospital stay (by 2023/24).
- Embed virtual wards and expand the number of conditions they can support within a community based stepped model of care that both promotes admission avoidance and earlier supported discharges (by 2023/24).
- Improve access to both general and specialist rehabilitation within the community setting and address the current variation in service availability, waiting times, and access across South West London (by 2024/25).
- Increase referrals from patients and health and care professionals to the two-hour urgent community response service to support people at risk of admission to hospital (by 2024/25).
- Increased the use of the universal care plan (UCP) for people at the end of life, people in care homes, and those with frailty and dementia (by 2024/25).

### Increasing early identification

**To do this we will:**

- Work with community and integrated networks to identify patients who would benefit from health promotion or prevention interventions which would prevent or delay the onset of their conditions (by 2023/24).
- Work with GPs to identify patients at risk of developing long-term conditions and/or frailty earlier and provide care and support to prevent the conditions developing (by 2023/24).
- Work alongside the prevention programme to develop and implement, evidenced-based prevention services to support and empower people to live healthy lives and better self-manage their condition (2025/26).
- Use health and social care data to identify people at risk of a fall and provide information to support self-referral (2023/24/25).

### Using technology to improve care

**To do this we will:**

- Utilise technology and data to identify patient needs early and use this information to support proactive management of their care (by 2023/24).
- Make tools such as urgent and universal care plans available, and visible to clinicians and professional across the system. The first phase will focus on our agreed priority cohorts enabling multidisciplinary community care, preventing unnecessary admissions, and enabling earlier discharges (by 2024/25).
- Enhance digital maturity and integration with care homes to provide better care for residents (by 2023/24/25).

### Enhancing and supporting our workforce

**To do this we will:**

- Work with hospital clinicians so that they understand the new models of care developed to provide care in people's home following a stay in hospital, for example virtual wards, and the clinical change that is required to make new models of care successful (by 2023/24).
- Baseline demand and capacity across community areas and work with the South West London workforce programme to address issues with recruitment and retention (2023/24).
- Work through the integrated care network to review the staffing and skill mix within the acute and community setting and ensure that our resources are in the right place in the most appropriate setting (2024/25).
- Train and work with third party organisations, for example, Age UK, Marie Curie, or other voluntary sector organisations to provide support to innovative service delivery models (2024/25).
- Work with social care, including care homes, so that they understand and are a core part of the new models of care (by 2023/24/25).
- Work with the end of life care network and providers including hospices and voluntary sector providers such as Marie Curie and Macmillan to improve end of life care across South West London (2023/24/25).

### Our work in focus – Supporting homeless people after hospital stays

People who are homeless and rough sleeping experience barriers to accessing and navigating health services, leading to significant health inequalities.

On average people who are rough sleeping:

- have a life expectancy 30 to 40 years shorter than the general population
- have disease rates that can be 10 times higher than the general population
- are six times more likely to attend A&E, four times more likely to be admitted and stay twice as long as housed people.

To reduce the health inequality gap we have a programme focused on improving homeless health services. In November 2021, the pathways hospital team at St George's Hospital focused on supporting people home from hospital using a model developed by the charity, Pathway.

The aim of the pathways team is to help people to access the accommodation and support they need to recover following a hospital stay. The team is made up of a GP, specialist nurse, a care navigator and two housing advisors. The team works with an individual to create bespoke care plans co-ordinating input from housing departments, mental health and addiction services, social services, community services and the voluntary and community sector partners. During March and April 2023, the team were referred 27 people who were experiencing homelessness. Of these, seven were rough sleepers and only one of those returned to the street after discharge.

During 2023/24, we are planning to expand the scope of the team to include other inclusion groups such as people from the gypsy, Roma and travelling communities, vulnerable migrants and sex workers. We will also establish a pathways team at Croydon Health Services to work with existing services who support people who are homeless and rough sleeping.

# Diagnostics

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

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

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

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

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

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

### What do we mean when we talk about diagnostics?

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

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



# People and communities tell us

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

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

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

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

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

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

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

# Our ambition

We want to increase access to high quality, fast diagnostic services for all patients. In doing this, we want to ensure that our patient's experience is improved, and health inequalities are eradicated.

# Our focus and actions

### Increasing diagnostic service capacity

**To do this we will:**

- Create additional diagnostics capacity in community diagnostic centres to have at least four sites located in communities across South West London by 2024/25.
- Invest in new diagnostic equipment and rooms providing more than 30 new pieces of diagnostic equipment including a modular CT scanner, five echocardiography machines, and three ultrasound machines. Several new diagnostics rooms will be established at the community diagnostic centres to provide additional testing capacity (by 2025).
- Develop a five-year forward plan for diagnostic demand and capacity in South West London by November 2023, to ensure future need for services can be planned for. This will include considering our demographic and aging population and ensuring that capacity is sufficient to meet this demand.
- Increase the number of diagnostic tests we can provide with existing capacity through efficiency improvements for example increasing our use of scanners and reducing unnecessary inappropriate scanning by 2026.

### Addressing health inequalities in accessing diagnostic services

**To do this we will:**

- Understand current rates of did not attends (DNAs) and reasons for these so that this can be minimised over the next five years (2023/2024).
- Establish monitoring to better understand groups that struggle to access diagnostic services in South West London and develop five year plans to address inequalities in access (2023/24).
- Using Core20plus5 and other health inequalities data, ensure that new community diagnostic centres to be mobilised in 2023/24 and 2024/25 are in locations where they are accessible by population groups with the greatest need including in the areas of the highest deprivation in South West London.

### Establishing a South West London imaging network

To do this we will:

- Design and implement a South West London imaging capital and procurement plan to ensure equipment is replaced as needed and we can reduce the amount spent on outsourcing services (2025).
- Deliver a South West London diagnostics digital roadmap (2025).
- Ensure that our pathways minimise the time to tests, allowing patients to choose to travel within South West London should they wish to, as our patient feedback tells us that timely diagnostic testing is sometimes more important than where the test takes place (by 2025).
- Develop streamlined diagnostics pathways, creating new and improved relationships between providers of diagnostic tests, that help us share workforce and images more easily across South West London providers, GPs, and specialised care centres (by 2026).
- Design and implement a South West London imaging network operating model that includes a governance and leadership structure to drive the work of the network (2023/2024).

### Enhancing our diagnostics and imaging workforce

**To do this we will:**

- Undertake workforce modelling to predict the workforce capacity and requirements to meet growth in demand and the expansion of services over the next five years (September 2023).
- Develop workforce plans to meet current and future diagnostics demand so that firm actions are in place to recruit, retain and develop our teams (by 2024).
- Complete international recruitment of diagnostics workforce including fifteen sonographers and ten echocardiographers (2023/24).
- Develop training academies for imaging, endoscopy, and echocardiography in South West London to support the career development of our own workforce (2026).

### Accelerating digital transformation

**To do this we will:**

- Explore opportunities for digital transformation that facilitates sharing of information across health services to enhance patient journeys and experience (2024).
- Develop interoperable digital solutions across South West London to allow diagnostic teams across South West London to work together better as a system and improve operational efficiency and effectiveness (2026).

### Developing the diagnostic referral pathway and supporting systems

**To do this we will:**

- Map current demand and referrals distribution across diagnostic services to enable appropriate use of services (2024).
- Conduct clinical audits to benchmark South West London diagnostics pathways against those of peers and seek opportunities for improvement (2024).
- Refine GP direct access for imaging services to ensure appropriate access across South West London (2025).
- Develop integrated clinical care pathways across South West London that enable "one-stop" approaches to patient care (2025).
- Develop the diagnostics referral pathway and supporting systems to address concerns raised by patients and their representatives to improve coordination, communication and to enhance patient experience (by 2025).

### Our work in focus – Queen Mary's Hospital community diagnostic centre

People from across Roehampton and Kingston have benefited from two community diagnostic centres, with the one stop shops delivering more than 240,000 additional life-saving checks since 2021.

The centre at Queen Mary's Hospital supported by the satellite site at Kingston Hospital offer patients a wide range of diagnostic tests, scans and checks reducing the need for hospital visits and getting them the care they need sooner.

They were opened as part of efforts by the local NHS to make services more convenient for people, especially those who live in deprived areas such as Latchmere, Queenstown, Hampton North, and Kingston's Cambridge Road Estate.

Patients can have several tests on the same day without needing to wait and a range of healthcare professionals, including GPs and hospital doctors, can refer them to the services.

It means patients can start treatment for serious conditions from cancer to heart and lung disease sooner – which can be more effective and may lead to better outcomes – or get the all-clear.

The large centre at Queen Mary's Hospital offers a huge range of tests and scans, including imaging (ultrasounds, X-rays, mammograms), cardiology tests (testing for heart conditions), pathology (testing body tissues and fluids), phlebotomy (testing blood).

Among the checks offered at Kingston Hospital are CT and MRI scans, echocardiography (looking at the heart and nearby blood vessels) and audiology (hearing and balance) assessments.

More diagnostic services are in the pipeline, with Kingston's centre due to expand in the coming year to increase testing capacity and help manage the backlog created by the pandemic.

### Our work in focus
### Hand Hub One-Stop Model: QMH Roehampton community diagnostic centre

In October 2022, the QMH Roehampton community diagnostic centre (CDC) established a Hand Hub which has seen more than 46 patients per month since its launch. This brought together clinical staff to support delivering diagnostics, treatment, and onward referral where necessary all in one visit. This reduces the number of visits people need to make to receive the care they need, provides earlier treatment and therefore better outcomes, and helps to better use capacity.

For example, a patient with carpal tunnel syndrome might have an outpatient appointment with a surgeon, followed by a nerve conduction study/an ultrasound, followed by a physiotherapy appointment. Without the Hand Hub this could require three separate visits, however with the one-stop model this can all be done in one visit to the CDC.

# Maternity

We are committed to respecting everyone who uses maternity services in South West London, most of whom are women. The language we use reflects this but we also recognise and affirm diverse gender identities and use gender neutral language where appropriate. Best practice in inclusive language is evolving and we will strive to reflect this.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## What our patients and communities say

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

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

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

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

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

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

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

# Our ambition

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

# Our focus and actions

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

- Always listen to women, birthing people and their families.
- Improve safety, outcomes, and experience.
- Grow, support, and retain our workforce.

These requirements underpin the following actions:

### Developing pre-conception care to support families

**To do this we will:**

- Develop pre-conception care to support women and families to plan pregnancies as safely as possible (by 2027).
- Implement integrated approaches to care for women with complex long-term conditions, such as chronic kidney disease, congenital heart disease, diabetes and epilepsy, who are planning to conceive, to optimise their health before and during their pregnancies to improve outcomes for them and their babies (by 2027).

### Improving choice, personalised care and continuity of carer for all mothers

**To do this we will:**

- Ensure that every woman is offered the choice of where to have her baby, whether at hospital, birth centre or home, and that this is discussed with her at regular periods throughout her pregnancy (by 2025).
- We will focus on supporting vulnerable women and families, as well as those from the most deprived areas, and identify and support with domestic abuse or other safeguarding risks (by 2025).
- Develop personal care and support plans that record conversations about choices, giving women ownership of their plans, which will be reviewed at each appointment (by 2025).
- We will engage with seldom heard communities via our patient involvement group, maternity and neonatal voices partnership (MNVP), and local community organisations to further improve services for these groups. We will feed in the experiences of women from all our communities, especially Black, Asian and minority ethnic groups into the improvement of our maternity services (by 2025).

### Improving safety, outcomes and experience for mothers and their babies

**To do this we will:**

- Build on interventions outlined in Saving Babies Lives Care Bundle to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth, and implement the national maternity early warning score and the newborn early warning trigger, and track tools to improve the care of unwell mothers and babies, enabling timely escalation where needed (by 2025).
- Extend maternity and neonatal voices partnerships, to cover each trust in South West London reflecting the diversity of the local population.
- Publish our equity and equality plans and target action to reduce inequalities in women's experience and outcomes (by 2025).
- Enhanced support for women to stop smoking during pregnancy (by 2027).
- Monitor each baby's growth through pregnancy and agree personal support and care plans for women with a high risk of having a baby with a low birth weight (by 2027).
- Increase education and awareness so that pregnant women are better able to detect and report when they believe fetal movements have reduced (by 2025).
- Detect and manage during pregnancy gestational diabetes (high blood sugar) that can develop in pregnancy, so that mothers are supported throughout their pregnancy.
- Detect and manage neonatal hypoglycaemia (low blood sugar) as low blood sugar in neonatal babies can result in poor neurodevelopmental outcomes (by 2025).
- Implement a standardised risk assessment to improve fetal monitoring whilst in labour.
- Improve our monitoring of mothers so that babies are delivered safety, and any deterioration of the mother and/or baby during labour and after the birth is seen and acted upon (by 2026).
- Implement and monitor actions arising from CQC maternity focus inspections and share learning across South West London.

### Enhancing postnatal care

**To do this we will:**

- Implement and embed our pelvic health services, bereavement services and improve access for women with mental health conditions for specialist support.
- Develop and implement a South West London Infant Feeding strategy to ensure it is implemented by hospitals and community services and that the baby friendly initiative is adopted, so that every baby has the best possible start to life (by 2024).
- Continually review infant feeding support available to women and identify key actions to increase breastfeeding rates.
- Implement the recommendations of the national postnatal framework to standardise the routine postnatal care that women and their babies receive in the first eight weeks after the birth (by 2025).

### Growing and supporting our maternity workforce

**To do this we will:**

- Ensure the right numbers of the right staff with the right skills are available to provide quality care for women and babies through regular audits of the 'birthrate plus' acuity midwifery staffing tool (by 2027).
- Support the retention and recruitment of all staff within neonatal units by continuing to invest in education and development (by 2027).
- Work with trusts and higher education institutions to maximise student placement capacity, ensuring the breadth and quality of clinical placements (by 2027).
- Work with our trusts and their leadership teams to ensure that our maternity and neonatal services have an open, compassionate and positive safety culture (by 2024).

### Supporting maternal medicine networks

**To do this we will**

- Through our South West London maternal medicine network we will identify women with complex maternity need for example, asthma, cardiac and neurological conditions, and provide enhanced care to achieve optimal clinical outcomes (by 2027).

### Enhancing learning to improve care and services

**To do this we will:**

- Review the findings of the national Care Quality Commission (CQC) annual maternity survey and determine South West London actions.
- Implement and embed the actions from the 'Three year delivery plan for maternity services' which addresses recommendations from the Ockenden, and Kirkup reviews (by 2027).
- Co-produce services and programmes with service users (by 2027).
- Expand the use of our 'Baby Buddy' app so that it is used by parents as a source of maternity information. Uptake and feedback of the app will be reviewed in 2025.
- Implement a training programme to upskill maternity support workers in line with NHS England's competency, education, and career development framework (by 2027).

### Our work in focus – Maternity

The continued gap between the mortality rates for women from Black, Asian, mixed and white ethnic groups has been widely documented for years through reports like the 'MBRRACE' reports and Women's charity like 'FIVEXMORE'

Data shows black women are 40% more likely to experience a miscarriage than white women, and deprived areas can have higher rates of still births.

Diane Weir, Service Improvement and Transformation Lead midwife for Epsom and St Helier, believes it is vital that women's stories need to be heard if positive changes are to be made.

She says: *"Women from a Global Majority have previously not been given the opportunity to have open discussions about their experiences with senior management from the hospital where they had birthed their babies. Meaning the maternity team were not able to hear about this experience, understand where things could have been better and make the necessary changes."*

Diane now holds focus group sessions twice a month for women from these communities to hear their stories about the care that they have received at Epsom and St Helier NHS Trust. The sessions have created a safe space for an open and honest conversation about their experiences.

The women's feedback is then shared with the maternity team, which allows discussion around unconscious bias, challenging stereotyping and changing attitudes and practices.

This service has been held as a success and we are looking to replicate it across South West London.

# Mental health, learning disability and autism

## Mental health

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

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

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

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

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

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

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

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

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

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

In South West London

£300 million

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

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

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

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

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

**Self-harm is increasing**

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

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

**Higher prevalence of dementia** than the London average

**Higher suicide rate compared to London.**

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

(Data source: Public Health England).

12%

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

45%

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

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

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

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

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

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

(Data source: QOF)

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

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

In addition to Covid-19 pressures, the cost-of-living crisis and the increased level of support required for people with complex needs have increased pressure within mental health pathways.

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

## People and communities tell us

Waiting times are much longer across all mental health services and there is a need for more support for people while they are waiting to be seen.

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

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

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

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

People from Black, Asian and minority ethnic backgrounds highlighted issues including:

- Some people have a lack of trust in health and care services and a feeling of not being listened to or understood.
- There is over representation of people from Black ethnic backgrounds in detention, inpatient and crisis mental health care.
- Some people experience shame or stigma around accessing mental health services and there is an under representation from Black, Asian and minority ethnic backgrounds accessing early mental health support.
- People highlighted the importance of strong relationships with care workers once people leave hospital care.



## Our ambition

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

## Our focus and actions

### Improving recovery rates and quality of life for serious mental illness and mild to moderate mental health conditions

**To do this we will**

- Develop a mental health inequalities work programme and allocate recurrent investment to tackle health inequalities in mental health (by 2024/25).
- Develop an approach to community level prevention, for example, parenting programmes, drawing on work underway at national level and using expertise in our local authority public health teams (by 2024).
- Work with communities and non-health organisations to promote mental health and wellbeing (by 2025).
- Implement a needs-based framework for children and young people and families and ensure how we provide services is both joined up and simplified (by 2024).
- Establish a comprehensive approach to physical healthcare for people with serious mental illness detailing expectations, support available and the roles of different professionals. Also ensure that physical health checks for people with serious mental illness are carried out and results are acted upon (by 2024).

### Improving levels of access to services across different communities

**To do this we will:**

- Work in conjunction with South London Listens (a partnership between the NHS, local authority and voluntary, community and social enterprise sector) to develop and deliver community-led change around mental health (by April 2024).
- Revise training curricula for all health and care professionals to include a mandatory set of competencies to understand/recognise, communicate and signpost to psycho-social support (by April 2024).
- Build upon the success of social prescribing and join up the offer across South West London to provide consistent and effective non-clinical support to develop and maintain mental wellbeing (by 2024).
- Deliver focused prevention activities for children and young people known to be at higher risk of developing mental health issues (by 2024).
- Ensure a range of digital support options are available to support people to access services and that these are regularly reviewed and updated, and uptake monitored (by 2025).
- Through place-based partnerships, work to address social and economic factors that have an adverse effect on mental wellbeing.
- Develop and deliver evidence-based mental health promotion programmes (by 2024).

### Reducing suicide and self-harm rates

**To do this we will:**

- Work with partners to further develop a co-ordinated approach to suicide prevention. This includes delivering suicide prevention awareness sessions in schools and the community and offering training around suicide prevention for professionals working with children and young people (by April 2024).
- Work to ensure reduced suicide and self-harm rates with zero suicide ambition for 2032.
- Further support patients following discharge from inpatient care to as this is known to be a time of heightened risk of suicide.

### Reducing rates of detention for men from black ethnic backgrounds

**To do this we will:**

- Provide more support into ethnic groups that analysis shows to be overrepresented in terms of crisis services and those detained under the Mental Health Act. Also address the underrepresentation of groups in early access and community mental health services to ensure everyone has equal access to the range of services available (by 2025).
- Launch a co-production group where we patient and carers share their experiences of services to inform the design of future services (by 2023).
- Undertake an evaluation of the ethnicity in mental health improvement project (EMHIP) to inform future service developments across South West London (by 2024).
- Further address racism and discrimination by delivering an anti-racism framework for mental health services (by 2024).
- Developing an inclusive and shared decision-making process so that patients are actively involved in decisions about their mental health treatment and given information to support their decision making (by April 2024).

### Increasing understanding of mental health issues and wellbeing amongst communities

**To do this we will:**

- Increase the availability of evidence-based prevention and early support initiatives (by 2024).
- 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 (by 2024).
- Continue to develop the 'whole school approach' with ongoing investment into schools' mental health support teams. The programme will focus on building emotional resilience, prevention, and early intervention.
- Improve support available for children and their families who are waiting to access mental health services within schools, transition to adult and wider mental health services (by 2025).
- Change the way that we design, fund, and deliver mental health services and the way that we collectively think about, talk about and support strong our mental health across and within our communities.

## Learning disability and autism

2.16% **of adults and** 2.5% **of children** nationally estimated to have a learning disability.

C.18 thousand people living in South West London with learning disabilities, autism or both and is expected to grow to approximately 20,000 people by 2030.

7,748 people were registered as having a learning disability with South West London GPs in March 2023.

**c.1%** of the population are autistic.

**Around 40% of autistic people have a learning disability.**

In South West London there are an increasing number of children and young people with a recorded diagnosis of autism.

Evidence shows that people with a learning disability and autistic people are more likely to face social, economic, and health inequality across England.

A lack of reasonable adjustments can be a barrier to accessing healthcare settings and to equal healthcare.

People with learning disabilities and autistic people are more likely to experience epilepsy and mental health problems.



### Nationally published data shows that:

People with a learning disability are 8.4 times more likely to have a serious mental health illness than those without.

Almost 8 in 10 autistic adults experience a mental health problem[9].

People with a learning disability can be at greater risk to their health due to lifestyle issues such as poor diet, low level of physical activity and social isolation. People with learning disabilities are more likely to be either underweight or obese than the general population. 37.5% of people were classified as obese compared to 29.9% of the general population.

People with a learning disability are less likely to have a cancer screen, nationally 52.5% of people with a learning disability have had a breast cancer screen compared to 68% of the general population.

People with a learning disability and autistic people experience poorer access and quality of care than people without.

Nationally on average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population and 14 years shorter than for men with a learning disability than for men in the general population.

**Data[10] indicates that autistic people die on average 16 years earlier than the general population.**

Disproportionately higher numbers of children and adults with a learning disability enter the criminal justice system.

9. Lever A & Geurts H (2016) Psychiatric Co-occurring Symptoms and Disorders in Young, Middle-Aged, and Older Adults with Autism Spectrum Disorder. Journal of Autism and Developmental Disorders 46(6), 1916-1930.
10. Premature Mortality in Autism Spectrum Disorder, The British Journal of Psychiatry, 2016.

## People and communities tell us

They want the voices of people with learning disability and autistic people to be heard across all health services to ensure good access, experience, and outcomes.

The needs of people with autism and learning disability are not always well understood across health services and the need for training for front line staff was emphasised.

Children, young people, and adults can be excluded from generic health services based on their diagnosis, lack of diagnosis or absence of reasonably adjusted services.

There were concerns around the lack of specialist community health services for autistic adults who do not have a learning disability including intensive support.

There is a need for better multi-agency collaboration. Agencies should work together around a person and agree, how the different services work together and who is taking the lead to agree the care and support plan and coordinate the plan across the services.

The need for clearer support pathways and information was emphasised, as was the need for better support and coordination across teams to support transition to adulthood and into adult services.

There was concern around timely access to autism / neurodevelopmental diagnostic assessment and availability of pre and post diagnosis support.

The is a need for improved early help, prevention, support, and information to people and their families including those with intermittent or low-level needs.

The needs of people from Black, Asian, and other ethnic backgrounds, the needs of autistic girls and women and LGBTQ+ people need to be recognised.

Autistic people felt they had long wait times for their diagnosis or mental health needs. They often felt autism was misunderstood by the professionals they saw for their care.

People with learning disabilities can feel misunderstood when they are in crisis and in A&E.

## Our ambition

We want people with learning disabilities and autistic people to:

- Have the best possible physical and mental health and access to good physical and mental healthcare, where their needs are understood, and their rights are protected.
- Lead active and fulfilling lives and live in their own home.
- Have the same life expectancy as the general population.
- Have access to, inclusive community services that meet their needs and that work together around the person and where inappropriate detentions and avoidable admissions to mental health hospitals no longer happen and people are prevented from reaching crisis point by receiving the right help at the right time in the right place.

## Our focus and actions

### Reducing preventable admission to mental health hospitals and reducing length of stay

**To do this we will:**

- Work with community providers to review services for children, young people and adults with a learning disability, autism or both and agree actions to improve these so that the need for inpatient care is reduced.
- Continue to roll out the South West London key worker service for children and young people up to the age of 25, for those most risk of a mental health inpatient admission, so that a personal care and support plan is in place.
- Ensure that 90% of children and young people with autism, learning disabilities or both have a designated keyworker (by 2025).
- Ensure compliance with the new NHS England dynamic support register and care, education and treatment review policy (published in January 2023) and continue to strengthen joined-up working across health, social care and education (by 2024).
- Develop case for change and option appraisals for changes to core services and exploring funding opportunities, for example for improved specialist community provision for autistic people and people with learning disabilities including enhanced / intensive support (by 2025).
- Improve consistency of learning disability child and adolescent mental health (CAMHS) services across South West London by developing a consistent service model for South West London for CAMHS learning disability provision (by 2025).

### Improving autism diagnostic assessment and autism support

**To do this we will:**

- Work in partnership with service providers to reduce current waiting times for autism diagnostic assessments and improve pre-diagnostic support for those waiting for an assessment (by 2028).
- Improve post-diagnostic support in alignment with NICE guidance, for example, family / carer support sessions, for autistic people following a diagnosis (by March 2028).

### Improving the health and wellbeing of people with learning disabilities and autistic people

**To do this we will:**

- Work in partnership with our local health services to ensure that they are compliant with statutory duties and guidance for the NHS in relation to autism and learning disability.
- Improve equitable access, to local health services, recognising that people with learning disability and autistic people may require additional support and reasonable adjustments to mainstream health services and screening programmes (by 2028).
- Improve the knowledge and skills of our staff so that they are better able to meet the needs of autistic people and people with learning disabilities across our health services, including rolling out the Oliver McGowan mandatory training on learning disability and autism so that safe, compassionate, and informed care is provided (by 2028).

### Reducing mortality and preventable deaths

**To do this we will:**

- Continue the learning from lives and deaths (LeDeR), a service improvement programme aimed at learning from the deaths of people with a learning disability and autistic people and make changes to services that help people live longer and healthier lives (by 2028).
- Work with South West London GP practices to continue to increase the uptake and quality of annual health checks and health action plans for people with learning disabilities (by 2028).
- Build on our targeted work to increase vaccination uptake amongst people with learning disabilities and autism. This includes recruiting and training community connectors (local people with lived experience) to support the uptake of vaccinations (by 2028).

### Improving quality of inpatient care

**To do this we will**

- Continue to maintain oversight of all autistic people and people with a learning disability who are in mental health inpatient settings and ensure effective care, education and treatment reviews take place, so they are in hospital for the shortest amount of time (by 2028).

# Our mental health provider collaborative

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

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

**Examples of areas of success include:**

- **66%** reduction in forensic readmissions.
- **93%** fewer children and young people placed out of area.
- Introduction of a crisis line supporting both adults and children.
- A pilot run by SWLSTG has informed the NHS111 Press 2 model to be implemented in 23/24. This will enable people ringing NHS 111 for mental health support will be able to speak directly to a mental health professional.
- Through the Complex Care programme, 136 South West London patients have been supported to step down into less restrictive settings by providing care closer to home. One example of this is the establishment of an enhanced intensive eating disorder service offering an alternative to a hospital admission.
- Introduction of a Nurse Development Programme with the aim of growing the number of mental health nurses, improving recruitment and retention by developing leadership skills training and advancing careers.

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

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

36% **Fewer** forensic patients out of area

66% **reduction** in readmissions

**1000+ new** complex care patient assessments

**100+ stepped down** to less restrictive environment

**Targeted investment** in South London-wide and new trust services

£9 million + **New care models** savings reinvested local services

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

SLP has a clear vision of:

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

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

The South London Mental Health and Community Partnership will:

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

To deliver the following outcomes:

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

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

# Primary care

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

**A picture of primary care in South West London:**

173
GP Practices

39
Primary care networks

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

**Funding**

**£271 million** delegated general practice primary care budgets

**£127.9 million**
The allocation for pharmaceutical, general optometry and dental (POD) services in South West London

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

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

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

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

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

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

Ease of getting through by phone

Satisfaction with appointment times

Overall experience

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

3117
whole time equivalent (WTE) staff employed by South West London's General Practices

977
GP WTE employed with 201 of GPs aged over 55 years.

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

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

## Pharmaceutical optometry and dental services in South West London

From 1 April 2023, we received delegated responsibility for the commissioning and management of NHS funded pharmacy, ophthalmology and dentistry (POD) services. These functions were previously commissioned by NHS England and managed by the London Regional Team.

We have agreed with our London Integrated Care Board (ICB) colleagues to:

- Manage the commissioning function for pharmacy, ophthalmology and dentistry (POD) once across London.
- North East London ICB will host the POD function on behalf of all London ICBs.
- Establish a London POD oversight group to oversee the functions.

In South West London we welcome the delegation of these functions which will enable us to integrate vital elements of care, access and provision into our place and system plans. This will take time; we need to fully understand the challenges and opportunities the delegation of POD provides us, and we plan to do this in the first year of the delegation. We are establishing discrete steering groups across each discipline and embedding these functions into our existing ICB governance.

We know that the POD functions are critical to improving health outcomes and the promotion of good health for the residents of South West London, this will include but not exhaustively:

- The promotion of good oral health, particularly for children.
- Better access to NHS dentistry.
- Further promotion of community pharmacy in being a key access and delivery partner across a wide a range of preventative and care.
- Embedding eye care and health into our considerations at both local and system services promoting tested innovative approaches across South West London.
- To consider local gaps and opportunities to deliver POD services in the community.

## People and communities tell us

### GPs

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

  Recognition that in some cases the NHS may not have the funding or staffing to meet all of our patients' expectations.

### Pharmacists

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

### Dentists

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

## Our ambition

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

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

- Developing primary care networks, **PCNs, and integrated neighbourhood teams** to deliver a range of co-ordinated and timely services at the right scale so that people can live their healthiest life and be independent for as long as possible.
- Ensuring that **general practice is accessible (as per the Government's primary care recovery plan)** to routine and urgent need through a variety of channels, as well as increasing access and face to face appointments for different levels of need, enabling patients to access the right clinical support.
- Ensuring that **primary care in South West London is a great place to work**. We want primary care in South West London to be a magnet for primary care professionals, where our people have fulfilling jobs which recognise their contributions and where they are supported to develop to the fullness of their potential.
- Developing our primary care **estate, digital initiatives, and IT infrastructure** to ensure our practices have the tools and environment to improve and develop.

## Our focus and actions

### Developing PCNs and integrated neighbourhood teams

**To do this we will:**

- Enable all PCNs to evolve into integrated neighbourhood teams and to have them up and running in neighbourhoods in the most deprived areas (by 2023/ 2024) and move to universal coverage throughout 2024 with full coverage (by 2024/25).
- Develop a risk stratification tool which will include core20PLUS5 analysis to identify and prioritise people who may benefit from a proactive care offer and integrate relevant data and services to ensure a holistic view of the support and care is provided to people (by 2024/25).
- Further develop integrated neighbourhood services that extend beyond traditional physical and mental health services to include social care, voluntary sector, self-management, and prevention support (by 2024/25).
- Work with our borough-based training hubs to ensure the necessary training and support is given to the leaders and roles within the local neighbourhood teams (by 2023/24).

### Improving care and streamlining access

**To do this we will:**

- End the '8am rush' for appointments by ensuring that our practices have a range of self-referral and self-care pathways, and when patients do need to speak to the practice, they will have a telephony system that is easy to use and helps patients get through promptly (by 2023/24).
- Through the additional role reimbursement scheme (ARRS) and improved GP retention we will continue to increase the overall workforce across primary care. For patients this will provide access to a wide range of skilled professionals to care for patients with complex and chronic needs (by 2023/24).
- Increase the number of appointments by 3% in 2023/24 across the year. In March 2023, 752,000 appointments were delivered in general practice compared just over 500,000 appointments in March 2019 (by 2023/24).
- Create timely access to routine and urgent care for patients with greater options for accessing care via GP hubs (by 2024/25).
- Strengthen the pathways between GPs and community pharmacies so patients can be booked in for a consultation with their local pharmacist for a range of self-limiting conditions (by 2023/24).
- Introduce preventative services to target the prevention of longer-term ill health conditions including the development of a directory of South West London prevention services particularly around smoking, immunisations, and long-term condition self-management (including digital apps) (by 2024/25).

- Expand the range of local and accessible services within primary care without waiting times or needing to go to hospital, for example delivering more spirometry appointments than in 2022/23 through PCNs working together to share staff, equipment, and buildings (by 2026).
- Take targeted health improvement action to:
  - Improve the uptake of learning disability health checks and dementia diagnosis with the aim of improving detection and health outcomes (by April 2024).
  - Roll out a new primary care specification to increase access to serious mental illness health checks (from 2023).

### Making primary care in South West London a great place to work

**To do this we will:**

- Encourage practices and PCNs to develop their clinical workforce and to provide a career path for those wishing to progress. We will work with PCNs and NHS England throughout 2023/24 to review progress and understand where further we can develop primary care staff.
- Listen to staff to understand and respond to their differing needs and use their feedback to improve recruitment, retention, and career development (2023/24).
- Increase automation software so that we reduce the administrative burden enabling primary care teams to concentrate on clinical care (2023/24).
- Improve health, wellbeing, and the resilience our staff by providing wellbeing, human resources, and organisational development support (by 2025).
- Have an inclusive workforce, representative of the areas they deliver services for, that is free from abuse, harassment, bullying and violence. Progress will be monitored via regular surveys across each practice (by 2024).
- Ensure flexible work policies are consistently available to all staff to support the needs of the service and our staff (by 2025).
- Implement a range of retention initiatives, for example, a GP retainer scheme, to keep as many GPs within primary care as possible (by 2025).

### Developing our primary care estate, digital initiatives, and IT infrastructure

**To do this we will:**

- Expand the roll out the NHS app so that it is viewed as the digital front door to primary care where patients can access a broad range of services with 90% of our practices promoting the application and its information (by 2023/24).
- Further invest in change management support for primary care in order to equip them with the skills to embrace new technologies and innovations, for example online consultations to help guide patients through the system as quickly as possible (by 2025).
- Work with system partners, practices and PCNs to develop a primary care estates strategy (by 2025).
- Modernise the GP IT platform moving GPs to the Microsoft N365 platform via a single secure South West London network, enabling flexible access across all South West London GP sites, strengthened resilience and increased security (by 2025).
- Provide corporate Wi-Fi to all South West London GP sites (by 2025).
- Re-configure the GP IT equipment to create space, simplify access to data and introduce docking stations so that GP users can work flexibly across South West London sites via corporate Wi-Fi (by 2026).
- Introduce a GP virtual desktop creating increased resilience and security, simplified support and the opportunity for GP users to access the virtual desktop on their own device (by 2026).

### Our work in focus – Online consultations with your GP

An online consultation allows a patient to contact a health care professional about a medical or an administrative query, by completing a free text form or a set questionnaire online via the practice website or an app. Practice staff then review the request and patients are directed to the most appropriate service, making sure all patients are seen in the right place at the right time.

Holmwood Corner Surgery in Kingston launched its new online consultation service in May 2022. Within 24 hours, patients receive their next step, whether this is a blood test appointment, a call from a GP or confirmation that a prescription has been sent to their designated pharmacy. This online system allows patients to pick the option that best suits them and reduces demand on busy phone lines for those who are happy to go online. There are always face to face appointments available for those who need them.

In January 2023, the practice received 2,800 queries through the system and more than a third were resolved without the need for a face-to-face appointment, freeing up time for patients who need quick medical attention.

**GP Annette Pautz said:**

***"The clinically designed system has proven incredibly useful for both our patients and practice. It helps GPs 'work smarter', prioritising those who need more urgent care, while still reacting quickly to simple requests such as repeat prescriptions."***



## Specialised care

Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. Examples include renal dialysis and transplantation, complex cancer surgery, chemotherapy and radiotherapy, cardiac surgery, and most hospital treatment for children. They deliver cutting-edge care and are a catalyst for innovation, supporting pioneering clinical practice in the NHS.

**£650 million**

The overall spend on specialised services in South West London provides in 2022/23.

The programmes of care with the highest specialised spend at South West London providers in 2022/23 were specialised cancer surgery (£61million), renal services (£49million) and neurosciences (£45million).

The acute programmes of care with the highest proportion of patients coming from outside of South West London to be treated at South West London providers were specialised endocrinology (75%), infectious diseases (74%) and children & young adult cancer services.

**120** patients have been newly diagnosed with HIV across South London between April 2022 and March 2023. A further 30 patients who had been previously diagnosed with HIV but are not currently in care have been re-engaged as a result of emergency department testing.

**41 thousand** people diagnosed with CKD in South West London. But estimated over 20,000 people in South West London have undiagnosed CKD meaning they are not receiving care and support to manage their condition and improve health outcomes.

Around **80%** of all people with CKD also have diabetes or hypertension or CHD – meaning there is opportunity to optimise the way people with multi morbid conditions are better supported.

Around **1 in 6** people have a neurological condition. 10-20% of all acute medical admissions are for neurology – big opportunity for improving end to end care for patients with neurological conditions

## People and communities tell us

We have worked with specific communities for particular specialised services to help us understand people's views and hear feedback.

**Heart conditions**

Work with communities in South London has been carried out to understand why some groups are less likely to access specialised services than the rest of the rest of the population. For example, in-depth engagement with the community to understand why people from Black, Asian and minority ethnic backgrounds are much less likely to get a specialised treatment for heart conditions (heart valve disease) than the white population.

Our Black African and Caribbean, Asian and ethnic minority communities told us that:

Ethnicity is often not sensitively considered during diagnosis and treatment discussions with health care professionals .

People felt that there were health inequalities in specialised services due to race, and that this contributed to a lack of trust from some of our communities towards NHS organisations and services. People also told us that when the NHS health professionals worked on those community relationships, and trust was built with individual clinicians, this helped build better relationships and wider trust within the community.

Because of these challenges, 'trust in NHS organisations and services' has become a factor in determining the health of people from Black, Asian, and ethnic minority backgrounds. To improve health outcomes, we need to work closely with communities to improve trust in our services and staff.

Some people felt that 'heart valve disease' was such a serious diagnosis that patients sometimes did not ask for support from their friends and family for fear of being a burden. We know this needs to be addressed as peer networks can play a vital role in supporting individuals through their diagnosis and treatment.

**Kidney Care**

We conducted extensive engagement to hear feedback about kidney care around proposals for renal services at St George's University Hospitals NHS Trust, and Epsom and St Helier University Hospitals NHS Trust. People told us that:

They wanted access to centralised and specialist renal services, better patient care and health outcomes and modern up-to-date facilities.

Continuity of care, and a high standard of compassionate care, should be maintained and strengthened.

They wanted more support to have home dialysis.

## Our ambition

Our ambition is that specialised services become fully integrated with GPs, hospital services and other community-based services – so that care is centred around the needs of the patient, and we have a focus on health promotion, prevention, early detection, and management.

We want all patients who receive complex treatments to have care that is:

- delivered in a joined-up way between different parts of the NHS with a focus on preventing the progression of their condition, while empowering people to stay well and improve their quality of life
- high quality, provided through specialised centres, delivering joined-up care for local people
- provided as close to home as possible
- accessible to everyone in our population in an equitable way. We will achieve this by working more closely with residents, patients, their families and carers, and local communities
- cost effective in delivery

## Our actions

### Improving joined-up working between different parts of the NHS – primary care, community care, hospital care and specialised care services

**To do this we will:**

- Continue the three two-year pilot programmes for neurology services, cardiac services and blood-borne virus testing commenced in 2022/23. Initial evaluation shows positive results and learning that we will use to plan future services.
- Develop and pilot a joined-up community-based sickle cell disease service across South West London, working across community services and specialist haemoglobinopathy services at St George's and Croydon Hospital to improve access, quality, and experience of care for patients with sickle cell disease.
- Improve prevention services, early detection, and management of chronic kidney disease, in the community by supporting primary care and GPs to improve identification and management of patients with chronic kidney disease alongside conditions such as high blood pressure and diabetes. Around 80% of people with chronic kidney disease also have diabetes, high blood pressure or coronary heart disease so we can improve detection and prevention of disease progression by using these existing channels.

### Providing more personalised care, empowering patients to better manage their conditions and wellbeing, supporting communities most affected by health inequalities

**To do this, we will:**

- Work with local communities to improve patient awareness and engagement of chronic kidney disease risk factors, healthy lifestyle information and the treatments available to keep well. This aligns with wider work around community health-coaching and self-management of long-term conditions.
- Implement peer-to-peer mentoring programme for children and young people with sickle cell disease, as part of a pan-London roll out of a pilot programme in North East London.

### Delivering high quality, accessible care, including access to world-class specialist care when needed. Working with neighbouring local systems – often across wider geographies than South West London:

**To do this we will:**

- Create additional capacity in paediatric intensive care with two new beds at Croydon University Hospital, by working with the South Thames paediatric network.
- Provide more joined-up and personalised care to support patients to make informed decisions around renal replacement therapy or conservative management. We will work with the South West London & Surrey renal network to pilot a programme to bring different health professionals together in one team to support patients with multiple conditions like heart and kidney problems, diabetes, and frailty.
- Improve specialist emergency care for sickle cell patients in crisis, including learning from pilot programmes in hospitals, working with the West London and South East London haemoglobinopathy coordinating centres.

- Change and improve services for neurology patients, with a focus on people who have epilepsy, multiple sclerosis, Parkinson's disease, and neuromuscular disorders. This will include better support in hospitals, from GPs in primary care, in community therapies, and by developing clear and easy ways to refer patients to specialist services when needed. We will also develop a regional 'functional neurological disorder' rehabilitation service to reduce waiting times, improve rehabilitation outcomes and increase virtual services, so patients can be treated at home.

### Taking delegated responsibility from NHS England

**To do this we will:**

- **Create a joint working agreement** – all Integrated Care Boards will agree Joint Working Agreements with NHS England to make sure we have clear oversight of specialist services. This will include being part of a joint London committee across the five London Integrated Care Boards and NHS England.
- **Implement a South London pathfinder pilot programme** – This programme will test some of the key processes we will need when we as the Integrated Care Board commission specialised services for our local health and care system.
- **Undertake a pre-delegation assurance process** –this is a test to check we are ready to take on these new responsibilities delegated to us from NHS England.
- **Full delegation of services from NHS England to the South West London Integrated Care Boards**
  - **Safe landing** – the Joint Working Agreement, pre-delegation assurance process and pilot programme will help support an effective move to the Integrated Care Boards commissioning the service to make sure this management arrangements 'land safely' with minimal disruption.
  - **Local objectives** - develop our knowledge and expertise to develop a set of local objectives for specialised services, joining-up these services with our wider programmes of work under the oversight of the South West London Specialised Board.

### Our work in focus
### Testing for HIV in all blood samples in South London emergency departments

All adult patients who attend an emergency department at any of the hospitals in South London are now tested for HIV if they are having routine blood tests.

This approach aims to increase early diagnosis rates and lead to timely treatment of HIV for those who are diagnosed as a result.

The process sees routine HIV screening of all patients who require a blood test as part of their treatment. Those who do not wish to be tested have the opportunity to opt-out. Patients who have a reactive result are then referred to dedicated HIV teams for confirmatory testing and ongoing care.

The benefits of routine opt-out HIV testing in emergency departments include:

- Earlier diagnosis, resulting in improved health outcomes for patients
- Reducing HIV stigma by normalising testing
- Reaching communities who would not test in any other healthcare setting

120 patients have been newly diagnosed with HIV across South London between April 2022 and March 2023. A further 30 patients who had previously been diagnosed with HIV but weren't currently in care are now in treatment as a result of this testing.

Those with HIV who take medication as prescribed and have an undetectable viral load can have long, healthy lives. An undetectable viral load also means HIV is not passed on.

Nine out of ten hospitals in South London now offer hepatitis B and C testing as well as HIV testing.

If each person newly identified as having HIV accesses the care and treatment that prevents them from passing it on to another person, the NHS saves at least £100,000. This is NHS cost of care for a newly diagnosed person.



## Supporting people to manage their long-term conditions

Long-term conditions, or chronic diseases, are conditions for which there is currently no cure, and must be managed by patients with support of medicines and other treatment. Supporting people with long-term conditions to live healthier, more independent lives is a key priority for South West London.

There are numerous long-term conditions, and these patients cross all care settings and South West London improvement programmes. This chapter primarily focuses on the *NHS Long Term Plan* (2019) clinical priorities: diabetes, respiratory conditions, musculoskeletal conditions (MSK), cardiovascular disease (CVD) and hypertension.

1 in 3 **people**
(about 500,000)
have been diagnosed with a long-term condition in South West London

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

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

### Pre Covid-19 in South West London:

- 176 thousand people had been diagnosed with hypertension
- 17 thousand people had been diagnosed with serious mental illness
- 18 thousand people had been diagnosed with chronic obstructive pulmonary disorder (COPD)
- 81 thousand people had been diagnosed with diabetes

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

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

### Long-term conditions account for:

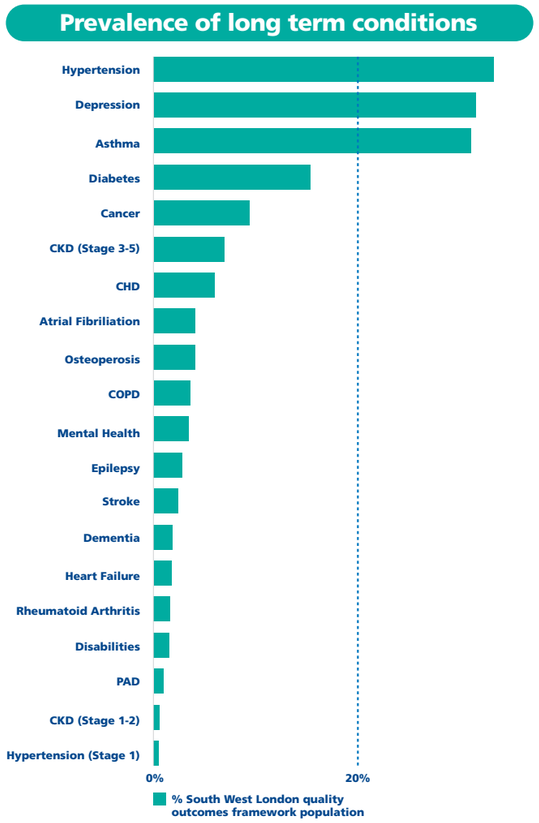
50%
of all GP appointments

64%
of all hospital outpatient appointments

70%
of all hospital bed days

70%
of health and care spend

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




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

### Cardiovascular disease (CVD)

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

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

one in four deaths in England are caused by CVD which equate to one death every four minutes.[11]

### Respiratory diseases

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

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

### Musculoskeletal (MSK) conditions

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

11. Public Health England

### Kidney disease

People living with chronic kidney disease (CKD) are at greater risk of preventable, premature death than people of the same age and sex with healthy kidneys. A large proportion of the estimated 40-50,000 deaths in England each year in people living with CKD, are due to serious cardiovascular events, such as strokes and heart attacks. Over 20,000 people have undiagnosed CKD in South West London.

### Diabetes

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

## People and communities tell us

**The common themes in the feedback from communities is the opportunity of education, supported self-management, social prescribing and the community and voluntary sectors in providing support services for people with a long-term condition. This will require building trusted relationships with vulnerable communities and working in co-production to develop and deliver services.**

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

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

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

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

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

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

## Our ambition

**We want to:**

- Prevent people from getting ill, or their illness deteriorating, by providing evidence-based education and wellness prevention services.
- Provide effective treatment to delay disease progression and avoid hospital care.
- Detect illness at an earlier stage.
- People with long-term conditions to live for longer in good health and reduce their requirement for hospital care.

## Our focus and actions:

### Preventing illness or illness deterioration by improving access to quality education and wellness services

**To do this we will:**

- Support people to live healthier for longer, through equitable access to quality education and wellness services by providing face to face or digital structured health education and physical activity courses, cardiac rehabilitation, pulmonary rehabilitation, and self-care digital support (by 2028).
- Develop high value, evidenced-based wellness and supported self-care services, where no offering currently exists, to help people to understand and better manage their long-term condition(s). There will be a South West London-wide prevention service offering for long-term conditions (by 2025/26).
- Further increase the number of people offered and attending our prevention programmes. Timely referrals will be supported by innovative solutions including risk stratification and automated call and recall processes, text messaging, and a self-management website which will provide essential support information. This will be supported by social prescribing and local community engagement outreach (by 2028).
- Support people in contact with NHS services to quit smoking. This will include all people admitted to hospital, expectant mothers, and all people admitted to mental health hospitals (by 2028).
- Implement the learning from our preventative care pilot and spread this across South West London to support the NHS to embed preventative care, for example, group appointments, patient expert programmes and community-based and community led prevention programmes (by 2025).
- Expand our community networks to engage with people in high-risk, high-deprivation populations on what they require in terms of prevention, detection, and management of their long-term conditions.

- Extend accredited training programmes to local volunteers as community health coaches so they are able to deliver co-produced and community-led prevention programmes. From 2024, this training will also include mental health.
- Extend the South London diabetes book & learn service and digital platform service to support obesity, cardiovascular disease, and respiratory conditions (by 2028).
- Expand the continuous glucose monitoring to support more patients with diabetes (by 2028).
- Trial a new service to support people to achieve remission of type 2 diabetes by using a digitally enabled low-calorie diet programme.
- Increase patient education and activation, South West London digital self-management application to support cardiovascular disease, hypertension, cholesterol, diabetes, asthma, and chronic obstructive pulmonary disease, COPD (by 2024).

### Providing timely and effective treatment to delay disease progression

**To do this we will:**

- Utilise patient dashboards, risk stratification and automation and digital tools to support primary care teams to identify the people who most need support with their long-term conditions and provide proactive, personalised preventative care (by 2028).
- Deliver timely, effective treatment to people for their long-term condition, with consistent annual diagnostic checks, high quality annual review appointments.
- Work with academics, social prescribers, local authority and community and voluntary partners to continue to improve our community engagement and outreach work, using community-based organisations to deliver services.
- Collaborate and build relationships with local organisations, especially in the community and voluntary sector, to better support people living in high health risk.
- Shift from a disease-specific long-term conditions model of care to a personalised and proactive long-term conditions model of care to better support people living with multiple long-term conditions.
- Develop a cardiometabolic care model and deliver joined-up care for patients with multiple cardiometabolic conditions, for example, diabetes, cardiovascular disease, and kidney disease, who are currently required to attend multiple appointments across different care settings and hospital specialities (by 2024).
- Explore a joint cardiac and pulmonary rehabilitation model (by 2026).
- Embed mental health considerations within our physical health early detection and prevention programmes (by 2026).
- Work with clinicians in primary care to proactively support patients with multiple long-term conditions before they are referred for hospital services.

### Identifying people with a long-term condition early

**To do this we will:**

- Provide further accredited training to local community champions to deliver co-produced and community-led early detection and signposting to local services. From 2024, this training will also consider mental health.
- Work with clinicians, data scientists and community partners to improve our identification of people at high-risk or who are undiagnosed by using data analytics, artificial intelligence and community engagement and outreach approaches (by 2028).
- Increase collaboration across local authority, voluntary sector, community sector and primary care to develop a simple, consistent, integrated, and equitable pathway of care so that patients with long-term conditions receive a timely and accurate diagnosis (by 2028).
- Work alongside the development of the single health and care record to explore options for patients to self-record diagnostic information, for example blood pressures checks taken at community led health checks that will automatically be visible within the single health and care record.
- Deliver more high-quality early detection assessments, in community and primary care settings (by 2026) through developing additional staff competencies and adopting new technologies, for example, diabetic foot checks.

### Listening to our communities and embracing innovation

**To do this we will:**

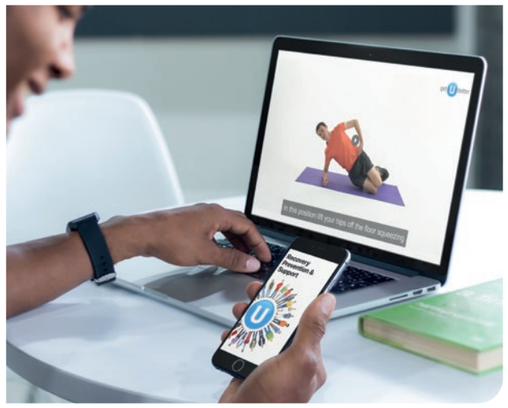
- Collaborate and build relationships with local organisations, especially in the community and voluntary sector, to better support people living in high health risk.
- Work innovatively and collaboratively with partners, for example, academics, local authority, community groups, voluntary sector, and technology partners, to maximise opportunities to improve long-term conditions detection, prevention, and optimisation of care.
- Make best use of technology and community assets, and the implementation of best-practice prevention enablers, to continue to improve prevention, identification, and treatment of long-term conditions.

### Our work in focus – Digital self-management programme

Musculoskeletal conditions are those that affect your joints like arthritis, spine, back or neck pain, and they have a huge impact on people's health, their work, and the health and care system. Over 30 million working days are lost due to musculoskeletal conditions every year in the UK and they account for 30% of GP consultations in England. Waiting lists for musculoskeletal services are also long and continue to grow. We are working to support local people with musculoskeletal conditions to help manage their health better themselves, be more independent and not have to rely so much on local health services.

We have developed a smart phone app powered by "getUbetter", to help people with musculoskeletal issues manage their own conditions. People can download the app or use the website to get information and advice to help them recover from injury, follow simple exercises to help them gain strength and get advice on what to expect so that they are able to understand their own condition or recovery more. This also means that in the long term they are less likely to need regular heath appointments as they have personalised information to help manage their conditions through the app, which also signposts local services and can be used to make a referral.

More than 90% of GP practices across South West London have now signed up to our digital self-management programme. As of March 2023, South West London has provided digital self management to over 26,000 patients with common musculoskeletal conditions and to support pelvic health. We are working with our NHS partners to develop similar services for people with long-term conditions, including patients on hospital waiting lists and those with cardiovascular and respiratory disease.





## Urgent and emergency care

Urgent and emergency care is the combination of GPs and other primary care services, 111, emergency departments and ambulances, community and mental health services providing same-day or unplanned care. It accounts for more than 40% of the total spend in South West London.


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

There are five emergency departments open 24/7 in South West London and five urgent treatment centres open at least 12 hours a day

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

600

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

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

We have 2,254 general and acute beds in South West London. In 2022, all our hospital beds had patients in them almost all the time and just under one in four patients have been there for more than 21 days.

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

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

In South West London, emergency departments expect to receive 100,000 patients per year brought in by ambulances

On average there are 700,000 primary care appointments a month and this will reach more than 1 million a month by 2026

When our hospital beds are full, this affects the whole system for example, people might have to wait a long time in an emergency department (ED), ambulances may be delayed at hospital, or people have to wait longer for a bed so they can be admitted or have a planned operation.

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

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




## People and communities tell us

Praise for the care and kindness of staff in South West London urgent and emergency care services.

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

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

A high number of people use A&E for their mental health, and some people suggested better signposting to mental health crisis services.

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

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

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

# Our ambition

Through partnerships between 111, acute, community and mental health, primary care, social care and the voluntary sector, we want responsive urgent and emergency care services that are understood by local people and that provide more, and better, care in people's homes, gets ambulances to people more quickly when they need them, sees people faster when they go to hospital and helps people safely leave hospital, having received the care they need.

# Our focus and actions

### Creating a simple and accessible urgent and emergency care offer that patients understand

**To do this we will:**

- Improve access to same day primary care, ensuring all patients contacting a GP practice are assessed or offered signposting at first contact with the practice.
- Increase the number of call handlers in the 111 service and develop more clinical roles so that we reduce the amount time it takes to answer calls.
- Review the out of hours service in 2023/24, linking more closely with primary care.
- Increase use of 111 online and the NHS App so that by 2026, patients use this facility as a first port of call when seeking urgent care.
- Develop and enhance the community pharmacy offer so that people with minor ailments see their pharmacy as the place to go for advice and support.
- Implement digital solutions to transform call handling within 111 services and make it easy for services to book a patient into the most appropriate service.
- Develop our urgent treatment centres to fully meet the expected national standards.
- Further develop the directory of services so that ambulance crews and other care professionals can take a patient to the right service quickly rather than to emergency department.
- Further embed same day emergency care services increasing the number of patients who do not need to be admitted to a hospital bed.
- Encourage our communities to use mental health crisis services by sharing information with our communities using a variety of channels including our community and voluntary sector relationships and networks and using social media platforms like Facebook and Nextdoor.

### Creating a resilient and flexible urgent and emergency care workforce that is able to deliver high quality and innovative care

**To do this we will:**

- In 2023/24, we will review our staffing needs and develop a five-year workforce plan to recruit, retain and develop staff.
- We will create and embed a clinical network to support our urgent and emergency care clinical leaders across South West London starting in 2023/24.
- Develop a clearer understanding of what support people working in urgent and emergency care services need, building a health and wellbeing offer that is tailored to staff working in this high paced environment (by 2028).
- Think differently about how to recruit and retain staff – for instance by working with national bodies as opportunities arise to develop innovative training and apprenticeship programmes and implement new ways of working such as rotational staffing models (by 2028).

### Improving the patient flow through the urgent and emergency care system

**To do this we will:**

- Implement more effective systems and services to eliminate long waits and queuing across the system, so that patients wait less time for an ambulance and that we reduce the time that people wait to go home from hospital.
- Work with partners to create community-based support so that people are supported to return home as soon as they are ready. As part of this we will expand our virtual wards scheme, so that patients can continue to receive the nursing and clinical oversight in their own home, aiming to achieve 70% occupancy (by winter 2023).
- Work with our acute and community providers to improve discharge processes in our trusts, and reduce the numbers of patients who no longer need to be in hospital.

### Building our urgent and emergency care services with patient experience at its centre

**To do this we will:**

- Make best use of the information we have through patient engagement, Healthwatch reports, and provider patient insight to ensure that we hear and act on what people are saying about our services.
- Produce consistent and timely communications to help people understand how to access and use urgent and emergency care services.
- Develop and implement new urgent care services jointly with patients so that we design around people's needs and expectations. Specifically, we will seek out the experience people living in the areas of highest health inequality, seldom heard communities who we know can have a poor experience of urgent care.

# Part Four: Working together at place

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

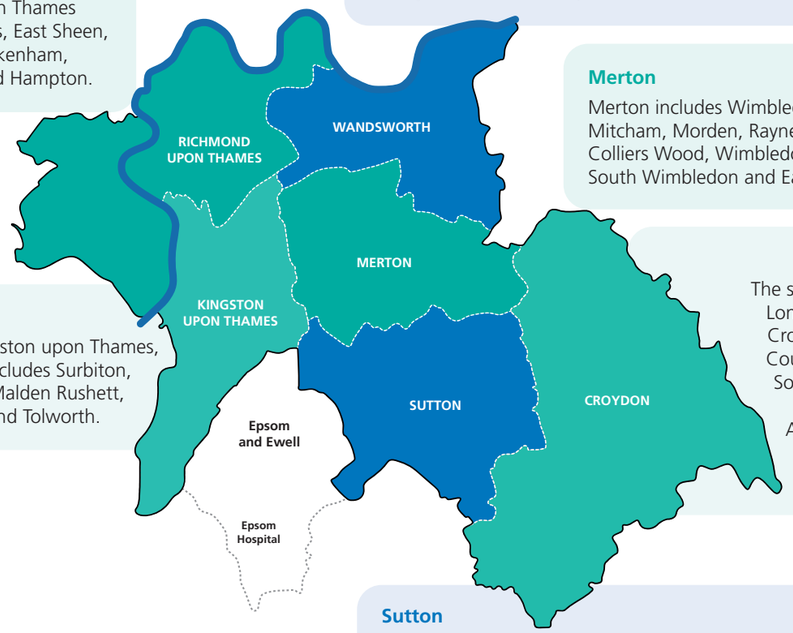
Our local place-based partnerships bring together the NHS, local authorities, Healthwatch, voluntary and community sector organisations and local residents to work together to understand and meet local health and well-being needs. Our six places in South West London are the same borough boundaries as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

**Richmond**

Richmond upon Thames includes Barnes, East Sheen, Mortlake, Twickenham, Teddington and Hampton.

**Wandsworth**

This inner London borough includes Battersea, Tooting, Putney, Balham, Roehampton, Furzedown and Southfields.




**Merton**

Merton includes Wimbledon, Mitcham, Morden, Raynes Park, Colliers Wood, Wimbledon Park, South Wimbledon and Eastfields.

**Kingston**

As well as Kingston upon Thames, the borough includes Surbiton, Chessington, Malden Rushett, New Malden and Tolworth.

**Croydon**

The second biggest London borough, Croydon includes Coulsdon, Purley, South Norwood, Norbury, New Addington and Thornton Heath.

**Sutton**

Sutton includes Beddington, Belmont, Carshalton, Cheam, Hackbridge, St Helier, Rosehill, Wallington and Worcester Park.

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

Feedback from health and wellbeing boards is summarised in appendix four.



## Croydon

Croydon is the largest of all the London boroughs in terms of population, with approximately **390,800** residents (ONS Census 2021).

51.6% of Croydon residents are from Black, Asian or minority ethnic groups.

The number of looked after children is the highest in London.

Of the **65,368** pupils in Croydon, **13%** (8,562) are receiving support for special educational needs and **4%** (2,604) have an Education, health and care plan for SEND.

Healthy life expectancy is **63.2 years** – the lowest in South West London.

**50%** of the Core20 most deprived residents in South West London live in Croydon and **40%** of all Croydon residents are in the Core20 (which means they are more likely to have depression, to have physical and mental health conditions and they are more likely to be admitted to hospital).

During the COVID-19 pandemic, **28%** of people reported feeling lonely often/ always or some of the time.

Within Croydon **1 in 6 adults** (67,000 people) has a mental health condition at any one time, with **38184** residents in Croydon living with depression which, makes up **9.77%** of the total population.

**2,692** people over the age of 65 have received a dementia diagnosis.

Croydon has **128** registered care homes and the largest Care Home provision within London with over **3000** beds.

**41.9%** of Year 6 children and **61.8%** of adults are overweight or obese with**12.63%** of people having hypertension.

Furthermore, Croydon has a high rate of diabetes, with **7%** of the population already diagnosed with the condition and up to 10,000 people estimated to have undiagnosed diabetes.

According to the Department of Levelling up Housing & Communities, at the end of Quarter 3 of 2022 (July to September 2022), there were a total of **1,981** households in temporary accommodation in Croydon. Of these,**1,386** had dependent children and a total of **2,656** dependent children were affected.

## People and communities tell us

We hear from residents and community groups through six Local Community Partnerships established in different parts of the borough. We also benefit from the insights of Healthwatch and other community partners through specific pieces of work to listen to residents. We have heard that people want:

Better **access** to services and healthy lifestyle support close to where they live.

**Community spaces** for adults and young people to connect.

Increased **mental health support** in community settings.

People also tell us about:

**Cost of Living:** Many in our community experience issues with cost-of-living and often report not knowing where to go to seek support.

**Inequalities:** People from Black, Asian, and minority ethnic groups as well as people with other protected characteristics sometimes do not feel listened to when seeking care.

**Ageing well:** Staying physically and mentally well and maintaining independence are the most important factors. Many older people experience issues with social isolation.

## Our ambition

Our ambition is to deliver better care and support tailored to the needs of our communities and available closer to home. We will meet this ambition by bringing together the borough's NHS physical and mental health services, along with primary care, social care and the voluntary sector; joining up services to provide better support for each individual's mental, physical and social needs.

**We will:**

- **Focus on prevention and proactive care.** Promoting positive wellbeing, preventing ill health or identifying and tackling it at the earliest possible opportunity.
- **Unlock the power of communities.** Connecting local people with each other to help them stay fit, healthy, and happier for longer.
- **Put services into the heart of the community.** Providing easier access to local services close to home, tailored to the needs of Croydon's communities.

In addition to these core aims we set out originally as a partnership, our experiences over the pandemic led us to commit to the following – we will:

- Support people to recover from the effects of the pandemic.
- Support our health and care workforce, along with carers.
- Focus on improving the health of particular groups of people by looking at their health needs, and social reasons for health issues.
- Focus on reducing the differences in opportunities, resources, and outcomes that exist among different groups of people, because of factors like as income, race, ethnicity, gender, education, or geographical location.



Our Health and Care Plan helps deliver the broader Croydon Health and Wellbeing Strategy set by the Health and Wellbeing Board, which set the following vision: 'Croydon will be a healthy and caring borough where good health is the default not the exception and those that experience the worst health improve their health the fastest'. This vision is underpinned by three key principles:

- Reducing inequalities
- Focusing on prevention, and
- Increased integration.

The Croydon Health and Wellbeing Strategy is being reviewed this year, in line with the elected Mayor of Croydon's business plan (2022-26), which includes the following ambitions:

- People can lead healthier and independent lives for longer.
- Children and young people in Croydon have the chance to thrive, learn and fulfil their potential.
- Croydon is a cleaner, safer and healthier place, a borough we are proud to call home.

### Our work in focus – Healthy Communities Together

- We created the Healthy Communities Together programme, funded by the National Lottery, as a partnership between the NHS, Croydon Council and the Voluntary and Community Sector (VCS) to build and strengthen local community partnerships in each of Croydon's six localities.
- We have established community hubs, led by the voluntary and community sector, to support residents to find information about issues such as housing and employment, connect with their community and access the resources in their neighbourhoods.
- Local community partnerships have worked together on community plans for their neighbourhoods. This supports the council and the NHS to plan services that respond to what matters to the local community.
- Working with Age UK Croydon and Croydon Voluntary Action, community groups can access grants and targeted contracts to support their community plans.
- The Kings Fund are supporting our partnership to measure the impact of the programme on people's health and wellbeing.

## Our plans to achieve our ambitions

### Focus on prevention and proactive care

We will establish family hubs to ensure that families can access early help when they need it. This offer will be for families with children from 0 to 19 years old (and up to 25 for young people with special educational needs and disabilities). The 'Start for Life' offer will focus on pre-birth to two years, covering parenting support, perinatal mental health support, infant feeding and home learning support for under five year olds to help them to be ready to start school.

We will improve services for children and young people with special educational needs and disabilities by focusing on early identification and support and delivering high-quality services that enable children and young people to thrive in their own communities and celebrate their accomplishments.

We will ensure that children and young people can access the right support for their mental health, including working with schools and the voluntary sector and using digital tools.

We will have a focus on working together where there are young people in mental health crisis and the link with family or placement breakdown, when a child or young person is looked after. This includes additional capacity in children's social care and the mental health crisis team as well as developing the right placement options to prevent young people having to stay in an inappropriate setting for their needs.

We will deliver new weight management services for children and young people and for adults which will support people to lose weight through psychological approaches, support with healthy eating and exercise advice to achieve sustainable changes.

We will work with our local voluntary and community sector organisations and primary care networks to improve outcomes for people with hypertension, which is an important part of increasing healthy life expectancy and reducing the gap in health inequalities. Primary care, including pharmacies across the borough will support with this. Outreach work in the community will identify people at an earlier stage and provide peer support.

We will work with partners to identify people who would benefit from early support and care coordination, such as those who are becoming frail. Teams of different health and care professionals from different in primary and community organisations will work together to improve care for these residents and keep them well.

### Unlock the power of communities

We will continue to help support all our communities to improve their health and wellbeing by working with the voluntary and community sector to connect with people in community settings. This includes the expert patient programme to offer peer support in communities most affected by long term conditions and health inequalities.

We will improve access, experience, and outcomes in mental health support for Black, Asian and minority ethnic communities. This programme is called the 'ethnicity in mental health improvement programme' and it will tackle inequalities by providing mental health services in trusted local setting like community centres and places of worship to encourage people who aren't accessing services through traditional NHS routes to access support.

We will focus on increasing recruitment from the local community by working with community groups to promote and engage on local opportunities in health and care. The local authority and Croydon Health Services are two of the borough's biggest employers and 'anchor institutions' in the community, working together with the voluntary and community sector and local GPs through primary care networks to encourage more local people from Croydon to work in health and care roles.

In line with our aim to support anchor institutions in the borough, we will work with the London South Bank University who have a site in Croydon to further develop our joint work to offer nursing and social work placements, connect local school and colleges with the site and run further open days promoting local jobs and training in health and social care.

We will also continue to develop our offer in the community for mental health services, building on the new roles of mental health personal independence coordinators employed by the voluntary sector and the health and wellbeing space in the shopping centre.

### Put services into the heart of the community

We will work in partnership with primary care partners to develop joint working in our neighbourhoods and support implementation of the South West London primary care strategy around strengthening primary care, improving access and increasing proactive care.

We will work more closely together when people first seek support from adult social care by bringing the council's services together with the information and advice offered by Age UK Croydon, with occupational therapists also part of the team, so that older people can get support to remain as independent as possible.

We will further develop our teams of different health and care staff in localities to improve care, focus on the individual and keep our residents well. We will do this by working together in the same place where possible and acting as one team, as well as and testing new approaches to co-ordinating people's care, including the use of digital tools.

We will work together on a shared approach to council, community, and NHS buildings to make efficient use of estates and support our joint working. Initiatives include the development of new health and wellbeing centres to provide frontline services where they are most needed and space for teams of staff from different organisations to work together.

We will continue to work together to improve people's experience of coming home from hospital. Croydon has been selected as one of six sites within the NHS England 'discharge integration frontrunner' programme. This is about ensuring we have the right capacity and services in the community for people when they leave hospital, so that they are able to recover and stay well.

We will work in partnership to develop the care home market, especially nursing homes to ensure we have the right provision and that we get the best value for the Croydon pound. We will continue to improve the care people receive in care homes through joint working with the voluntary and community sector to reduce social isolation in care homes and improve people's mobility and strength.

We will increase early diagnosis and promote living well with dementia. This will include a focus on prevention, improved liaison across physical and mental health services, as well as ensuring people have the right palliative and end of life care.

# Kingston

There is a six year gap in life expectancy between the most and least deprived men, and four year gap for women with the gap widening for both over the last decade

The number of people over the age of 80 is set to grow by 37% in ten years

**32%** of Kingston residents are from ethnic minority backgrounds

There are **11,400** carers[12] in the borough providing unpaid care for people, mostly in their own homes.

Mental ill health is more common in our most deprived populations

Kingston has higher levels of air pollution (fine particulate matter) than England as a whole

Tobacco is the number one risk factor for both ill health and premature disease in adults aged 20-69 in Kingston

Being overweight is the second highest risk factor for ill health and third highest risk factor for premature death

Kingston has higher levels hospital admissions for falls for the over 65s than England as a whole (20/21)


12. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/unpaidcareenglandandwales/census2021

## People and communities tell us

Within Kingston we have established Community Voices Kingston to foster strong partnership and collaboration. Its purpose is to provide a space for hearing the voice of Kingston residents through voluntary sector organisations and community groups who represent them.

We work closely with Healthwatch Kingston who focus on understanding the needs, experiences and concerns of people who use health and social care services and speak out on their behalf.

Through these mechanisms people have told us mental health is an issue facing people at all life stages in Kingston. The Kingston mental health activity audit identifies:

There is a lot of good work, for example, the mental health in schools programme. But we need to improve our referral processes into mental health services.

There are lots of great initiatives in terms of supporting parents, identifying children, and providing resilience. However, there is a lack of free counselling across the board and more needs to be done to provide interpreting services, as refugees and other migrant communities are more likely to be in crisis.

Evidence from surveys show that Black, Asian and minority ethnic groups don't feel able to access all existing services. It would be helpful to do more targeted work with these communities to co design services.

Feedback from local people as part of the Kingston health and care plan refresh (2022) supports this, with poor mental health identified as an issue and it was welcomed by people as a key part of the plan. In addition, digital exclusion is identified as an issue especially for older people and those with disabilities. The impact of wider determinants of health is also identified as a priority for local people, as well as tackling social isolation and loneliness.

## Our ambition

Kingston Place partnership has agreed overarching priorities for the borough. These will be delivered through:

- A whole system approach to improving the health and care outcomes for our population.
- An ambition that tackles health inequalities in our underserved communities and, supports the most vulnerable in our populations
  - a specific focus on our young people by improving access to emotional health and wellbeing support
  - and our elderly frail population addressing the physical and socio-economic factors they face.
- By addressing some of the factors causing ill health in Kingston, such as inactivity and poor diet, we can also support our ambition to meet our carbon reduction goals by increasing our active travel, insulating our homes and improving our diets.




## What we've achieved so far – one case study

**Our work in focus – Keeping people well – proactive anticipatory care**

Working with stakeholders and system partners, the proactive anticipatory care model was developed to target and support people with rising health and social care risks and complexity. At the centre of the model is a weekly team meeting which includes representation from a dedicated core team of professionals from different organisations.

This work has been accelerated by a development programme to help health and care professionals effectively support people by proactively managing their care. This was done through the delivery of five connected module and monthly skills sessions.

Since the beginning of the programme, 522 new patients have been discussed at team meetings across the two participating PCNs.

Initial evaluation shows a 55% reduction in patients using urgent or unplanned care services when they have been part of the programme for four months or longer.

We have had excellent feedback from both patients and carers.

***"This service needs to be everywhere! It helps people like me manage a lot better in their own homes for longer".*** Patient quote

***"All people with needs like my aunts should be cared for in this way. The team are fantastic".*** Carer quote

## Our plans to achieve our ambitions

### Our approach

We will take a population health management approach to focus on and prioritise our areas of most need to ensure that care is joined up for our most frail and vulnerable communities. The development of more 'hubs' where people can access a range of community, social and health support continues as part of our integrated working approach.

Within Kingston we continue to focus on our overarching themes - our 'golden threads' across all life stages. These are:

1. Recognising all carers;
2. Tackling inequalities in health to reduce disparities for those most disadvantaged
3. Tackling obesity; and
4. Promoting the mental health and resilience of residents to improve health and wellbeing across the life course.

This plan supports delivery of the Kingston joint Health and Wellbeing Board strategy that consists of four key themes:

- Mental health
- Older people and people with long term conditions
- Addressing the needs of socially excluded and disadvantaged groups
- Children and young people.

This strategy is currently being refreshed in line with the joint strategic needs assessment.

To deliver our ambitions, we have described our actions in three sections: 'start well, live well, age well' so we can be specific about the actions for each phase of life.

### Actions

### Start well

**Maximise the mental wellbeing and resilience of our children and young people**

- We will develop a new model of mental health care for children and young people aged 0 to 25 to provide swift, timely and flexible support based on their holistic needs with an emphasis on prevention and early intervention.
- We will work with children and young people to
  - ensure that the voice of the young person is heard and that it is reflective of the needs of a wide range of needs including those young people who are carers.
  - increase community participation by children and young people, in community, volunteering, sporting and other activities to increase their resilience and general wellbeing

  - co-produce and promote peer-led services that support their mental health and reduce involvement in self-harm and risk-taking behaviours, such as substance misuse.
  - implement preventative programmes that increase safety and emotional wellbeing and reduce serious youth violence and exploitation.
- We will work with parents, schools and carers to:
  - build resilience and take a community-based approach using teams from different professions.
  - provide advice and support to parents and carers at all developmental stages to build their confidence in caring for their child and supporting their mental health and emotional wellbeing.
  - provide additional support for those supporting looked-after children, to build their confidence in supporting the children and young people's mental health and emotional wellbeing.
  - strengthen the early identification and assessment of young carers to ensure their mental health and wellbeing needs are met and supported.

**Improve the health and wellbeing of children and young people by tackling childhood obesity.**

- Promote breastfeeding and safe infant feeding practices to support the nutrition of babies and infants in their first 1,001 days.
- Work with all schools to implement initiatives that actively promote pupils' healthy weight through healthy eating and regular physical activity.
- Expand parent-led programmes that promote healthy eating and active play for children in their early years and implement a healthy lifestyle programme for parents and children aged five to 11.
- Enhance and expand our local oral health promotion offer.
- Create more opportunities for children and young people to take part in active play, sport and adventurous activities, including targeted programmes for those who need support to reach and maintain a healthy weight.
- Use school travel planning to maximise opportunities for children to safely walk, scoot or cycle to school.
- Develop an obesity strategy with a particular emphasis on whole-family approaches to reducing obesity and maintaining healthy weight.
- Promote healthy lifestyle activities for families via online platforms such as 'connected Kingston' and through social media campaigns.
- Work with businesses to promote the 'healthy catering commitment' or better food options and promotion in our local food businesses.
- Work to develop Family Hubs in key locations in the borough.

**Give children and young people with special educational needs and disabilities (SEND) opportunities to flourish and be independent.**

- Improve the early identification of children and young people with SEND through better coordinated multi-agency working and information-sharing.
- Work with children and young people and their parents and carers to ensure they can have their say and are involved in decisions about their own education, health and care support.
- Improve the range, quality and accessibility of information on local education, health and care services for children and young people with SEND, their parents and carers and the professionals who support them.
- Good progress has been made to improve the quality and timeliness of education, health and care assessments, plans and reviews to ensure they support and achieve agreed outcomes, promote resilience and independence, and provide good value for money. We will continue to maintain the progress in this area.
- Deliver an improved therapy offer for children and young people with SEND.
- Develop the local neuro-developmental service for children and young people to improve the timeliness of assessments and pre-and post-diagnostic support, including support with their mental health needs.

**Increase the uptake of childhood vaccinations:**

We will seek to better understand parent's/carer's concerns about vaccinations and then work to improve vaccine confidence and uptake through conversations with trusted health professionals and vaccine champions/peers.

## Live well

**Reduce health inequalities for adults with or at risk of having poorer health.**

- An enhanced approach to tobacco control, with a focus on areas and groups with higher levels of smoking, especially amongst adults with anxiety or depression and across all maternity and Health Visiting services.
- Take an increased focus on promoting and facilitating physical activity and healthy lifestyles, including active travel, across the borough with a focus on areas with lowest levels. Targeting areas of need and early intervention.
- Work with communities where we know there are people with poorer health outcomes or have limited access to services.
- Develop Kingston's Black, Asian and minority ethnic mental health partnership and action plan to tackle inequalities.
- Support, grow and promote local community groups and physical activity groups through 'Connected Kingston' to enable residents to be socially connected, keep active and improve their health and implement the recommendations from the recent evaluation to improve support to groups not currently able to access it.
- Support and grow local community solutions to helping residents access good quality food at a reasonable cost. Acknowledging that this is affecting the health of residents and staff across anchor organisations.
- Encourage Kingston employers to sign up to the business in the 'community good business charter'.
- Increase the mental health awareness of frontline staff and community members, particularly those working with people exposed to risks to their mental health, to improve the identification and support of those with mental health problems.
- Encourage local organisations in Kingston, in particular voluntary and community organisations working with groups experiencing health inequalities to become 'be well hubs'[13] and improve access to support with mental health in the community.

**Support people to manage long-term conditions.**

- Build the capacity and capability within the community to support self-management, self-care, promoting health and social prescribing community offers.
- Ensure that our work includes a focus on areas and groups that have the highest levels of long-term conditions in the borough (which differ by different condition).
- Roll out the proactive anticipatory care (PAC) model across all PCNs by 2022 to proactively support people with long term conditions. This model helps local people plan-ahead, be more in control and manage changes in their health and wellbeing, working together with local community.
- Provide a range of support to people including expanding IAPT (psychological talking therapies) and the use of digital health promotion tools to support self-care and manage long term conditions.
- Develop Integrated delivery hubs, for people with serious mental illness, which will provide a range of health and social care services as well as links to voluntary sector services to provide additional support for service users.
- Adopt a population health management approach to a system wide transformation of diabetes care in the borough.

**Support people to have good physical and mental health, have a healthy weight and regular physical activity to prevent ill health.**

- Increase access to and promote physical activity opportunities, including active travel.
- Train staff and volunteers to become 'connected Kingston' champions to increase awareness of the offers available in the community that support good physical and mental health and wellbeing.
- Communicate and engage with target groups based on our local knowledge and national survey results.
- Improve the detection of people at risk of developing long term conditions through the promotion of health checks and national and local screening programmes, particularly amongst those at greatest risk of ill health. Including mental health.
- Community health and wellbeing coaches to be trained and work proactively with target communities who are at risk of developing long term conditions.
- Promote in-person and online prevention courses such as the 'healthier you' national diabetes prevention programme (NDPP) for people at risk of developing type 2 diabetes and health and fitness classes.
- Promote lifestyles services and adult weight management for adults supported by the Public Health England grant and through links with adult education, and the adult education budget.
- Improve access to bereavement support services based on the recommendations in the recent report on community engagement.
- Refresh and implement Kingston's suicide prevention strategy.
- Work with our anchor institutions to ensure the London living wage, support people into employment through apprenticeships and workforce opportunity development. In particular, we aim for more people with a learning disability will have the opportunity to take up and sustain paid employment so maintaining their independence.

13. The South London Listens Action Plan includes establishing 120 'Be Well' hubs for people to turn to when they feel their mental health is low or simply to feel more connected with their local community.

## Age well

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

- Support community groups working with older people to become 'Be well' hubs, and older people to become mental health champions.[14] Increase the ways of identifying people who are lonely and supporting them to access local services. Work with older people, particularly those who are not accessing existing services, to develop ways for them to build social connections.
- Further develop digital support and learning for older people.
- Work with partners, including local businesses, in Kingston to promote collaborative action to promote healthy ageing in line with the centre for better ageing 'age friendly communities' model.
- Increase and promote volunteering opportunities for older people.
- Analyse social care providers to understand current levels of anxiety and depression amongst clients and identify those with the highest need to focus on promotion and implementation of mental health first aid training to health and social care staff working with older people.
- Promote courses for adults including carers to develop support networks to reduce loneliness and isolation, improve mental wellbeing, learn new skills or build on existing skills.
- Within the context of a compassionate community model, engage with the community to understand how to support the bereaved and to develop an appropriate response.

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

- Increased use and access to integrated digital end-of-life care plans across Kingston in all care settings including acute hospital and care homes through engagement and training.
- Review end of life care and palliative training needs for health and social care staff and voluntary sector in Kingston, with a view to developing a plan to address the gaps.
- Adoption of a compassionate communities population-based approach to end-of-life care and bereavement to increase identification of bereaved people and increase of acknowledgement/ signposting to bereavement of support and services.
- Support care homes to be more digitally integrated across the health and social care system, including using clinical tools in care homes to manage their residents safely and consistently.
- Increase the number of people with dementia and their carers identified early and provided with post-diagnosis support and ongoing advice by implementing nationally recognised memory services national accreditation programme (MSNAP) standards within our memory assessment units within 2022 and working with partners to support success.
- Improve services and support for people with dementia by undertaking a whole system partners review of and implementing the Kingston dementia strategy. We will also develop new dementia care home facilities in the borough, increase primary care support and shared-care protocols to enable people to be better managed in the community. We will also review our post-diagnostic support offer across health, social care and the community (including wider facilities such as parks and housing.

14. For more detail see the South London Listens Action Plan



## Merton

The gap in life expectancy between the **10%** most deprived and the 10% least deprived in Merton is **7.7** years for males and 5 years for females.

**1 in 5** residents are physically inactive

1 in 9 adults feel lonely often/always

Living with obesity and being overweight: 1 in 5 children in reception are overweight and obese rising to 1 in 3 children in year 6.

EAST MERTON

Of the **340,000** population in Southwest London that have the most health needs, **29,000** are located in East Merton

The gap in life expectancy between the **10%** most deprived and the 10% least deprived in Merton, is 7.7 years for males and five years for females

Frailty is higher in Morden and East Merton. An estimated **10%**, or **2,764** residents aged over **65** live with frailty

There are **16,000-20,000** unpaid carers in Merton

More than half of Merton's population is of working age and is projected to increase by almost 3,000 people by 2035.

## People and communities tell us

Health, care and community organisations in Merton have worked closely for many years and, since the pandemic, remain committed to reduce inequalities, join up services and make real differences to people's lives. Insights and feedback from community groups, service users, carers and families informed the refresh of the Merton local health and care plan in 2022, key themes were:

We need to talk to and listen to communities in their own spaces/ environments, understand their needs and invest in them and empower them.

Cultural sensitivity needs to be considered in all work we plan and deliver, and communities need to be part of this planning and delivery.

Mental health and emotional wellbeing are vitally important across start well, live well and age well.

Improving transitions between the three life course areas was consistently raised, and how each life course area implicitly impacts other areas e.g. parental mental health impacts children; smoothing transitions/ provision between organisations and borough boundaries is also important.

Improved information and communication about local services across the whole health, care, and VCSE spectrum is required, and we need to raise awareness about how to access/refer to services.

We need to develop a strategy about how to share communications, outputs of engagement and information better across partners, to include building communities of practice for staff across organisations.

We need to consider living and working environments across the borough and how developing Merton as a healthy place can improve health and wellbeing. Regenerating high streets and making best use of green space is key for residents.

## Our ambition

The Merton local health and care plan sets out the ambitions for the local place-based partnership. The vision is **"Working together to reduce inequalities and provide truly joined-up health and care services with and for all people in Merton, so they start, live and age well in a healthy place".** The key priorities across the life span are:

### For start well our priorities are:

- Change how people access health and wellbeing services
- Improve integration of children's services
- Be focused on mental health and wellbeing

### For live well our priorities are:

- Change how people access health and wellbeing services
- Improve and optimise access to information on primary care
- Be focused on prevention

### For age well our priorities are:

- Support older people to access resources in the community
- Improve access to and integration of services
- Be focused on frailty

Across the life course areas, we have 14 projects identified to achieve change and improvement against our priority areas in the local health and care plan.

Projects are at different stages ranging from initiation to delivery, we have also incorporated new local projects identified through the South West London investment funds and added to this to support our local ambitions.

We also have enabler work streams around prevention, workforce and communications and engagement to build place partnership through delivery.

### Our work in focus – Health on the high street in Merton

The Health on the High Street initiative began in summer 2022 as a creative way of supporting to people across Merton and is a key element of our local health and care plan. Following the success of the Covid-19 vaccine programme, we aimed to change the way we deliver our services and enable our partners to reach new people across the borough. This has involved the creative use of libraries, community centres and cafes as healthcare venues, running everything from mental health support to vaccination clinics. It is also about bringing people together, boosting their social wellbeing and addressing loneliness.

Health on the high street projects have included a memory café in Morden, with Alzheimer's Society. The monthly drop-in at the Metronome Café is a chance for anyone worried about their own or a loved one's memory to talk to the experts and share their worries.

Two well-attended winter health fairs in Mitcham and Raynes Park gave people the chance to meet voluntary organisations and find out about their activities and support – as well as having blood pressure, diabetes and cancer screening checks and a hot curry lunch.

Other loneliness-busting sessions have ranged from a LGBT+ history month coffee morning for older people to monthly drop-in mental health counselling.

We are now working with local charity Wimbledon Guild on an eight-week online guided course to improve personal wellbeing, by eating well, being more active or having a better understanding of your mental health.

## Our plans to achieve our ambitions

We have 14 projects identified across start well, live well, age well to achieve change and improvement against our priority areas in the local health and care plan.

Each project tracks outputs, outcomes and impact ensuring link to the priority areas. Many projects have built in evaluations and these are to be reviewed by the Merton Place Committee.

**In addition to these projects, we have plans to:**

- Integrate neighbourhood teams providing joined-up care to residents and patients by health and care professionals coming together in teams structured around the needs of the individual.
- Transform community services into a key partner in the treatment of health conditions and health promotion as part of these joined-up teams.
- Strengthen our primary care networks (groups of GP practices working together) to lead health and social care across neighbourhoods.
- Work closely with children's services and schools on promoting and maintaining health.
- Tackle mental health through trailblazer school services and developing mental health services which are specifically designed to be accessible by people from our Black, Asian and minority ethnic communities.
- Develop the Mitcham health and wellbeing hub to deliver much needed primary and community-based services to an area where need is higher, and service take-up is lower.
- Deliver community and prevention health services from the high street to encourage people to use them in familiar settings.
- Focus on our frail, older residents to deliver support, equipment, and services in their homes to avoid falls, hospital admissions and support people coming home from hospital more quickly.

**To do this we will:**

- Bring together staff, services and funding streams from different organisations where we can.
- Develop our primary care networks (groups of GP practices working together) to better support communities at neighbourhood level.
- Put the voluntary sector at the heart of our work.
- Put prevention first.
- Identify buildings and local premises for to deliver services.

### Start Well

- We will develop a new mental health hub which will support children and young people with mental health issues in the community. We will see more young people with mental health conditions in community settings, aiming to reduce acute admissions.
- Work in partnership with our Local Authority to develop Family hubs for neighbourhood support, prevention, and treatment to families in need.

- We will continue to target childhood obesity through partnership work with local schools to reduce the number of children with obesity numbers in Merton.
- Build on our 'special educational needs and disabilities' (SEND) partnership and recent inspection review to deliver excellent SEND provision and 'alternative provision' across Merton, reducing the need for education health and care plans.
- We will increase childhood immunisations across Merton.

### Live well

- Develop a range of services targeted at addressing overrepresentation of black and ethnic minorities in acute mental health settings. We will measure attendance and outcomes of residents accessing community based mental health initiatives.
- Promote health and access to communities we know do not access health care when they need to. Led by local authority colleagues, we are supporting the delivery of an programme of prevention, health, and wellbeing services and on the high street to local communities in Merton. We will evidence better take-up of services through high street, café's and library setting.
- Provide health checks in non-clinical settings such as foodbanks, libraries, faith settings. Evidence increased numbers of residents from Black, Asian and minority ethnic backgrounds and eastern European backgrounds accessing services from both clinical and non-clinical settings.
- Develop the Mitcham health and wellbeing hub – a centre of services in Mitcham for the surrounding east Merton residents. Reduce obesity and long-term condition prevalence in the longer term.
- Increase awareness and promote healthy activity across Merton through innovative initiatives such as 'beat the street' to create long lasting behaviour change to get more people physically active in Merton. 10% of the Merton population has already been reached – a significant proportion of the community who identified as doing no physical activity previously.
- Further develop 'actively Merton' a partnership initiative, steered through our new place governance to join up and promote existing activities and services with the aim of improving access, really exploiting the green spaces and vibrant voluntary sector within Merton.
- Working with our developed voluntary sector of over 400 organisations to deliver health care and prevention services in the community including developing local sites which align to the regeneration of neighbourhoods.
- Work with St Georges University Foundation NHS Trust and South West London and St George's Mental Health NHS Trust, as anchor institutions and large local employers to create to internships and apprenticeships for local people.

### Age well

- We will focus on frailty using 'population health management' data to reach into the communities that need it the most. Reduce hospital admissions and readmissions for people considered frail.
- We will care for people in their own homes, including working in partnership with the voluntary sector.
- Improve mental health and physical health indicators for people living alone for example, by bespoke support to those who are socially isolated with a befriending service as we know this promotes both better physical and mental health.
- Promote non-sport-based activity in our frail populations linking in with library initiatives to provide activity-based support to older adults.
- Increase the number of older people using active initiatives in non-clinical settings such as libraries.
- Taking health initiatives such as dementia support into our local high streets, using void retail space, libraries and cafés to support and promote services to residents.



## Richmond

**19,604 (36%)** people have more than one long term condition

Obesity rate doubles between reception (4.7%) and year 6 (11.1%)

There are an estimated **4,600** children aged 5–19 years old with a diagnosable mental health disorder.

**105** ,10–24-year olds were admitted to hospital as a result of self-harm

**1 in 3** adults in Richmond drink over 14 units of alcohol a week

**6th** highest borough in London for emergency hospital admissions for falls

**1,412** (4.0%) over 65-year olds in Richmond with a recorded prevalence of dementia

An estimated **15,800** people provide some level of unpaid care

The number of 65s is set to increase by almost **50%** over the next 20 years

## People and communities tell us

Within Richmond we have established 'Community Voices Richmond' to foster strong partnership and collaboration. Its purpose is to provide a space for hearing the voice of Richmond residents through voluntary sector organisations and community groups who represent them.

We work closely with Healthwatch Richmond who focus on understanding the needs, experiences and concerns of people who use health and social care services and speak out on their behalf.

Public Perspectives on Healthy Living in Richmond shows that a key driver of inequality in Richmond is financial status. This often limits access to support to address the behavioural factors related to long term conditions. Financially disadvantaged people came from a range of demographics, employment, and occupational statuses however, people from minority ethnic groups, particularly those describing themselves as Asian, describe cost as a barrier to addressing healthy living factors (particularly with regard to healthy eating).

People with and long-term conditions report more often that they face emotional and psychological difficulties in changing their healthy living behaviours compared to people without a reported disability. They also more frequently cited disability and fatigue as a barrier to being physically active. Despite these barriers, they reported that they are motivated to change their physical activity to maintain or improve their health.

Psychological barriers to change, as well as fatigue are also more prevalent within the barriers described by those with long term conditions. There is also evidence that this group of people are more motivated by a desire to maintain and improve their current health (1 in 4) than those without long term conditions or disabilities (1 in 17). Personalised information is also important to supporting people with long term conditions to remain healthy. (ref as above but also JSNA).

Community feedback has identified areas of health and care provision requiring focus, highlighting mental health across the life span, additional support needs for carers, people living with disabilities and/or long-term conditions. Feedback has also identified that mainstream services to support healthy lifestyles such as smoking cessation and weight loss services are not readily accessible.

Feedback from local people as part of the Richmond health and care plan refresh (2022) supports this with mental health, support for carers and the wider determinants of health highlighted.


## Our ambition

Our Richmond Place health and care partnership is focussing on three key priority areas:

- Identifying and engaging with the most vulnerable in our communities to identify unmet need and support our children and young people's emotional and mental health.
- Addressing life-style behaviours to promote physical activity and healthy eating whilst reducing risky behaviours to reduce the risk of cancer and other long-term conditions such as diabetes, cardiovascular disease, CVD, and supporting people's mental health.
- Supporting our frail and elderly population within a co-ordinated system to reduce social isolation and the effects of dementia.

**Richmond Joint Health and Wellbeing Board Strategy**

This plan supports delivery of the Richmond Joint Health and Wellbeing Board Strategy (2016-2021) that aims to address:

- Children and young people's - mental health, obesity and immunisation uptake.
- Adults - with long-term conditions, mental wellbeing, cancer screening, lifestyle behaviours, air quality and climate change.
- Older people – living independently and dementia, loneliness and social isolation and cancer screening and immunisations.

### Our work in focus – Health in your Hands

The Health In Your Hands (HIYH) project has been running within the Hampton and Teddington PCNs for 8 months, targeting one of the most deprived communities in the borough within the Hampton North Ward. The focus of the project is on the prevention, early identification and self-management of LTCs for people facing health inequalities. The project is delivered through a wellbeing co-ordinator embedded within the wider social prescribing team.

The project provides dedicated capacity to outreach into communities facing inequalities. These communities have disproportionately higher prevalence of conditions such as hypertension, diabetes and obesity.

In addition, this project looks beyond health services, by addressing the wider determinants of health, supporting residents to navigate housing, education, employment and financial issues. The project has developed strong relationships with organisations within the voluntary sector and the council's community engagement team and public health.

**This has been well received and identified people at risk of developing long term conditions:**

*A lady received a health check, and her BP reading, according to protocol set by GPs, indicated hypertension stage 3 and potential hypertensive crisis. We called the on-call GP to seek medical advice. The GP booked her in for a same-day emergency appointment.*

*A client from the GP patient list was signposted to the Hampton community health fair. She was referred into 2 organisations to support with her energy bills and accessing benefits/financial support she didn't know she was entitled to. She then also received a health check, which indicated that her blood pressure, BP, was elevated. This has been passed onto her GP and she has been advised to keep a seven day diary to measure her BP. She will now be referred into additional support from HIYH and will be linked in with social support, such as befriending.*

# Our plans to achieve our ambitions

In order to deliver our ambitions, we have broken down our actions into 'start well, live well, age well' so we can be specific about the actions for each phase of life.

## Our approach

### Prevention framework

Underpinning our work is our prevention framework, an umbrella framework for delivering a whole systems approach at three interconnected levels – people, community and environment.

This allows the local Place to agree priorities using an evidence-base and behavioural insights from local people. Our ambition is to enable equity and community action, promote collaborative working, and identify sustainable solutions so we can have a longer-term impact on health outcomes for local people.

### Working with partners and the voluntary sector

We will work with our partners including voluntary sector and carers to collaborate on new models to deliver care and provide support for our changing demographic. The 65+ population in Richmond is set to increase by 28% by 2033 therefore, we need to join up our infrastructure to provide support where it is needed.

### Population health management approach

We will take a population health management approach to focus on and prioritise our areas of most need to ensure that care is joined up for our most frail and vulnerable communities.

In order to achieve this we will build on the work we have been doing to support our older and frail residents by organising our workforce around our communities to ensure the specific needs of each community can be met. This will include working closely with our partners and voluntary sector organisations.

# Our Actions

## Start well

### Improve emotional wellbeing, mental health and resilience

- We are working closely with schools to enable them to support children and young people's mental health and keep children in education, through the development of mental health ambassadors, and improving communication between health and schools.
- With young people, co-produce and promote peer-led services that reduce involvement in self-harm and risk-taking behaviours.
- Provide advice and support to parents and carers to develop their confidence in caring for their child.

### Provide opportunities for those with special educational needs and disabilities (SEND) to flourish and be independent

- Improve the early identification of SEND through improved working together with partners and information-sharing.
- Work with children, young people, parents and carers to input into and be involved in decisions about their own education, health and care support.
- Support schools to deliver 'quality first teaching' so that they can support more children and young people in mainstream settings and achieve good outcomes.
- Improve the quality and timeliness of education health and care assessments, plans and reviews, and ensure they promote independence, and provide good value for money.
- Develop the neuro-developmental service to improve timeliness of assessments and pre- and post-diagnostic support.

### Promote a healthy weight approach

- Build on the stage three baby friendly initiative accreditation to promote breastfeeding and safe infant feeding practices to improve nutrition of babies and infants in their first 1,001 days.
- Encourage all schools to implement initiatives that actively promote healthy weight through healthy eating, regular physical activity; Maximising opportunities for children to safely walk or cycle to school.
- Expand parent-led programmes that promote healthy eating and active play for children in their early years. Implement a healthy lifestyle programme for parents and children aged five to 11 years.
- Promote healthy lifestyle activities via online platforms and through social media campaigns.
- Create more opportunities for children and young people to participate in active play, sport and adventurous activities, including targeted programmes for those who need support to reach and maintain a healthy weight.

### Reduce youth violence and exploitation

- Implement preventative programmes to reduce serious youth violence and exploitation.

## Live well

### Support people to stay healthy and manage their long-term health conditions

- We are working with primary care networks (GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices) to target our areas of inequality so we can identify and support people with a higher risk of developing long term conditions specifically cardiovascular disease, diabetes, falls and frailty.
- We will work with communities to increase awareness of the lifestyle behaviours and risk factors, and so increase the uptake of prevention services.
- Build a social prescribing model to support personalisation for more patient choice and control over their care.
- Develop a culture of health and wellbeing by providing healthy working environments, supporting those working with long-term conditions, working with health and care organisations to sign up to the healthy workplace award and extending this to voluntary and business sectors in the borough.

### Promote mental wellbeing and support people who experience poor mental health to avoid mental health crisis

- Bringing together health and care professionals and voluntary sector meetings to discuss and resolve complex mental health needs for patients that fall between health and care organisations.
- Increase access to the improving access to psychological therapies (or talking therapies), with a specific emphasis on vulnerable groups to meet the national access target.
- Deliver a suicide and self-harm prevention strategy to improve identification of risk and support people to get the help they need.

### Reduce health inequalities for people with learning disabilities

- Increase the uptake of GP annual health checks for those with learning disabilities in line with national targets to ensure they receive support and care for their health needs.
- Support Mencap to deliver the 'treat me well' campaign across Richmond health providers.
- Increase the number of people with a learning disability able to live independently in settled accommodation by focusing on increasing the availability of supported living schemes.
- We will work with our anchor institutions to ensure where at all possible that local people receive the London living wage and are supported into employment through apprenticeships and workforce opportunity developments. Through this more people with a learning disability will have the opportunity to take up and sustain paid employment to help them maintaining their independence.

## Age well

**Encourage active, resilient and inclusive communities that promote healthy ageing and reduce loneliness and isolation**

- Continue to build on the strengths of local communities to increase the opportunities for residents to get involved and live happy, active, and fulfilling lives.
- Continue to promote wellbeing and healthy lifestyles to give people the best chance to stay well, independent and resilient for as long as possible.
- Implement the enhanced health in care homes framework to continue to improve the quality of health and care of people living in care homes.
- Develop and expand our social prescribing offer to reduce social isolation with a specific focus on carers.

**Support people to live at home independently and for as long as possible, including people with dementia**

- Work to join-up health and care teams in the community, identify people with frailty early and support older people with complex health and care needs.
- Review and redesign how we support people when they leave hospital – improving 'discharge to assess' pathways in line with 'home first' principles and make the most of available resources.
- Provide joined-up and timely support in the community to help people regain or maintain their independence and avoid hospital admission.
- Focus on falls prevention across the borough, ensure people have the right support to reduce the risk of repeat falling and associated injury.
- Implement the dementia strategy across our communities with a focus on care home residents.

**Support people to plan for their final years so they have a dignified death in a place of their choice**

- Support residents to plan for their old age and have sensitive conversations about end of life care, and progress delivery of our end-of-life care strategy.
- Improve care coordination and information sharing across health and social care organisations including rolling out access to urgent care to care homes.
- Review bereavement services to identify any potential gaps and ensure the needs of the whole population including those harder to reach are served.


# Sutton

It has over **90** parks and green spaces.

Sutton is within the top **10%** most densely populated of all local authorities in England

Population has grown by **10%** between 2011 and 2021

**43%** of the population were from Asian, Black, Mixed/ Multiple and White non-British ethnic backgrounds

About **18** of every **100** residents live in poverty (London average: 30 in 100)

**17%** (36,000) of Sutton residents are in the core 20 or most deprived population in South West London – median age 35 years

**10%** of residents are black, this is one of the smallest ethnic groups in Sutton but the largest proportion of people in this most deprived or core 20 group

The rate of referrals to secondary mental health services for children increased by over **16%** in only two years (up to 2019/20)

**five of every 100 pupils** in Sutton's schools has a plan for their special educational needs or disabilities (SEND)

**1 in 3** of the population have a diagnosed long-term condition (national average: 1 in 4).

The rate of depression has almost doubled from **6.2%** to 11.2% in eight years

**63%** of adults are overweight or obese (London 56.0%).

**4.7%** of residents over 65 have a dementia diagnosis

**12%** of adults over 65 live alone, contributing to loneliness


# People and communities tell us

They are concerned about the impact of Covid-19 and recovery

They need support with mental health issues such as depression, isolation and anxiety

About the myths circulating among the communities about the effectiveness and safety of vaccines

About their interest in seeing empty retail space used by community projects

They are concerned about access to medical support, such as routine NHS appointments and face to face contact with GPs

Lots of positive feedback and support for the model of engagement we used during the Covid-19 pandemic where we held listening events, and said they would like to continue this approach as we move forward

They are concerned about the impact of the cost of living crisis

# Our ambition

### The Sutton plan and local health and care plan forms our Sutton health and wellbeing strategy

Our NHS ambition is closely linked and part of 'the Sutton plan and local health and care plan which forms our health and wellbeing strategy. We have a shared vision and principles to deliver the best preventative, proactive and reactive health and care we can. In everything we do, we believe in challenging the status quo to get the best out of the Sutton pound.

- Our ambition is for local people to play an active role in maintaining their own wellbeing as part of our community. We also plan to use insight from our engagement with communities to and data to help us create tangible actions to improve the health and well-being.
- We will work with heath and care partners to improve poor health and reduce health inequalities by harnessing the assets and strengths of local communities.
- We will make sure that Sutton residents start well in life as children and young carers, live well as adults, and age well with dignity. We will build on the collaboration, innovation and new ways of working that emerged during the Covid-19 pandemic to support delivery of health and wellbeing outcomes for local residents.

- This is a refreshed plan of action that aims to deliver the following health and care priorities over the next two years:
  - **Working with our communitie**s to co-develop a shared vision for how we improve our health and well-being
  - **Tackling health inequalities** and the social determinants of health in vulnerable groups such as people with a learning disability: adult and young carers; vulnerable migrants; Gypsy, Roma, Traveller and lesbian, gay, bisexual and transgender (LGBT) communities
  - **Improved health and wellbeing** of the population especially in light of Covid-19 pandemic with particular focus on mental health, cardiovascular diseases, diabetes, musculoskeletal, MSK, and obesity
  - **Community services and GP primary care networks working together** – integrated neighbourhood teams to support proactive approach to managing population health needs at neighbourhood levels

### Our work in focus – Learning Disabilities Conference

The Learning Disabilities Conference was jointly organised with people with learning disabilities, family and carer representatives in March 2023.

65 people attended to hear from adults and young people with learning disabilities, families and carers about what life is really like for them in Sutton and to discuss suggestions and ideas on how to make improvements.

People with learning disabilities, families and carers shared the challenges they face in the borough and what works and doesn't work for them. Different community groups, including Sutton Mencap, Sutton Parent Carer Forum, Community Action Sutton, Nickel Support, Speak Up Sutton, Choice Support and Advocacy for All also attended.

People discussed the positives, negatives and ideas for improvement in transport, access to health, social care, housing, leisure & culture, town centres and work.

Action Group leads provided updates on the three priority areas identified in the refreshed Learning Disabilities Strategy The Leader of the Council and people attending the conference also made promises about what they could do in the next six months to help make Sutton a better place for people with learning disabilities, their families and carers.

## Our plans to achieve our ambitions

Our joint response to health and care challenges identified in this plan have been framed around six connected Sutton health and care transformation programmes organised across start well, live well, age well. Each of the six programmes has dedicated actions:

### Children and young people

- Develop family hubs in Sutton so that services can be accessed in one place.
- Parenting programmes to support families with universal credits, conflict at home, or those with children with autism spectrum disorder or attention deficit hyperactivity disorder.
- Conduct a community focussed review of our children's centres in Sutton to recommend how services should be delivered.
- Respond to community need in Roundshaw & Tweeddale.

### Population health and health inequalities

- Work with our community to develop a communication plan so that all our residents know what health problems exist where they live and what they can do about this.
- Use data about health inequalities to deliver projects that target local need, for example the special care models in Carshalton (diabetes) and Wallington (obesity and MSK osteoarthritis).

### Mental health

- Continuing to bring primary and community services for people with serious mental illness together, including dedicated groups, increased mental health workers and the reintroduction of peer support worker services within Sutton GP practices.
- Support people with serious mental illness to stay physically healthy through annual health checks.
- Increasing access to psychological therapies for long-term conditions support.

### Learning disabilities

- Enable people with learning disabilities to live in a place they call home, including assessing whether those living out of borough could be better supported if they returned to Sutton.
- Make sure people with learning disability are part of our community, including opportunities for meaningful work and short breaks.
- Support people with learning disabilities to stay well by increasing the number of annual health checks carried out by GPs.

### Frailty

- Enabling our residents to remain independent at home, for example by addressing isolation of our elderly residents living in high-rises (especially in Cheam and South Sutton).
- Enabling patients to remain well after they have been discharged from hospital by providing a virtual ward with help from pharmacy, GPs and hospital consultants.
- Responding rapidly when care home residents start to get unwell; our community nursing team aims to attend in two hours to avoid hospital admissions.

### Integrated neighbourhood teams

- Provide a single point of access for community and GP services at neighbourhood level.
- In these neighbourhood teams, non-clinical resources will also be available, so that other complex issues such as money, welfare, employment and housing can be accessed alongside health and care.

### Anchor programmes

So that we can best support the health and well-being of our residents, we are building long-lasting partnerships with other institutions in Sutton. We have started joint programmes with the following organisations:

**Sutton Council**

- St Helier renewal programme: Improving local employment opportunities and skills, support social wellbeing and invest in physical regeneration.
- Affordable housing supply programme: Improving access to affordable housing because we understand how important this is for health and well-being.
- Voluntary and community sector grant programmes (recovery and rebuild funds): Grants to address wider determinants of health such as social isolation and financial hardship.

**Sutton Council & Epsom and St Helier University Hospitals NHS Trust**

- NHS learning disability employment pledge: working in partnership with the David Forbes Nixon programme we are creating more job opportunities for people with learning disabilities and autism aged 18-25 years. Specifically, St Helier Hospital will provide work placements which will be supported by Orchard Hill College.

## Wandsworth

327,506
residents in 2021

Second largest population in inner London

Wandsworth has one of the youngest populations in the country

Wandsworth as having one of the fastest rates of population growth in London

**1 in 3** people are from an ethnic minority

Almost **1 in 3** residents live alone

Wandsworth has one of the highest employment rates in the country, at almost 80% with five vibrant town centres.

One in five residents reported low happiness, satisfaction, and high anxiety scores.

**½** of the adult population is classified as overweight or obese

**4 in 10** residents report that they drink over 14 units of alcohol per week, the highest proportion in any London borough


## People and communities tell us

We have heard from a large number of people from all walks of life in Wandsworth. They have told us what is important to them, what they need from health and social care services and how we can strengthen and support the vibrant communities in the borough. This insight was used to develop the health and care plan priorities. Residents and patients noted:

There should be greater provision of emotional wellbeing services for children and support for parents - some services in the wider community are currently not easy to access with long waits.

Some people felt children and young people should be involved in the wider group and community rather than doing healthy activities in isolation.

Easy and quick access to mental health services was highlighted as important by many.

There should be easy access to people with expertise to help, advise and provide information, including prevention and self-management to keep well.

The barriers to accessing diabetes self-management services should be explored.

Intergenerational projects with schools and young people should be included in our plans to reduce social isolation.

There should be more support in place for people with dementia, including lifestyle services and cognitive rehabilitation.

Working together with communities to deliver health and care. There have been some excellent examples of this during the pandemic, we want to do more of it.

We recognise the wider determinants of health; how issues such as poverty and specifically food poverty are linked to wellbeing, in some cases compounding disadvantage and negative outcomes.

Patients want access timely primary care support via multiple channels They are concerned about the cost of living crisis.

We are strengthening relationships with our voluntary and community sector organisations, who are crucial in supporting and engaging with our residents. The 2022/23 Investment Fund has been a catalyst for co-producing a wide range of innovative community-based services created by statutory organisations and the voluntary and community sector. We plan to continue to use these partnerships to embed and develop the health and care priorities.

# Our ambition

The Wandsworth health and care plan is focused on the areas where we can have the greatest impact by working collectively to improve health and wellbeing. Within each life course of start well, live well and age well, three overarching themes have been identified:

- **Integration** – we want to work together across health and social care to improve support that unites physical, mental and social care and empower people to lead happy fulfilling lives. Integrated care means wrapping care around the individual through neighbourhood teams and working with the community to deliver the best possible results for the people of Wandsworth.
- **Health inequalities** – collectively focus on reducing barriers to access, improving experience and outcomes, through greater co-production, meaning that services are designed and delivered with the community and residents as equal partners. We will work with our community organisations, particularly in the more deprived areas, to promote health and care in a way that is accessible to our communities. This may be delivering services through initiatives such as community champions in settings such as food banks and community centres rather than traditional health settings.
- **Prevention** – keeping people well and as independent as possible by taking a proactive approach to work together to jointly improve the health and wellbeing of Wandsworth residents. The newly developed Wandsworth prevention framework will support collaborative prevention work at the individual, community and environment level. We will use a population-based approach.

We aim to work together across health and care to support people to live their healthiest lives. We want neighbourhood teams to reflect the diversity of the populations they serve and include at their heart community and voluntary organisations. We aim to raise the prevention agenda across all sectors to ensure every contact counts and we make the most every appointment or contact with our services. We need to work more closely with schools to promote lifelong health for our children.

We will keep older adults out of hospital with support and treatment services such as rapid response, and through working together to support people in their homes. We will proactively identify people who are at risk of deterioration and hospitalisation with a range of primary, social and voluntary support in and around their home with access to a wider range of professional support roles.

## Wandsworth health and wellbeing strategy

Wandsworth Council, through the Director of Public Health and system partners are reviewing and refreshing the joint local health and wellbeing strategy (JLHWS), which will outline where and how we should target our work over the next five years. This is due for publication in the Autumn 2023.

The previous Wandsworth health and wellbeing strategy (2015-2020) informed the development of the Wandsworth health and care plan. This strategy detailed local priorities in Wandsworth as:

1. **Healthy places** – we will work to ensure regeneration and development schemes are opportunities to improve people's health and wellbeing (with a specific focus on Roehampton and Latchmere and potential to expand to Tooting). To create healthy places, the focus should be on four areas; Urban design, healthy homes, building community assets and health protection.
2. **Targeted interventions** – we will identify the people most in need through plans to support employment, give intensive support to those most in need, and develop healthy living hubs.
3. **Mental health** – we will make mental health as important as physical health in improving health and reducing inequalities. The focus should be on prevention, early intervention and control and recovery.



### Our work in focus – Community health checks in Wandsworth

This project was about supporting people to manage their own long-term condition as part of the live well theme in Wandsworth's health and care plan.

Working with a wide range of community partners, we developed a programme of community health checks and clinics, giving people at risk of diabetes or cardiovascular disease a safe space take control of their own health. The project also involved building capacity within community groups to support people to manage their condition, promoting better health and greater independence.

The project involved six health and wellbeing events across six primary care networks between January and March 2023. We held the events in places where people meet and on housing estates, targeting those at highest risk of poorer health outcomes and who are less likely to access traditional health services. The venues included a foodbank, a church, a leisure centre and a mosque.

During the events people received in health checks including for type 2 diabetes, blood pressure and irregular heartbeat, alongside education, awareness and health coaching sessions. In total, 183 people attended the events and we carried out 130 health and wellness checks.

A further six events are planned in this year, concentrating on the Tooting, Battersea and Roehampton, areas. These future events will have a greater focus on linking people to a range of support services.

# Our plans to achieve our ambitions

To deliver our ambitions, we have broken down our actions into 'start well, live well, age well' so we can be specific about the actions for each phase of life.

## Start well

Over the next five years we want to tackle childhood illness, obesity, mental health and educational needs to ensure our young people are healthy, happy and prepared for adulthood. We will work more closely with schools to promote lifelong health for our children.

### Reduce childhood obesity

- Work with leisure and environment partners to encourage more use of open spaces, playgrounds, and sporting activities.
- Insight work to support better understanding of the characteristics, demographics, and cultural reasons for children and young people at risk of obesity.
- Deliver a family weight management programme with an information sharing agreement to improve work between organisations and develop a 'think family approach'.
- Participate in 'healthy schools London' programme to encourage participation and work towards sustainable and long-term change.

### Improving mental health and wellbeing for children and young people

- Continue to support trailblazers project in schools – this includes peer-led parenting courses and practical support for children in schools.
- Achieve greater coverage of PATHS program – this is a whole school approach to well-being and mental health including training and education for young people.
- Deliver South London and Maudsley's (SLAM) empowering communities (EPEC) – delivering a whole community approach to resilient parenting by giving practical advice education and training on mental health resilience.

### Vulnerable adolescents

- Bringing together health and care organisations to set-up a multi-agency risk, violence and exploitation (MARVE) panel for young people who go missing, are at risk of criminal or sexual exploitation, or who are exhibiting harmful behaviour.
- Working with the 'family safeguarding team' – working together to provide whole family support and intelligence sharing, to identify young people in the community and reduce offending and re-offending. A mobile 'youth bus' will support this programme.

## Live well

### Addressing ethnic inequalities in mental health

We will roll-out and test new community-led models to improve access, experience and outcomes in mental health for everyone and reduce inequalities. Including:

- Working closely with our local community to run four health and wellbeing hubs as part of the 'EMHIP' programme of work to promote healthy lifestyle sessions, increasing access and to health and wellbeing support, mental health and wellbeing clinics in the community. This puts local groups and services together, using a hub and spoke model empowering people in our Wandsworth community to deliver care.
- Active wellbeing programme - patients with serious mental health issues can have access to a 10-week personal training programme targeted at those with the most serious and enduring mental health illness.
- These work programmes are about developing effective and sustainable partnerships between residents, the voluntary and community sector, the NHS and local authorities to improve health and wellbeing, reduce health inequalities and empower our communities.

### Support people to identify and manage their long-term condition

- Hosting of six health and wellbeing events to identify early and improve treatment of the complications of diabetes and cardiovascular disease, in a safe space in the community, supporting people to take control of their own health.
- Build the capacity and skills in the community to support self-management supporting health and independence.

### Support people to stay healthy

We will work together to develop and expand community health checks and health clinics, enabling people at risk of diabetes or cardiovascular disease to be identified in a safe space in their community, empowering them to take control of their own health including:

- Cancer screening with the 'connecting health communities' project to help increase opportunities for cervical and breast cancer and to address any health inequalities.
- Delivering NHS health checks 'relaunch and restore' programme to address impact of the covid-19 pandemic.
- Promoting NHS health checks and smoking cessation services on the 'health bus'.
- Diabetes prevention through education and a structured programme.
- Adult weight management programme to promote health improvement initiatives for weight management, physical activity opportunities measuring attendance and referrals.

### Co-ordinate the local contribution to health, social and economic development to prevent ill-health

- Work with St Georges University Foundation NHS Trust and South West London and St George's Mental Health NHS Trust, as anchor institutions and large local employers to create to internships and apprenticeships for local people.
- Work with local businesses, education, and health partners to reduce risks to ill-health for staff, students, patients and the local population.
- Funding pilot schemes to reach our global majority and seldom heard populations through community organisations, providing funding and looking to mainstream success when pilots cease.

## Age well

We will keep older adults out of hospital with support and treatment services such as rapid response and through integrated working will support people in their homes. We will proactively identify people who are at risk of deterioration and hospitalisation with a range of primary, social and voluntary support in and around their home with access to a wider range of professional support roles.

### Integrating services

We will work across organisational and professional boundaries, shaping the care around the needs of the person, including:

- Improving services for people when they leave hospital with increased care provided closer to home, reducing unnecessary admissions into hospital and shortening lengths of stay nonce in hospital.
- We have developed a clinical virtual ward model to enable people to come home quicker with the right clinical support.
- Improved recovery and reablement support with more care at home, care home and step-down bed provision.
- Support for mental health service-users once they leave hospital providing temporary accommodation and additional assessment services for mental health patients.
- Urgent (two hour) community response service to prevent people being admitted to hospital with London Ambulance Service (LAS).
- We will put the voluntary sector at the heart of our integrated teams.

### Care & nursing homes

Strengthen our support and offer to care and nursing homes, including homes with residents with a learning disability or dementia. Including:

- Implementing the best practice standards from the 'enhanced health in care homes' framework by 2024.
- Increasing number of people with a universal care plan in place – this means people's care and support wishes are digitally shared with healthcare professionals, following a conversation between a healthcare professional (such as a doctor or nurse) and the person in their care.
- Rolling out the digital care record for care homes for better communication between homes health and care organisations.
- E-red bag scheme – sharing communication between health and care professionals to speed up people leaving hospital.
- Dementia early support – improving the quality of care through training care home staff.

### Falls prevention

- We will increase the number of falls monitoring devices and equipment to allow people to remain safe and supported in their usual place of residence.
- Improve our Falls Prevention service by setting up a falls network with more evidence-based prevention programmes in voluntary sector and community settings. This will be supported by St Georges Hospital community therapy specialist service.
- Increase the number of people at risk of fractures being referred for bone density scanning.

### Improving dementia support in the community

- We will strengthen our support and offer to care and nursing homes through our enhanced health in care homes programme, including homes with residents with a learning disability or dementia. This will include
- Support care homes to meet digital requirements to connect to a shared care record and work with care homes to ensure they develop their workforce digital capabilities.

- Reducing social isolation by using more social prescribing, care navigators in voluntary sector and befriending services.

### Focus on unpaid carers

Supporting carers to live healthy lives, including:

- Improve the recognition and identification of carers by GPs, and extended carer appointments.
- Improve the recognition of young carers and develop a range of support options including within school and learning environments.
- Support carers to stay well and look after themselves and be socially connected with their community through an increase in social prescribing & voluntary services to reduce social isolation and a reduction in the use of emergency and crisis services.

# Part Five: Quality and safety

Improving quality is about making health care safe, effective, patient-centred, timely, efficient and equitable[15]. In South West London we will work together across our organisations to deliver quality improvement, embedded in a patient safety culture, so that we improve care, avoid harm and improve the experience of those who access care.

## The quality picture in South West London

**Areas where we are improving**

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

**Trust CQC ratings as of 2 March 2023**

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

| Organisation Name | Inspection Category | Publication Date | Overall | Safe | Effective | Caring | Responsive | Well Led | Maternity | Combined quality | Use of resources |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Central London Community Healthcare NHS Trust | Community Health NHS and independent | 15.06.20 | ● | ● | ● | ● | ● | ● | | | |
| Croydon Health Services NHS Trust | Acute Hospital NHS non Specialist | 22.02.23 | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Epsom and St Helier University Hospitals NHS Trust | Acute Hospital NHS non Specialist | 19.09.19 | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Hounslow and Richmond Community Healthcare NHS Trust | Community Health NHS and Independent | 19.10.18 | ● | ● | ● | ● | ● | ● | | | |
| Kingston Hospital NHS Foundation Trust | Acute Hospital NHS non Specialist | 14.12.22 | ★ | ● | ● | ★ | ● | ★ | ● | | |
| South West London and St George's Mental Health NHS Trust | NHS Mental Health Service | 20.12.19 | ● | ● | ● | ● | ● | ● | | | |
| St George's University Hospitals NHS Foundation Trust | Acute Hospital NHS non Specialist | 18.12.19 | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| The Royal Marsden NHS Foundation Trust | Acute Hospital NHS Specialist | 16.01.20 | ★ | ● | ★ | ★ | ★ | ★ | | | |
| South London & Maudsley NHS Foundation Trust | NHS Mental Health Service | 20.08.21 | ● | ● | ● | ● | ● | ● | | | |

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



## Our ambition

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

## Our focus and actions

### Delivering safe care and embed a learning health system

**To do this we will:**

- Implement the initiatives in the NHS patient safety strategy across the ICB and ICS and ensure these are embedded to support safety improvement (by 2025).
- Create safer systems of care that reflect continuous learning and improvement, understanding and learning from errors and excellence and adopting best practices (by 2025/26).
- Year on year, strengthen our safety culture and work with trusts to ensure that their staff feel safe and able to challenge situations without repercussions.
- Maximise the provision of harm-free care using a variety of measures that continue to inform our providers (by 2025/26).
- Continuously work to reduce risk and empower, support, and enable people to make safe choices and protect them from harm, neglect, abuse, and breaches of their human rights; and ensure that we learn from experience and share this across South West London.

### Delivering effective care

To do this we will:

- Strengthen our approach to learning from system wide quality information through the effective use of South West London's quality dashboard, ensuring that National Institute of Clinical Excellence (NICE) clinical guidelines are reflected in how we measure outcomes (by 2025).
- Develop our peer review and peer assurance framework across South West London to reduce unwarranted variations of clinical care and share best practice and learning across the system (by 2024).
- We will continuously improve the quality of our health and care based on research, evidence, NICE quality standards benchmarking and clinical audits, sharing these across South West London.

### Providing a positive experience and outcome for our patients and staff

**To do this we will:**

- Act on patients' experiences of care and use their feedback, compliments, and complaints to make service improvements that improve the quality of health and care.
- Implement the methodology in the new *"framework for involving patients in patient safety"* through the appointment of our Integrated Care Board and providers' patient safety partners (by 2024).
- Make sure that those who do not have a voice, those who are under-represented or who cannot speak for themselves are heard. In turn, this will lead to services that are coordinated, inclusive and equitable.

### Reducing health inequalities: deliver equitable care

To do this we will:

- Further progress our activities to improve outcomes for our children and young people, and adults in our Core20PLUS5 population and the delivery of the CORE20 connectors programme applying the asset-based community development (ABCD) approach.
- Complete phase one of the development of South West London's equity dashboard, using metrics that follow the life course approach (by 2024).
- Implement South West London's developing anti-racism framework, once approved in line with London's strategic commitments to address racial inequalities (by 2025).
- Year on year, deliver the Integrated Care Board's equality statutory functions including the public sector equalities duties and the functions of the Equality Act 2010.

### Focusing on prevention and self-care management

**To do this we will:**

- Develop a system-based prevention plan that underpins our priorities and goals for the people of South West London so that we prevent ill health, tackle health problems earlier and prevent them from becoming worse. Further information is available in the prevention chapter of this document.
- Ensure prevention is fully integrated into our policies and guidelines to maximise potential at-scale to improve people's health and wellbeing across their lifetime and address health inequity (by 2026/27).
- Work in partnership with local authorities and public health on a range of preventions programmes including healthy early years, healthy childhood, sexual health, substance misuse, tobacco cessation, physical activities, health checks and community development.

### Delivering our quality statutory duties

**Safeguarding**

**To meet our safeguarding duties, we will:**

- Work with providers to ensure that all South West London commissioned organisations meet their statutory safeguarding responsibilities, with clear leadership and lines of accountability, appropriate policies and procedures, and safeguarding training so that children and adults at risk of harm are protected.
- Ensure effective oversight arrangements are in place across South West London to deliver the requirements outlined in the safeguarding accountability and assurance framework (SAAF).
- Meet the requirements set out in the NHS England support offer (May 2023), by:
  - Delivering phase two and three of the child protection information sharing system supporting priority areas of care such as sexual health services.
  - Having a named safeguarding midwifery lead for female genital mutilation across our system.
  - Reducing serious violence within the healthcare setting and beyond, developing an improvement plan with our community safety partnerships.
  - Supporting the identification of domestic abuse with the use of independent domestic violence advisors working with primary care, and local maternity and neonatal systems.

**Looked after children**

**To meet our looked after children duties we will:**

- Work with Health providers and Local Authorities to look at the pathways for initial health assessments and reviews to ensure that assessments and reviews are undertaken in a timely manner as per national guidance.

### Infection and prevention control

**To meet our infection and prevention control duties we will:**

- Work with all South West London healthcare providers and care homes to reduce health care associated infections including clostridium difficile, methicillin sensitive staphylococcus aureus and gram-negative blood stream infections (GNBSI).

**All age continuing care**

All age continuing care (AACC) is a collective term for services provided by the NHS and includes continuing healthcare, funded nursing care, children and young peoples' continuing care, jointly funded packages of care with local authorities and education and other services that provide NHS funding for patients to meet their needs once they have been discharged from hospital. These services assess and provide funding for the care of individuals of all ages to meet their ongoing complex health and care needs.

### All age continuing care

**To meet our all age continuing care duties we will:**

- Develop an integrated approach to continuing healthcare (CHC) across the six boroughs of South West London.
- Standardise the use of one resource allocation tool across South West London to reduce variation in commissioned packages of care.
- Reopen the children's & young people's any qualified provider (AQP) framework to enable a wider cohort of providers with specialist clinical expertise to tender.



# Part Six: Making South West London a great place to work

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

**34,000**
People are employed in the NHS in South West London. We are also supported by a large number of volunteers, voluntary sector organisations and carers

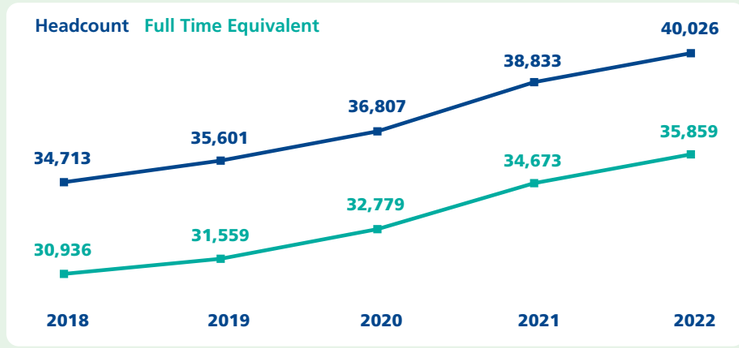
**10%**
of staff work in a primary care setting

**42 years**
the average age of our staff

**16.3%**
of our staff are over the age of 55

**Total Workforce**

This chart shows the increase in primary, secondary workforce overtime.



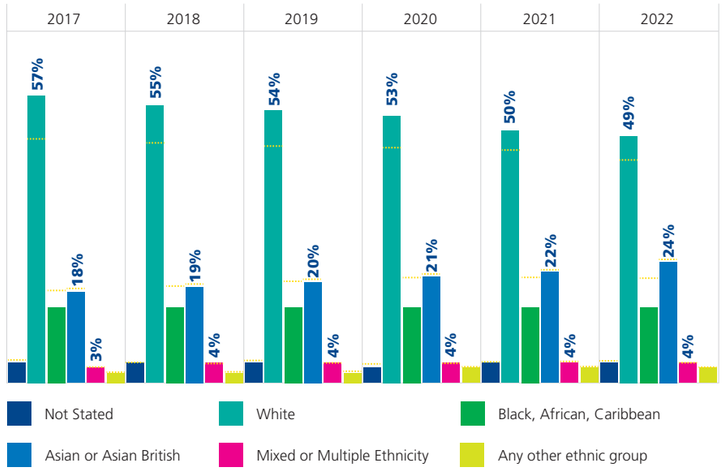

**16.5%**
of our staff leave South West London each year

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

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

**£11.7 million**
As large employers, we have an apprenticeship levy to spend on apprenticeship training which we do not always fully use

## Ethnicity of our workforce over the years. Percentage split by ethnicity, by year.



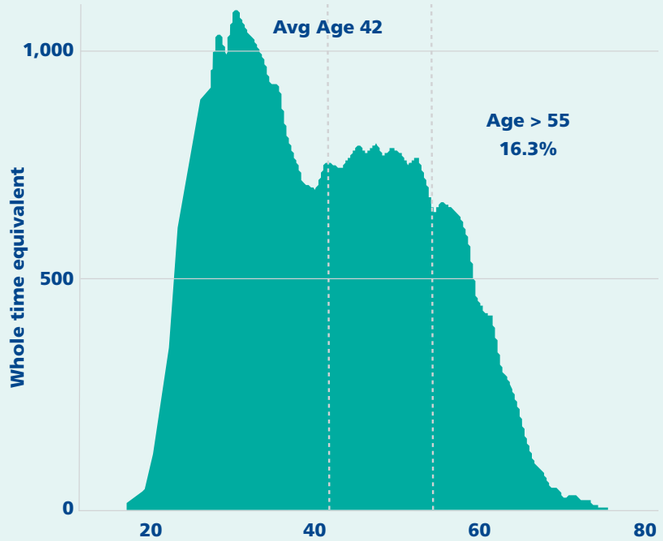

We have seen changes in the ethnicity of our staff over the last few years. In 2022, staff who identify as white make up 49% of our workforce (57% in 2017). Asian or Asian British staff make up 24% of our workforce, up from 18% in 2017.

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

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

## Age distribution

The average age of the workforce is **42** with **16.3%** of the workforce over 55.




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

## Nursing and midwifery

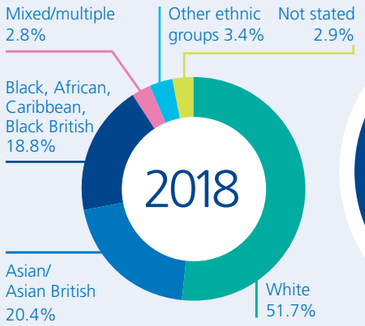
**13%**
Growth in nursing and midwifery staff since Dec 2018 up by 1,066 posts

**42 Years**
Average age

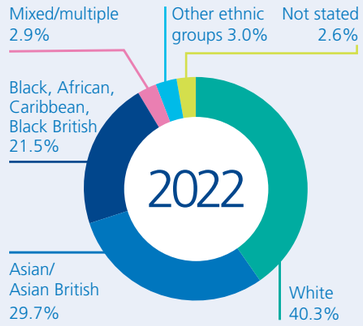
**88%**
of nursing and midwifery staff are female

**18.3%**
Band 5s have the highest turnover

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




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




The highest turnover in nursing and midwifery is those over 55

## Allied health professionals (AHP)

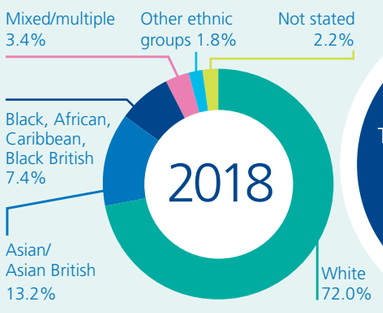
**14%**
Growth in allied health professionals (AHP) since Dec 2018 up by 294 posts

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

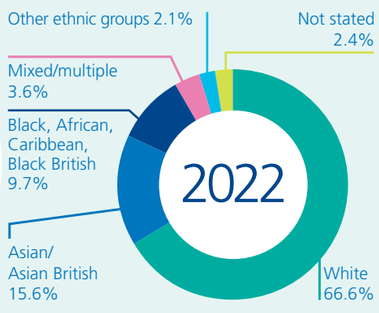
**39 Years**
Average age of AHPs with over 8% over the age of 55

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

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




**Ethnicity**
The profile of allied health professionals in South West London between 2018 and 2022 has changed as follows:




## Medical staff

### Consultants

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

**48 Years**
Average age of a consultant

**54%**
Male

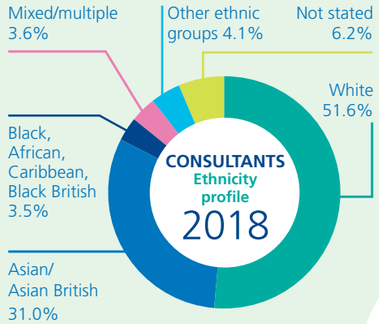
**7.3%** Of our consultants leave
**9.7%** Of medical staff over 55 years old leave
**6.6%** Of medical staff Under 55 years old leave

### Junior doctors

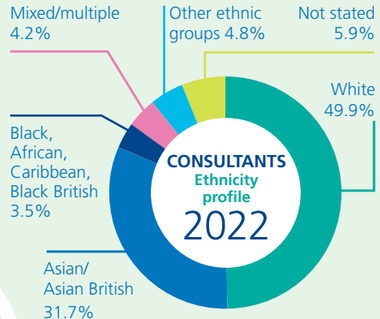
**16%**
Growth In all other medical staff since Dec 2018 up by 351 posts

**34 Years**
Average age of all other doctors

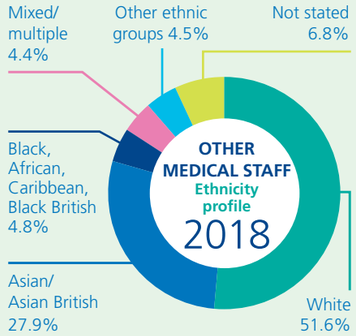
**56%**
Female

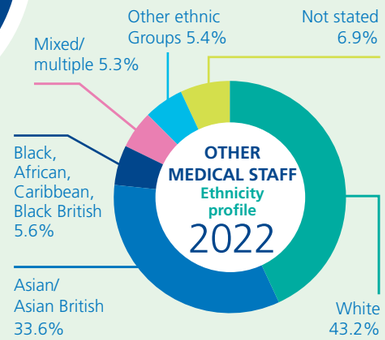



Female




**Ethnicity**
The profile of medical staff in South West London between 2018 and 2022 has changed as follows:



## General practice surgery

**39**
Primary care networks covering South West London

**46 Years**
Average age

**994 GPs**
Across South West London

**63.7%**
of GPs are female

More people providing direct care

**Paramedics** **Pharmacies** **Social prescribers**

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

### Sickness rates in South West London

Sickness in South West London trusts range from

**3.6% to 5.9%**

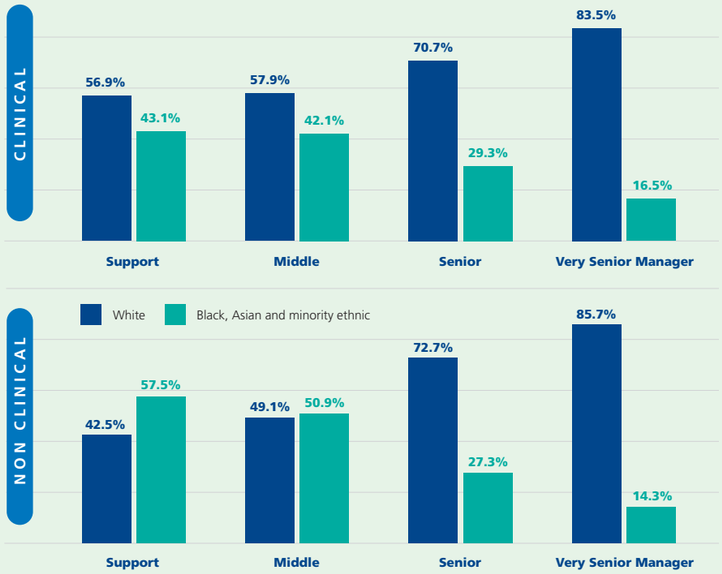
## Diversity and workforce race equality

**51%**

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

**1.7**

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




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

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

## Our big workforce challenges

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

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

## People and communities tell us

**Patients and local people have told us:**

They would like compassionate treatment from staff who care.

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

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

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

## Our ambition

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

## Our focus and actions

To meet our ambition, we have set five key priority programmes through which we will create at a workforce environment that fosters innovation, enhances patient care, and supports the growth and development of our staff. Our five programmes are:

1. Improving our workforce supply
2. Enhancing heath & wellbeing
3. Improving workforce modelling, planning & redesign
4. Increasing belonging and Inclusion
5. Harnessing training, education & talent

### Improving our workforce supply

We will think differently about how we design roles and recruit to vacancies, including: how we address posts with high turnover and those with high vacancy rates that might be difficult to recruit to; leveraging our role as anchor institutions to create a vibrant local labour market and address wider health determinants and health inequalities, and reduce our reliance on bank and agency spend by improving our recruitment to vacancies.

**To do this we will:**

- Develop a single point of information for healthcare jobs across South West London and use social media platforms and channels with engagement of high impact influencers to develop culturally competent content to encourage underrepresented communities to consider jobs in healthcare (by 2024).
- Introduce simplified language and content of adverts, job descriptions and person specifications to ensure readers receive accessible and appropriate information about the job requirements. This will enable applicants across South West London to easily identify and apply their existing and transferable skills gained through lived experience and previous employment. (2023/24/25).
- Review the applicant journey in South West London to identify challenges encountered by applicants and implement improvements. This work will focus on increasing the quality of each touchpoint of the pathway.

***For example, we are working with the South West London and St George's Mental Health Trust workforce team to innovate and redesign the entire health care assistant employment pathway (by 2024/25).***

- Work with further education colleges to support people currently unemployed into supported employability programmes which are aligned to work experience. This will build strong interview skills and job readiness.

***For example, continued close working with the Richmond and Hillcroft Community college to upskill their Information, Advice and Guidance Leads to become more confident in their approach to working with learners who wish to join the NHS.***

- Develop accessible guidance and resources to implement 'project-based work experience' across primary and secondary care employers. This guidance will be developed in video format with subtitles as well as online print, to support people who are hard of hearing and those with learning disabilities (by 2023/24).
- Offer an additional 150 work experience placements across the ICB to provide opportunities to members of the local community to gain insight into a career in the NHS.
- Identify hard to recruit to roles, and work with healthcare partners to understand barriers to NHS employment and develop targeted community recruitment approaches to address this.

***For example, the NHS England estates and facilities workforce programme, which seeks to increase the diversity and inclusivity of estates & facilities departments across South West London. We have designed a course in partnership with the South Thames College Group, which seeks to equip local unemployed people with skills that will help them to find jobs in estates and facilities within South West London provider organisations.***

- The Acute Provider Collaborative will procure and implement a new applicant tracking system for secondary care providers to support automation and process improvement in the South West London recruitment hub, further reducing the time to hire in year, and improving the applicant and manager experience.
- In 2023/24, develop an apprenticeship strategy and reinvigorate our apprenticeship programme, ensuring that roles with high attrition or long-term vacancies are automatically considered for apprenticeships so that we increase the number of apprenticeships year on year.

- Increase the numbers of clinical staff we recruit to our hospitals from overseas by 20%.
- Increase the promotion of the '350 careers in the NHS' to our local community (including those in education) in our capacity as an anchor institution in South West London.
- Increase our overall workforce across primary care through the additional role reimbursement scheme (ARRS) and improved GP retention. For patients this will provide access to a wide range of skilled professionals to care for those patients with complex and chronic needs (by 31 March 2024).
- Engage with primary care staff to understand and respond to differing motivational needs to improve recruitment, retention, and career development.
- Improve succession planning across our organisations, for example in mental health for roles affected by approaching retirement, putting succession plans in place for 50% of posts at band 7 or above in 2023/34, increasing to 100% in 2024/25.
- Undertake a detailed review of our mental health clinical workforce recruitment and retention challenges and develop plans to improve. This will include detailed focus on nursing and allied health professionals challenges in child and adult mental health services (by 2024).
- Implement improvements to the attraction, recruitment, and onboarding process in mental health, with recruitment teams focusing on high vacancy areas, improving employer branding, and encouraging individuals to return to practice by utilising alumni networks (initiating in 2023/24).
- Review the range of non-pay benefits across South West London to enhance the recruitment package.

## Enhancing health & wellbeing

We will support the health and wellbeing of our people by continuing to develop our range of services and support. This includes supporting staff with the cost of living, including expanding our range of non-pay and other benefits, and fostering a culture of continuous improvement by creating psychological safety at all staff grades and across all functions.

**To do this we will:**

- Review the range and use of our current health and wellbeing support in 2023/24 and develop a system-wide health and wellbeing plan for the next three years which is recurrently resourced.
- Improve joint working between health & wellbeing hubs and the occupational health programme to improve interfaces and increase referrals to occupational health for health & wellbeing related issues.
- Through our health inequalities team, work with London health and care partners to review the recommendations and actions from the Cost of Living Evidence Report by the Institute for Health Equity, commissioned by the Greater London Authority, and agree South West London-wide action (from 2023/24).
- Support staff with the cost of living; including expanding our range of non-pay and other benefits action (from 2023/24).
- Improve and increase return-to-work conversations in our acute trusts to support our people and reduce the rate of sickness/absence.
- Develop a plan to reduce long term sickness by 2.5%, undertaking a deep dive into sickness reasons and identifying prevention areas (by 2025/26).

## Improving workforce modelling, planning & redesign

We will build demand and capacity planning models to improve workforce forecasts, support the redesign of roles so that our workforce meets our future needs and models of care, explore the use of digital innovation to create more capacity for our people so that they have more time to care, and create centres of excellence, for example, diagnostics, supported by the latest technology, to simplify and speed up what we do.

**To do this we will:**

- Scope the opportunity of developing a cloud-based data warehouse that supports data sharing, collaboration, easy access to data, portability of our workforce and identifies efficiencies in operational and strategic workforce planning (from 2023/24).
- Create an environment of digital readiness and literacy across the workforce. Ensure that all managers across the ICB have access to robust workforce data and are able to interpret and analyse data to make improvements in efficiency, patient care pathways and experience (by 2026/27).
- Improve our ability to triangulate demand, finance, and workforce data. This will ensure consistent methods for analysis across the ICB and will be achieved via development of a consolidated provider level dashboard (by 2023/24).
- Establish quarterly operational workforce meetings between the ICB and providers to improve the annual operational planning cycle and track delivery of workforce actions to deliver the ICB's financial recovery plan.
- Develop a single staff bank across South West London to streamline processes and reduce costs (by 2024/25).
- Our acute providers will review their existing workforce to determine opportunities for the use of different professional and staff groups and skill mix to support delivery and improve retention. This review will also explore how they might build upon the current mutual aid framework, collaborate further, and integrate more closely with the voluntary, community, and social enterprise sector (from 2024/25). For more information on our actions for the acute care workforce please see our acute care chapter.
- In our community services, develop a demand and capacity model across all community areas, to develop three-year forecast/projection for workforce plan to account for recruitment and retention challenges.
- Work through the integrated care network to review the staffing and skill mix within the acute and community setting and ensure that our resources are in the right place in the most appropriate setting (by 2024/25).

## Increasing belonging & inclusion

We will develop a way of working that means equality, diversity, and inclusion (EDI) is at the forefront of everything we do so that we make a positive difference for staff and our patients, taking action to be a fair, non-discriminatory NHS that is representative of the communities we serve.

NHS England have released the NHS equality, diversity, and inclusion improvement plan which will help drive change through collective action and accountability. The ICB will play a significant role in the delivery and oversight of the NHS equality, diversity, and inclusion improvement plan for South West London Integrated Care System.

**To do this we will:**

- Develop a framework and dashboard to become an anti-racist system, collating and analysing data and information to identify racial bias, enable measurement of racial equality and support improvements (in 2023/24).
- Review the governance and impact of the current EDI Health Inequalities Board and develop a strategy that supports the ICB ambitions through the lens of inclusion. This will include oversight of and support from the ICS to provider organisations in relation to the medical workforce race equality scheme (by 2024/25).
- Roll out a South West London positive action development programme for current leaders to generate innovative and inclusive system leaders for the future, leaders who will help to create a more inclusive environment.
- In 2023, introduce a disability advice line, an innovative support service that gives confidential independent disability advice, offering managers advice, supporting staff and prospective employees with long term conditions to improve their employment journey.
- From 2023/24, to support our international recruits we will pilot and introduce a new mobile application called 'Ask Aunty' for nurses, doctors, midwives and therapists to get the best support and access to internal and external personal, pastoral, culture, psychological worth and emotional wellbeing support.
- Establish a South West London equality, diversity, and inclusion staff network to improve connections across individual provider networks and increase peer support and the sharing of learning across South West London (by 2024).
- Review and embed the 'Freedom to Speak up Guardian' infrastructure across the system, linking in with the inclusion and belonging priorities and relevant areas of the NHS staff survey to see improvements over time in the levels of trust and psychological safety (by 2024/25).
- Continue to focus on leadership and board development across the system to improve our working environments to ensure they are inclusive and compassionate.
- Take action across our organisations to reduce in the diversity gap at senior leadership and very senior manager level (band 8 and above).
- Review annual workforce race equality schemes, workforce disability equality schemes and other data and feedback sources and agree system-level actions to enhance organisational-level actions to accelerate change.

## Harnessing training, education & talent

We will develop our people to deliver new models of care and ways of working; support our people to develop so that they do not have to leave South West London to grow; value and invest in our managers and leaders so that they have the skills they need to perform at the highest standard and get the very best from their jobs.

**To do this we will:**

- Invest in our managers, developing apprenticeship programmes to support their development, so that they have the skills they need to perform at the highest standard and get the very best from their jobs. This will include enrolling these staff on NHS England and localised programmes whilst ensuring active participation and implementation of learning is monitored (by 2024/25).

- To support social mobility, we will undertake a skills audit of our current workforce to understand our workforce current qualifications and aspirations and map these against our future need focusing on target roles. This will include those who have travelled from overseas and are currently working in entry level roles and hold postgraduate qualifications in a range of sectors. This will inform the development of a talent pool and the creation of frameworks to support training and development needs for professional groups and staff where it will aid retention (by 2023/24).
- Map current training, development and talent programmes taking place across the system to determine scope and capacity to bring them together as a system wide offering via a South West London Academy (by 2024/25).
- Work with senior leaders across the system to improve the numbers of appraisals undertaken.
- Improve the quality of appraisal conversations, seeking to understand the aspirations of our staff and linking this to relevant resources such as the ICB appraisal support.
- Revise the 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. Implementing the framework by April 2024, and training 75% of staff trained by end of 2025.
- Offer training around suicide prevention for professionals working with children and young people so support our co-ordinated approach to suicide prevention.
- Roll out of the Oliver McGowan mandatory training on learning disability and autism, which aims to provide the health and social care workforce with the right skills and knowledge to provide safe, compassionate, and informed care to autistic people and people with a learning disability. Launch and deliver the e-learning module across the system by April 2024.
- Implement a training programme to upskill maternity support workers in line with NHS England's competency, education, and career development framework (by 2027).
- Support change management in primary care to equip people with the skills to embrace new technologies and innovations, for example online consultations to help guide patients through the system as quickly as possible (by 2025).
- Enhance our existing 'grow your own' pathway, reviewing and improving the growth of local talent (from 2023/24).
- Work in partnership with the South West London allied health professionals council and faculty to explore possible approaches to allied health professionals educational practices to ensure that allied health professionals are supported to succeed from the very beginning of their careers.



# Part Seven: Digital, data and population health management

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

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

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

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

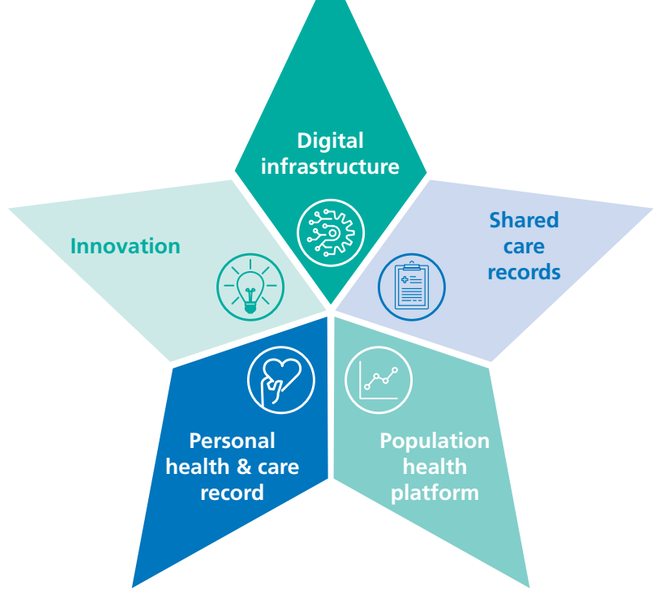



**Figure 1: Our digital 'north star' encapsulating our five digital priorities**

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

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

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

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

## Using population health management to improve health and care

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

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

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



## People and communities tell us

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

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

Engagement found that in groups more likely to experience health inequalities residents were worried about digital exclusion. For example, older people, people living with dementia, people with a learning disability, people with autism, people with sight loss, and people for whom English is not their first language. While younger people were usually more confident to access digital healthcare, reports found a variance in willingness, ability, and confidence to use digital services and a continuing demand for face-to-face appointments. More generally only among those aged 75 and over, does internet use start to decrease.

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

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

## Our ambition

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

## Our focus and actions

**Patients and people are empowered to take control of their own health and wellbeing in partnership with health and care professionals**

**To do this we will:**

- Give people the information and tools they need to support themselves to self-care, including self-care applications that interact with their health and care record, and support people to be cared for in their preferred place of care (by 2024/25).
- Make better information available at the point of care for patients and our clinicians so that they can make more informed decisions about care (by 2024/25).
- In 2023, begin to connect technology in people's homes and support the continued development of virtual care (by 2028/29).

**Staff can collaborate around an individual seamlessly across organisational boundaries supported by robust digital infrastructure**

**To do this we will:**

- Further develop a single end-to-end health and care record that our staff and patients can access and use (by 2028).
- In 2023, begin to use digital transformation to support the mobility of patients and staff across multiple settings and organisations (by 2028/29).
- Begin to free up clinical time through the use of digital technology (by 2023).
- Implement our three-year digital transformation investment plan by 2025/26 which includes:
  - An infrastructure maturity assessment, electronic patient record procurement options, cloud assessment, cyber maturity assessment. These will help us prioritise areas of investment to maintain stability of our vital digital systems.
  - The implementation of Cerner Millennium electronic patient record at Epsom and St Helier University Hospitals NHS Trust. This will align with St George's University Hospitals NHS Foundation Trust and put the organisation on a good digital footing (by 2026).
  - Supporting the financial recovery plan by scoping a number of projects which include convergence of IT contracts, reduction in IT devices, development of an unified communications solution and the use of automation capabilities to improve productivity (by 2023/24).
  - Implementation of the patient portal in acute hospitals in South West London with the expansion of capability to book and change outpatient appointments but also diagnostic appointments going forward (by 2023/24).
- Create a joined-up digital platform to enable staff to access the systems they need, wherever they are and reduce bureaucracy and frustration often felt by our frontline line staff through digitalised solutions (by 2025/6).
- Develop our digital workforce, so we have the right people with the right skills to propel digital acceleration and transformation across the NHS. In addition to our digital specialists, we will develop the digital capabilities and skills of all our people (by 2028/29).

**The ICS is a data driven system that tackles inequalities, improves population outcomes, and drives up productivity, supporting social and economic development, enabled by the population health management roadmap**

**To do this we will:**

- Deliver the actions in population health management roadmap particularly those relating to data, information, and the creation of a system-wide intelligence hub.
- Promote innovation that supports patients and staff, whilst addressing digital inequalities and exclusion by continuing to offer a range of ways in which people can receive care and support and interact with the NHS (by 2028/29).
- Develop a data strategy to improve how we capture and use data, moving from a reactive way of using data to a proactive one, improve analysis and insights, and create a consolidated view of data across the Integrated Care Board. This includes continued work with partners to improve data quality (by 2023/24).
- Create a system-wide intelligence hub to join-up data and information more effectively, remove duplication and help deliver better patient care (by 2024/25).
- Improve our analytical skills and capability to make better use of all the data available, using the intelligence and insight gained from our communities to improve the outcomes for patients (by 2024/25).



# Part Eight: Our estate and green plan

In early 2020, the London estates board published the London estates strategy. This was the first London wide health and care estates strategy in the 70-year history of the NHS and marked a turning point in how London's health partners, alongside national partners, want and need to work together.

The vision set out for all Londoners, regardless of their background or where they live, to have access to a world class health service in world class facilities. The strategy identifies that to provide a sustainable, fit for purpose estate, one which can support the delivery of our clinical needs, we need to stop working in organisational silos, take a long term and holistic view of acute, mental health, community and primary care estates and ensure policy and funding decisions that have a major impact on the condition of our estate are taken in London, by London.

The South West London estates strategy was set out in 2018, supported by local health and care estates strategies across the boroughs. We now need to create a new estates strategy for the system so that it is relevant and of inherent value to the ICS and reflects the changed landscape. The new strategy will need to respond to the ICB priorities laid out in this Joint Forward Plan, our increased emphasis on the green agenda, and support financial recovery. We will ensure that the new South West London estates strategy focuses on:

- **Delivering value to patients** and ensuring that the estate supports the future model of care and how patients access care in the future.
- **Supporting transformation** linking with developments in digital infrastructure and innovation, the way that our people work and our net zero targets.
- **Bringing together our partners** ensuring that we have a clear plan to make better use our existing estate collectively, to support backlog maintenance investment and to progress prioritised strategic capital schemes.

In South West London, we have a complex estate across our care settings. Our estates footprint consists of:

**585,000** square metres across sites occupied by our trusts

**66,300** square metres across 212 GP sites

| | | | |
|---|---|---|---|
| **5** General Acute sites | **5** Community hospital sites | **23** Mental health sites | **204** different landlords (GP owned property, public sector landlords and third party landlords) |

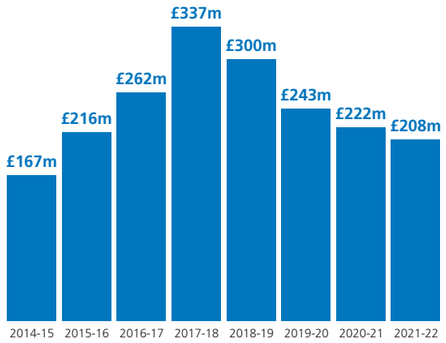
| | | | | | |
|---|---|---|---|---|---|
| **2** Specialist hospital sites | **98** non hospital sites | **18** support facilities | **1380** Consultation/ examination rooms | **362** Treatment rooms | **117** Group rooms |

*Source: Estates Returns Information Collection, ERIC, 2021/22; DHSC SHAPE data, November 2022*

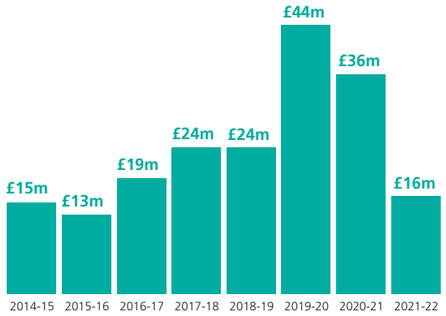
We will review our estates portfolio data with our partners as part of the new strategy, including our footprint, our underutilised space, our costs, and our energy consumption.

Tackling backlog maintenance (BLM) and improving the infrastructure within acute and mental health hospitals and community and primary care facilities to ensure that we have fit for purpose and safe health and care facilities has been, and remains, a key priority across the ICS. As a system over the past few years we have been investing in and reducing backlog maintenance across our providers, with our backlog maintenance cost falling from £337 million in 2017/18 to £208 million in 2021/22.

**Yearly BLM cost (£)**




**Yearly Investment to reduce BLM (£)**




We have also endeavoured to go further and support larger scale developments to make more substantial and impactful change where affordable. Recent estates developments include:

- the modernisation of the mental health estates at the Springfield hospital site, including new hospital units to building research establishment environmental assessment method, BREEAM, standard alongside air source heat pumps, water retention ponds and the planting of 700 new trees,
- a new 22-bedded intensive treatment unit at Croydon University Hospital which is on track to complete in 2023/24,
- building capacity in the community to deliver diagnostics services outside the acute hospital setting to tackle waiting lists for tests and scans in Kingston and Croydon,
- building extra theatre and critical care bed capacity to support the delivery of more activity to address waiting lists for operations and treatment at Purley Hospital, Croydon University Hospital and St George's hospital sites,
- replacing capacity of the Roehampton wing, that contained gynaecology, ear, nose and throat, and audiology services, at Kingston Hospital following a fire incident,
- supporting the Covid-19 vaccination programme,
- progressing a new health centre on Sleaford Street in response to the Nine Elms housing development,
- moving forward with modernising Epsom and St Helier Hospitals and building a brand-new specialist emergency care hospital in Sutton, and
- the Oak Cancer Centre in Sutton, which will speed up the translation of world-leading research into breakthroughs in treatment and care.

We know that we can go further and use our estate better together as a collective system. We have void space in some buildings and across others we are duplicating efforts, for example across our corporate office space. We also are cognisant of how much has evolved over the past few years with the advancements in technology and changing working patterns instigated by the Covid-19 pandemic, and that our needs as a health system and the needs of our population have changed as a result.

We are contending with a shrinking capital investment budget that needs to support patient and staff safety first and, alongside our financial recovery, this may mean we are limited in what we can invest in going forward. We may need to let go of some of our poor condition and expensive estate so we can reinvest in better quality buildings and direct our financial resources to supporting services sustainably. We will seek to find innovative ways to support investment in our infrastructure including working more closely with our public sector partners.

The ICB and its partner trusts have used a risk-based approach to prioritising capital expenditure via a collaborative planning process which has been in place and refined since 2021/22, the first year that a system capital envelope was allocated. This process ensures that safe, high-quality services are central to prioritisation decisions. The ICB governance structure includes a dedicated capital group for such discussions with partner stakeholders.



## People and communities tell us

A lot of NHS buildings are in poor repair.

We should be working with councils to look for opportunities to solve some of our estate's challenges.

Some hospitals and some wards are very old and need to be upgraded to bring them up to modern standards. A poor environment can affect people's mood and general wellbeing.

Services need to be more flexible and offer different levels of support to people in their own homes.

## Our ambition

We are in the process of developing our new estates strategy in conjunction with our partners which will set out where we are, where we want to be and how we will get there.

It is important to us that estates is an enabler to ensuring patients have the appropriate access to services, reducing health inequalities, transforming our services, supporting our reduced carbon emissions targets, enabling how we want to work as a health system and across health and care, and supporting the broader economy.

We anticipate that that these themes will feature in our developing strategy:

| Themes of the developing estates strategy | |
|---|---|
| **Right size** | • Right size the estate for the services we offer patients<br>• Future proof estates need as the use of technology evolves<br>• Reduce duplication of support space, prioritising investment in patient areas |
| **Improving the condition** | • Invest in priority backlog maintenance and aging estates issues - but factoring in our future estates blueprint whilst prioritising safety<br>• Eliminate backlog maintenance and critical infrastructure risk by existing buildings that are in poor condition and will not be needed in the future |
| **Enhanced functionality** | • Ensure estate is appropriate for the mode and activity<br>• Create flexible estate that can respond to changing patient needs<br>• Respond to evolving ways of working including the integration of health and care Ensure staff are able to work across organisational boundaries |
| **Right place** | • Ensure that that we are in the right locations to support patient access and our models of care<br>• Enable out of hospital care through accessible, local estate<br>• Ensure that we respond to health inequalities |
| **Driving efficiencies** | • Maximise use of our existing assets across our partners<br>• Invest in new estate where existing space is already fully utilised and there is evidence of future need, taking into account innovative models of care and digital developments<br>• Ensure the most economic estate is used for an activity/service<br>• Deliver at scale across the system where more economic |
| **Creating a sustainable estate** | • Reduce our carbon footprint and environmental impact of our services in line with the South West London green plan<br>• Design the estate to ensure it is fit-for-purpose, lean and minimises our carbon footprint<br>• Ensure that any new investments move our estate towards carbon net zero and meet planning regulatory carbon targets, for example BREEAM Excellent. |

We will apply our risk-based approach to prioritisation to future years and across all settings, including our primary care and community care infrastructure requirements, so to ensure that we apply our resources to the areas where we can make the greatest impact in terms of making our buildings safe, providing patient access and health inequalities, addressing the carbon footprint and value for money.

We will also better align to infrastructure planning by our councils and the Integrated Care Partnership to ensure that we understand and respond to critical population needs and are getting synergies across the public sector.

## Our focus and actions

In the next year, we will be developing our estates strategy, linked closely with digital and workforce strategies so that we have a holistic approach to infrastructure, as well as taking action to support the financial recovery plan.

**To do this we will:**

- Review how we use our estate across our health and care partners.
- Agree strategic priorities and actions, including land sales where land is surplus to NHS requirements to allow us to invest in new and modern facilities and reducing void space by fully utilising our space or letting go of space we do not need.
- Network our estates and facilities teams to get better value from our common areas of spend and suppliers.

## Our green plan

In October 2020, a new strategy, 'delivering a net zero National Health Service', was published by the greener NHS national programme. It outlines that "The climate emergency is a health emergency. Climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS'. It explains that 'the situation is getting worse, with nine out of the 10 hottest years on record occurring in the last decade and almost 900 people killed by heatwaves in England in 2019.

Without accelerated action there will be increases in the intensity of heatwaves, more frequent storms and flooding, and increased spread of infectious diseases …'

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

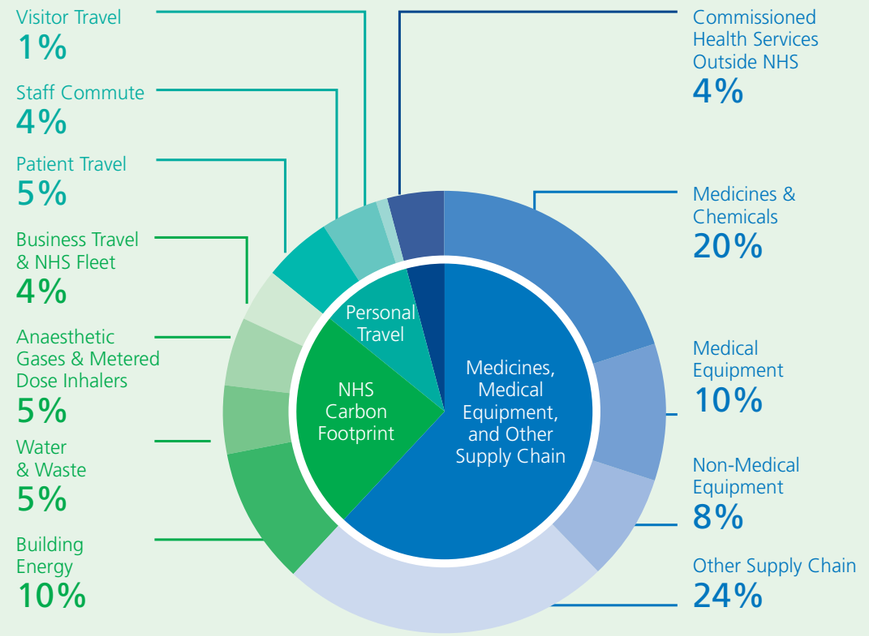



**Figure above: Sources of carbon emissions by proportion of the NHS Carbon Footprint Plus**

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

- All trusts have **green plans in place** that support the NET zero strategy
- All trusts well **below national desflurane reduction target**
- Numerous **sustainability days and awareness campaigns successfully completed**
- **Surgical instrument recycling** processes introduced
- **Electrical vehicle charger infrastructure projects** implemented and underway
- **UK's first reduced carbon patient menu** introduced by a South West London trust
- **Heat decarbonisation** projects initiated across trusts
- Switch to **renewable energy** across trust sites
- **Carbon neutral food suppliers** introduced
- **Electric fleet** introduced across trusts
- **Safe re-usable theatre equipment** practices introduced
- Created **green spaces** and increased plant biodiversity at trust sites
- **Cycle to work** and active travel incentive schemes in place
- **Digital appointments increased**, with some trusts exceeding national targets
- **Nitrous oxide waste reduction** plans initiated with leak tests complete on all sites
- All trusts now have **carbon footprint calculations**
- **Solar panel** installations underway trust sites
- **MDI recycling points setup**, awareness schemes initiated to switch use
- All trusts have **switched to recycled paper**
- **LED lighting** transition projects underway



## People and communities tell us

- Many people said that what they valued most about where they lived, were the green space and parks.
- Open spaces and green parks were felt to improve mental and physical wellbeing and create spaces for communities to thrive.
- Litter and antisocial behaviour were highlighted as reducing the enjoyment of these spaces.
- Traffic and air pollution were key negative aspects of the local environment and seen as barriers to healthier living. Reducing traffic was seen as being the main way to improve air quality.
- People said there was not enough emphasis on the role of walking and cycling as health determinants, given the positive impact on health. They felt 'active travel' has the potential to tackle obesity, increase exercise levels, reduce local air pollution, and has mental health benefits.
- Some older people, people with disabilities and those who identify as living with long-term conditions find active travel and accessing our green spaces challenging.

## Our ambition

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

Tackling climate change in health and social care provides us with an opportunity to both think differently and do things differently together. Having a South West London system-wide approach we can deliver benefits in terms of partnership working, collaboration and efficiency, whilst ensuring we tackle the challenges of the climate emergency and improve the wider factors of health.

**Our areas of focus for the next five years are:**

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

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

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

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

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

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

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

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

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

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

## Our focus and actions

### Developing our workforce and leadership

**To do this, we will:**

- Develop a leadership and staff pledges so that we are all working to the same goals.

### Ensuring we have sustainable models of care

**To do this, we will:**

- Create measurable action plans that will materially improve the sustainability of our services.
- Embed sustainability into our culture: If we are to be successful in changing our behaviours and operations sustainability needs to a part of everything that we do.
- Work across organisational boundaries: We will increase the scope of our activities and reach out across to primary care, local authority and other partners that were not with us at the start of our journey.

### Leveraging digital transformation

**To do this, we will:**

- Make it easier for our partners to collaborate, share information and best practice: in order to learn from and support one another in moving towards and championing our common net zero goals.

### Reducing our carbon emissions in our travel and transport

**To do this, we will:**

- Continue to transition to electric fleets for our patient, intra-site and courier transport.

### Promoting healthy food and nutrition

**To do this, we will:**

- Co-ordinate activities and communications that will help change the behaviours of our people – both when they work and when they are not working.

### Reducing carbon emissions in our estates and facilities

**To do this, we will:**

- Implement 'green surgery checklist' principles across our clinical activities.
- Use only recycled paper in South West London and reduce total paper usage year-on year.
- Create recycling points for metered-dose inhalers in all GP surgeries and community pharmacies, and ensure guidance on appropriate inhaler usage is clear and helps reduce prescriptions for these products.

### Reducing waste and supporting patient choice of medicines

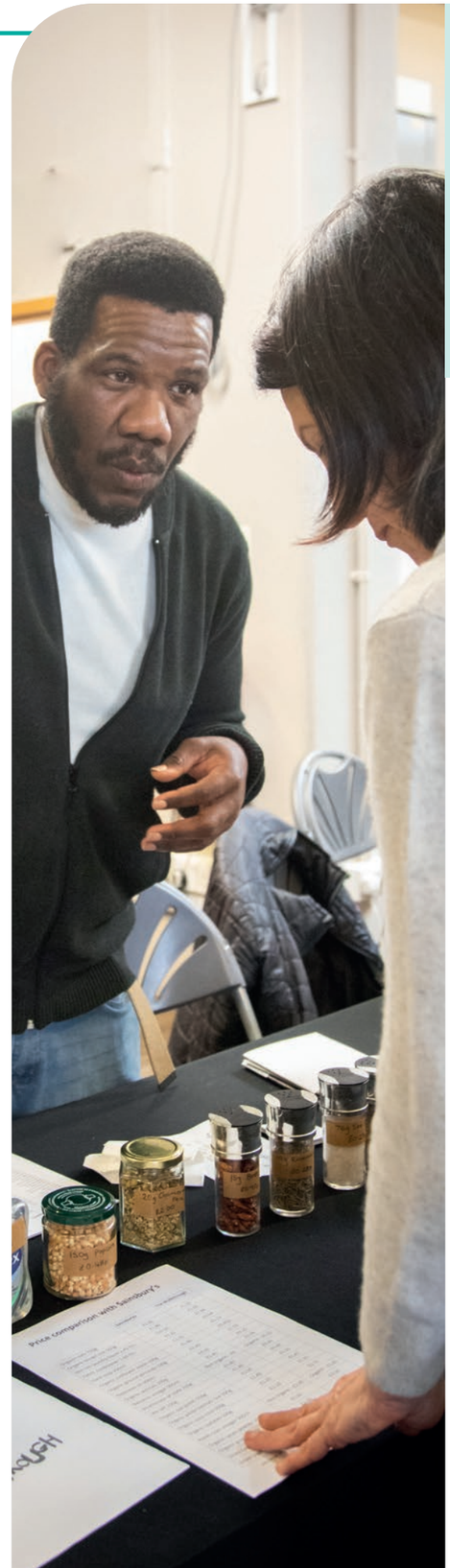
**To do this, we will:**

- Reduce nitrous oxide wastage and procurement by 2024.
- Reduce desflurane usage across the ICS by 2024.

### Better understand our carbon data

**To do this, we will:**

- Better establish our system-wide carbon footprint baseline across our different settings and understand how we can best measure our impact.






# Part Nine: Performance and outcomes

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

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

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

We have the fewest long waiters in London for both routine and cancer waits. In May 2023, Epsom & St Helier have the fewest patients waiting over 62 days for cancer treatment. Of all the acute trusts in London, Kingston Hospitals Foundation NHS Trust has the fewest patients waiting over 52 weeks.

We are also relatively strong in dementia diagnosis, we consistently exceed the national ambition to recover the rate to 66.7% (Our performance against this target in May 2023 is 71%).

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

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

In 2022/23, diagnostic performance has been impacted by increased two-week wait referrals and greater urgent demand. Although diagnostic activity has increased, urgent and two-week wait patients are prioritised, meaning that routine patients have unfortunately had to wait longer. There has been a particular focus to reduce the wait time to a diagnostic test, resulting in a 40% reduction in patients waiting over six weeks since September 2022.

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

### Improve our A&E wait times

Hospitals, local boroughs, and care homes are working together across South West London to improve the flow of patients through hospitals and onward to their homes or to other rehabilitation facilities. This past year, we implemented our initiatives to treat patients in their homes with 'hospital at home' (clinical visits), the two-hour urgent community response, and the London Ambulance Service urgent community response car. We are expecting to achieve the national target of seeing 76% of A&E patients within four hours by 2024, and plan to exceed this threshold consistently to improve our patient experience.

### Right patient, right place, first time

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

### Improve wait times from referral to treatment

Through our hospitals and our acute provider collaborative, we are committed to continuing our reduction of overall wait times, and plan to have no patients waiting 65 or more weeks for routine treatment by March 2024. Our cancer collaborative, RM Partners, has developed plans with our hospital trusts to deliver the diagnostic and treatment capacity needed to improve the increase in waiting times seen as a result of the pandemic. There is more information about this in our acute and cancer care chapters.

### Diagnose patients more quickly to help to reduce wait times

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

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

### Reduce unwarranted variation across the ICB

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

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

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

As we deliver our plans and ambitions for the next five years, we will also develop our system outcomes so that we can track the impact of our actions.

### Getting the primary care part right

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



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

We are continuing our focus on improving access to mental health support for both adults and children and young people, building on our existing mental health liaison services in our emergency departments, and introducing a crisis line supporting both adults and children. For example, South West London and St George's Mental Health Trust has run a pilot that informed the upcoming NHS111 press 2 model so that people ringing NHS111 in need of mental health support will be able to speak directly to a mental health professional.

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

Our adult mental health admissions were below the London average this year, and The South London partnership continues to work towards eliminating inappropriate adult acute out of area placements. In 2022/23, we reduced the number of children and young people placed out of area by 93%.

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

### Looking after people with a learning disability and people with autism

Although we have successfully achieved the 2022/23 target of 75% of people with a learning disability having an annual health check, we want everyone with a learning disability to have proactive primary care.

In the support of the national ambition to reduce the reliance on mental health inpatient care, we will work to ensure that we meet the South West London 2023/24 trajectory for reducing the number of people with learning disability or autism who are admitted. Where a hospital admission is needed, we are working to improve the quality of care that a person receives.

### Improving our performance and oversight

We want to understand and manage our system performance so that we can take action where required and so that we meet our operating plan and national requirements and the ambitions set out in this five-year plan.

**To do this we will:**

**Deliver the actions outlined in this five-year plan.** We will support people in South West London to start well, live well, age well, and reduce health inequalities, prevent ill health and provide excellence healthcare for those who need it.

**Ensure that there is access to the data we need to monitor and improve our performance and make informed plans for the future.** We have operationalised our ICB dashboard, and this year, we will develop it to cover all available mandatory metrics. We will make this and our regular reports available to all stakeholders in the ICB via our health insights business intelligence portal.

**Continue to work collaboratively and more effectively with system partners on performance.** We will streamline our interaction with system partners to enable more efficient, systemwide dialogue that drives productivity and improvement in access.

**Optimise our oversight process, so that we know what our biggest successes and risks are.** We will develop and maintain an early warning system, providing visibility of our biggest risks and concerns, stratifying them, and enabling the ICB to address these systematically.

**Ensure that there is understanding of our performance position, so that our responses are right and proportionate.** We will ensure that all data is viewed in the correct context, benchmarking with appropriate peer groups and across the nation. We will enable the system to view information through the lens of structural and environmental determinants (such as seasonality, critical incidents, and other socio-economic events), so that our real position is viewed relative to national ambitions and the right decisions are made for our population.

## Understanding the success of our actions

In developing our Joint Forward Plan, we have considered how we will we know whether we have achieved the ambitions described in each chapter. We have therefore identified both outcome metrics and output measures to assess both the progress of and the impact of our actions in this plan. We are in the process of developing the baselines for the outcome metrics to support progress reporting from July 2023. We have listed below several examples of outcome metrics and output measures, the full list can be found in appendix two.

### Output measure

- From 2024/25, population health management is being used by primary care networks, particularly in the development of integrated multi-disciplinary neighbourhood teams and sharing the learning.
- All young people aged over 13 with a diagnosis of asthma, have access to a digital asthma care plan by 2026.
- A single South West London radiology information system and picture archiving system is in place by March 2024.

### Outcome metric

- No patient waiting over 52 weeks for treatment by April 2025.
- At least 95% of people receive their diagnostic test within six weeks of the test being requested by March 2025.
- We will increase annual appointments in general practice by circa 5%, with face-to-face appointments increasing to circa 65% by March 2024.

In addition to the measures and metrics identified for the Joint Forward Plan our individual programmes, for example, mental health, urgent and emergency care, and digital, have specific metrics that measure the progress and successes of their plans.



# Part Ten: Our finances

South West London Integrated Care Board (ICB) manages a healthcare budget of c£3 billion per annum, with an additional c£2 billion of funds coming to local healthcare providers from other commissioners. These funds are given to the ICB based on a national formula, which estimates how much the local population will use services based on our demographics.

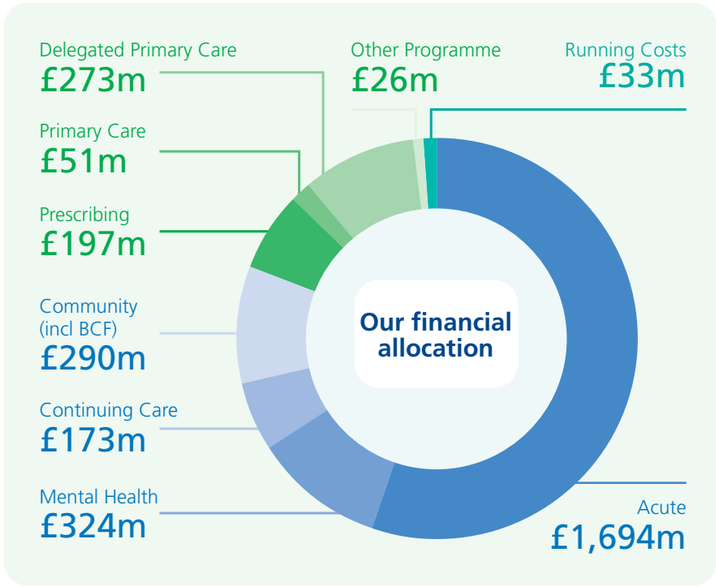
## Our financial allocation and how we use our money

The chart to the right shows the how we spend our £3 billion budget.

As outlined in the previous chapters, our priorities are improving the health of local people, reducing health inequalities, and delivering high quality care – at the same time we must ensure that services offer value for money for the taxpayer.

We are clear that achieving the ambitions in this five-year plan will require us all to work together differently, as we shift our focus from treatment to prevention, support people to make healthy choices, and improve our services and the way we provide care. To achieve this, we need to reduce our cost base and be able to move our funding around the system.

We have faced unprecedented times over the last few years, with all staff, particularly those on the frontline, working tirelessly to continue to care for local people during the pandemic and beyond. To provide care during Covid-19, we received additional temporary funding and, as we move out of the pandemic, we need to bring our spending back in line with pre-pandemic levels.

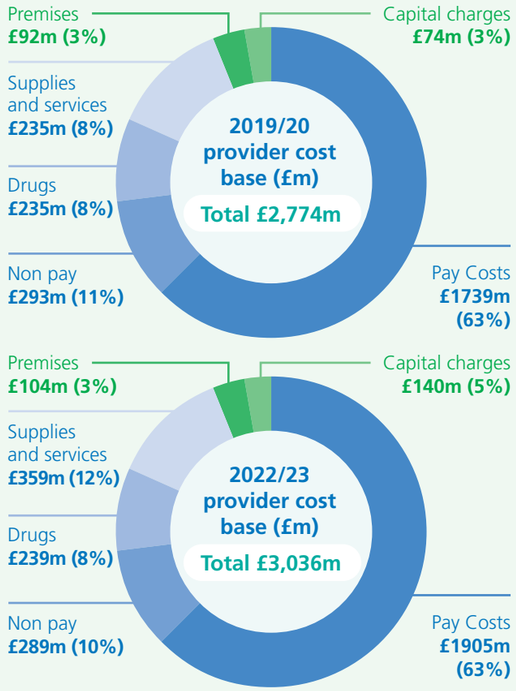



## Our financial challenge

The national funding allocation formula suggests that currently South West London receives more funds than are required for the health needs of our population, and so our funding is going to decrease over the next five years by c£150m. In parallel, our cost base has grown during the Covid-19 pandemic as new services have been developed, different ways of working have been required, and the impact of high inflation has created a widening financial gap.

## Understanding our cost growth

There has been a significant total, real terms, cost increase across South West London providers between 2019/20, and 2022/23, driven largely by pay costs premises and depreciation.




### Breakdown of the cost increases between 2019/20 and 2022/23

- **Pay costs** – £166m (9.6%) real terms increase across all staff type and pay groups
- **Supplies and services** – £18m (5.4%) real terms increase
- **Premises costs** – £12m (13.0%) real terms increase
- **Other non-pay costs** – £4m (1.4%) real terms decrease
- **Drugs costs** – £4m (1.8%) real terms increase
- **Capital charges** – within capital charges the depreciation costs increased by £66m (89.2%), of which, financial reporting standard policy changes have driven a £32m increase in depreciation, and c. £155m investments made since 2019/20 primarily due to the pandemic, improving flow and digital investments have driven a further £24m cost pressure driven through increased depreciation.
- **Total** – (9.4%) real terms increase in costs

Our overall proportions of our cost base have stayed relatively static, but we have seen notable increase in certain areas. With the major proportion of the growth (over 70%) in pay. Overall workforce costs have grown by 9.6% since 2019/20 across South West London, so understanding and finding solutions to our workforce challenges in both the short and longer term will be critical to managing our spend.

## Our financial plan over the next five years

All the NHS partner organisations in South West London are working closely together to meet our financial challenge and develop a five-year financial recovery plan.

Our financial recovery plan identifies five key areas, where we can drive out cost through our three-prong approach: grip and control, efficiency and productivity, and transformation. Whilst savings need to be made within 2023/24, we will not be making significant changes to frontline services as part of these plans. Any transformation that requires service change will continue to be driven by improving the quality of care for local people.

Further details on our initiatives can be found on page 162

## Achieving our financial plan

**Our approach focusses on three prongs:**

Grip and Control

- **Grip & control** – actions and measures we are taking now to reduce spend immediately across the system through strengthening of controls

Efficiency & productivity

- **Productivity & efficiency** – by treating more patients within a shorter time period and at less cost.

Transformation

- **Transformation** – working collaboratively to transform services in South West London so they are higher quality, easier to access and cost less. Our ambitions and actions to transform care and services are outlined in the preceding chapters of this five year plan.

**We have developed nine principles for delivery of our financial sustainability programme.**

1. An effective and efficient structured programme
2. Robust but also agile approach
3. Senior and visible leadership at a programme and workstream level
4. There will be a multidisciplinary programme board to oversee delivery of programmes
5. The overarching programme will be supported by a system delivery support unit
6. An integrated and coordinated programme
7. Scrutiny from at all levels within the system
8. Strong accountability and engagement
9. Ensure the appropriate quality standards are maintained

## Enhancing current governance structures to support delivery

We have established a Financial Recovery and Sustainability Board which will provide the key system level, senior oversight of our financial sustainability plan.

This is a significant programme of work and to support this our multidisciplinary programme board will oversee the detailed workstream delivery.

The solution groups of this programme are being aligned to existing system, acute provider collaborative and provider meetings - but with the following strengthened support:

- Clear leadership and delivery plans which are common to system and providers
- Project delivery and resources from all system partners
- Creation of a system delivery support unit to enable benefits tracking, analytics, and reporting.

We are committed to a programme that is focused on sustainable improvements, where we deliver high quality services for minimum cost, with engaged system leaders. This programme will be continuously reviewed and updated for:

- Any new opportunities identified,
- The impact of any changes to the NHS financial framework
- To reflect the current delivery of programmes

# South West London Financial Recovery Plan

To support financial viability an initial integrated five year financial recovery plan is being developed to enable South West London to be sustainable. The Financial Recovery Plan is ambitious and stretching, and complements existing cost improvement plans and financial grip and control measures to remedy current financial challenges. The delivery of the financial recovery plan is supported by the three prong approach to finance in South West London.

## The South West London Financial Recovery Plan

**Productivity and efficiency**

### Establishment, agency and productivity

Ensuring a productive and appropriate workforce to meet the needs of SWL, ensuring quality and value for money.

- Joint agency rate card for SWL
- Increase theatre productivity to 85%
- Skill mix review for allied healthcare professionals
- Collaborative staff bank created for SWL
- Rebase the workforce to meet demand post Covid-19
- Activity based job planning for clinicians
- SAFER staffing establishment reviews on wards and maternity

### Collaboration and elective pathways

Improving access for the people of SWL through greater collaboration and adoption of new ways of working.

- Increase theatre productivity through mutual aid and use of elective hubs in SWL
- Benefits of SWL pathology network
- SWL imaging network benefits
- Acute provider collaborative benefits
- Outpatient transformation
- Place based collaboration

### Urgent and emergency care pathways

Focusing on health prevention and care closer to home to improve the health outcomes of our local population.

- Optimise virtual ward capacity across SWL
- Increase use of same day emergency care to prevent admissions
- Utilisation of urgent community response
- Implement proactive anticipatory care
- Improve length of stay
- Discharge pathway review

**Transformation**

### Community, prescribing and continuing Health care (CHC)

Ensuring our community and primary care services meet demand.

- High cost drug review
- Improve value in packages of care
- Drug and product switches
- Reduction in prescribing of drugs with limited clinical value
- GP IT Transformation
- Meeting care standards for assessment
- CHC efficiency across SWL

### Group estates and Corporate functions

Alignment of corporate services, estates and procurement at different levels to generate best value for money.

- IT contracts and licence reviews
- Adoption of new legal services operating model
- Transport and common transport protocols
- Single procurement of services
- Implementation of robotic process automation within digital strategy
- Estate lease reviews
- Additional corporate income

**Outcomes**

- Access to clinical services across SWL
- Reduction in high cost agency staffing
- Recovery of services post Covid-19
- Improved productivity and efficiency
- Improved delivery to NHS standards
- Savings delivered

**Financial grip and control**

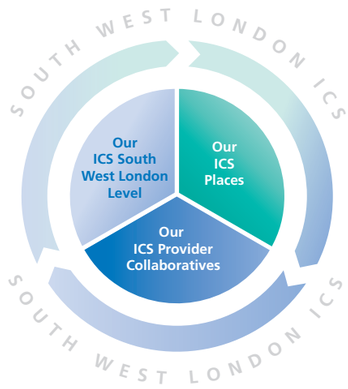
# Part Eleven: Developing together

## Our integrated care system

South West London Integrated Care System (ICS) was created on 1 July 2022. System Leaders in South West London built on our strong partnerships across the health and system to co-design our Integrated Care System and make sure we were ready to take on our new statutory responsibilities from 1 July 2022. You can read more about the ICS and our work at www.southwestlondonics.org.uk

Our Integrated Care System is made up of three parts as described in the diagram below:

**Figure 1: The three parts of South West London ICS**




### 1.1 System

Our partnerships across South West London have supported us in bringing about positive change to support the local population as well as ensuring high quality health and care across the system. In order to continue our good work, we have been developing our system governance and strategies to support us over the coming years as our new ICS develops.

Our Integrated Care System is overseen by the:

- **South West London Integrated Care Partnership (ICP)** – A statutory committee jointly formed between the NHS integrated care board and all South West London local authorities. Our ICP brings together a broad alliance of partners concerned with improving the care, health and wellbeing of the people in South West London.

- **South West London Integrated Care Board (ICB)** – The statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services. The ICB is supported by the following governance arrangements:

| Formal Committees of the ICB | Strategic Advisory Boards | Provider Collaboratives | Delivery Boards |
|---|---|---|---|
| • Are a part of the formal infrastructure of the ICB<br>• Are chaired by non-executive members<br>• Report formally into the Integrated Care Board | **These Boards:**<br>• Have a role across both the ICB and the ICP<br>• Ensure clinical leadership and advise the board on clinical strategy<br>• Ensure the ICS meets its requirements for engagement with communities | **The Collaboratives:**<br>• Lead on specific pieces of work for the ICB<br>• Some collaboratives have financial delegation from the Board within agreed limits | **These Boards:**<br>• Each have a system Executive SRO<br>• Are set up to support delivery of the priorities of the ICB<br>• Some are required through national direction, i.e. UEC Board |

## 1.2 Places

Our ICS places, aligned to our six local authorities Croydon, Kingston, Merton, Sutton, Richmond and Wandsworth, are an important part of our system. Our six places work closely with NHS providers, local authorities, primary care, the voluntary sector, and local communities to deliver their key responsibilities:

- Support and develop primary care networks which join up primary and community services across local neighbourhoods.
- Simplify, modernise and join-up health and care, including through technology and by joining up primary and secondary care where appropriate.
- Understand and identify, using population health management techniques and other intelligence, people and families at risk of being left behind and to organise proactive support for them.
- Coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

We recognise the importance of our continued work together at place to ensure high quality support to local people.

## 1.3 South West London provider collaboratives

We have a strong history of working together in South West London, which enabled us to develop successful collaborations with NHS providers across South West London.

Our providers are working closely together to ensure that we can achieve the benefits of working at scale and mutual aid where needed.

There are three provider collaboratives in South West London:

- South London Mental Health and Community Partnership, SLP, brings together:
  - South West London and St George's Mental Health NHS Trust
  - South London and Maudsley NHS Trust
  - Oxleas NHS Foundation Trust
- **South West London Acute Provider Collaborative**, brings together:
  - Croydon Health Services NHS Trust
  - Epsom and St Helier University Hospitals NHS Trust
  - Kingston Hospital NHS Foundation Trust
  - St George's University Hospitals NHS Foundation Trust
- **Royal Marsden Partners** brings together all South West London and North West London organisations supporting the NHS cancer pathway, including primary, acute and specialist providers and screening services

The collaborations of our providers has led to significant achievements in the recovery of services and waiting lists following the pandemic.

## 1.4 Clinical and professional leadership

We are committed to supporting clinicians and professionals to develop high-quality services for local people. We have embedded clinical leadership in all components of our ICS.

In 2020/21, we established 15 elective recovery clinical networks to support restarting elective surgical operations and treatments. Over the last two years, the networks, each led jointly by acute and primary care clinicians, continued to support our hospitals to work together to transform services and to make sure our patients got the treatment they needed.

The clinical leadership that has been the cornerstone of the ICB will continue to drive forward the design and delivery of local services to improve the quality of health and care.

## Strategy and innovation

### Strategy development

We are committed to a collaborative leadership approach for the benefit of local people across South West London. We have a committed and experienced team of people working within our ICB, our partnerships and providers.

Our role as an ICB means that we lead the development of our system alongside our partners across South West London. In addition to the development of the Joint Forward Plan, we work with our partners and lead on the development of our key system strategies and plans. recent examples include

- **South West London mental health strategy** The ICB has worked in partnership with the South London Mental Health Partnership (provider collaborative) to develop a new mental health strategy this year. As part of the development of the strategy, South London Mental Health Partnership have delivered a wide range of engagement with services users, staff and stakeholders to make sure that the strategy meets their needs.
- **Primary care strategy** Our ambition is for people in South West London to get the information, care and support they need quickly and be able to use primary care services in the way that suits them best. We are developing our primary care strategy for publication later this year.

A key component of our approach to strategy development is working with local people to develop our plans and approach. To ensure this happens consistently, we have together developed a people and communities strategy for South West London to support teams in engaging people and communities.

## System innovation

### Research and innovation

Research and innovation is a key a priority in South West London, with a specific focus on real world evaluation allowing us to quickly identify which innovations are having the most impact on the frontline for our public, patients and staff.

We have established a research and innovation forum with partners including the Health Innovation Network (the Academic Health Science Network for south London), the South London Clinical Research Network and King's Health Partners (the academic health science centre for south London) to understand the specific needs for different communities and groups of people in South West London. This allows us to identify and support a range of innovations, from traditional research trials through to innovative individuals with ideas to pilot. We are also represented on the board of the Health Innovation Network, as one of our key innovation partners.

### Incentivising innovation

In September 2022, the Integrated Care Partnership Board established the South West London Investment Fund. The funding aims to give partners the opportunity to suggest innovative projects that could have a big impact on health and wellbeing across South West London, capturing community energy and enthusiasm for real health benefits. The investment fund for 2022 was comprised of two streams: the innovation fund and the health inequalities fund.

The focus of the innovation fund for the first year was winter resilience and sustainability. Partners across the South West London were asked to bid for funding for innovative ways to support health and care over winter. £2.7million of funding was released for 36 schemes.

Our health inequalities fund has awarded £1.6 million into system-wide health inequalities programmes, and £2.7 million awarded to schemes at place. In total there were 55 health inequalities projects and programmes across place and the system in 2022/23.

For this financial year 203/24, the fund will focus on supporting the delivery of the ICP strategic priorities. We are designing an innovation fund collaboration event for all stakeholders across South West London to provide an opportunity to come together to discuss emerging ideas in groups to foster collaboration and innovation.

**South West London ICB organisational development**

We have a designed an organisational development (OD) programme to support the development of the Integrated Care System in South West London. This programme is designed to bring together system leaders, develop the ICB, progress leadership development and to tackle system issues.


## Programme 1. Designing our system together

On the 18 November 2021 we launched 'designing our system together' programme at our cornerstone event at the Kings Fund. The simulation event was designed to test our system design, further build relationships. and work on issues together. The event was well attended and tested a number of system design elements. Feedback received has confirmed participants appetite to run further simulations on 'real' South West London challenges.

On 24 May 2023, we brought together c.280 people from across South West London to help us design the actions under the Integrated Care Partnership's (ICP) strategic priorities. The outputs from this session will be fed into the ICP's five-year strategy.

## Programme 2. Leading South West London ICS

**Integrated Care Board development programme**

This programme of work supports the development of the newly formed ICB in 2022. Both the ICB CEO and Chair are committed to investing in the board and its development, recognising the importance of nurturing the system-wide leadership community to address the challenges it faces. To support that commitment, they appointed a development partner on a board development plan.

The programme seeks to develop a unitary board with a clearly articulated purpose, set of values, and accompanying behaviours to enable successful collaboration.

Over the past eight months, a range of activities has been undertaken as part of the programme, including interviews with board members and a series of development workshops. These activities have helped to identify areas of strength within the board, as well as areas that require further development.

**Integrated Care Partnership development**

A series of seminar workshops have been run with the Integrated Care Partnership Board to review the health and care needs of the people of South West London and use this, and feedback from people and communities, to develop the partnership's strategic priorities for the next five years.

## Programme 3. Transforming together

**ICB compassionate and inclusive leadership programme**

We have commissioned a learning partner to support our compassionate and inclusive leadership programme, the aim of which is to explore and build an inclusive and compassionate culture through our most senior leaders. The programme has been developed to inform, challenge, and extend thinking and apply that thinking to the practical ways in which leaders act as cultural influencers in the organisation. The inclusive aspects of this programme align with the board development programme. The programme is currently underway with approximately 60 ICB staff members attending the course including executive directors.



**NHSE place organisational development programme**

In 2022 four of our places Kingston, Richmond, Merton, and Croydon participated in the NHS England place organisational development programme. This place development programme worked with local places to:

- Develop a compelling vision, strategy, governance, and leadership arrangements to drive and sustain improvement.
- Provide access to coaching, action learning, and national best practice resources to enable them to deliver change rapidly on the ground.
- Equip leaders in places with practical tools, techniques, and approaches that embed and deliver effective population health management (PHM).

A further wave of place organisational development support is currently being explored by NHS England.

**Provider collaborative senior management team development**

We are working with the collaboratives to design our plans for senior management OD within our provider collaboratives, once our partnership delivery arrangements are finalised.

## Programme 4. Leading clinical transformation together for clinical leaders

The ICB is currently reviewing clinical and professional leadership and we will bring this together in our new clinical and care professional leadership framework. We will finalise the design and content for the clinical leadership development programme when this review is completed towards the end of 2023.

# Appendix One: Our core ICB functions

The table below indicates the primary source here we describe how we enact the legislative requirements; however, they are reflected throughout the document.

| Legislative requirement | Description | Primary details can be found in the following chapter(s) |
|---|---|---|
| **Duty to involve the public** | The plans should describe how: • the public and communities were engaged in the development of the plan • the ICB and partner trusts will work together to build effective partnerships with people and communities, particularly those who face the greatest health inequalities, working with wider ICS stakeholders to achieve this • activity at neighbourhood and place level informs decisions by the system and how public involvement legal duties are met and assured. | Part one: about South West London |
| **Duty to patient choice** | Each ICB must act with a view to enabling patients to make choices with respect to aspects of health services provided to them. | Part three: developing the NHS in South West London |
| **Duty to obtain appropriate advice** | Each ICB must obtain appropriate advice to enable it to effectively discharge its functions from persons who (taken together) have a broad range of professional expertise in (a) the prevention, diagnosis, or treatment of illness and (b) the protection or improvement of public health. | Part two: reducing health inequalities and preventing ill-health, part three: developing the NHS in South West London, and part eight: developing together |
| **Duty to promote innovation** | Each ICB must promote innovation in the provision of health services (including in the arrangements made for their provision). | Part eight: developing together |
| **Duty in respect of research** | Each ICB must facilitate or otherwise promote (a) research on matters relevant to the health service and (b) the use in the health service of evidence obtained from research. | Part eight: developing together |
| **Duty to promote education and training** | Each ICB must have regard to the need to promote education and training so as to assist the Secretary of State and Health Education England (now NHS England) in the discharge of the duty under that section. This duty relates specifically to persons mentioned in section 1F(1) National Health Service Act 2006. They are "persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England". | Part five: workforce |
| **Duty as to climate change, etc** | Each ICB must have regard to the need to (a) contribute towards compliance with (i) section 1 of the Climate Change Act 2008 (UK net zero emissions target) and(ii) section 5 of the Environment Act 2021 (environmental targets), and (b) adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008. | Part six: estates and our green plan |
| **Addressing the particular needs of children and young persons** | The plan must set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25. | Part three: developing the NHS in South West London, specifically in the spotlight on children and young people |
| **Addressing the particular needs of victims of abuse** | The plan must set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic and sexual abuse, whether children or adults). It must have due regard to the provisions of the Domestic Abuse Act 2021and accompanying statutory guidance, and relevant safeguarding provisions. | Part ten: quality and safety |
| **Describing the health services for which the ICB proposes to make arrangements** | The plan must describe the health services for which the ICB proposes to make arrangements in the exercise of its functions. | Part one: about South West London and part three: developing the NHS in South West London |
| **Duty to promote integration** | Plans should describe how ICBs will integrate health services, social care and health-related services to improve quality and reduce inequalities. | Part one: about South West London, part two: reducing health inequalities and preventing ill-health, part four: working together at place, and part eight: developing together |
| **Duty to have regard to wider effect of decisions** | In making decisions about the provision of healthcare, an ICB must consider the wider effects of its decisions, also known as the 'triple aim' of (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing), (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies. | Part one: about South West London, part two: reducing health inequalities and preventing ill-health, part four: working together at place, part eight: developing together and part ten: quality and safety |
| **Financial duties** | The plan must explain how the ICB intends to discharge its financial duties. | Part nine: our finances |
| **Implementing any JLHWS** | The plan must set out the steps that the ICB proposes to take to implement any JLHWSs to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007. | Part four: working together at place |
| **Duty to improve quality of services** | Each ICB must exercise its functions with a view to securing continuous improvement in: the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and outcomes, including safety and patient experience. | Part ten: quality and safety |

| Legislative requirement | Description | Primary details can be found in the following chapter(s) |
|---|---|---|
| **Duty to reduce inequalities** | Each ICB must have regard to the need to (a) reduce inequalities between persons with respect to their ability to access health services and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. There is also a duty to have regard to the wider effects of decisions on inequalities. The duty to promote integration requires consideration of securing integrated provision across health, health-related and social services where this would reduce inequalities in access to services or outcomes achieved. | Part two: reducing health inequalities |
| **Duty to promote involvement of each patient** | ICBs and partner trusts have a duty to involve people and communities in decisions about the planning, development and operation of services commissioned and provided. | Part one: about South West London |



# Appendix Two: Our outcome measures and output metrics

| Area | Outcomes | Outputs |
|---|---|---|
| **Reducing health inequalities** | • Achieve the outcomes of Core20PLUS5 clinical areas for children and young people and adults by 2027/28. | • Create employment opportunities and increase asset-based models for local Core20PLUS communities through our local connectors to help improve access and engagement of health service amongst the Core20PLUS population by 2027/28. |
| **Preventing ill-health** | • Halve the number of smokers on GP records to 6.75% in South West London by 2027/8.<br>• A year-on-year increased uptake of immunisation programmes with end goal of reaching national targets and bypassing national averages.<br>• Every adult in South West London knows their ABC numbers (atrial fibrillation, blood pressure, cholesterol) by 2027/28. | • In 2025/6, all healthcare and public services staff are implementing Making Every Contact Count. |
| **Acute care** | • No patient will wait over 65 weeks for treatment by April 2024.<br>• No patient will wait over 52 weeks for treatment by April 2025 | |
| **Spotlight on cancer** | • 62-day referral to treatment standard will be consistently delivered by Sept 2024.<br>• 20% additional population coverage invited for targeted lung health checks per year, to ensure full coverage by 2026/7. | |
| **Spotlight on children and young people** | • By 2025/26, children, young people and their families with SEND will report that their needs have been identified in a timely way and receive the right help at the right time, as measured through place.<br>• Increase in the number of children reaching a good level of development (GLD) from a low point of 51% towards the national GLD of 65.2%. | • The social determinants of health are understood, and a proportionate universalism approach is in place by 2027.<br>• All young people aged over 13 with a diagnosis of asthma, have access to a digital asthma care plan by 2026. |
| **Community care** | • Reduced waiting times for community services by 2025/26.<br>• Increased referrals to 2 Hour UCR with a phased increase over 2023/24 and 2024/25 and with a particular focus on referrals from 111, care homes, tech providers and self-referrals.<br>• Increased numbers of people dying in their preferred place of care with a phased increase over 2023/24 and 2024/25. | |
| **Spotlight on diagnostics** | • At least 95% of people receive their diagnostic test within six weeks of the test being requested by March 2025. | • Single South West London radiology information system and picture archiving system by March 2024. |

| Area | Outcomes | Outputs |
|---|---|---|
| **Spotlight on maternity** | • Reduced the number of preterm deliveries from 8% to 6% by 2027.<br>• Births under 27 weeks will have occurred in the right place at least 80% of the time by 2025. | |
| **Mental health, learning disability and autism** | • Ensured people get access to talking therapies to provide support for mild to moderate anxiety and depression with at least 39,523 people accessing these services annually by 2023/24 and 75% of people accessing services within six weeks and 95% within 18 week waiting times targets.<br>• Ensured at least 60% of referrals to Early Intervention in Psychosis teams are seen within two weeks.<br>• 90% of children and young people with the most complex needs at risk of being admitted to a mental health hospital (identified as red or amber on the Dynamic Support Register) will have a designated keyworker by March 2024 for children and young people up to the age of 18 and by March 2025 for children and young people up to the age of 25. | • Community health offer in place for autistic people with complex needs. (Pending case for change approved).<br>• Consistent CAMHS learning disability service model and provision across South West London. (Pending case for change approved). |
| **Primary Care** | • Increase annual appointments by circa 5% with face-to-face appointments being circa 65% by 31 March 2024.<br>• Learning disability health checks and dementia diagnosis will exceed 75% via the roll out of the new primary care specification by 31 March 2024. | • Integrated neighbourhood teams within each of our 39 PCNs that focuses on an initial population by March 31st 2024 with full coverage by 31 March 2025.<br>• General practice staff will have the ability to feedback on what makes South West London a great place to work and where we can improve further throughout 2023/24.<br>• There will be 681 full time equivalent ARRS roles in place by April 2024 meaning that more patients will be able to access an even wider range of services in primary care by 31 March 2024. |
| **Spotlight on specialised services** | • Reduction in frequency of admission and length of stay for patients with sickle cell by 2024/25.<br>• Increased number of patients on CKD registers by end 2023/24.<br>• Increase in acceptance of emergency referrals in paediatric intensive care by end 2023/24.<br>• Reduction in A&E attendances / unplanned admissions for patients with chronic neurological conditions by end 2023/24. | |

| Area | Outcomes | Outputs |
|---|---|---|
| **Spotlight on supporting people to manage their long-term conditions** | • 90% of people living with atrial fibrillation effectively treated with oral anticoagulants by 2028.<br>• 77% of those with hypertension identified and treated to their blood pressure target by 2024.<br>• Increased the number of patients with a cardiovascular disease risk score >20% receiving lipid lowering therapies to 60% by 2024.<br>• Increased the number of people with diabetes meeting all 3 NICE treatment targets to 45% by 2028.<br>• By 2028, a reduced percentage of patients with chronic kidney disease require dialysis and/or a transplant.<br>• By 2025, develop respiratory measurements to be able to better monitory care and outcomes of respiratory patients.<br>• Reduced the number of COPD-related admissions, with fewer patients diagnosed with COPD in our hospitals year on year until 2028. | • By 2025, develop respiratory measurements to be able to better monitory care and outcomes of respiratory patients.<br>• 500 local community champions will be provided with accredited training to deliver health awareness and early detection events by 2028. |
| **Spotlight on urgent and emergency care** | • By 2028, the number of people in hospital who do not have criteria to reside at any one time will be reduced.<br>• We will work to reduce the number of patients in Mental Health Crisis waiting for extended periods in our EDs, getting them to the right place sooner. | • By 2028, 95% of people in the emergency department with a decision to admit will be moved to a bed in less than 4 hours.<br>• By 2024, we will have reduced the number of ambulances that wait over an hour to handover patients in ED to near zero. |
| **Our workforce** | • Reduce the time to hire by annum.<br>• 20% of new management posts will be apprenticeships per annum.<br>• Achieve lower than the London average for sickness/absence.<br>• 25% of eligible staff undertake positive action development programme training per annum. | • Anti-racism framework developed and ratified in 2023/4. Implemented from 2024/25 onwards. |
| **Our estate and green plan** | • Reduction in backlog maintenance.<br>• We will have a good understanding of our carbon emissions and how to reduce these in line with our national target. | • We will have a good understanding of our carbon emissions and how to reduce these in line with our national target. |
| **Data, digital, and population health management** | • By 2028/29, shifted from disease-specific care to population health improvement and prevention, focused on health and wellbeing measures developed with our communities, which focus on the right care being given at the right time by the right person.<br>• From 2023/24, continue to enable better self-management by providing patients with timely access to information, advice and care, digital technologies can help improve health outcomes and prevent complications. | • From 2024/25 population health management is being used by PCNs, particularly in the development of integrated multi-disciplinary neighbourhood teams and sharing the learning. |
| **Our finances** | • Reduced non elective length of stay improving value weight activity (VWA) metric.<br>• Increased investment in community and mental health services, as well as prevention and addressing health inequalities. | • Breakeven financial position by the end of March 2024/25. |

| Area | Outcomes | Outputs |
|---|---|---|
| Quality and safety | • Year on year, through our reporting insights, for example, friends and family tests, patient reported outcomes measures, complaints, PALS, patient surveys, and other qualitative feedback methods. An overall improvement in patients' experiences and outcomes from using healthcare services. | • In five years, an increase in proportion of patient activities with an accurate ethnicity code.<br>• Clear agreed strategy for reducing serious violence in health setting and supporting identification of domestic abuse by 2025. |



# Appendix Three: Our two-year delivery plan

## Acute care

- Improve the experience patients have of our care, including:
  - Improving the hospital environment
  - Focusing on the fundamentals of care for inpatients including ward accreditation schemes
  - Improve the amount of time it takes to respond to complaints
  - Improve experiences of patients and their carers when they are discharged from acute hospitals, providing them with better education and resources to feel supported
- Reducing waiting across the system from patients waiting for an ambulance all the way through to people waiting to go home from hospital
- Deliver pathway changes from primary care through to specialist services, using diagnostics at the beginning of pathways
- Work to have single points of access across South West London in certain speciality services
- Explore areas in services such as estates, digital and human resources to improve sustainability
- Invest in Community Diagnostic Centres in Queen Mary's Roehampton, Kingston, and Croydon
- Ensure timely access and reduce waiting times
- Provide mutual aid where surges in demand have been identified at a specific hospital
- Contribute to recovering the deficit position within South West London health economy
- Maximise delivery of performance
- Enhance surgical capacity at Kingston and Croydon and upgrade intensive care units in St George's, Kingston, and Croydon

## Cancer

- Embed cancer referral guidance, ensuring that 80% of patients urgently referred for a lower gastrointestinal cancer investigation have had faecal immunochemical testing (FIT) in primary care
- Proactively engage with those less likely to come forward with cancer symptoms and develop interventions that give people the confidence to speak to their GP about their symptoms
- Reduce variation in early-stage diagnosis by working with primary care partners in the parts of South West London where fewer cancers are diagnosed and treated through the urgent cancer pathway
- Improve cancer patient pathways so that we consistently treat patients with cancer within 62 days of urgent referral, and consistently meet this standard
- Create a new community-based expert assessment service for people who have breast pain
- Increase the number of patients who are referred to 'vague symptom' clinics, creating resilient and sustainable non-specific rapid diagnostic clinics
- Identify more communities that are not engaging in screening programmes, by tracking demographic characteristics against cancer staging data, and develop targeted engagement
- Work with partners to remove inequalities in the uptake of national cancer screening programmes by population group, focussing on bowel cancer screening in men, and in cervical cancer screening with women under 30
- Improve speed of diagnosis for lung cancer, working towards the national optimum pathway of 49 days from urgent referral to treatment

## Children and young people

- Develop targeted education and communication programmes starting from pre-conception and throughout the maternity journey
- Work with primary care to ensure that families can access immunisations at times that are convenient to them
- Monitor the uptake of the MMR vaccination on an ongoing basis
- Develop an all-age immunisation strategy to increase vaccination up take
- Work with our early years partners to ensure children take up a free targeted (two-year-old) or universal (three and four) early education place
- Work with our early years partners to ensure that parents and children engage with the health visiting two and a half-year-olds developmental check
- Work across the system to enrich language and communication support for all children
- Ensure follow up support for those children requiring additional assessments following two and a half-year check
- Agree a standard asthma care plan and digital platform for children and young people
- Continue to examine asthma data and use the data to improve the management of asthma, reduce the need for secondary care and target resource to vulnerable populations
- Monitor the use of asthma bags
- Pilot an air quality/air pollution project that is co-produced with primary school children

## Community care

- Review how we commission and deliver community services and how we use enablers such as better care fund contracts, sections 75 arrangements, local authority services and other non-statutory services
- Identify the priority population segments, such as long-term conditions requiring specialist support, for example, cardiovascular disease, neuro rehabilitation, musculoskeletal input, define a new model of care that describes how services will develop to support peoples changing needs
- Identify population groups, such as end of life care, falls, and frailty, and implement new models of care
- Work with stakeholders including patients and carers to scope services to create a single framework for the delivery of community services focussed on preventative, proactive and reactive responses
- Work collaboratively with partners to develop and deliver a core hospital discharge model
- Embed virtual wards and expand the number of conditions they can support within a community based stepped model of care
- Work with community and integrated networks to identify patients who would benefit from health promotion or prevention interventions
- Work with GPs to identify patients at risk of developing long-term conditions and/or frailty earlier
- Use health and social care data to identify people at risk of a fall and provide information to support self-referral
- Utilise technology and data to identify patient needs early and use this information to support proactive management of their care
- Work with hospital clinicians so that they understand the new models of care developed to provide care in people's home following a stay in hospital and the clinical change that is required
- Baseline demand and capacity across community areas and work with the workforce programme to address issues with recruitment and retention
- Work with the end of life care network and providers including hospices and voluntary sector providers such as Marie Curie and Macmillan to improve end of life care across South West London
- Increase the take up of the pro-active care model, particularly for those who are frail
- Work with colleagues in primary care to develop community services around primary care networks or neighbourhoods
- Promote the principle of 'home first' across the acute and community setting. This will include creating clear escalation pathways into step up bedded capacity as alternatives to admissions into acute units
- Improve access to both general and specialist rehabilitation within the community setting and address the current variation in service availability, waiting times, and access

## Community care

- Increase referrals from patients and health and care professionals to the two-hour urgent community response service
- Increased the use of the universal care plan for people at the end of life, people in care homes, and those with frailty and dementia
- Make tools such as urgent and universal care plans available, and visible to clinicians and professional across the system. The first phase will focus on our agreed priority cohorts
- Work through the integrated care network to review the staffing and skill mix within the acute and community setting and ensure that our resources are in the right place in the most appropriate setting
- Work with third party organisations, for example, Age UK, Marie Curie, or other voluntary sector organisations to provide support to innovative service delivery models

## Diagnostics

- Develop a five-year forward plan for diagnostic demand and capacity. This will include considering our demographic and aging population and ensuring that capacity is sufficient to meet this demand.
- Understand current rates of did not attends (DNAs) and reasons for these
- Establish monitoring to better understand groups that struggle to access diagnostic services in South West London and develop 5-year plans to address inequalities in access
- Design and implement a South West London imaging network operating model that includes a governance and leadership structure to drive the work of the network
- Undertake workforce modelling to predict the workforce capacity and requirements to meet growth in demand and the expansion of services over the next five years
- Complete international recruitment of diagnostics workforce
- Explore opportunities for digital transformation that facilitates sharing of information across health services to enhance patient journeys and experience
- Map current demand and referrals distribution across diagnostic services
- Conduct clinical audits to benchmark South West London diagnostics pathways against those of peers and seek opportunities for improvement
- Create additional diagnostics capacity in community diagnostic centres to have at least four sites located in communities across South West London
- Invest in new diagnostic equipment and rooms providing more than 30 new pieces of diagnostic equipment
- Establish several new diagnostics rooms at the community diagnostic centres to provide additional testing capacity
- Using Core20plus5 and other health inequalities data, ensure that new Community Diagnostic Centres are in locations where they are accessible by population groups with the greatest need including in the areas of the highest deprivation
- Design and implement a South West London imaging capital and procurement plan
- Deliver a South West London diagnostics digital roadmap
- Ensure that our pathways minimise the time to tests, allowing patients to choose to travel within South West London should they wish to
- Refine GP direct access for imaging services to ensure appropriate access
- Develop integrated clinical care pathways that enable "one-stop" approaches to patient care
- Develop the diagnostics referral pathway and supporting systems to address concerns raised by patients and their representatives

## Digital, data and population health management

- Begin to free up clinical time using digital technology
- Support the financial recovery plan by scoping a number of projects which include convergence of IT contracts, reduction in IT devices, and the use of automation capabilities to improve productivity
- Implement the patient portal in acute hospitals with the expansion of capability to book and change outpatient appointments and diagnostic appointments
- Develop a data strategy to improve how we capture and use data, moving from a reactive way of using data to a proactive one, improve analysis and insights
- Give people the information and tools they need to support themselves to self-care, including self-care applications that interact with their health and care record, and support people to be cared for in their preferred place of care
- Make better information available at the point of care for patients and our clinicians
- Create a system-wide intelligence hub to join-up data and information more effectively
- Improve our analytical skills and capability to make better use of all the data available, using the intelligence and insight gained from our communities to improve the outcomes for patients

## Our estates and green plan

### Estates

- Commence development our estates strategy, linking closely with digital and workforce strategies
- Review how we use our estate across our health and care partners
- Agree strategic priorities and actions, including land sales where land is surplus to NHS requirements to allow us to invest in new and modern facilities and reducing void space by fully utilising our space or letting go of space we do not need
- Network our estates and facilities teams to get better value from our common areas of spend and suppliers.
- Implementation estate strategy

### Green

- Reduce nitrous oxide wastage and procurement by 50%
- Further reduce desflurane usage across the NHS in South West London
- Implement 'Green Surgery Checklist' principles across our clinical activities
- Create recycling points for metered-dose inhalers in all GP surgeries and community pharmacies, and ensure guidance on appropriate inhaler usage is clear and helps reduce prescriptions for these products
- Carbon emissions are further reduced in targeted buildings

## Health inequalities

- Deliver and evaluate the targeted and focused interventions for our PLUS groups and populations with a focus on:
  - Core20PLUS community connectors
  - Improving outcomes for black and ethnic minority communities through an anti-racism framework.
  - Tackling prescription poverty for our care leavers.
  - Improving 'flu vaccinations for our homeless communities and other inclusion health groups
  - Improving children and young people's oral health
  - Learning disabilities community connectors
  - The ethnicity and mental health project
  - Developing the health equity fellowship for our workforce and partners
- Engage and work with system partners and communities on the priorities for South West London and set out a three-to-five-year delivery plan

## Health inequalities

- Work collaboratively with health colleagues to collectively ensure we pay the London Living Wage and develop and implement local schemes to support with the cost of living
- Review the work of our anchor institutes and develop the next phase of the action plan
- Implement race and ethnicity analytics initiative to collate data and information on racial bias and awareness in the workplace, setting a benchmark for annual review. Recommendations and actions from the analysis will inform the development of framework
- Launch and publish the health inequalities strategic delivery plan
- Improve employment opportunities through the Core20PLUS community connectors programme to help improve health outcomes of the most deprived and marginalised groups in South West London
- Developing expected outcomes as part of our equity dashboard, co-produced with communities, that enable measurement of racial equity
- By 2026, continue to work with voluntary, community and social enterprise organisations to engage communities impacted by racial health inequities using co-production to support improvement and better outcomes

## Long term conditions

- Extend accredited training programmes to local volunteers as community health coaches to deliver co-produced and community-led prevention programmes
- Increase patient education, activation, and digital self-management to support cardiovascular disease, hypertension, cholesterol, diabetes, asthma, and COPD
- Develop a cardiometabolic care model and deliver joined-up care for patients with multiple cardiometabolic conditions, who are currently required to attend multiple appointments across different care settings
- Provide further accredited training to local community champions to deliver co-produced and community-led early detection and signposting to local services
- Implement the learning from our preventative care pilot and spread this across South West London to embed preventative care
- All patients with long-term conditions are offered annual assessments and review
- All patients with long-term conditions receive information on their condition and tips on how to self-manage their condition

## Maternity

- Implement and embed our pelvic health services, bereavement services and improve access for women with mental health conditions for specialist support
- Develop and implement an infant feeding strategy to ensure it is implemented by hospitals and community services and that the Baby Friendly Initiative is adopted, so that every baby has the best possible start to life
- Continually review infant feeding support available to women and identify key actions to increase breastfeeding rates
- Work with our trusts and their leadership teams to ensure that our maternity and neonatal services have an open, compassionate, and positive safety culture
- Ensure that every woman is offered the choice of where to have her baby, whether at hospital, birth centre or home, and that this is discussed with her at regular periods throughout her pregnancy
- Focus on supporting vulnerable women and families, as well as those from the most deprived areas, and identify and support with domestic abuse or other safeguarding risks
- Develop personal care and support plans that record conversations about choices, giving women ownership of their plans, which will be reviewed at each appointment

## Maternity

- Engage with seldom heard communities via our patient involvement group, maternity, and neonatal voices partnership (MNVP), and local community organisations to further improve services for these groups
- Implement the national maternity early warning score and the new-born early warning trigger, and track tools to improve the care of unwell mothers and babies, enabling timely escalation where needed
- Extend maternity and neonatal voices partnerships, to cover each trust reflecting the diversity of the local population
- Publish our equity and equality plans and target action to reduce inequalities in women's experience and outcomes
- Detect and manage neonatal hypoglycaemia (low blood sugar)
- Implement a standardised risk assessment to improve fetal monitoring whilst in labour
- Implement the recommendations of the national postnatal framework to standardise the routine postnatal care that women and their babies receive in the first 8 weeks after the birth

## Mental Health, learning disabilities, and autism

- Establish a comprehensive approach to physical healthcare for people with serious mental illness detailing expectations, support available and the roles of different professionals
- Develop an approach to community level prevention
- Implement a needs-based framework for children and young people and families and ensure how we provide services is both joined up and simplified
- Work in conjunction with South London Listens (to develop and deliver community-led change around mental health
- Revise training curricula for health and care professionals to include a mandatory set of competencies to understand, communicate and signpost to psycho-social support
- Join up the offer to provide consistent and effective non-clinical support to develop and maintain mental wellbeing
- Deliver focused prevention activities for children and young people known to be at higher risk of developing mental health issues
- Through place-based partnerships, work to address social and economic factors that have an adverse effect on mental wellbeing
- Develop and deliver evidence-based mental health promotion programmes
- Work with partners to further develop a co-ordinated approach to suicide prevention.
- Launch a co-production group where patient and carers share their experiences of services to inform the design of future services
- Evaluate the ethnicity in mental health improvement project (EMHIP) to inform future service developments
- Deliver an anti-racism framework for mental health services
- Develop an inclusive and shared decision-making process so that patients are actively involved in decisions about their mental health treatment
- Increase the availability of evidence-based prevention and early support initiatives
- Expand the availability of parenting programmes, perinatal mental health services and early years support for families in partnership with local authorities for vulnerable parents
- Ensure compliance with the new NHS England dynamic support register and care, education and treatment review policy and continue to strengthen joined up working across health, social care, and education
- Develop mental health inequalities work programme
- Work with communities and non-health organisations to promote mental health and wellbeing as full partners
- Ensure a range of digital support options are available to support people to access service
- Provide more support into ethnic groups that analysis shows to be overrepresented in terms of crisis services and those detained under the Mental Health Act

## Mental Health, learning disabilities, and autism

- Continue to develop the 'whole school approach' with ongoing investment into schools' mental health support teams
- Improve support available for children and their families who are waiting to access mental health services within schools, transition to adult and wider mental health services
- Ensure that 90% of children and young people with autism, learning disabilities or both have a designated keyworker
- Develop a case for change for changes to core services and exploring funding opportunities
- Develop a consistent service model for South West London for CAMHS learning disability provision

## Prevention

- Develop and deliver South West London data and digital strategies, tackling digital exclusion and building on requirements for digital self-care apps
- Rollout a smoking cessation offer to every smoker or tobacco user across all Southwest London hospitals, maternity services, and mental health trusts
- Work with our communities to understand and adopt healthier lifestyles and develop a healthy weight programme
- Build on the successful 'WinterFit' intervention in pharmacies to better integrate them with our work in personalised care
- Develop a South West London immunisation strategy to improve uptake of childhood immunisations, school age vaccinations and adult vaccinations and to improve system response to outbreaks
- Act on feedback from people and communities to give them the right information to make informed decisions about vaccinations
- Strengthen our approach to outbreaks of infection and environmental threats Increase use of NHS health checks, community health and well-being checks and case finding in community pharmacy to identify people with high-risk conditions
- Develop digital support to help people navigate what is available to support them when diagnosed with a long-term condition
- Utilise social engine marketing to divert people to the right advice and care
- Develop a health intelligence platform and health inequalities framework so that we can better understand our population's health and better measure the impact we are making
- Ensure that physical activity is routinely encouraged and supported throughout healthcare consultations
- Work with partners to help make South West London greener and help reduce the impact climate change is having on the social and environmental determinants of health
- Identify low uptake of cancer screening programmes and work with NHS England to increase uptake and coverage to over 70

## Primary care

- Work with our training hubs to ensure training and support is given to the leaders and roles within the local neighbourhood teams
- End the '8am rush' for appointments by ensuring that our practices have a range of self-referral and self-care pathways, and when patients do need to speak to the practice, they will have a telephony system that is easy to use
- Continue to increase the overall workforce across primary care through the additional role reimbursement scheme (ARRS) and improved GP retention
- Increase the number of appointments by 3% across the year

## Primary care

- Strengthen the pathways between GPs and community pharmacies so patients can be booked in for a consultation with their local pharmacist for a range of conditions
- Roll out a new primary care specification to increase access to serious mental illness health checks
- Encourage practices and PCNs to develop their clinical workforce and to provide a career path for those wishing to progress.
- Listen to staff to understand and respond to their differing needs and use their feedback to improve recruitment, retention, and career development
- Increase automation software to reduce the administrative burden
- Expand the roll out the NHS app so that it is viewed as the digital front door to primary care where patients can access a broad range of services with 90% of our practices
- Enable all PCNs to evolve into integrated neighbourhood teams
- Develop a risk stratification tool which will include Core20PLUS5 analysis to identify and prioritise people who may benefit from a proactive care offer
- Further develop integrated neighbourhood services that extend beyond traditional physical and mental health services to include social care, voluntary sector, self-management, and prevention support
- Create timely access to routine and urgent care for patients with greater options for accessing care via GP hubs
- Introduce preventative services to target longer-term ill health conditions including the development of a directory of South West London prevention services
- Provide wellbeing, human resources, and organisational development support
- Ensure flexible work policies are consistently available to all staff
- Implement a range of retention initiatives
- Further invest in change management support for primary care to equip them with the skills to embrace new technologies and innovations
- Work with system partners, practices and PCNs to develop a primary care estates strategy
- Modernise the GP IT platform moving GPs to the Microsoft N365 platform
- Provide corporate Wi-Fi to all South West London GP sites

## Quality

- Work with trusts to ensure that their staff to feel safe and to be able to challenge situations without repercussions
- Support people to make safe choices and protect them from harm, neglect, abuse, and breaches of their human rights
- Develop our peer review and peer assurance framework to reduce unwarranted variations of clinical care and share best practice and learning across the system
- Act on patients' experiences of care and use their feedback, compliments, and complaints to make service improvements that improve the quality of health and care
- Implement the methodology in the new "framework for involving patients in patient safety''
- Make sure that those who do not have a voice, those who are under-represented or who cannot speak for themselves are heard. Further progress our activities to improve outcomes for our children and young people, and adults in our Core20PLUS population and the delivery of the CORE20 connectors programme applying the asset-based community development (ABCD) approach
- Complete phase one of the development of our equity dashboard
- Deliver the equality statutory functions including the public sector equalities duties and the functions of the Equality Act 2010
- Implement the initiatives in the NHS patient safety strategy and ensure these are embedded to support safety improvement
- Strengthen our approach to learning from system wide quality information through the effective use of South West London's quality dashboard
- Implement South West London's developing anti-racism framework in line with London's strategic commitments to address racial inequalities

## Specialised care

- Continue three two-year pilots for neurology, cardiac and blood borne virus testing
- Implement peer-to-peer mentoring programme for children and young people with sickle cell disease
- Create additional capacity in paediatric intensive care with two new beds at Croydon University Hospital
- Pilot supportive care pathway to support patients make informed decisions around renal replacement therapy or conservation management
- Improve specialist emergency care for sickle cell patients in crisis
- Transform neurology patient pathways for chronic neurological conditions, through enhanced support in district general hospitals and primary care Develop joint working agreement with NHS England to secure joint oversight of specialist services
- Test key processes around delegation of specialised services for the South London pathfinder pilot
- Test readiness for taking on new delegation responsibilities
- Pilot an integrated community-based sickle cell disease service
- Improve patient awareness and engagement of CKD risk factors, healthy lifestyle information and the treatments available to keep well
- Develop our knowledge and expertise to enable us to develop an agreed set of local objectives for delegated specialised services

## Urgent and emergency care

- Improve access to same day primary care, ensuring all patients contacting a GP practice are assessed or offered signposting at first contact with the practice
- Review the out of hours service
- Embed a clinical network to support our urgent and emergency care clinical leaders
- Implement more effective systems and services to eliminate long waits and queuing across the system
- Work with partners to create community-based support so that people are supported to return home as soon as they are ready
- Working with primary care create timely access to urgent care for patients with greater options for accessing care via GP hubs
- Increase the number of call handlers in the 111 service and develop more clinical roles to reduce the amount time it takes to answer calls
- Implement the outcomes of the out of hours review
- Complete a review our staffing needs and developed a five-year workforce plan
- Working with our community care colleagues to promote the principle of 'home first'

## Workforce

- Develop a single point of information for healthcare jobs with simplified language and content
- Develop accessible guidance and resources to implement 'project-based work experience' across primary and secondary care
- Offer an additional 150 work experience placements
- Increase overall workforce across primary care through the additional role reimbursement scheme (ARRS) and improved GP retention.
- Develop a system-wide health and wellbeing plan for the next three years
- Improve joint working between health & wellbeing hubs and the occupational health programme
- Review the recommendations from the Cost of Living Evidence report by the Institute for Health Equity

### Workforce

- Support staff with the cost of living; including expanding our range of non-pay and other benefits action
- Improve and increase return-to-work conversations in our acute trusts
- Review current health and wellbeing support and develop a system-wide health and wellbeing plan
- Scope a cloud-based data sharing warehouse for strategic workforce planning
- Improve our ability to triangulate demand, finance, and workforce
- Develop a framework and dashboard to become an anti-racist system
- Introduce a disability advice line
- Pilot new mobile application 'Ask Aunty' for nurses, doctors, midwives, and therapists
- Analysis of current workforce to map skillsets
- Development of a talent pool support training
- Roll out Oliver McGowan mandatory training on learning disability and autism
- Enhance our existing 'grow our own' pathway, reviewing and improving the growth of local talent
- Engage with primary care staff to understand differing motivational needs to improve recruitment, retention, and career development
- Improve succession planning in mental health for roles affected by approaching retirement
- Implement improvements to the attraction, recruitment, and onboarding process in mental health
- Review the range of non-pay benefits to enhance the recruitment package
- Develop a plan to reduce long term sickness
- Develop a single staff bank
- Support acute workforce to use different professional staff groups and skill mix to support delivery and improve retention
- Develop a demand and capacity model across all community areas, to improve recruitment and retention
- Review the governance and impact of the EDI health inequalities board and develop an inclusion strategy
- Embed the 'Freedom to Speak up Guardian' infrastructure across the system
- Develop apprenticeship programmes
- Map current training, development, and talent to bring them together as a system-wide offering via a South West London Academy
- Work with senior leaders across the system to improve the metrics around appraisal
- Improve the quality of appraisal conversations
- Revise the training curricula to include a mandatory set of competencies around psycho-social support
- Support change management in primary care with the skills to embrace new technologies and innovations

Footnote: our finances have a detailed financial plan – please see the plan on a page for further information



# Appendix Four: Health and Wellbeing Board Statements

We have received the following statements from the six Health and Wellbeing Boards in South West London. These statements are provided as part of the national requirement for the Joint Forward Plan to include a statement of the final opinion of each Health and Wellbeing Board consulted in the development of the Joint Forward Plan.

### Croydon Health and Wellbeing Board Statement

Thank you for involving the Health and Wellbeing Board in the development of the NHS Joint Forward Plan for South West London. Croydon's Health and Wellbeing Board received a paper on the NHS Joint Forward Plan and the developing Integrated Care Partnership Strategy in March 2023 and we submitted our existing Health and Wellbeing Strategy priorities and the objectives in the Mayor of Croydon's Business Plan that link to these themes to help ensure they were reflected. The Plan that has been produced for South West London is a really good high-level document. The strategic priorities are well-aligned, but of course, drilling down into the specifics at each place will be the key to successful delivery. We know that even within each borough there can be significant differences and working together using gap analysis will help us address some of the inequalities.

The Croydon Health and Wellbeing Board is currently reviewing the Health and Wellbeing Strategy for Croydon. This will then inform future refreshes of the Croydon Health and Care Plan and we will share it with the ICB to help drive continued close working on delivery of shared actions across the system.

Cllr Yvette Hopley
Chair of Croydon Health and Wellbeing Board

### Kingston Health and Wellbeing Board Statement

Kingston welcomes the priorities identified in the five-year forward plan for the NHS in South West London and the engagement methodology used to agree the priorities. We also appreciate the acknowledgment of the role of the Place based Health & Care Plans and the recognition within the JFP of the areas of work best done at a multi-borough level rather than duplicating the content of these Place based plans.

However given the financial challenges faced by the NHS in SWL, Kingston would like greater assurance that the necessary resources will follow the aspirations outlined in the plan. Whilst different boroughs in SWL have different needs, all boroughs have communities with high need and this should be reflected in the work undertaken to reduce inequalities, with the resources necessary to deliver this work, in-line with the four key aims of the ICS.

Kingston looks forward to greater clarity on governance and accountability across the ICS. As yet it is still unclear where accountabilities lie, and where in the system key decisions are made, particularly relating to use of resources: at the ICB or at Place.

Kingston's Health & Wellbeing Board looks forward to the implementation of the first 2 years of the plan, including dedication of the necessary resources to do this effectively.

Cllr Andreas Kirsch
Rotating Chair of Kingston Health & Wellbeing Board

## Merton Health and Wellbeing Board Statement

The Health and Wellbeing Board in Merton is pleased to have the opportunity to consult and comment on the Joint Forward Plan. We have considered the draft and the final versions, and we believe the JFP has improved and developed as it has progressed through the consultation and adoption stages. We are particularly pleased to see the focus on and inclusion of health inequalities in the Plan as this is the cornerstone of both the council health and wellbeing strategy and our local health and care plan.

Going forward, we welcome our partnership working with the Southwest London ICB through the Place borough committee and our Health and Wellbeing Board. We hope that the Integrated care partnership will enable all those involved to tackle health and care inequalities.

Cllr Peter McCabe
Chair of Merton Health and Wellbeing Board

## Richmond Health and Wellbeing Board Statement

Richmond's Health and Wellbeing Board were pleased to formally be consulted on the Joint Forward Plan in March 2023 and, having been involved in its development, were pleased to confirm its final opinion that the Joint Forward Plan does represent a shared delivery plan for the integrated care strategy both in South West London and in Richmond upon Thames, taking into account the current Joint Health and Wellbeing Strategy (2016-21) and the emerging Joint Local health and Wellbeing Strategy (JLHWS) for the next five years (which is well advanced and will shortly go out for statutory consultation in Summer 2023, for formal adoption and final publication in Autumn 2023).

The Board welcome the close working partnership with the SWL Integrated Care System, particularly with the Richmond Place ICS, but also with the SWLICS' Integrated Care Partnership and the ICB, and look forward to being closely involved in its implementation and close integration with our emerging JLHWS priorities: 17 steps to health and wellbeing.

Cllr Piers Allen
Chair of Richmond Health and Wellbeing Board

## Sutton Health and Wellbeing Board Statement

Thank you for sharing the South West London Joint Forward Plan with the London Borough of Sutton. We note that the strategy aligns well with the aims of the local Sutton Health and Care Plan and the challenge now is how the SWL system works together to deliver the strategy.  We look forward to working collaboratively to ensure that responsibility for deliverables are clear and that system resources are allocated to the correct level to align and maximise the synergies between system, place and neighbourhood working.

Cllr Ruth Dombey OBE
Chair of Sutton Health and Wellbeing Board

## Wandsworth Health and Wellbeing Board Statement

We are particularly interested in the vital issues of prevention, and addressing health inequalities, and feel that these have been addressed to a good extent throughout the document. We will continue to take a keen interest in how well the ambitions set out in the Plan will be delivered, and progress monitored, in these areas.

Cllr Graeme Henderson
Chair of Wandsworth Health and Wellbeing Board



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July 2023