South West London Integrated Care System

South West London Integrated Care Partnership Strategy 2023-2028

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Foreword

Our Integrated Care Partnership Strategy is the result of great conversations with health and care partners and communities across South West London. It is clear that we all share a real determination to improve the health and wellbeing of our residents.

The key to health and care improvement lies in each of our six Place partnerships. These partnerships work together to address the health and care needs of local people, and our Local Health and Care Plans form the foundation for action.

Over the past five years, we have grown as a partnership and strengthened how we do things together. By working together at scale across South West London when it is right to do so, we really make a difference because we can focus our efforts and investment on shared priorities.

There are areas of deprivation within all our six boroughs, and we know that many local people are really struggling. We need to harness this sense of urgency to support our communities, both now and in planning for the future. We must focus on prevention and early intervention for mental health and physical health, so people stay healthier for longer, and have less need to access services, and we need to address the deeply rooted inequalities that still exist in our society.

We recognise that with the financial situation for all of us is becoming more challenging, matched with the health and care need from local people increasing, we need to work differently and better together. Our Integrated Care Partnership Strategy explains the journey we have been on to understand each other's challenges, review the data, the evidence and health needs, as well as considering the views and concerns of local people across our six places.

You will see in our strategy we have worked together to identify areas for action to:

- Tackle and reducing health inequalities
- Prevent ill-health, promote self-care and support people to manage their long-term conditions
- Support the health and care needs of children and young people
- Positively focus on mental well-being
- Support for older and frail people in the community

As well as taking action on our cross-cutting areas of:

- Equality, diversity and inclusion
- Championing the green agenda
- Elevating patient, carers and community voices
- Workforce

We would like to take this opportunity to thank all of our partners from across health and care in South West London and to all those people and communities who took the time to share their views.

We look forward to continuing our work together. This strategy is a living document that we will refresh together every year.

Cllr Ruth Dombey
Leader of Sutton Council and Co-Chair of South West London Integrated Care Partnership

Mike Bell
Chair of NHS South West London and Co-chair of South West London Integrated Care Partnership

1. Introduction

The South West London Integrated Care Partnership (ICP) want people in our boroughs to ***Start Well; Live Well; Age Well.***

Our partnership brings together organisations across our South West London boroughs: Croydon, Kingston, Merton, Richmond, Sutton, and Wandsworth to:

- prevent ill health
- support people to thrive, live more independent lives and manage their health to stay well
- reduce the health inequalities that exist
- improve health, wellbeing, and outcomes for our residents
- provide the very best health and care services by working together to provide seamless care to those who need it, and
- get the best value from our resources

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. Our first Integrated Care Partnership strategy outlines our priorities for change and the collective action we will take to improve health and care for the people of South West London.

Working together with our six Places

South West London is comprised of six Places where partners come together to address the health and care needs of their local populations. Their priorities for action are brought together in Local Health and Care Plans. Our Integrated Care Partnership is anchored in our places and their priorities which have been built up from local joint strategic needs assessments, as well as Health and Wellbeing Strategies.

Working together as a whole system

We are clear that we should only take South West London-wide action 'at-scale' where there is strong evidence that focussing our effort and resources would deliver the biggest improvements for local people. The Integrated Care Partnership Board considered the following principles to help determine which areas we should focus on:

1. **Need:** Is there a significant or compelling need at South West London level and does this theme address any unmet need or inequity?
2. **Prevention:** Is there an opportunity to prevent ill health and encourage people to self-manage their own health?
3. **Deliverability:** Is there any existing programme of work we could accelerate in order to maximise impact on the population?
4. **Strategic fit:** Is there multiagency energy and commitment to proceed with this as a theme?
5. **Productivity:** Will this theme make better use of resources, or provide better or enhanced value?

We are also clear that any action that we agree at South West London level should not duplicate what is happening to drive improvement at Place. The following important considerations were identified by the board:

Target our focus on:

- The greatest impact and tangible outcomes
- Getting the basics right
- Good communication
- Residents' satisfaction
- Workforce retention

Resident and community voice

- Listen to the voices of people and carers
- Seek service user and community opinion
- Use deliberative approaches like citizens panels
- Ensure that our priorities are supported by public and community voice

Impact areas to think about

- Address wider determinants over a longer timeframe
- Impact on environmental footprint
- Impact on healthy life expectancy of the target group
- Confront health inequalities and measure outcomes for local populations
- Grasp opportunities for prevention, and holistic care
- Early intervention is key

We must assess:

- Achievability and impact
- What is best done at scale
- What will reduce inequalities
- What addresses the greatest needs in our population
- Co-design and co-production, listen to the voices of people and carers
- The evidence base of what works best and work with local communities to apply this across our system
- Use of deliberative approaches like citizens panels
- That our priorities are supported by public and community voice

Constraints

- Be realistic about capacity and capability of workforce to deliver
- Reduce dependence and cost in the system by specifically reducing inequalities
- Sustainable models for the green agenda
- Agree which interventions empower and enable independence

Enablers

- Accelerate digital change
- Use of public health evidence and local insights
- Population health management
- Workforce

Outcomes

- Ensure a positive impact on health outcomes
- Evidence progress, some outcomes are long-term so we must utilise the use of proxy measures
- Ensure positive impact on whole system finance, including social care
- Ensure we benefit the greatest number of people, weighted to support smaller populations
- Assess to what extent the issue will be in 5/10 years; prioritise interventions with most long-term impact
- Address Core20PLUS5
- Develop a prevention framework to put health, social care and wellbeing on more equal footing
- Promote future benefit-quality of life

Approach

- Pragmatism over perfection; a rolling programme of common issues that lead to whole system approaches and be pragmatic with what is possible to deliver
- Explicitly set out to learn and adapt
- Specify the added value of delivering at South West London level vs place
- Value is also about stopping things that have limited value; we must assess what is working
- Take a holistic approach to prioritisation

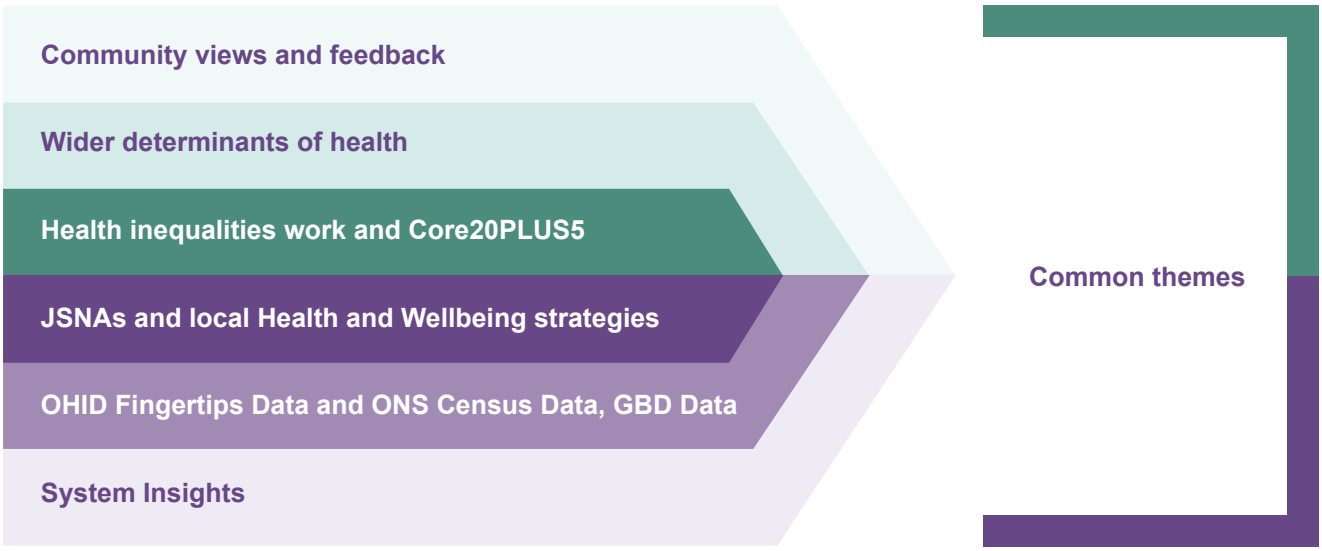
Developing as a partnership

We have made a positive start on developing as a partnership and all partners are committed to strengthening our relationships and ways of working as we start to deliver our shared priorities. This will mean working together at every stage of design and delivery. There is a particular opportunity for the partnership to add value by enabling voluntary and community sector organisations to play a greater role in supporting people to improve their health and wellbeing. The development of the South West London Voluntary, Community and Social Enterprise (VCSE) Alliance is an important part of this.

2. Assessing the needs of our population

In assessing the needs of our population and determining priorities we have listened to our local public health experts, ICP Board members, South West London system leaders, and local communities. In addition, we have reviewed existing joint strategic needs assessments (JSNAs), Health and Wellbeing Board strategies and health outcomes and considered the wider determinants of health.

To support the development of the priorities, the Integrated Care Partnership Board brought together a needs assessment group which considered the following:



When assessing the needs of our population, we have often described 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 have therefore been developed for each of our six boroughs to address local needs and can be found on our website **here**.

When reviewing the mapped local priorities and plans that are set out in each of each of the local health and care plans, the following common themes and actions were identified:

Start Well
- Mental health
- Healthy weight
- Special education needs and disabilities
- Health and wellbeing of looked after children
- Early Years
- Children and young people's transition
- Physical health

Live Well
- Long-term conditions (including diabetes, cardiovascular disease, respiratory)
- Mental health
- Prevention (including healthy lifestyle)

Age Well
- Healthy ageing
- Loneliness and social isolation
- Support for people with dementia
- Supporting carers
- Care and support at the end of life
- Frailty
- Falls prevention

Cross cutting themes: Reducing health inequalities, Increasing prevention, and early intervention, healthy places, integrated services, support to carers

Our needs assessment

Our opportunity for good health starts long before when we might need health and care, and so the responsibility for the health of the public extends beyond the health and social care system to the circumstances in which people are born, grow, live, work and age.

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

We have analysed our wider determinants of health and the indicators of health variation, a summary of these are given on the next page.

Indicators of the wider determinants of health

GOOD WORK

The number of people claiming out of work benefits in August 2022 is **50% higher than pre-pandemic**.

OUR SURROUNDINGS

Air pollution is **higher than the national average**.

Access to private outdoor space and public green space is **below the national average** (Office for National Statistics health index).

MONEY AND RESOURCES

22.7% of our population earn below the London living wage.

In 2020, **9.8% of households were in fuel poverty**. Average household energy bills have risen from £764pa in 2021 to approximately £3500pa in 2022.

TRANSPORT

The percentage of adults walking for travel 3 days per week **fell between 2017/18 and 2019/20**.

HOUSING

Affordability of home ownership **has worsened since 2002**.

Household overcrowding is worse than it is nationally.

The rate of households in temporary accommodation in South West London is **more than double the national average**.

EDUCATION AND SKILLS

The number of 16–17-year-olds not in education, employment, or training (NEET) is **better than the national average**.

FOOD, DIET, AND WEIGHT

Obesity rates double between Reception and Year 6, then again to adulthood.

FAMILY, FRIENDS, AND COMMUNITIES

People in South West London reported **feeling lonely during the pandemic more than the national average**.

When reviewing the health needs of our population we identified the following overarching themes:

Indicators of health variation from our needs analysis

MENTAL HEALTH

Admissions for self-harm are **higher than the national and regional average**.

Prevalence of depression varies significantly within Places, **an average of 12.7% difference** between the GP practice with the highest and lowest prevalence.

HEALTHY LIFESTYLES

Smoking, alcohol, high BMI (body mass index), high fasting blood glucose, and hypertension are the **leading causes of disease-adjusted life years (DALYs) in South West London**.

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).

LONG TERM CONDITIONS

Ischaemic heart disease, cardiovascular disease, chronic obstructive pulmonary disorder (COPD), diabetes, and MSK conditions are the **top contributors to DALYs and mortality in South West London**.

CANCER, SCREENING AND VACCINATIONS

Cancer screening uptake is **below regional and national average**, and deaths under 75 due to malignant neoplasm are **above the London and national average** in 5 of the 6 Places. Cancer is the **number 1 cause of mortality in South West London**.

SUPPORTING CARERS AND INCLUSION HEALTH GROUPS

Further analysis or modelling may be required to identify unmet need as **often people in these vulnerable groups are not accessing healthcare** and so are not reflected in the data available.

The completed needs assessment for South West London can be found on our website here.

3. Acting on the views and concerns of local people

The views and concerns of local people and communities have been key in helping us work together to decide our priorities.

A phased approach to our on-going engagement

Phase 1
Context from communities to support 'Needs Assessment' discussion
October 2022

Snap-shot of current concerns and views from communities including input from local outreach work, insight reports – including from Healthwatch, local surveys, intelligence from voluntary and community sector networks, community and health champions

Summary on page 9 shows shared themes common to each Place - summaries discussed and reviewed by Place communications and engagement groups

Phase 2
Engagement to inform discussion document
October to December 2022

Test approach & 'phase 2 questions' with Integrated Care Partnership (ICP) members

Build on phase 1 analysis by deeper review of existing partner insight - analysis of 100 engagement reports

Engage with agreed questions: ICP members, key partners, VCSE, Healthwatch, South West London People's Panel, health and care staff

Phase 3
Engaging on Discussion Document and delivery
Jan to April 2023

Test discussion document with ICP members, health inequality groups, key partners, communities, health and care staff

Feed into prioritisation and Integrated Care Strategy

Agree our final ICP shared priorities

Phase 4
ICP Action Workshop and action development
May to July 2023

300 health and care leaders, people and community voice representatives and staff joined together for an Action Workshop

Discussing ideas for actions for each of our six priority areas

Co-chairs for each priority to agree actions to be outlined in our ICP Strategy

Our engagement in developing our shared priorities for our partnership began back in autumn 2022 when we asked all our South West London partners to share existing insight and engagement reports developed over the previous 12 months. We were particularly keen on reports that describe what matters most to local people in their health, care, and wellbeing.

We reviewed over 100 reports from partners including Healthwatch, the voluntary and community sector, NHS trusts, public health, Place councils and Place-based engagement teams. You can read our analysis of these 100 reports on our website here. We updated this insight review in March 2023, see the link at the top of page 16. This in-depth analysis of all our community insight helped inform the development of the proposed priorities for our Integrated Care System Strategy discussion document that we published in January 2023.

Alongside this analysis, we asked ICP members and key partners and our South West London People's Panel to prioritise a set of 10 draft focus areas that emerged from the needs assessment.

Our South West London People's Panel is made up of over 3,000 people reflecting the demographics or each place. 170 members of the people panel gave us their detailed views about our proposed priorities.

This helped us gather views on our potential future priorities, ambitions, and challenges we face in improving health and well-being and reducing health inequalities across South West London.

In January 2023, we published *'Shaping our Integrated Care Partnership priorities – discussion document'.*

Shaping our Integrated Care Partnership priorities - discussion document - South West London ICS

The discussion document sets out the process we developed to determine our proposed shared priorities.

Agreeing our shared priorities

Following the publication of '*Shaping our shared Integrated Care Partnership priorities*' we invited our system partners to share their views on:

- Our recommended ICP priorities
- The four proposed workforce programmes
- Any other areas where our partners could work together

In addition to sharing with these key partners we also:

- Published the discussion document and a call for responses on our ICS website at Shaping our Integrated Care Partnership priorities - discussion document - South West London ICS
- Distributed the discussion document through our borough communications and engagement professional networks and community groups and stakeholders
- Featured the discussion document in our South West London and Place stakeholder updates each month which go to over 3,000 local people.

In total, we received 21 responses from our partners that helped us shape and iterate our priorities. Overall, the feedback was supportive for our proposed priorities, covering a broad range of themes, including broad statements of support and for the recommended priorities and proposed workforce priority programmes and indicated support for our work to date and proposed priorities, on which we requested views. Feedback also covered some proposed specific amendments, suggestions for wider collaboration, and widespread interest in the next stage development of delivery plans linked to the proposed priorities.

These further developed priorities were approved at our Integrated Care Partnership Board meeting in April 2023 and are detailed later in this document.

4. Our Priorities

Our review of the health needs assessments, existing Joint Strategic Needs Assessments, Place health and care plans, Health and Well-being board strategies, and the views of people and communities, has identified the following Integrated Care Board priorities:

Tackling and reducing health inequalities we will continue to work across organisations, places, neighbourhoods to tackle health inequalities in everything we do.

Preventing ill-health, promoting self-care and supporting people to manage their long-term conditions including a focus on healthy eating, physical activity, smoking and alcohol misuse and mental wellbeing and link up with offers in community. A focus on both primary and secondary prevention, which will include supporting people to manage long-term conditions, for example, diabetes, chronic obstructive pulmonary disorder (COPD), musculoskeletal conditions (MSK), cardiovascular disease (CVD) and ischaemic heart disease.

Supporting the health and care needs of children and young people including looked after children, children with special educational needs (SEND), reducing obesity, dental decay, alcohol misuse and 'risky behaviour', mental health, childhood immunisations and wellbeing particularly the transition to adult mental health service.

Positive focus on mental well-being including dementia, addressing the anticipated increase in need, easy and appropriate access for people when they are in a mental health crisis, services as close to home as possible and supporting people to return safely home from hospital. Making sure our children and young people have the best possible experience and outcomes when receiving care and treatment, including timely access with good coordination between children and adult services.

Community based support for older and frail people including addressing loneliness and social isolation, bereavement and improving their experience, health and wellbeing and preventing hospital admission and when in hospital to support them to get home quickly.

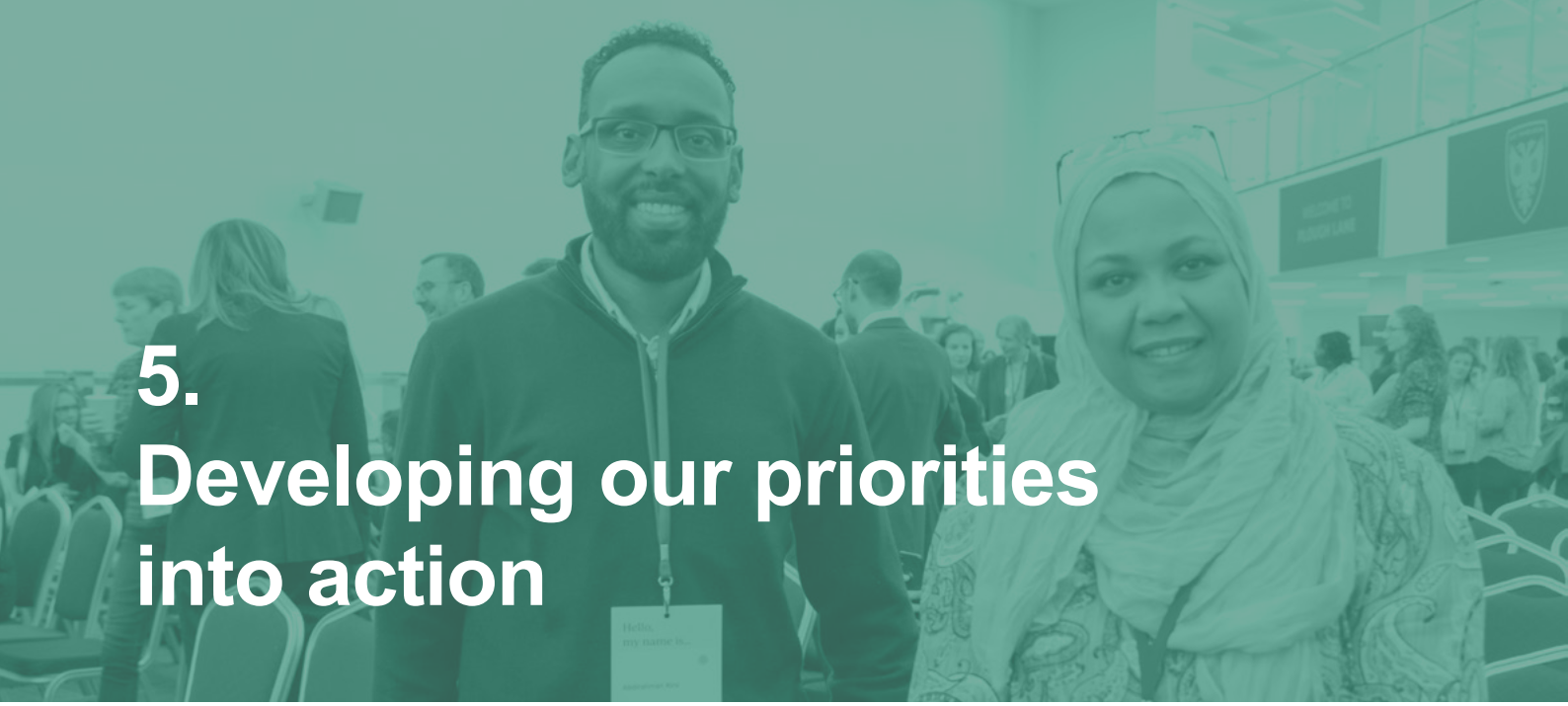
In addition, the following cross-cutting areas of focus were proposed as underpinning the delivery of our future priorities:

Equality, diversity, and inclusion including tackling racism and discrimination.

Championing the green agenda for example sustainability, air quality, our estate and responding to climate change and related health issues.

Elevating patient, carers, and community voices including their role in decision making, co-production and the codesign of services.

Workforce including making South West London a great place to work, targeting difficult to recruit to roles, designing our workforce of the future, and supporting local people into employment.



5. Developing our priorities into action

We wanted to make sure that the actions to address our priorities were anchored in the needs of local people and communities, and our organisations. On Wednesday 24 May 2023, around 300 representatives from the local NHS provider trusts, our six local authorities, voluntary and community sector, Healthwatch and local people, joined us to discuss and help shape the practical actions we could deliver together across our partnership.

Aligned with the agreed priorities we created six working groups who looked in detail at:

Tackling our system-wide **workforce challenges**

Reducing **Health Inequalities**

Preventing ill-health, promoting self-care and supporting people to manage long term conditions

Supporting the health and care needs of **children and young people**

Positive focus on **mental well-being**

Community-based support for **older and frail people**

Each of our six working groups were also asked to consider the cross-cutting themes of equality, diversity and inclusion, the green agenda and elevating the patient, carer and community voice.

The actions agreed from the workshop have been brought together with other key information to form this Integrated Care Partnership Strategy.

We wanted to make sure that we invited a range of voices to the conference to make sure we developed our ICP priorities in partnership with local people and communities. We invited key community and voluntary organisations, local connectors, champions and people with lived experience to join us and made sure they joined the priority rooms that they felt most comfortable with. This supports our ambitions to work collaboratively with the voluntary and community sector but also meant that we had vibrant, cross-sector discussions as part of the day to help shape our priorities with people and communities at their core.

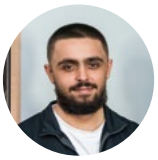
Councillor Ruth Dombey, Integrated Care Partnership Co-Chair, said:
"We are really lucky here in South West London to have such a vibrant community and voluntary sector – there are so many dedicated people who care about their communities and understand the lives of the people living here.

"I honestly think that this is a once in a lifetime opportunity to do something different, but we can only do it if we bring together the voices of everyone in the community."

Mike Bell, Integrated Care Partnership Co-Chair, said:
"The event was a really important opportunity to bring together all of our partners across the NHS, local authorities and, critically, the voluntary sector.

"Almost 300 people joined us – all of them bursting with ideas on how we can work together and make a real difference for the health and care of the population of South West London."

Ima Miah, Chief Executive of the Asian Resource Centre, said:
"For me, it's really important that we get across the community voice. Whether you're looking at things like long term conditions or health inequalities we are the representatives of the community and it's important to hear that voice because you can't meet a need unless you know the need."



Darren, Young People's Champion

"I feel like opinions have been listened to today and also respected."

Sarah Blow, Chief Executive Officer for South West London Integrated Care System, said:

"We're committed to making a difference to the lives of local people and tackling health inequalities. A huge thank you to everyone who came along and shared their ideas for how we can make a difference together."

Mike Jackson, Chief Executive of Richmond and Wandsworth Councils, said:

"Two things that struck me are that we need to shift the focus towards prevention, and what I've heard overwhelmingly is that we need to help people to live well."

The event was introduced by Cllr Ruth Dombey and Mike Bell as the co-chairs of the Integrated Care Partnership and we then showed a short video featuring residents, community leaders and staff to ensure that the day was grounded in the experiences and needs of people in South West London.

You can watch this video on our website here.

You can watch a short film of the day on our website here.

People and communities: views and concerns

You can read the full analysis of 180 insight reports on our website here.

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

People and communities tell us

As you will read in each of our priority 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.

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

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unities

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

6. Tackling and reducing health inequalities

South West London is diverse in its population and health needs across our six Places. There are differences for residents across South West London when it comes to access, experience and outcomes of health and care services and treatments.

There are many social, economic, and environmental factors that can limit a person's ability to be healthy, creating health inequalities. Some population groups are at greater risk of poor health due to social and economic factors like where they live, their income status, race, ethnicity, disability, and sexual orientation.

We will work across organisations, Places, and neighbourhoods to tackle health inequalities in everything we do. This means addressing avoidable, unfair, and systematic differences amongst specific population groups, so that everyone can reach their full potential.

1 in 8 children
in South West London live in low-income families.

62,000
households experience fuel poverty

The **20%** most deprived population are slightly younger and are disproportionately from Black ethnic backgrounds and living in Croydon.

50%
of our most deprived residents live in **Croydon**, compared to **4%** in **Richmond** and **2%** in **Kingston**.

The most deprived people in our population are more likely to have depression, diabetes, COPD, mental health conditions, epilepsy, and learning disabilities, and are more likely to have two or more long term conditions.

There are differences in referral and access rates for services across ethnic groups with many ethnic minority groups less likely to be referred and access services than white groups.

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:

- Lots of people are struggling at the moment due to cost of living related issues, and tell us they are more likely to face barriers to leading a healthy lifestyle, using health and care services, and accessing prevention services like screening or 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 health and care staff.
- Some Black, Asian and minority ethnic groups reported mistrust and being fearful of public services due to previous experiences of racism. This can then influence how people feel about treatment decisions.
- Across all groups we spoke to, we heard that specialised or tailored support is not always provided or available and this can often lead to poorer health. People often need some specialised or tailored support that is not always provided or available. This can mean reliance on family members to accompany people to appointments to translate and support, or to help with digital interactions. This is not always appropriate.
- Some health and care staff do not always use inclusive or culturally competent language. They can make inappropriate assumptions about the cause of an illness, for example for example health problems being attributed to sexuality.

Core20PLUS5

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.

Core20: looks at the 20% most deprived population, as identified by the national index of multiple deprivation, 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 and people with learning disability.
- **5:** five clinical areas of focus for adults and children and young people. The five clinical areas for adults are maternity, chronic respiratory disease, hypertension, serious mental illness, and early cancer diagnosis. The five clinical areas for children and young people are asthma, epilepsy, mental health, diabetes, and oral health.

Our focus

As a partnership, our areas of focus for collective action are:

Addressing the wider determinants of health and wellbeing

To do this we will:

- Work together across the system to accelerate the adoption of the London Living Wage across our organisations.
- Establish an anti-racism framework across our system in order to reduce racial disparity and inequity for the people of South West London and our staff, aligning with the Mayor of London's five strategic commitments for London.
- Create an Integrated Care Partnership Health Inequalities Fund and use our core20PLUS5 analysis to fund improvements to address health inequalities in each of our six Places.
- Work in partnership to influence the planning of the built environment to support healthier lifestyles for communities most impacted by health inequalities.

Scaling up innovation to improve outcomes for people in our most deprived areas and our most vulnerable people

To do this we will:

- Support innovative approaches to tackling health inequalities at local and system level by reviewing and sharing best practice.
- Improve access to data and insights to allow system partners to foster collaboration and challenge across our system and ensure we can monitor and inform the impact that we are making.
- Embed the Core20PLUS5 framework to improve a shared understanding of health inequalities across the partnership and enable action to reduce health inequalities.

Empowering our communities to improve their health and wellbeing

To do this we will:

- Learn and build on examples of best practice of community empowerment, such as the South London Listens campaign, which engages with communities so that they define the issues - which are most meaningful to them - and are then involved in the design and delivery of the solution.
- Work with people and communities so that they have the skills, resources, and support to enable them to create solutions for themselves and their communities.
- Through Healthwatch and other local voluntary, community and social enterprise (VCSE) organisations, maximise the opportunity to reach deep into communities affected by health inequalities, so that they influence the planning and delivery of services. We will work with communities so that they have a greater say in the planning of their neighbourhoods including social and economic renewal.

7. Preventing ill-health, promoting self-care, and supporting people to manage their long-term conditions

We want to support people in South West London to live long and healthy lives. We want the care for people with long-term conditions to be proactive, holistic, preventive, and person-centred. Many of the health needs of our residents 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.

Over **50%**
adults are overweight or obese

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

There are about 90,000 people in South West London with hypertension who are unaware of their condition

More than a half of those aged 50-64 who are economically inactive (people who are neither working nor looking for work) is due to a long-term illness

1 in 4 deaths in England are caused by cardio-vascular disease, which equates to one death every four minutes

Musculoskeletal (MSK) conditions such as back pain account for 30% of GP consultations

Seven in 10 people who report living with a long-term MSK condition are overweight or obese

People and communities tell us

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

- 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.
- 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.

Our focus

There are multiple programmes across South West London that focus on prevention and helping people to 'live well' across a range of initiatives. This strategy does not attempt to cover all of those. As a partnership, we think we can have a significant impact through a shared focus on healthy weight and reducing obesity, as we know this can have a significant impact on healthy life expectancy and on specific conditions like diabetes and cancer.

As a partnership, our areas of focus for collective action are:

Developing a whole-system approach to healthy weight and reducing obesity

To do this we will:

- Use the available evidence and what residents tell us works for them to identify the most effective interventions across the South West London system, to improve healthy weight and reduce obesity. This could include targeted approaches based on population health data and the use of digital tools and a focus on what the voluntary and community sector can do to connect with our communities and support them to be active and healthy.
- Agree how we can shift resources to where they are needed to have an impact on healthy weight, with a focus on reducing inequalities and on stopping doing things that are not working.
- Work together to improve access to and acceptability of affordable, healthy food by scaling up successful, local initiatives.
- Focus on the health and care workforce to support staff with increasing their exercise, including active travel to work, for example, walking or cycling. We will consider how we engage with other local employers to extend this further.
- Develop our shared partnership approach to engaging and communicating with communities on physical activity and healthy eating.

Maximising the ability of the voluntary and community sector to support people to lead healthier lifestyles

To do this we will:

- Reduce barriers to the voluntary sector's ability to play a full role in supporting health and wellbeing, for example by working through issues of data sharing together and demonstrating longer term value for money.
- Work together to secure long-term funding arrangements for voluntary sector programmes and services that are effective in connecting with our communities and improving people's health and wellbeing.
- Build on the work of social prescribing and health coaches to widen access to preventative activities in the voluntary and community sector, and support the voluntary and community sector to build their capacity and access funding.

Developing personalised self-care for people with long-term conditions

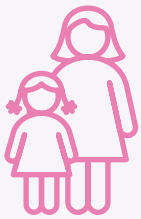
To do this we will:

- Create solutions for self-care which reflect the needs of different communities through meaningful co-production with those communities, such as asking people, 'What do you need to be able to manage your long-term condition?'.
- Review existing self-care programmes in South West London, for example, health and wellbeing coaches, expert patient programme and other types of peer support to build a shared understanding of what works to inform future service development.
- Increase the use of digital care plans by training health and care staff and considering how more people can be encouraged to use them.
- Increase access to training and equipment for people who are currently digitally excluded, where a digital offer is what they want.
- Increase equity of access to self-care by improving visibility of what is on offer both digitally and in person, through a broad range of channels, for example, social media, faith and community groups, and sports organisations.

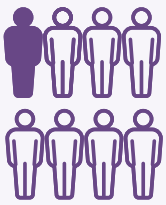
8. Supporting the health and care needs of children and young people

We want children and young people to have the best start in life and a good education, enabling them to live well, flourish and achieve their full potential. We want children and young people to receive the right support, in the right place at the right time, in order to fulfil their potential and build parental trust.

Across our six boroughs in South West London, we have approximately 332,000 children and young people aged 0-18 years.



Our population is slightly younger compared to the average for England



1 in 8 children in South West London live in relatively low-income families – this is much higher in some parts of South West London

Obesity in all boroughs is higher in our deprived areas. Around 30% of children are above a healthy weight between reception and year 6.

Less than half of children received NHS dental care last year and we have a higher-than-average rate of hospital admissions for dental caries in the 0-5 age group

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

The highest early years foundation stage profile (a statutory assessment of children's development at the end of the early years foundation stage) attainment gap is in Croydon where 33% of children do not achieve this target

People and communities tell us

- There are increasing levels of mental health issues in children and young people, with long waiting times for treatment. This is impacting the health and wellbeing of our young people and their ability to access education and their education attainment.
- Children and young people felt a lot of their life experiences happen online with social media making their mental health needs worse.
- It is sometimes difficult to understand what services and support are available to children and young people.
- There are sometimes long waits and delays for children, their carers and families to access support.
- There were some differences in the willingness of parents to vaccinate their children against flu, Covid-19, measles, mumps, and rubella (MMR), and polio. For example, while 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.

Think children and families

All partners in the system are asked to 'Think children and families' in all our decisions, choosing to prioritise our resources to support the wellbeing of children and young people and build resilience in families.

Our focus

As a partnership, our areas of focus for collective action are:

Reducing health inequalities for children and young people, focusing on safeguarding, and looked after children

To do this we will:

- Support families to build resilience and help keep families together where possible by joining up our efforts on prevention and early intervention and bringing our data together across the system to better enable early support and better start in life.
- Share learning from safeguarding reviews across the system to build a culture of continuous improvement in partnership.
- Listen to and act on what care experienced children and young people tell us they need, for example, in relation to housing, education employment, health, and cost of living crisis.

Improving the physical health of children and young people in South West London

To do this we will:

- Work collaboratively across health, education, and social care to improve outcomes for children and young people linked to long term conditions such as asthma, diabetes, epilepsy, and obesity, by promoting access to shared data, system collaboration and by communicating successes and challenges.
- Work collaboratively across health, education, and social care to standardise care plans for long-term conditions, starting with asthma, with a view to implementing a digital platform to improve joint working and communication.
- Take a system-wide approach to supporting parents to vaccinate their children against 'flu, to ensure that we will make every contact count, so that parents and young people with agency are able to make a fully informed decision.

- Work collaboratively across health, education, and social care to introduce an inclusive Park Run to support the physical health of children with special education needs and disabilities (SEND).
- Address the wider determinants of health through supporting parents and children to adopt healthy lifestyles and diet which will support a good level physical health, including oral health.
- Learn from pilot projects, such as the air quality pilot for asthma in Merton, and the existing work on excess weight in different boroughs, and implement lessons learned across South West London.
- Work together across the system to ensure sustainable health and care services, where there are particular challenges in service capacity, recruitment and retention of the workforce, for example, therapies, mental health and community paediatrics.

Taking a partnership approach to maternity care

To do this we will:

- Work together to support the implementation of national and regional maternity transformation programmes, including recommendations from reports such as Ockenden and Kirkup, by joining up our data and information and our communications with parents and communities.
- Work together to support the development of early communication in childhood, such as a consistent approach to the 2.5-year. This includes early language identification and intervention measures and signposting parents and carers to wider opportunities for support in their local community.
- Shape our approach to tackling inequalities by listening to different voices, including young parents, care leavers, mothers, fathers, and co-parents, by supporting the voluntary and community sector to reach the parents and communities who are more likely to experience inequalities.
- Take a joint approach to prevention and early support by working together on the areas where evidence shows we can have the most impact, including perinatal mental health, continuity of care, and infant feeding.

Children and young people's mental health

Working together to join up physical and mental health and improve the emotional wellbeing of children and young people is an agreed priority for the system-wide Children, Young People and Maternity Board. This is a shared priority with the mental health workstream, and our collective actions are set out in section 9.

Working together to improve outcomes for children and young people with special education needs and disabilities (SEND)

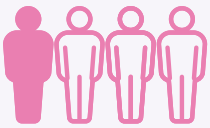
To do this we will:

- Listen to children and young people with SEND and their families to work together on future developments.
- Ensure delivery of statutory functions of the Children and Families Act.
- Support monitoring of impact and service improvement through an Integrated Care System data dashboard on SEND.
- Work collaboratively to improve transition pathways between children and adult health services for those for whom we maintain a statutory responsibility.
- Develop consistency of practice across South West London for children and young people with SEND, by supporting the work of designated clinical and medical officers at Place, and by improving access to therapies for children and young people with SEND.

9. Positive focus on mental well-being

In South West London, we want to create healthy places that promote wellbeing and for everyone to have access to the right support, at the right time for their emotional and mental health. We have recently developed our Mental Health Strategy for South West London following extensive engagement across the South West London system, including all our Places, people with lived experience and carers.

We recognise that many influences come from wider factors such as employment, education, housing, and community, and we will work together to address these. Our services will work effectively together and with people who use our services, to ensure we meet their needs and that they receive the support they need in the most appropriate setting.

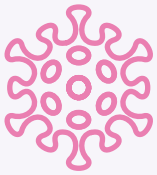


At least one in four people will experience a mental health problem at some point in their life

One in six adults has a mental health problem at any one time.

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

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



During the Covid-19 pandemic, on average more people in South West London reported feeling lonely often/always or some of the time than the average for London and England.

People and communities tell us

- Waiting times have grown longer across all mental health services and there is a need for more support for people while they are waiting to be seen.
- Services, organisations, and communities should work together to support people and manage demand on services, for example local authorities and schools for young people, more peer support, and the voluntary sector to have better links into NHS services.
- People from Black, Asian and minority ethnic backgrounds highlighted issues including a lack of trust in health and care services and a feeling of not being listened to or understood.
- People highlighted the need of support to reduce mental health illness. This includes strong relationships with carers following a hospital admission and access to support that reduces the impact of social isolation, the cost of living crisis and digital isolation.
- 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.

Our focus

As a partnership, our areas of focus for collective action are:

Improving the mental wellbeing children and young people (CYP)

To do this we will:

- Increase our understanding of effective mental ill-health prevention for children and young people, by reviewing the evidence base, seeking feedback from service users, carers, and professionals, and measuring outcomes of innovation and pilot work.
- Increase effective universal mental health and wellbeing support for children and young people in settings such as schools, primary care, and community services by taking a joint commissioning approach to service provision, guided and informed by data and our community voice.
- Increase awareness to support self-help and early diagnosis and reduce stigma by supporting children and young people to normalise talking about mental wellbeing.
- Ensure earlier intervention and reduce barriers to accessing services by increasing awareness of the range of specialist services in the heart of our communities, through schools, the voluntary and community sector and faith groups.
- Improve transition of children and young people from child and adolescent mental health services (CAMHS) to adult mental health services by ensuring the right support is available and through better joined up working.

Enabling healthy environments that increase mental wellbeing

To do this, we will:

- Increase understanding of what makes different environments healthy and positive for mental wellbeing, both from a community and a services perspective.
- Support service user-led assessment of services and environments to check for appropriateness in terms of disability, age, and cultural needs.
- Identify a small number of areas of focus where we can work together to decrease unsafe environments and increase healthy places that support mental wellbeing. This could include positive workplaces, stable housing and green spaces.

- Consider what we can do as health and care organisations to develop a culture in South West London where we value and embed kindness and respect and provide opportunities to build connections between people, especially where those links have been damaged by the Covid-19 pandemic.
- Increase staff wellbeing by creating safe spaces to enable open conversations about how things are going through training, reflection and debrief time and demonstrating tangible action on feedback.

Improving mental health literacy and reducing stigma

To do this we will:

- Building on the South London Listens programme, increase community co-creation and empower communities to hold us to account by building on existing links, networks, and resources across the partnership.
- Develop effective and coordinated communications campaigns to support positive mental wellbeing, sharing key messages such as “it’s okay not to be okay” alongside existing mental health and wellbeing support resources.
- Create a directory of services by first mapping our resources and services across the boroughs to increase our own understanding and access to relevant and up to date information so we can better signpost individuals.
- Consider how we can maximise opportunities to ‘make every contact count’, so that when services are engaging with people, we consider mental health as well as physical or social needs.

Understanding complex needs and co-occurring issues to better support our residents

To do this we will:

- Improve our understanding of what is ‘complex’ and extend this to co-design a single person-centred framework that describes complex needs using common language across agencies.
- Review existing services for people with complex needs and develop plans for any improvements.
- Co-create definitions of outcomes with people with lived experience and ensure they are person-centred.

10. Community based support for older and frail people

We want to ensure our residents get the person-centred care and support they need to age well, living in their own home and community wherever possible.

South West London has an ageing population – the average age has increased by 1-3 years since 2011, and over the next 10 years we expect an increase in the number of older residents – around 25,000 more.

High numbers of people live with age-related conditions, multiple long-term conditions and high numbers of people end up in hospital after a fall.

Anywhere between **20 – 30%** of the hospital admissions[1] could be avoided through proactive identification and management within community.

We have higher than the regional average rates of dementia.

On average, men live 1 more year in good health than women but this ranges from 63.2 years in good health in Croydon to 70.2 years in Merton.

36.3% of women and **22.7%** of men over the age of 65 were living alone in 2021/22

1 in 10 people over the age of 65 are unpaid carers, with over half of those who provide care do so for more than 50 hours a week

1 SUS data comparison between 2018/19 and 2022/23

People and communities tell us

- Experience of loneliness and isolation in older people were exacerbated by the pandemic and can affect physical and mental health.
- Support for healthy ageing, such as preventing and addressing frailty, should focus on staying physically and mentally well, and helping older people to maintain independence.
- Older people need to have a range of options for accessing information and services to prevent digital exclusion. Many prefer face-to-face appointments.
- People living with dementia would like better information provision, in one place. More help to navigate services and access support should be provided where necessary.
- We should continue to become more dementia friendly and increase training for healthcare and public sector staff.

Our focus

As a partnership, our areas of focus for collective action are:

Making South West London dementia friendly

To do this we will:

- Work with dementia charities to determine the characteristics and requirements of a dementia friendly system and develop a plan to get there.
- Map the current organisations and businesses across South West London who are dementia friendly ensuring that this information is readily available to both people with dementia, and their carers and professionals.
- Work together to increase the number of organisations, including businesses, who are designated dementia friendly. We will particularly focus on organisations which support people with dementia who experience the most health inequalities.
- Increase dementia awareness by providing and promote dementia awareness training across South West London such as ‘dementia friends’ training.
- Support people to become ‘dementia friends’ ambassadors.

Reducing and preventing social isolation in South West London communities

To do this we will:

- Identify older people who are or are at risk of becoming social isolated. We will do this by using existing data sources in a more joined up way, for example, census data, housing and adult social care data, and GP registers.
- Roll out the proactive care model across South West London. The proactive care model brings together professionals across health and care in multi-disciplinary teams to develop personal support plans for people at risk of experiencing issues such as hospital admission, breakdown in care and social isolation.
- Connect people to activities and support networks to help alleviate the social isolation they may be experiencing. Care navigation, such as social prescribing, is one way a person can be supported to access a range of activities provided by voluntary and community organisations.
- Work with the prevention priority to support older people to access training and equipment for people who are currently digitally excluded, where a digital offer is what they want.

South West London frailty network

The South-West London Frailty Network is a system-wide forum comprising of representatives across health, social care and wider Local Authority services, and the voluntary sector. The overall aim is to work together in partnership across the system to develop a more coordinated response to the challenge of frailty and specifically to move our focus towards proactivity and prevention. This requires a joined-up focus on developing proactive, community-based services and assets that will help lead to prolonged independence for people frailty. In turn, this results in a more sustainable community-based frailty offer, that places less demand on reactive urgent, emergency, and acute services.

Social prescribing

Social prescribing is a way GPs, nurses, link workers and other health and care professionals can refer people to a range of local services to meet their non-clinical needs. In South West London, we will take a more holistic approach to a person's health and wellbeing by focusing on what matters to them, by expanding and promoting social prescribing to support older people to live fulfilling lives in their own communities.

- Build on the existing borough based social prescribing models to ensure it is embedded into each local community network. We will also expand the range of link workers who work specifically with those population groups who experience the worse health outcomes.
- Map the current service offers in all boroughs that support people who are experiencing or at risk of experiencing social isolation ensuring that this information is readily available to both people and their carers and professionals.
- Work together to address gaps in current services with a particular focus on support to older people who are experiencing social isolation and health inequalities.

Elevating the voices of patients, carers, and communities

We need to hear from people themselves about what would help them to feel more connected and less isolated and to engage with them where they are.

Working together to prevent older people having falls

To do this we will:

- Identify people who are at risk of falling by using existing data sources in a more joined up way, for example, housing data and adult social care data, GP registers.
- Ensure that everyone who reports experiencing a fall is followed up and offered support to prevent future falls.
- Review good practice examples and develop our falls prevention services to ensure that we have the very best offers across all six of our Places.
- We will use our data to identify our communities and population groups where the incidence of falls is higher than predicted. Working with those communities and the voluntary sector groups, we will co-produce our falls prevention services to ensure that they are delivered in a way that is accessible to the community and meets their needs.
- Support the further roll out of falls prevention training and education. This will include ensuring all health and care professionals who work with older and frail people develop and maintain basic professional competence in falls assessment and prevention.
- Develop training and information to be shared more widely across health and care, community services such as the VCSE, carers and people who are at risk of falling.

Supporting the wellbeing of unpaid carers

To do this we will:

- Identify an unpaid carers champion from the ICP membership. Their role will be to ensure that consideration is given to the needs of unpaid carers by ensuring the policies and service developments in our organisations recognise the importance of what they do.
- Promote the needs of carers across the partnership ensuring that we make the best opportunity of events such as the annual carers week.
- Encourage people to identify as carers so that they can access the support available to them. We will promote the use of the carers toolkit which has been developed by NHS England and its partners to help health and social care professionals in identifying, assessing, and supporting the wellbeing of carers and their families.
- Increase our understanding of access to, and quality of, respite available to unpaid carers across South West London, by listening to what carers tell us and analysing the current offer across our six Places.

11. Workforce

Approximately 80,000 people are employed in the health and care sector in South West London making it the third largest employment sector in South West London. Our population is also supported by a large number of volunteers, voluntary sector organisations and carers.

IN SOUTH WEST LONDON:

Number of staff

In the NHS, approximately **34,000** staff

In adult social care, approximately **35,000** staff

The average vacancy rate:

for NHS in 2022/2023 was **12.6%**

for adult social care in 2021/22 was **11.5%**

People leaving their jobs

In the NHS in 2022/23, **4,141.60** whole-time equivalents (WTE), which is up 6% from 2021/22

In adult social care in 2021/22, **29.9%**

Gender

In the NHS, **74.5%** of the workforce are female

In adult social care, **81%** of the workforce are female

Age

In the NHS, the average age is **42** years old

In adult social care, the average age is **47** years old

The statistics shown here relate to adult social care and the NHS in South West London. As a partnership, there is more to do to describe the full picture across our workforce, including children's social care, other Council services and the workforce of the voluntary and community sector.

People and communities tell us

- They would like compassionate treatment from staff who care.
- Staff shortages and pressurised environments can often mean some staff don't have the time to listen or consider the specific health and care needs of individuals, or their backgrounds, for example ethnicity, neurodiverse people and trans people.
- In some communities, particularly Black, Asian and minority ethnic communities, there is mistrust and fear about using public services due to experiences of racism.
- People with long-term conditions would like to be recognised as experts in their condition as many have lived with illness for years.
- People are keen to be 'partners' with health and care professionals around their care plans and decision-making.

Our focus

Given its importance in every priority and organisation, tackling our system wide workforce challenges has been agreed as an Integrated Care Partnership priority.

As a partnership, our areas of focus for collective action are:

Targeting difficult to recruit health and care roles so that we reduce vacancies and improve our services and care

To do this we will:

- Agree the **three most difficult to recruit roles** across the partnership and target action to support recruitment processes.
- **Increase permanent recruitment in roles with high levels of agency staff.** We will **reduce agency spend** so to support continuity of care to service users and residents and focus on recruitment and retention of our permanent workforce. We will target **three roles** with the highest numbers of agency staff; to increase the percentage of staff in those roles who are directly employed.

Making South West London a great place to work to improve retention, attract new people into South West London, and support the health and wellbeing of our people

To do this we will:

- All partners working towards achievement of the Mayor of London's Good Work Standard, including paying staff and contractors at least London Living Wage to reflect the high cost of living in the capital.
- Review the South West London health and wellbeing offer so that we look after those who look after others and explore ways to improve this.
- Improve how easy it is for our staff to move between organisations in South West London so that they can develop and grow without having to leave South West London.
- Establish an anti-racism framework across our partnership (please see the health inequalities section for further information).

Supporting local people into employment to reduce health inequalities, support the cost-of-living crisis, better reflect the communities we serve and help tackle poverty

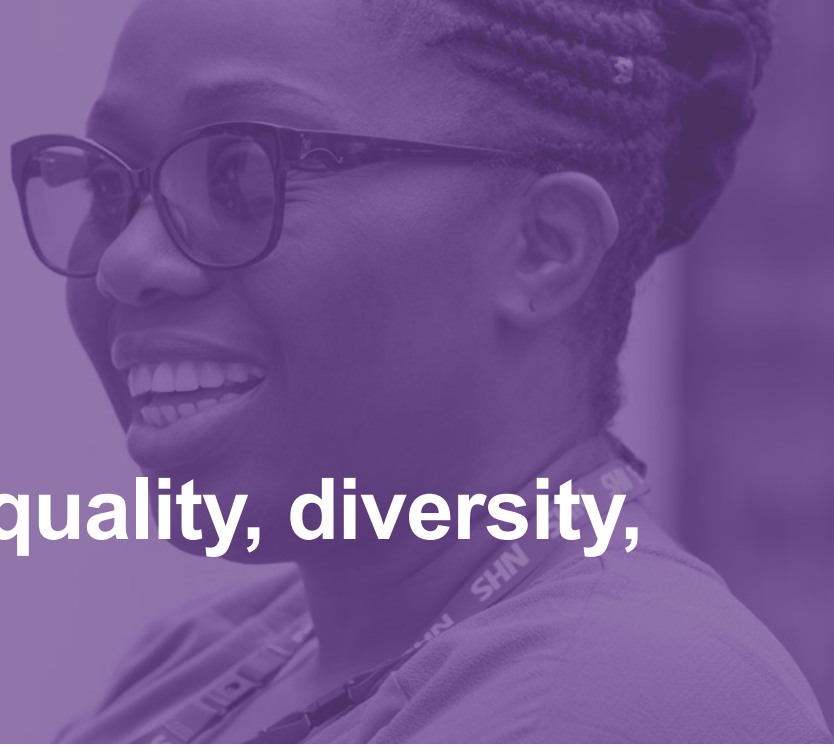
To do this we will:

- **Increase apprenticeships and work experience placements.** As part of work on apprenticeships, we will work with partners to secure and fill 100 work experience opportunities or placements in five priority roles to support people to gain new skills and learning to prepare them for employment in our system. We will work with our managers to develop next steps into apprenticeships within these areas.
- **Employ 100 young people into health and care roles.** Collaborating with schools, universities, and organisations who work with young people, ensuring the breadth of roles and opportunities available are promoted, and providing support with application processes, career development and support for young people choosing health and care employment.
- Develop an Integrated Health and Care Workforce Academy that includes all partners, building on the Mayor's skills academy programme (NHS) and the adult social care workforce academy to support local people into good jobs in health and care. The plan to be developed may include:
  - Actively promoting jobs and careers in health and social care, including career pathways through system wide recruitment campaigns targeted to local people and communities.
  - Promoting career development options with the potential to develop an integrated career advisory/support service.
  - Proactively work with local community groups to support people from our most disadvantaged communities into good jobs in health and care.

Designing our future workforce identifying new or different roles that will be needed to support health and care in the future

To do this we will:

- Review the vision for health and care organisations across South West London over the next ten years and the workforce requirements that will be required to deliver this vision.
- Review expected growth, workforce data, and national requirements for health and care workforce, as well as staff feedback, and consider how roles could be designed differently in the future to address the changing needs of our residents, the impact of technology and the ongoing need for increased productivity.
- Identify the critical skills and capabilities for any new roles and agree the training and development required to support these. We will also consider how new roles and models of working could support service areas where health and care roles are difficult to recruit.



12. Championing equality, diversity, and inclusion

South West London is diverse in its population and health needs across our six Places. Our Core20PLUS5 data shows us:

Core 20 (339k population)	Remaining 80 (1.35m population)

Age

Core 20		Remaining 80	
35	38	64	70	82	84
Median		Healthy Life Expectancy		Life Expectancy	

Ethnicity

Core 20				Remaining 80			
16%	14%	24%	7%	12%	11%	48%	68%
Asian		Black		Other		White	
2 in 10 are in C20		4.5 in 10 are in C20		2 in 10 are in C20		1.5 in 10 are in C20	

Borough

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

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

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

Long-Term Conditions

29.5% have a long-term condition

28.6% have a long-term condition

Improving equality, diversity and inclusion is a priority for all organisations across South West London and there is a tremendous amount of action being taken in each to address their individual priorities.

Tackling inequality is our guiding principle and we are committed to being a fair, compassionate, and inclusive Partnership. We will champion our most vulnerable residents, including those who may suffer from prejudice or discrimination because of who they are or their circumstances.

Equality, diversity, and inclusion will be a 'golden thread' running through everything we do, and how we work together, so that we provide the very best services and care for all people living in South West London.

In an earlier section of our strategy, we outline the action we will take to to reduce the health inequalities that exist. This year will see us introduce an anti-racism framework which will enable measurement of progress in improving racial equity.

Throughout our strategy we highlight the experiences and views of people and communities so that their needs and experiences drive what we do. We will continue to engage our communities to understand their experiences, barriers and challenges in accessing and using our services so that we can continue to improve these.

All our partner organisations are committed to preventing discrimination and improve equality and are working towards achieving this in different ways. For example:

- The Wandsworth Community Empowerment Network and Croydon BME Forum are leaders in the Ethnicity in Mental Health Improvement Programme, to reduce racial inequalities in access to, experience of and outcomes in mental health services.
- There is an active London Association of Directors of Social Services Equality and Diversity Programme, and the People at Heart of Care Work Programme includes a commitment on combating inequality in the social care workforce, starting with the roll out of the Social Care Workforce Race Equality Standards.
- The NHS Workforce Race Equality Standard (WRES) is used across the NHS in South West London to improve the experience of ethnic minority staff and the diversity of NHS leadership, through collecting, analysing, and acting on specific workforce data.

- The NHS is developing a disability advice line (DAL) aims to support and engage people with disabilities and long-term health conditions by offering confidential independent disability advice. The DAL will introduce and raise awareness of 'disability potential' within South West London and measure its impact through the increased number of disabled people at every stage of the recruitment process.

Ethnicity in health and adult social care workforce

In the NHS, black and ethnic minority staff make up **51%** of the workforce, compared to **49.9%** in London

In adult social care, black and ethnic minority staff make up 61% of the workforce.

Black and ethnic minority staff are significantly underrepresented in senior leadership roles – in the NHS in South West London, over 80% of senior management positions filled by white staff.

The vital work of our partnership would be impossible without the fantastic work of the very broad range of people who provide our services and care, our people. As employers, we remain committed to promoting equality and diversity for them.

We value and welcome their different ideas, skills, backgrounds, and experiences and aim to foster a culture that values our people, promotes wellbeing and mental health, and provides support to enable all our people to thrive.

We are clear that a diverse and inclusive workforce ensures better care for our communities. We will work together to continue to build a diverse and inclusive workforce that reflects and understands the people we serve.

The workforce, paid and unpaid, of our voluntary and community sector in South West London is extremely diverse. A range of organisations across all our places, from large umbrella groups to small grassroots groups plays a key role in connecting with, supporting, and representing all of our diverse communities.

13. Championing the green agenda

Climate change is a global health emergency. As a Partnership we recognise that we all have a role to play in tackling climate change and are committed to acting together to take action.

Climate change is widening disparities in health, with some communities suffering worse outcomes than others in terms of flooding, urban overheating and food and water scarcity. We will work with the Greater London Authority on reducing the impact of climate change on the health of our population and through our NHS and local authority Green Plans, we will also work to advance our environmental sustainability.

Our surroundings impact our health. For example, we know that air pollutants are emitted from a range of both man-made and natural sources and not only impact our climate but also impact our health. Many everyday activities such as transport, industrial processes, energy generation and domestic heating can have a detrimental effect on air quality. Poor air quality is a serious public health issue which increases the risks from heart and lung disease.

- Air pollution 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 regional average.

Access to green space is another factor that influences our health. There is growing evidence of the physical and mental health benefits of green spaces. This evidence shows the role green spaces can play in improving mental health, increasing longevity in older people, and lowering rates of obesity[2].

Extreme temperature is also a risk factor. Both extreme cold and warm temperatures have the greatest effect on older people. Other people at risk include those with long-term or pre-existing health conditions, people with disabilities, very young children including babies, pregnant women and birthing people, people experiencing deprivation, rough sleepers and those living in areas at risk from flooding or extreme heat including heavily urbanised localities such as town centres.

Tackling the causes and mitigating the impacts of climate change will provide us with an opportunity to improve health and care. Cutting down emissions will reduce adverse weather pressures on our services, reduce admissions to hospital and improve the health of our communities. Our Partnership will therefore work together on our collective green priorities. Together, we will:

- Make it easier for our partners to collaborate and share information and best practice, so that we learn from each other and move towards and championing our common Net Zero goals.
- Work collectively to reduce the impact of climate change on the health of our population by raising awareness and supporting vulnerable groups and communities.
- Change the way in which we do things including the promotion of sustainability, identification of local risks and development of plans to manage and adapt to climate change.

Our partners have made great progress, with significant achievements in medicines, estates, procurement, and transport. We will create a framework for us to progress with greater momentum, maintain consistency across our Partnership, and embed sustainability into our culture, so that it is part of everything that we do.

2 Briefing8_Green_spaces_health_inequalities.pdf (publishing.service.gov.uk)

14. Elevating the patient, carer and community voice

As a partnership we are committed to making sure we hear the experiences and views of our patients, carers and local communities. This cross cutting theme will be implemented in each of our priority areas.

Our partnership includes our Voluntary, Community and Social Enterprise (VCSE) Alliance and our six Healthwatches who all play an integral role in supporting our inclusive approach to elevating the patient, carer and community voice.

We will make sure that we do this by:

- **Inclusive representation** of our people and communities – **involving the right people in the right conversations and amplifying the voices of people with lived experience and carers, inclusive of all protected characteristic groups and people of all socioeconomic backgrounds**. We are committed to having the right voices in our decision making groups, within our partnership and working in our delivery groups to take forward our priorities.
- **Starting early and continuing our conversations** – build on what we have already heard and involve people at the beginning of the development of our plans.
- **Guided by insight and intelligence** – making sure that our decisions are informed by our local insight and intelligence, ensuring that we take a population health approach which is informed by what both our local quantitative and qualitative data tells us.
- **Adopting principles of coproduction** – where possible we work in a way which involves people who use health and care services, carers and communities in equal partnership. We engage with people early so that their views can meaningfully influence the design, delivery, and evaluation of health and care services.

As a partnership we will work together to make sure that engagement of our local people and communities elevates these voices. **We will collectively use our networks and relationships to hear from a more diverse group of people, including those who do not routinely engage with health and care services.** We are committed to community led engagement and approaches that will strengthen our understanding of our communities, their views and experiences. **We will work hard to put people and communities at the centre of how we work together to improve the health and well-being of South West London residents, with a focus on health inequalities.**

15.
Thank you to our partners

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We would like to thank all our partners for sharing their insight and engagement work and for supporting us in delivering all of our engagement work. 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 Integrated Care Partnership priorities and strategy. You can read our full insight report with our partners and networks across South West London on our website.

Our partners in South West London

Our six local authorities:

- London Borough of Croydon
- Royal Borough of Kingston upon Thames
- London Borough of Merton
- London Borough of Richmond upon Thames
- London Borough of Sutton
- London Borough of Wandsworth

Our South West London Integrated Care Board

Our six local Healthwatches:

Croydon | Kingston | Merton | Richmond | Sutton | 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

Croydon Neighbourhood Care Association

Kingston Voluntary Action

Merton Connected

Richmond Community Voluntary Services

Wandsworth Care Alliance

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

Your Healthcare

Our 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 our six Places

The London Ambulance Service

Our NHS provider collaboratives:

Royal Marsden Partners

South West London Acute Provider Collaborative

South London Mental Health and Community Partnership

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www.southwestlondonics.org.uk

South West
London
Integrated
Care System