South West London Integrated Care System

Meeting Pack

South West London Integrated Care Partnership

20 July 2023
5.30pm to 7.30pm

MS Teams

South West London Integrated Care Partnership Board

Thursday 20 July 2023
17.30 to 19:30
MS Teams

	Time	Agenda Item	Sponsor	Enc
01	17.30	**Welcome, Introductions and Apologies**	Co-Chairs	
02		**Declarations of Interest** *All members and attendees **may** have interests relating to their roles. **These interests should be declared in the register of interests.** While these general interests do not need to be individually declared at meetings, interests over and above these where they are relevant to the topic under discussion should be declared.*	All	01
03	17.35	**Minutes, Action Log and Matters arising** Minutes and actions arising from the SWL ICP Partnership meeting held on the 19 April 2023	Co-Chairs	02
04	17.40	**South West London Integrated Care Partnership Strategy**	Rachel Flagg	03
05	17.55	**South West London Integrated Care Partnership Governance**	Rachel Flagg	04
06	18.10	**South West London Investment Fund** • SWL Innovation Fund 2022/23 Scheme progress report for information • Innovation Fund Project Spotlight 2022/23 - SWL Winter Fit - Sutton: Cheam & South Sutton Loneliness Project - Advanced Care Planning for people attending Croydon Health Services Emergency Department • SWL Investment Fund Revised Approach 2023/24	Angela Flaherty Catherine Heffernan/ Amit Patel Michelle Rahman Karen Barkway Angela Flaherty	05 Verbal 06
07	18.50	**The Voluntary, Community and Social Enterprise (VCSE) Alliance in the Partnership**	Sara Milocco	07

	Time	Agenda Item	Sponsor	Enc
08	19.15	**Any Other Business**	All	
09	19.20	**Meeting close**	Chair	
10	19.20	**Public Questions -** Members of the public are invited to ask questions relating to the business being conducted today. Priority will be given to those received in writing in advance of the meeting.	Chair	

Next Meeting: 4 October 2023: Hotel Antoinette, Wimbledon, SW19 1SD

NHS South West London Integrated Care Partnership Board Register of Declared Interests July 2023

Name	Current position (s) held in the ICB .	Do you have any interests to declare? (Y or N)	Declared Interest (Name of the organisation and nature of business)	Financial Interest	Non-Financial professional Interest	Non-Financial Personal Interest	Indirect Interest	Nature of Interest	From	To	Action taken to mitigate risk
Elaine Clancy	**Chief Nursing Oficer** ICB Board Member ICP Board Member Quaity & Oversight Committee Member People Board Member	Y	1. Langley Park Girls School 2. 1930 Fund for District Nurses			1 2		1 School Governor Langley Park Girls School 2 Trustee 1930 Fund for Disrict Nurses	1 September 2017 2 December 2022	ongoing	Declared and discussed where relevant with conflicts of Interest Guardian
Sarah Blow	**ICB Chief Executive** ICB Board Member ICP Board Member Attendee of the Remuneration and Nominations Committee Member of Recovery & Sustainability Board	Y	1. LAS				1	1. My son is a band 3 call handler for LAS outside of SWLondon	Jan-22	Present	Individually determined
Karen Broughton	**Deputy Chief Executive / Director of People & Transformation** ICB Board Member ICP Board Member Attendee of the Remuneration and Nominations Committee People Board Member Member of Recovery & Sustainability Board	N	Nil Return								
Dr John Byrne	**Executive Medical Officer** ICB Board Member ICP Board Member Member of the Quality Oversight Committee Member of the Finance and Planning Committee Member of Recovery & Sustainability Board Member of the People and Communities Engagement Assurance Group (PCEAG)	N	Nil Return								
Helen Jameson	**Chief Finance Officer** ICB Board Member ICP Board Member Attendee of the Finance and Planning Committee Attendee of the Audit and Risk Committee	N	Nil Return								
Jo Farrar	**Partner Member Community Services** Member of the ICB Board Member of ICP Board Richmond Place Member People Board Member	Y	1. Chief Executive Kingston Hospital NHS Foundation Trust 2. Hounslow and Richmond Community Healthcare NHS Trust	1 2				1. CEO of Provider Trust in SWL 2. CEO of Provider Trust in SWL	1 2019 2 2021	Present	Declared and discussed where relevant with Conflicts of Interest Guardian
Dr Nicola Jones	**Partner Member Primary Medical Services** ICB Board Member ICP Board Member Member of the People and Communities Engagement Assurance Group (PCEAG)	Y	1. Managing Partner Brocklebank Practice, St Paul's Cottage Surgery (both PMS) and The Haider Practice (GMS) 2. Joint Clinical Director, Brocklebank PCN 3. Brocklebank PCN is part of Battersea Healthcare (BHCIC) 4. Convenor, Wandsworth Borough Committee 5. Primary Care Representative, Wandsworth 6. Co-Chair Cardiology Network, SWL ICS 7. Clinical Director Primary Care, SWL ICS	1 3 4 5	2 6			1. Practices hold PMS/GMS contracts. Dr Nicola Jones holds no director post and has no specific responsibilities within BHCIC other than those of other member GPs.	1. 1996 2. 2020 3. 2018 4. 2022 5. 2022 6. 2022 7. 2022	1-7 Present	Adherence to COI policy
Ruth Dombey	**Partner Member Local Authorities** ICB Board Member Joint Chair of the ICP	N	Nil return								
Dr Dino Pardhanani	**Sutton Place Member** GP and Sutton Place Convenor ICP Board Member	Y	1. Primary Care Representative, Sutton Place 2. Clinical Director Central Sutton Primary Care Network 3. NED (Chair) of Sutton PCNs CiC 4. NED SWLPPA CiC 5. Mulgrave Road Surgery – GP Principle	3 4 5	1 2			1. Primary Care Representative, Sutton Place 2. Clinical Director Central Sutton Primary Care Network 3. NED (Chair) of Sutton PCNs CiC 4. NED SWLPPA CiC 5. Mulgrave Road Surgery – GP Principle	1 July 2022 1 July 2019 1 July 2021 1 July 2022 1 Nov 2004	Present	Declared discuss where relevant with the Conflicts of Interest Guardian
Dr Gillian Norton	**Provider Chair** **S**t. George's & Epsom & St Helier Hospitals ICP Board Member	Y	1. Representative Deputy Lieutenant London Borough of Richmond 2. Chair London Borough of Richmond Voluntary Fund 3. Member of the UK Commission on COVID Commemoration			1 2 3		1. Representative Deputy Lieutenant London Borough of Richmond 2. Chair London Borough of Richmond Voluntary Fund 3. Member of the UK Commission on COVID Commemoration	2016 2018 21/07/22	ongoing ongoing 31/03/23	
			1. Lewisham and Greenwich NHS Trust								

Mike Bell	**ICB Board Chair** ICP Board Co-Chair	Y	2. Director at MBARC Ltd (Research and consultancy company which works with central and local government and the NHS). Current clients are: •W□ elsh Government - Financial inclusion and Social Justice services - since 2013 - ongoing •N□EL ICS - Executive Coaching - since 2020 - ongoing •N□CL ICS - Primary Care development - May 2022 - 2023 •V□isiba Health Care - Chair UK advisory Board Jan 2022 ongoing •S□urrey Physion - Strategic Adviser Feb 2023 ongoing •W□ A Communications - Strategic Adviser Mar 2023 ongoing •D□AC Beachcroft - Strategic Adviser April 2020 ongoing •Z□PB - Strategic Adviser 2018 ongoing •R□innova - Strategic Adviser 2022 ongoing	1. 2.				1. Chair of Lewisham and Greenwich NHS Trust 2. Director of MBARC Ltd	1. Jul 2022 2. 2013	Present	Declared and discussed where relevant with Conflicts of Interest Guardian
Dr Carol Cole	**Provider Chair** **Central London Community Healthcare** ICP Board Member	Y	1. Chair of Together for Mental Wellbeing 2. Trustee, Age UK			1 2		1. Chair of Together for Mental Wellbeing 2. Trustee, Age UK	2017 2020	To date To date	
Name	**Current position (s) held in the ICB .**	**Do you have any interests to declare? (Y or N)**	**Declared Interest (Name of the organisation and nature of business)**	**Financial Interest**	**Non-Financial professional Interest**	**Non-Financial Personal Interest**	**Indirect Interest**	**Nature of Interest**	**From**	**To**	**Action taken to mitigate risk**
Sukhvinder Kaur-Stubbs	**Provider Chair** **Hounslow and Richmond Community Healthcare** ICP Board Member	Y	1. Chair of Thames Water Customer Challenge Group 2. Chair of Regeneration for London Legacy Development Corporation 3. Board Member Regulator for Social Housing 4. MD of Engage – Building Networks of Trust 5. Governor of the Leathersellers Federation of Schools	1 2 3 4		5		1. Chair of Thames Water Customer Challenge Group 2. Chair of Regeneration for London Legacy Development Corporation 3. Board Member Regulator for Social Housing 4. MD of Engage – Building Networks of Trust 5. Governor of the Leathersellers Federation of Schools	July 21 2018 July 21 2012	2018	
Ann Beasley	**Provider Chair** **South West London & St. George's Mental Health Trust** ICP Board Member Chair of Recovery & Sustainability Board	Y	1. Vice Chair, St George's University Hospitals NHS Foundation Trust 2. NED, Epsom and St Helier University Hospitals NHS Trust 3. Company Director, Alzheimer's Trading Limited 4. Trustee, NHS Providers	1 2	3 4			1. Vice Chair, St George's University Hospitals NHS Foundation Trust 2. NED, Epsom and St Helier University Hospitals NHS Trust 3. Company Director, Alzheimer's Trading Limited 4. Trustee, NHS Providers	Oct 2016 Jun 2021 Oct 2021 May 2020	to date To date To date To date	
Cllr Yvette Hopley	**Croydon Health & Wellbeing Chair** ICP Board Member	Y	1. Cabinet Member for Health & Adult Social Care (Croydon) 2. Chairman Health & Wellbeing Board (Croydon) 3. Governor for South London and Maudsley NHS Foundation Trust – Croydon 4. Member Croydon Adult Social Services Users Panel 5. Member Croydon Safeguarding Board 6. Member Croydon Voice of the People 7. Member Croydon Adult Social Services Review Panel 8. Member Autism Board 9. Vice Chairman South East Cancer Help Centre 10. Rotary Community Consortium – Started to offer support during COVID		1 2 3 4 5 6 7 8 9	10		1. Cabinet Member for Health & Adult Social Care 2. Chairman Health & Wellbeing Board 3. Governor for South London and Maudsley NHS Foundation Trust – Croydon 4. Member Croydon Adult Social Services Users Panel 5. Member Croydon Safeguarding Board 6. Member Croydon Voice of the People 7. Member Croydon Adult Social Services Review Panel 8. Member Autism Board 9. Vice Chairman South East Cancer Help Centre 10. Rotary Community Consortium – Started to offer support during COVID	May 2022 May 2022 May 2022 May 2022 May 2022 May 2022 May 2022 May 2022 May 2013 May 2020	Present Present Present Present Present Present Present Present Present Present	
Cllr Peter McCabe	**Merton Health & Wellbeing Chai**r ICP Board Member	tbc	to follow								
Cllr Piers Allen	**Richmond Health & Wellbeing Chair** ICP Board Member	Y	1. Remuneration (TBD by ICB Remuneration & Nominations Comm) as non-Executive Convenor of Richmond Place Based Partnership Committee 2. Remuneration (TBD by ICB Remuneration & Nominations Comm) as non-Executive Convenor of Richmond Place Based Partnership Committee 3. Chair of Richmond Health & Wellbeing Board 4. Elected member for London Borough of Richmond upon Thames; Lead member for adult social care, health & public health; Chair, Adult Social Services, Health & Housing Committee, LBRuT 5. Lead for Health, Wellbeing & Adult Care (including Public Health) — London Councils 6. Council of Governors, Kingston Hospital Foundation Trust (Local authority rep for Richmond Council) 7. Spouse is Head of Nursing (Cancer and Supportive Services) and Lead Cancer Nurse for Guy's & St Thomas' NHS Foundation Trust 8. Trustee/Director, The Mulberry Centre, Isleworth (Cancer Support Centre)	1		2 3 4 5 6 8	7	1. Remuneration (TBD by ICB Remuneration & Nominations Comm) as non-Executive Convenor of Richmond Place Based Partnership Committee 2. Remuneration (TBD by ICB Remuneration & Nominations Comm) as non-Executive Convenor of Richmond Place Based Partnership Committee 3. Chair of Richmond Health & Wellbeing Board 4. Elected member for London Borough of Richmond upon Thames; Lead member for adult social care, health & public health; Chair, Adult Social Services, Health & Housing Committee, LBRuT 5. Lead for Health, Wellbeing & Adult Care (including Public Health) — London Councils 6. Council of Governors, Kingston Hospital Foundation Trust (Local authority rep for Richmond Council) 7. Spouse is Head of Nursing (Cancer and Supportive Services) and Lead Cancer Nurse for Guy's & St Thomas' NHS Foundation Trust 8. Trustee/Director, The Mulberry Centre, Isleworth (Cancer Support Centre)	1 July 2022 1 July 2022 23 May 2022 23 May 2022 7 June 2022 23 May 2022 March 2021 23 Aug 2022	Current Current Current Current Current Current Current Current	Compliance with ICB CoI Policy Compliance with ICB CoI Policy Compliance with ICB CoI Policy Compliance with ICB CoI Policy Compliance with ICB CoI Policy Compliance with ICB CoI Policy Compliance with ICB CoI Policy Compliance with ICB CoI Policy

Cllr Graeme Henderson	**Wandsworth Health & Wellbeing Chair** ICP Board Member	N	Nil return								
Anna Popovic	**Director of Children's services** ICP Board Member	N	Nil return								
Annette McPartland	**Director of Adult Social Services** ICP Board Member	N	Nothing to declare								
Iona Lidington	**Director of Public Health** ICP Board Member	tbc	to follow								
Caroline Dwyer	**Growth & Economy** ICP Board Member	Y	1. Non Executive Director Shoreham Port Authority 2. Non Executive Director Jersey Development Company 3. Member Office of Road and Rail Regulation Expert Panel 4. Commissioner National Preparedness Commission	1 2 3	4			1. Non Executive Director Shoreham Port Authority 2. Non Executive Director Jersey Development Company 3. Member Office of Road and Rail Regulation Expert Panel 4. Commissioner National Preparedness Commission	2014 2021 2020 2021	To date To date To date To date	
Brenda Scanlon	**Croydon Place Member Chair of Age UK Croydon** ICP Board Member	tbc	to follow								
Dr Sy Ganesaratanam	**Merton Place Member** **GP Medical Director Merton Federation** ICP Board Member	tbc	to follow								
Shannon Katiyo	**Wandsworth Place Member Director of Public Health** ICP Board Member	N	Nil Return								
Nick Merrifield	**Kingston Place Member** ICP Board Member	Y	1.Director, Kingston GP Chambers Ltd 2.Clinical director, New Malden and Worcester Park PCN 3.Spouse works for The Health Foundation, which awards grants and does consultancy work	1. 2.			3	1.Director, Kingston GP Chambers Ltd 2.Clinical director, New Malden and Worcester Park PCN 3.Spouse works for The Health Foundation, which awards grants and does consultancy work	2011 2010 2021	To date To date To date	Recuse from relevant decisions, declare within a meeting if relevant
Sabah Hamed	**Kingston HWBB Chair** ICP Board Member	N	Nil return								
Fenella Merry	**Director of Resources** ICP Board Member	N	Nil return								
Sir Douglas Flint	**Provider Chair** **The Royal Marsden NHS Foundation Trust** ICP Member	N	Nil return								

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Yemisi Gibbons	**Provider Chair Croydon Healthcare Services** ICP Board Member	Y	1. Chair, Owner – Soma Healthcare Ltd – Private sector social care provider 2. Non-Executive Director – Oxleas NHS Foundation Trust 3. Non-Executive Director – North East London (NELFT) Foundation Trust 4. Registrant member of Fitness to Practice Committee – General Pharmaceutical Council	1 2 3 4				1. Chair, Owner – Soma Healthcare Ltd – Private sector social care provider 2. Non-Executive Director – Oxleas NHS Foundation Trust 3. Non-Executive Director – North East London (NELFT) Foundation Trust 4. Registrant member of Fitness to Practice Committee – General Pharmaceutical Council	Apr 2012 Jan 2017 May 2021 Mar 2014	Ongoing 31st Jan 2023 31st Jan 2023 Ongoing	
Alyssa Chase-Vilchez	**Healthwatch Representative Chair of Kingston HealthWatch** ICP Board Member Member of the People and Communities Engagement Assurance Group (PCEAG)	N	Nil return								
Mike Jackson	**Participant Member Local Authorities CEO of Richmonad & Wandsworth LA** ICB Participant ICP Member	N	Nil return								

Draft Minutes
South West London Integrated Care Partnership
19 April 2023, 17:30-19:00
Antoinette Hotel, The Broadway, Wimbledon, SW19 1SD

Chair: Cllr Ruth Dombey

Members:	**Designation & Organisation**
Health Members	
Sarah Blow (SB)	Chief Executive Officer (CEO), SWL ICB
Karen Broughton (KB)	Deputy CEO/Director of Transformation and People, SWL ICB
Helen Jameson (HJ)	Chief Finance Officer, SWL ICB
Nicola Jones (NJ)	Primary Care Services representative - GP
Ann Beasley (AB)	Provider Chairs representative – Chair, SWL and St George's Mental Health NHS Trust
Yemisi Gibbons (YG)	Provider Chairs representative – Chair, Croydon Health Services NHS Trust
Carol Cole (CC)	Provider Chairs representative - Chair, Central London Community Healthcare NHS Trust
Gillian Norton (GN)	Provider Chairs representative – Chair, Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust
Local Authority Members	
Cllr Ruth Dombey (RD)	ICP Co-Chair – Chair, Sutton Health and Wellbeing Board
Cllr Piers Allen (PA)	Chair, Richmond Health and Wellbeing Board
Cllr Graeme Henderson (GH)	Chair, Wandsworth Health and Wellbeing Board
Carolyn Dwyer (CD)	Growth and Economy representative - Strategic Director of Development, Growth and Regeneration, Sutton Council
Annette McPartland (AM)	Director of Adult Services representative - Director of Adult Social Care and Health, Croydon Council
Iona Lidington (IL)	Director of Public Health representative, Kingston Council - Director of Public Health / Assistant Director Healthy & Safe Communities, Kingston Council
Place Members	
Dr Nick Merrifield (NM)	Kingston Place - Primary Care Development Lead - GP
Dino Pardhanani (DP)	Sutton Place - Committee Convenor - GP
Brenda Scanlan (BS)	Croydon Place - Chair of Age UK Croydon
Other Members	
Alyssa Chase-Vilchez (ACV)	HealthWatch representative - SWL Healthwatch ICS Executive Officer
Sara Milocco (SM)	Voluntary Sector representative – VCSE Director for the Alliance
Dr Gloria Rowland (GR)	Clinical Senate Co-Chair - Chief Nursing and Allied Professional Officer and Director for Patient Outcomes, SWL ICB
Dr John Byrne (JB)	Clinical Senate Co-Chair - Executive Medical Director, SWL ICB
In Attendance	
Andrew Demetriades (AD)	Programme Director: ICS Development, SWL ICS
Charlotte Gawne (CG)	Executive Director of Stakeholder & Partnership Engagement and Communications, SWL ICS

Maureen Glover (MG)	Corporate Services Manager (ICS)
Apologies	
Cllr Sabah Hamed (SH)	Chair, Kingston Health and Wellbeing Board
Shannon Katiyo (SK)	Wandsworth Place - Director of Public Health, Richmond and Wandsworth Councils
Jo Farrar (JF)	Richmond Place - Chief Executive of Kingston Hospital and Hounslow and Richmond Community Healthcare NHS Trust, Kingston and Richmond Place Executive Lead
Sir Douglas Flint (DF)	Provider Chairs representative - Chair, The Royal Marsden Hospital NHS Foundation Trust
Sukhvinder Kaur-Stubbs (SKS)	Provider Chairs representative – Chair in Common of Kingston Hospital NHS Foundation Trust and Hounslow and Richmond Community Healthcare NHS Trust
Cllr Peter McCabe (PM)	Chair, Merton Health and Wellbeing Board
Cllr Yvette Hopley (YH)	Chair, Croydon Health and Wellbeing Board

No.	AGENDA ITEM	Action by
1.	**Welcome and Apologies**	
	The Chair welcomed everyone to the meeting. Apologies received were noted and with no further apologies the meeting was quorate. The Chair welcomed the new Voluntary Sector representative, Sara Milocco (SM), to her first ICP meeting.	
2.	**Declarations of Interest**	
	A declaration of interest register was included in the meeting pack. There were no further declarations relating to items on the agenda. The ICP **noted** the register of declared interests.	
3.	**Minutes of the last meeting dated 12 January 2023**	
	The minutes of the last meeting held on 12 January 2023 were **agreed** as an accurate record. There were two actions on the Action Log, both of which had been closed.	
4.	**Revised Terms of reference**	
	Andrew Demetriades (AD) presented the item and noted that the Terms of Reference had been brought to the Integrated Care Partnership (ICP) Board to approve the amendment to Section 6.5 Quorum. The ICP Board **approved** the revised Terms of Reference.	
5.	**Responses to Shaping our Integrated Care Partnership Discussion Document**	

	AD presented the report which provided a summary of the feedback and response to the engagement undertaken with the ICP's partners on the "Shaping our priorities for the South West London Integrated Care Partnership" discussion document. The feedback would inform the next steps in developing the South West London Integrated Care Partnership Strategy which would be produced for publication in Summer 2023. Cllr Ruth Dombey (RD) thanked the team for all their work and said she was pleased to see the level of responses from across a good geographical spread. Mike Jackson (MJ) noted the comments made by the LA had been well reflected and was in agreement with the proposals about how the additional comments made by the LA would be taken forward. It was noted that it would be helpful to include a more explicit reference in the document to the responsibilities the majority of organisations had in relation to their statutory duties for safeguarding. Brenda Scanlan (BS) commented on a point in the document where some stakeholders had requested that workforce ambitions be extended in year one to include social care and asked whether this was because some of those stakeholders genuinely see NHS pressures as a higher issue in terms of workforce or whether some of the issues about social care recruitment were not fully appreciated or known. It was recognised that many discussions took place about health and social care but this did not necessarily mean this was understood by the audience. AD reflected on a paper that had been brought to a previous meeting on the Social Care Workforce Strategy and noted that a lot of work was still ongoing to map out the position across the system from both a health and social care perspective. There was a need to communicate the fact that both health and social care had distinct challenges and the key issue was to identify where there was a need to work together across the system. In response to John Byrne (JBy) AD reflected that it was important, as part of Health Inequalities delivery planning, to be explicit about what was already being done in relation to CORE20PLUS5 and what further actions needed to be taken. It would make absolute sense to make sure, although it is a cross cutting issue, there is a priority for the partnership about having an anti-racism strategy that we can be explicit about in the final strategy. In relation to CORE25PLUS5 it was noted that it would made a huge difference to bring all of the data together that was held by both health and the LA and this should be explored further. SB acknowledged the huge amount of data held on the local population and explained that this was used differentially for different things. CORE20PLUS5 had proved helpful in setting a base line and it was now possible to measure whether an improvement in health had been seen and to judge ourselves against success. It was noted that there was a need to work together on the data strategy in relation to how to bring it together and use the data to inform what we do. Karen Broughton (KB) noted that as the ICP priorities were developed both health and LA data was brought together. There was a joint LA and health group which steered the design of the needs assessment chapter and which used both sets of data. Iona Liddington (IL) highlighted that prevention and early intervention were a key part of the document but there was a need to look at the inequalities piece. LA areas like housing, education, employment opportunities, all played into this not	

	just health. There was a need for clarity about how we are going to work together across SWL to make a difference and it was hoped that this would form part of the planning day. The ICP **approved** the recommended amendments to the ICP's priorities; **noted** the engagement responses to the ICP Strategy discussion document that had been received; **noted** the key themes raised from stakeholders in response to the discussion document and the questions on which views were sought; **noted and supported** the proposed further actions detailed in the report which would be addressed in the further development of the ICP Strategy prior to publication in Summer 2023.	
6.	**Next Steps in developing the South West London Integrated Care Partnership Strategy**	
	AD presented the report which outlined the proposed next steps in developing the South West London ICP Strategy which would be published in Summer 2023. RD recognised it was a big ask to take day out of people's working week but stressed the importance of having the appropriate people attend the ICP Conference on 24 May to do the detailed work. In response to IL it was noted that the Planning Committee included LA representatives. CG made the comment that it would be helpful to have participation of Health Watch and the Voluntary Sector to ensure the voice of the community was heard. The ICP **agreed** the proposed approach to finalise the ICP Strategy including the running of an ICP system wide Conference planned for 24 May 2023; noted that the final ICP Strategy would be received at the meeting of the ICP Board in July prior to publication.	
7.	**Joint Forward Plan – Phase One**	
	KB presented the report which highlighted the development of the South West London ICP Board's Five-Year Joint Forward Plan. SB noted that it was the intention to include each of the Place and Health & Wellbeing Boards priorities in the plan and that although it was a 5-year plan there was a requirement to refresh the plan on an annual basis. KB responded to Gillian Norton (GN) about her concerns in relation to the sheer scale of what had been included in the plan and how it could be delivered, particularly at a time when resource was being taken out of the system. It was noted that there was a huge amount to do and the work would be set over a 5-year period. Annual delivery plans would be developed that would take into account the resource required to deliver the changes. It was important to be ambitious but also to make sure the plan was deliverable and that there was clarity about what would be focused on each year. RD noted that the speed of change of the people living in SWL was happening much more quickly than expected with more poverty and deprivation being seen in outer London. It was recognised that there was a need to make sure, as a	

	partnership, we were equipped and funded in order to cope with the increased level of need. RD also noted that the organisation still had the expectation that people would come to us but there was a need to think about how to go to the places people were to have those conversations. JBy welcomed the fact that health inequalities and prevention were at the top of things to do which was really positive and there would be an opportunity to design services that would take into account the changing demographics in SWL and to focus on health inequalities. RD noted the positive feedback and that the Joint Forward Plan would be taken to the IBC Board in June for approval. The ICP **noted** the development of the South West London ICP Board's Joint Forward Plan and that the plan would set out the NHS' actions to support delivery of the Integrated Care Strategy.	
8.	**SWL Innovation Fund: Proposed approach for 2023/24**	
	KB presented the paper which proposed a revised approach to the Innovation Fund process for 2023/24 including a range of planned improvements building on the feedback given in relation to the 2022/23 process and experience. In response to SM, RD noted that it would be helpful to have feedback from the voluntary sector, particularly about the process. It would be important to learn from previous experience and improve because input from the voluntary sector organisations could make a massive difference in helping deliver our priorities. SB noted that the financial plan and innovation funding had not yet been signed off by NHSE. Although the IBC was not in a position to confirm the funding yet it recognised that there was a need to start moving ahead. In response to RD's question about how this would work in practice, SB acknowledged that there was a risk associated with starting the process now and that this was a decision for the whole system to make but it was important to highlight to the Board the need to make sure the organisation kept this funding. There was a discussion about the way the innovation funding would be used and the suggestion was made to consider extending those projects that had operated this year, which had proved successful and were showing benefits, rather than starting new projects. SB noted that the principle of the innovation fund was to pump prime short-term schemes to cover the winter and which were meant to finish by the end of March. This position could be reviewed at the Partnership level but if the funding was used to continue schemes already started it would not be possible to invest in new priorities for the following year. SB noted that that where projects had started, were beneficial to the local system and were demonstrating savings there were other alternative sources of gaining funding. RD made the observation that it was not possible to get the process right every time but there was a need to continue the conversations about how to get best value. In response to Anyssa Chase-Vilchez (ACV), KB clarified that the priorities would be taken from the range of areas AD presented earlier in the meeting, unless the Board decided differently. It was noted that all feedback had been taken on	

	board, consideration would be given to smaller organisations that may not have the infrastructure larger organisations have and that whatever process was put in place in the future it would be easy to administer. SM said it would be helpful to see who received the funding last year and how it was spent to identify whether there were any initiatives that could be worked on without starting afresh. KB responded that a feedback session had been undertaken with every organisation who took part but the evaluation had not yet been concluded but this would be brought back to a future Board. KB agreed to send SM a summary of how the funding had been distributed and spent. **Action:** KB to send SM a summary of how the innovation fund for 2022/23 had been distributed and spent. In response to IL, HJ confirmed that the health and inequalities funding was included in the allocation budget but had not yet been signed off by the system. IL asked how people would bid for the health and inequalities funding when the process was completed and Gloria Rowland (GR) responded that this would follow the same process as for the innovation fund. SB noted that the Inequalities Partnership Group across the system managed the inequalities fund on our behalf. In response to RD, HJ noted that the NHS budget setting process was complex but it was hoped the plans would be finalised by the beginning of May. The budget would then be reviewed by the Board and submitted to NHSE to agree. Following a discussion it was recognised that members of the Partnership Board considered it was not feasible to set up a programme and deliver it in 8 months. SB noted it was important to understand the amount of time implementation took and suggested that one option would be to start in six months, run for 18 months thereby splitting the cost over two consecutive years. This would allow groups to have a longer time to consolidate and do the work. This funding gave an opportunity to do something really different and SB asked members of the group to provide feedback. In response to ACV about priorities that would be taken forward, KB referred to the event that was being run on 24 May where people would be asked to design actions that would deliver in one to two years and then beyond. It might be possible at that point for the group to identify whether there were priorities for investment and innovation that could be recommend to the ICP. JBy said there had been a helpful conversation about NHS funding but noted innovation funds came down through other routes and suggested the partnership consider how it could bring all of its collective funding to the table. RD noted that this was an important point and there was a need to think about the opportunities across SWL and how everything could be brought together in a more collaborative way. RD thanked Board members for a helpful and productive discussion. The Board agreed the recommendation to change the timescale from 1 year to 18 months in order to allow more time to set up the process. This approach would be taken to the ICB Board.	**KB**

	The ICP **noted** the update on the progress of implementing the improvements to the Innovation Fund processes. The ICP **agreed** that the process for 2023/24 should be changed to build in more time for set up and the timescale would be changed from 1 year to 18 months	
09.	**Any Other Business**	
	The next Partnership Board would include a look at assets and capital across both Primary and Secondary Care and working in a more collaborative way. RD noted that this was the last meeting for two colleagues and thanked AD and GR for the fantastic work they had done and wished them well in the future.	
10.	**Public Questions**	
	Amanda Begley, Executive Director for Digital Transformation at Health Innovation Network and a member of the public in SWL made an offer about being a critical friend, having personal experience of running national and regional funds, and offered support perhaps with regard to running sessions on evaluating and administering funds. KB would make contact with Amanda Begley to follow this up. **Action:** KB to contact Amanda Begley to discuss her offer of support in relation to the innovation fund.	**KB**
11.	**Date of next meeting**	
	Thursday 20 July 17:30 – 19:30	

SWL INTEGRATED CARE PARTNERSHIP BOARD ACTION LOG
20 JULY 2023

Date	Reference	Action	Responsible Officer	Date for completion	Action 2	Status	Committee	Type
19.04.2023	8	**SWL Innovation Fund 2023/24** Karen Broughton to send Sara Milocco a summary of how the innovation fund for 2022/23 had been distributed and spent.	Karen Broughon	Jul-23	Completed - Paper from January ICP Meeting details the spend and summarises each successful scheme	Closed	Integrated Care Partnership	Action
19.04.2023	10	**Public Question from Amanda Begley, ED for Digital Transformation at HIN.** Karen Broughton to contact AB to discuss her offer of support in relation to the innovation fund.	Karen Broughton	Jul-23	Completed AB has been contacted.	Closed	Integrated Care Partnership	Action

South West London Integrated Care System			
Name of Meeting	Integrated Care Partnership Board		
Date	Thursday, 20 July 2023		
Title	The South West London Integrated Care Partnership Strategy		
Lead Director (Name and Role)	Karen Broughton, Deputy Chief Executive/Director of Transformation and People		
Author(s) (Name and Role)	Chloe Hardcastle, Deputy Director of Transformation and Strategy Rachel Flagg, Director, Integrated Care Partnership Development		
Agenda Item No.	04	**Attachment No.**	03
Purpose	Approve ☒	Discuss ☒	Note ☐

Purpose

The purpose of this report is to ask the Integrated Care Partnership Board to provide feed back and agree the South West London Integrated Care Partnership Strategy.

Executive Summary

Background

In December 2022, the SWL Integrated Care Partnership (ICP) developed a set of priorities to improve the health and care for our population. These draft priorities were described in a discussion document published in January 2023. Partner organisations and local groups discussed the document and a wide range of feedback was received.

In April 2023 the ICP Board considered the feedback and agreed amendments to the priorities, based on what they had heard. The ICP Board agreed that the next step would be for the final strategy and action plan to be co-produced by system partners though a system-wide conference in May 2023.

ICP system-wide event, 24 May

On 24 May 2023, around 300 representatives from the local NHS, Local Authorities, voluntary and community organisations, Healthwatch as well as people from across our communities, came together to help shape and agree the practical actions to drive genuine change across our priority areas. These are:

- 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

A wide range of organisations and roles were represented across the six places, including:

- System leaders from across Local Authorities, the NHS and the voluntary sector
- Subject matter experts for each of the six strategic priorities
- Local champions, connectors and people with lived experience
- Staff representatives

In the weeks following the event, the workstream co-leads have been working to refine and distil the outputs from the event and to triangulate those with existing system-wide priorities, into a set of collective priorities and collective actions.

Key Issues for the Board to be aware of

The attached strategy has been designed to be high level and simple in its design. As requested by the Board, the strategy intentionally focuses on a small number of high-impact collective actions where we can deliver at scale, or where actions at place can be spread or accelerated.

Delivery plans for the strategy and the outcomes framework will be presented to the ICP at its next meeting.

Recommendation

The Board is asked to:

- Discuss and agree the ICP strategy.
- Note that delivery plans for the strategy and the outcomes framework will be developed and shared with the Board as part of regular updates to be programmed into the forward plan.

Conflicts of Interest
No conflicts have been identified.

Corporate Objectives This document will impact on the following Board Objectives	The draft strategy sets out our areas of focus and collective actions in relation to the strategic priorities agreed by the ICP Board in April (as set out above).

Risks This document links to the following Board risks:	There is a risk that the strategy cannot be fully delivered due to financial constraints and capacity within the partner organisations.

Mitigations Actions taken to reduce any risks identified:	All partners are asked to prioritise existing system resources towards delivery of the strategy. An investment fund, that could in part support delivery of the ICP strategy, will be discussed at the ICP Board meeting on plan on 20 July 2023

Financial/Resource Implications	See risks and mitigations above.

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	As part of developing delivery plans, we will identify where EIAs may be necessary in relation to specific projects.

What are the implications of the EIA and what, if any are the mitigations	None at this time.

Patient and Public Engagement and Communication	There is a chapter in the draft strategy that sets this out.

Previous Committees/Groups Enter any Committees/Groups at which this document has been previously considered	**Committee/Group Name**	**Date Discussed**	**Outcome**
	ICP Board	12/01/2023	ICP Strategy discussion document presented
	ICP Board	19/04/2023	Amendments to ICP strategic priorities agreed
		Click or tap to enter a date.	

Supporting Documents	Annex 1: Draft South West London Integrated Care Partnership Strategy Annex 2: Full outputs from the Integrated Care Partnership event 24 May 2023

South West London Integrated Care System

South West London Integrated Care Partnership Strategy 2023-2028

Contents

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

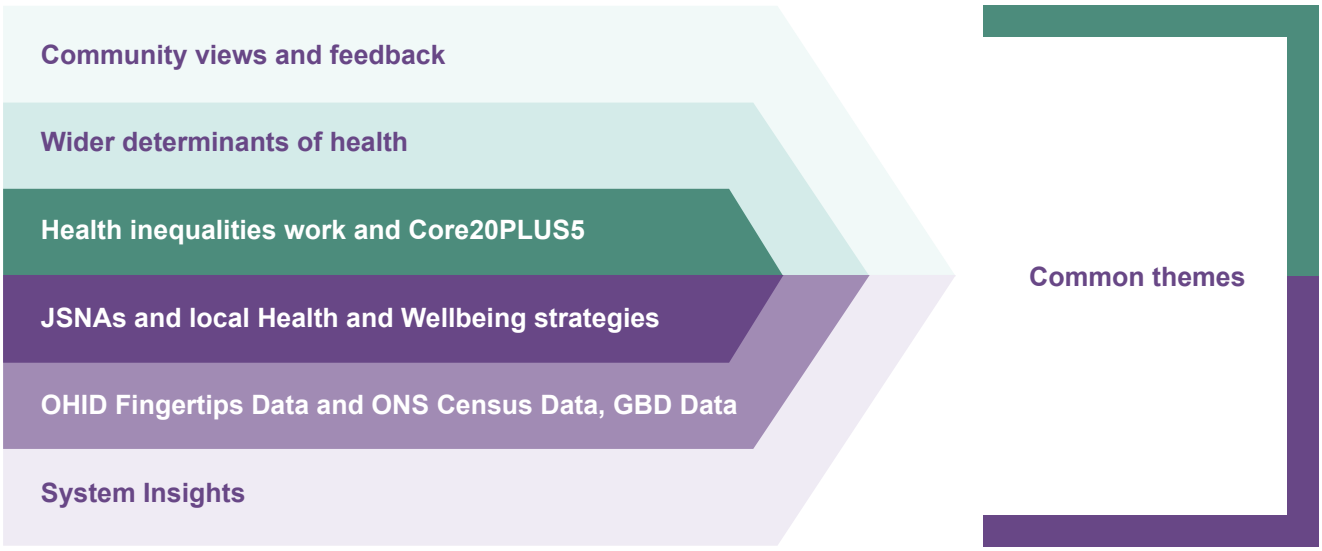
Developing as a partnership

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.

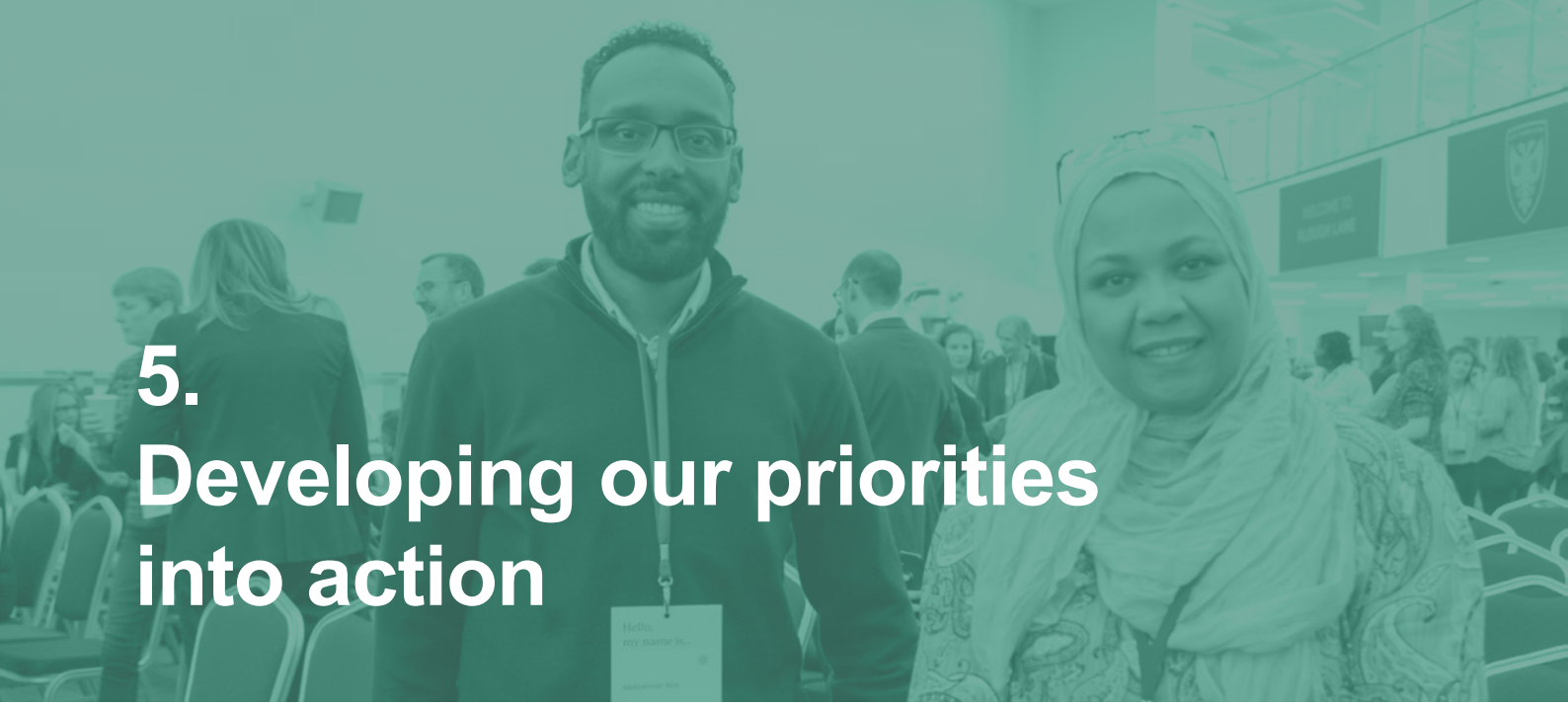
In addition, the following cross-cutting areas of focus were proposed as underpinning the delivery of our future priorities:

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.

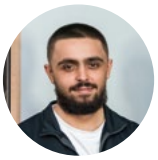
Councillor Ruth Dombey, Integrated Care Partnership Co-Chair, said:
"We are really lucky here in South West London to have such a vibrant community and voluntary sector – there are so many dedicated people who care about their communities and understand the lives of the people living here.

"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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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

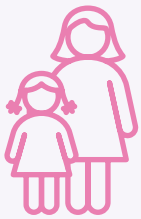
To do this we will:

- 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.

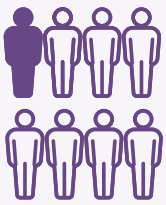
8. Supporting the health and care needs of children and young people

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)

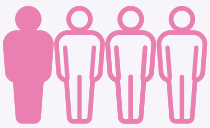
To do this we will:

- 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.

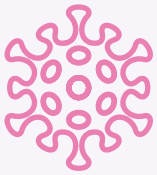


At least one in four people will experience a mental health problem at some point in their life

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

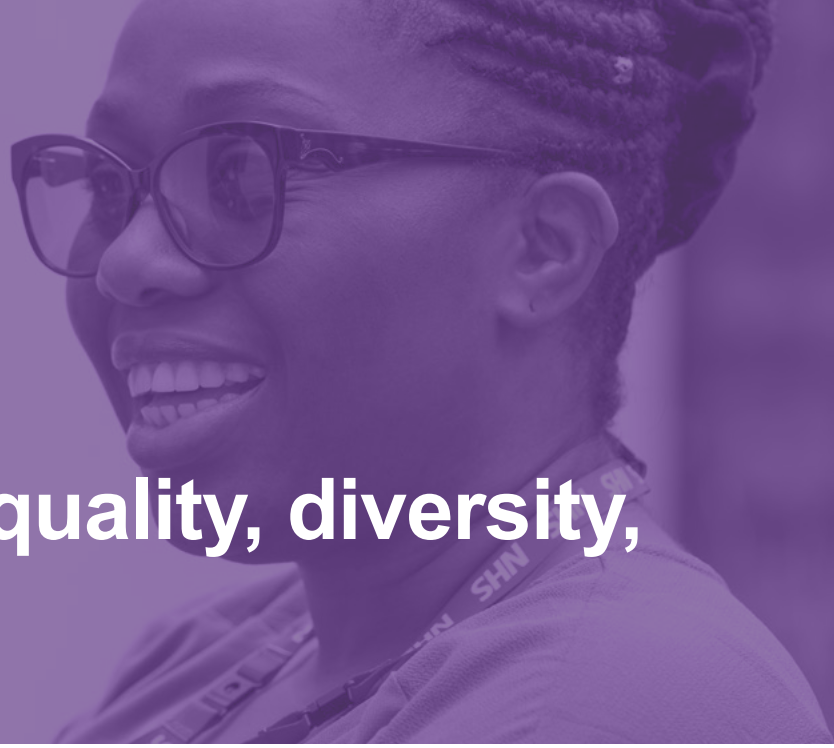
To do this we will:

- **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

Thank you to our partners

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

July 2023

www.southwestlondonics.org.uk

South West
London
Integrated
Care System

Action workshop for South West London Integrated Care Partnership

24 May 2023

South West London Integrated Care System

KALEIDOSCOPE Health and Care

On the day: Purpose

On Wednesday 24 May 2023, the South West London Integrated Care Partnership (ICP) came together to agree how they can make a difference to lives of the local people in all the six boroughs of South West London.

Over 250 leaders from health, local government and voluntary and community services joined community members and representatives from Healthwatch for an ‘Action workshop for South West London Partnership’ which sought to:

- **Bring relevant stakeholders together** from across the ICP, providing an opportunity to develop working relationships & amplify the voices in our communities
- **Co-create ICP Priority Area Action Plans** for our six strategic priorities
- **Inform the write up** of the Integrated Care Partnership strategy
- **Understand areas where consensus cannot be reached**, and to have a plan to move these forward.

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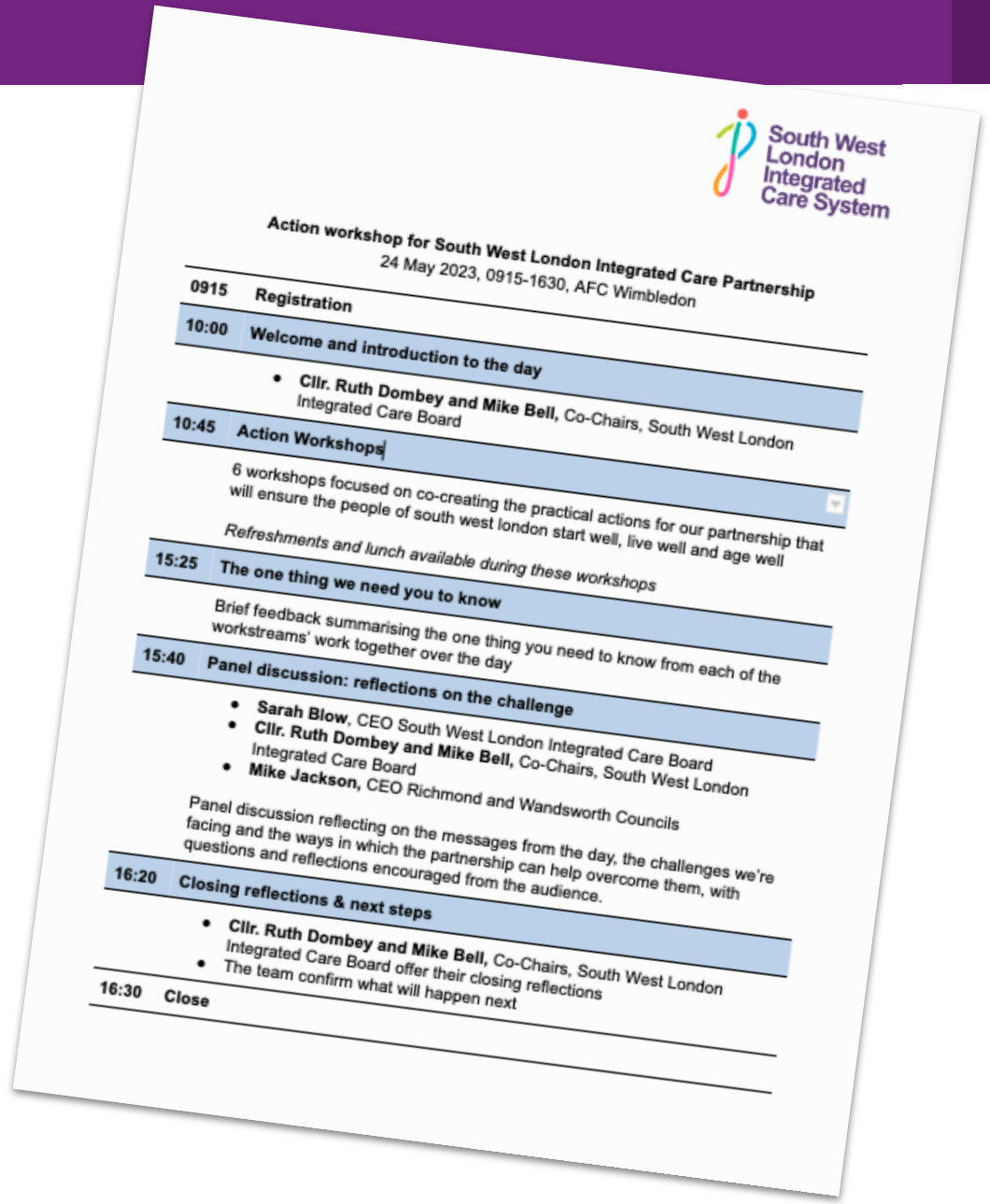

South West London Integrated Care System

Action workshop for South West London Integrated Care Partnership
24 May 2023, 0915-1630, AFC Wimbledon

0915	**Registration**
10:00	**Welcome and introduction to the day** • **Cllr. Ruth Dombey and Mike Bell,** Co-Chairs, South West London Integrated Care Board
10:45	**Action Workshops** 6 workshops focused on co-creating the practical actions for our partnership that will ensure the people of south west london start well, live well and age well *Refreshments and lunch available during these workshops*
15:25	**The one thing we need you to know** Brief feedback summarising the one thing you need to know from each of the workstreams' work together over the day
15:40	**Panel discussion: reflections on the challenge** • **Sarah Blow**, CEO South West London Integrated Care Board • **Cllr. Ruth Dombey and Mike Bell,** Co-Chairs, South West London Integrated Care Board • **Mike Jackson,** CEO Richmond and Wandsworth Councils Panel discussion reflecting on the messages from the day, the challenges we're facing and the ways in which the partnership can help overcome them, with questions and reflections encouraged from the audience.
16:20	**Closing reflections & next steps** • **Cllr. Ruth Dombey and Mike Bell,** Co-Chairs, South West London Integrated Care Board offer their closing reflections • The team confirm what will happen next
16:30	**Close**

Who helped create our action plans?

Over

250

participants joined, from a wide range of organisations and roles across the 6 boroughs of the South West London Integrated Care System

South West London Integrated Care System

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How did we get to today?

- The South West London Integrated Care Partnership (ICP) developed a set of priorities for our partnership to work on together, to improve the health and care of our population.
- These draft priorities were described in a discussion document and partners and stakeholders were invited to review and comment.
- Partner organisations and local groups discussed the document and a wide range of feedback was received from across the system.
- In April 2023, the ICP Board considered the feedback and agreed amendments based on what they had heard.
- Following this process we agreed 6 strategic priorities for the partnership. These are outlined on the following slide.

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Our agreed ICP 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.

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The 6th priority area is workforce. This has been agreed as a year 1 priority by the ICP Board. As a result of this workforce was considered by all workstreams, as well as being a stand alone workstream in its own right. The 4 areas of focus for the workforce work stream are described on the following slide.

Cross-cutting and year 1 priorities

As well as our 6 priority areas, the following 3 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 co-production of improvement and design of services and emphasising their role in decision making.

And in discussion with the ICP board it was agreed that, given its importance in every priority and organisation, that tackling our system wide workforce challenges should be our ICP focus for the first year.

Four emerging work programmes have been identified **for our year 1 workforce priority:**

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

Targeted action around difficult to recruit to roles roles for targeted action to be agreed across our health and care partnership

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

Supporting local people into employment to reduce health inequalities, supporting the cost of living, roles to reflect the communities we serve and help tackle poverty.

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Opening plenary - our ICP co-chairs

To kick off our conversations, we heard from Cllr. Ruth Dombey and Mike Bell - the Co-Chairs of South West London Integrated Care Partnership.

Ruth started by formally introducing Mike in his newly appointed position of ICP Co-Chair and Chair of the ICB Board. She then went on explain how we had identified the 6 priority areas to be discussed during the day, before flagging that this conference was the first time we have brought the partnership together in this way. She described our aim for the event was to be truly collaborative in determining our partnership focus, attention and actions. To do so, she and Mike wanted to harness the talent, expertise and energy of the people in the room to co-create the concrete actions that will help us deliver our 6 strategic priorities.

Mike explained that the people in the room had been invited because their leadership, expertise and lived-experience would make a real difference to the conversations we wanted to have. He drew attention to the range of people we had in the room and emphasised the importance of placing our community and patient voices at the centre of our discussions and decisions. To help with this, he introduced a short video which summarised the themes that arose from our work analysing over 180 reports of the views and feedback of people and communities from across the Partnership.

Our people and communities - how we can make a difference to them, as a Partnership

We watched a short video that gave us an insight into some of the key themes that came through in the analysis of both: our SWL population need and the feedback given to us by our communities on the things that affected their health.

These key themes included:

- **Communication**
- **Cost of living**
- **Joining up services**
- **The importance of community and connection.**

To view this short film please **click here**.

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Action workshops

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The Action Workshop approach

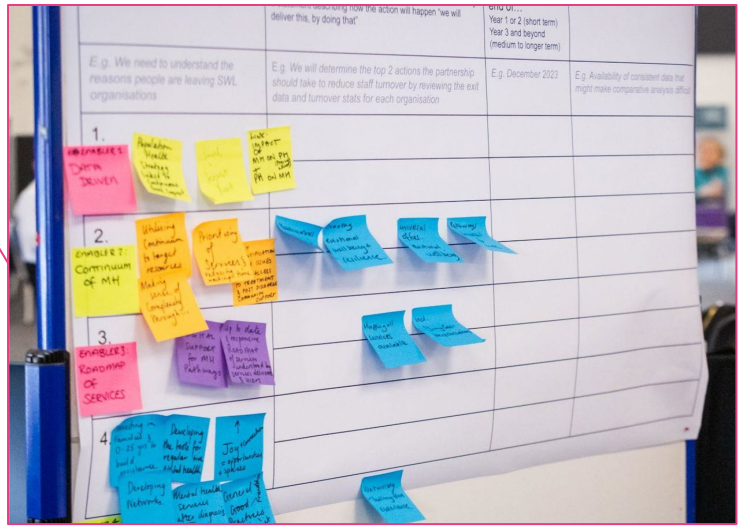
Workstreams were divided into 2 groups:

Group A: those which would benefit from co-creating a set of 4 areas of focus to help deliver the strategic priorities with people in the room. These groups started with long lists, or topic areas to co-prioritise.
Group B: those where it was felt that there already a reasonable level of collective agreement on 4 possible areas of focus to start with.

- ➔ All groups were invited to check and challenge the areas of focus to help co create the right set to focus on
- ➔ Once there were 4 agreed areas of focus, the groups spent their time together building a logic model per area of focus: focusing on the actions needed to deliver their goals.
- ➔ At the end of their time, groups reviewed logic models against the 3 cross cutting themes (see slide 7) and against each other to check for overlaps or possible areas of tension.
- ➔ The session closed with the group thinking about the one thing the rest of the conference needed to hear about their work together in their workstream.

Participants were provided with a set of supporting information to help them through the day:

- Core information about the population and the South West London ICS
- Workstream specific information, outlining why this area was a strategic priority, summarising the views of patients and communities on this area and noting some of the work already ongoing
- Core information about the cross cutting themes and year 1 workforce priority



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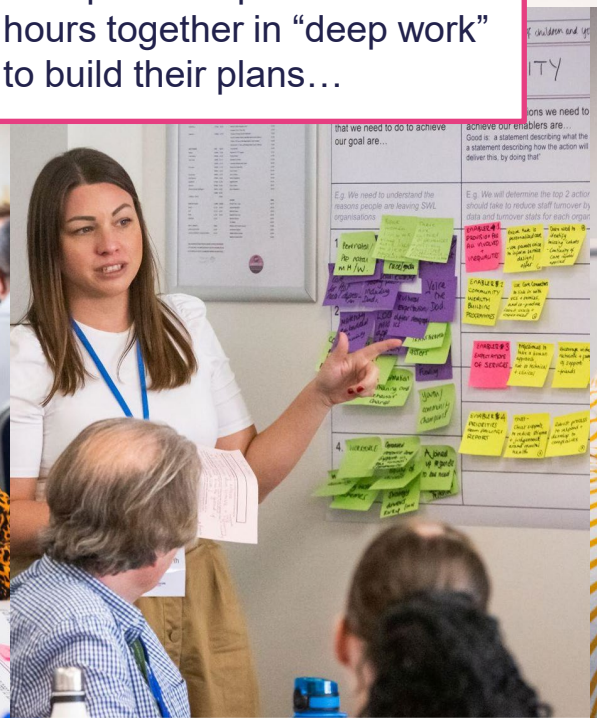
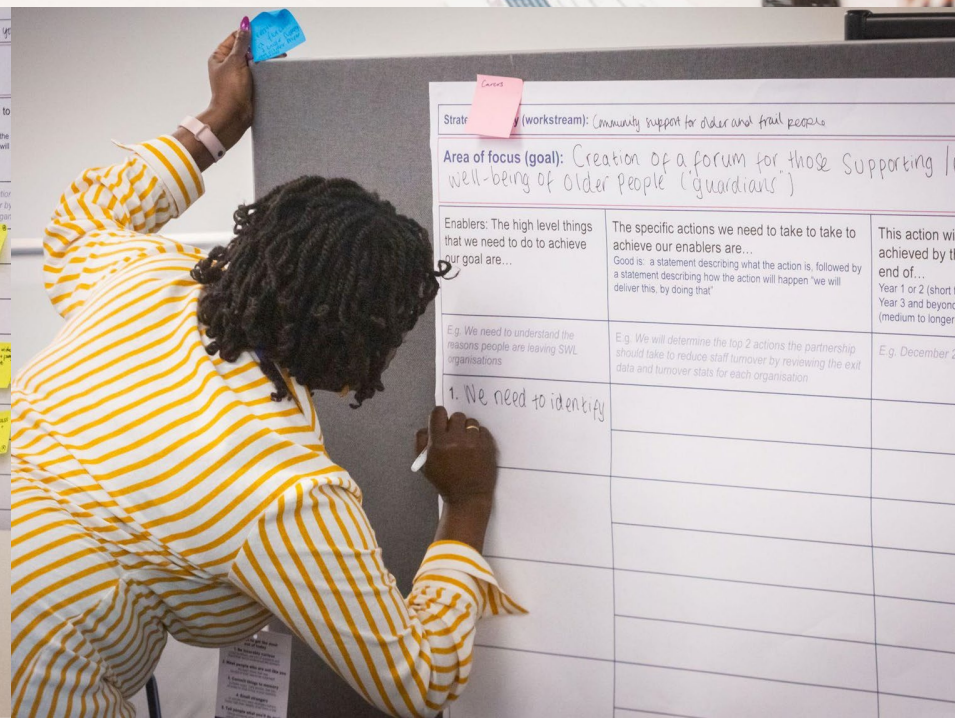
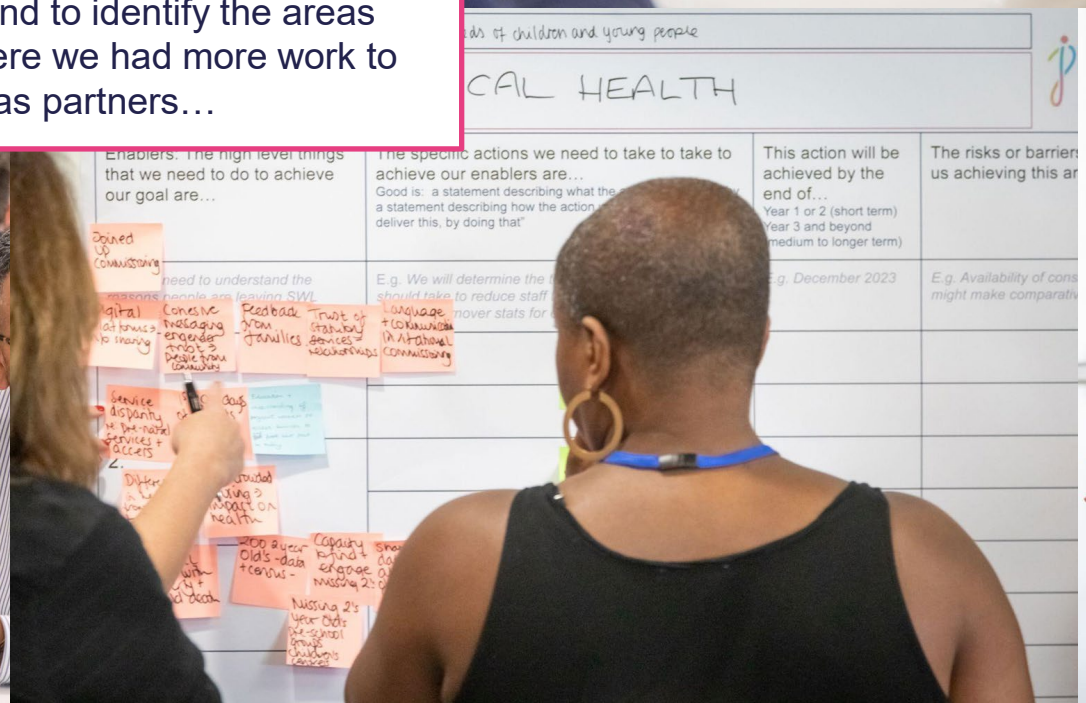
Groups then spent the next 4 hours together in “deep work” to build their plans…





…and to identify the areas where we had more work to do as partners…



Workstream 1: Community based support for older and frail people

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Workstream 1: **Community based support for older & frail people**

This workstream was co-chaired by:

- Nicola Jones
- Annette McPartland

The co-chairs set context for the workstream, including describing what patients, carers and communities had said about support for older and frail people.

The group started with a long list of possible areas of focus and spent their first hour collectively agreeing which 4 areas of focus they thought would have the most impact in supporting the delivery of this strategic priority.

After some discussion around possible themes the 4 areas of focus that this group agreed to prioritise were

- **Social Isolation**: reducing & preventing social isolation in South West London communities (place, ward, localities etc)
- **Falls Prevention**: reduce incidents of falls in South West London
- **Dementia:** the journey through the dementia pathway to be personalised, informed & supported
- **Carers**: creation of a forum for those supporting/ enabling the well-being of older people ("guardians") in South West London

They then worked together to build 4 logic models for each of these areas of focus.

Strategic priority (workstream): Community based support for older and frail people

Area of focus 1(of 4): Social Isolation: reducing & preventing social isolation in South West London communities (place, ward, localities etc)

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. Identify social isolation (risk stratification, health inequalities, population health, unpaid carers)	We will gather outputs of existing knowledge - e.g. ASC surveys, social housing providers, census	6 months	Lack of a clear lead in South West London
	We will understand local services/gaps at place level and share best practice, give people opportunities to engage (table tops)	6 - 12 months	
2. Identify cohort affected by social isolation (why/ how) - e.g. people with dementia, ethnic minorities, people with mental health conditions, bereaved people)	We will make every contact count! As a partnership, empower local voluntary sector organisations to manage social isolation!	Med. - Long Term	
	We will ensure collaborative working with carers and care homes (in case cared for dies or moves into care home)	Med. - Long Term	
3. Respond to group with existing resources (continue with what works well & address unmet need & gaps)	We will support people to prepare for retirement - prevention		
4. Connecting isolated people to services - e.g, GP, social prescribers			

South West London Integrated Care System

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Strategic priority (workstream): Community based support for older and frail people

Area of focus 1(of 4): Social Isolation: reducing & preventing social isolation in South West London communities (place, ward, localities etc)

Cross cutting themes & year 1 priorities

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	How does this action relate to our cross cutting themes/year 1 priority of workforce?
1. Identify social isolation (risk stratification, health inequalities, population health, unpaid carers)	We will gather outputs of existing knowledge - e.g. ASC surveys, social housing providers, census	**Green agenda** - minimise the use of paper forms (NB. digital inclusion implication) Balance of digital & F2F meetings **EDI** - yes, gathering knowledge across barriers and think outside box. Ensure use of voluntary sector **Elevating the voices of patients, carers and our communities** - need to consider how we engage to get the information e.g. GP practices, pharmacies, restaurants/ cafes, especially key links; churches and faith groups **Workforce priorities** - think about intergenerational opportunities e.g. Duke of Edinburgh opportunities, "Rent a Gran"
	We will understand local services/gaps at place level and share best practice, give people opportunities to engage (table tops)	**Green agenda** - potentially, consider prints vs digital and balance of F2F to digital meetings **EDI** - yes as above **Elevating the voices of patients, carers and our communities** - yes as above **Workforce priorities** - together can draw out workforce opportunities
2. Identify cohort affected by social isolation (why/ how) - e.g. people with dementia, ethnic minorities, people with mental health conditions, bereaved people)	We will make every contact count! As a partnership, empower local voluntary sector organisations to manage social isolation!	**Green agenda** - yes, reduces travel and digital traffic **EDI** - yes, try to support each individual **Elevating voices of patients, carers and our communities** - Yes.
	We will ensure collaborative working with carers and care homes (in case cared for dies or moves into care home)	**Green agenda** - ? **EDI** - yes, as carers often excluded **Elevating voices of patients, carers and our communities** - yes - theese are under-recognised groups - often excluded **Workforce** - will need leadership for the project.
3. Respond to group with existing resources (continue with what works well & address unmet need & gaps)	We will support people to prepare for retirement - prevention	**Green agenda** - yes **EDI** - potentially as supports all groups **Elevating voices of patients, carers and our communities** - is person centered **Workforce** - yes, leadership/ delivery of project.
4. Connecting isolated people to services - e.g, GP, social prescribers		

Strategic priority (workstream): Community based support for older and frail people

Area of focus 2(of 4): Falls Prevention: reduce incidents of falls in South West London

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. Identify people at most risk of falls (in all places people call home) (digital)	Using up data to stratify and identify cohort *investment in exercise groups to prevent risk of falls*	Short	
	We will raise awareness in population & in people's services (profs/ VCS etc) by running a SWL campaign - safety in home & community (link to national campaign?)	Short	
2. Standardise screening and assessment tool (reflects national & professional guidance)	We will decide whether this should be part of all assessment tools in terms of risk? Link to frailty score	Short	
3. Agreed approach to interventions & services available/ timeframes to address issues raised under 2. (shared core plan (VCP digital) with all home settings eligible)		Short	
4. Training & Education - wider public, awareness raising, carers/ staff knowledge & skills/ people what to do if they fall (use community assets)	We will ensure wider/ increased use of standardised frailty tool	Short	
	Targeted education programme on what to do if you fall or see someone else fall over		

South West London Integrated Care System

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Strategic priority (workstream): Community based support for older and frail people

Area of focus 2(of 4): Falls Prevention: reduce incidents of falls in South West London

Cross cutting themes & year 1 priorities

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	How does this action relate to our cross cutting themes/year 1 priority of workforce?
1. **Identify people at most risk of falls (in all places people call home) (digital)**	Using up data to stratify and identify cohort *investment in exercise groups to prevent risk of falls*	**Green agenda** - walking groups would encourage activity, may contribute to maintaining the local environment e.g. litter pickers, conservation **EDI** - yes would be no exclusion criteria, commissioned to be equal & equitable **Elevating voices of patients, carers and our communities** - community led approach, so would be determined locally **Workforce priorities** - yes, requires people to support implementation, likely to be embedded in VCS activity, so skills & training required.
2. **Standardise screening and assessment tool (reflects national & professional guidance)**	We will decide whether this should be part of all assessment tools in terms of risk? Link to frailty score	
3. **Agreed approach to interventions & services available/ timeframes to address issues raised under 2. (shared core plan (VCP digital) with all home settings eligible)**		
4. **Training & Education - wider public, awareness raising, carers/ staff knowledge & skills/ people what to do if they fall (use community assets)**	We will ensure wider/ increased use of standardised frailty tool	
	Targeted education programme on what to do if you fall or see someone else fall over	

South West London Integrated Care System

KALEIDOSCOPE Health and Care

Strategic priority (workstream): Community based support for older and frail people

Area of focus 3(of 4): Dementia: the journey through the dementia pathway to be personalised, informed & supported

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. Living well with dementia	We will adopt best practice, e.g. the scottish 5/8 pillars care model for example	Short term	
	We will provide lifelong support post diagnosis including dementia care coordinators	Short term	
2. Dementia friendly community in South West London	We will adopt an appropriate quality consistent standard of care/ services across SWL incl. buildings, awareness & services	Short term	
	We will mandate good quality dementia training for all 'commissioned' services	Short term	
3. Support to carers of people with dementia	We will listen to people with dementia and their 'guardians' incl. carers	Short term	
	We will flag dementia on records and systems to enable appropriate communication to right person and care.		
4. Relationship with key people &/or professionals along journey (e.g. navigator)	We will adopt a 'could it be dementia?' way of diagnosis	Short term	

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Strategic priority (workstream): Community based support for older and frail people

Area of focus 3(of 4): Dementia: the journey through the dementia pathway to be personalised, informed & supported

Cross cutting themes & year 1 priorities

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	How does this action relate to our cross cutting themes/year 1 priority of workforce?
1. Living well with dementia	We will adopt best practice, e.g. the scottish 5/8 pillars care model for example	**Green agenda** - yes, local care + support network **EDI** - dignity, respect, avoids labels and being stranded **Elevating voices of patients, carers and our communities** - yes, involve them in adopting **Workforce priorities** - yes, new workforce, different workforce.
	We will provide lifelong support post diagnosis including dementia care coordinators	**Green agenda** - local support closer to home **EDI** - yes, support will take **Elevating voices of patients, carers and our community** - yes **Workforce priorities** - yes, different workforce fit for purpose to deliver the model of care - dementia care coordinator
2. Dementia friendly community in South West London	We will adopt an appropriate quality consistent standard of care/ services across SWL incl. buildings, awareness & services	**Green agenda** - local people providing local services involving & engaging those like TFL -> more use **EDI** - yes, developing the standard has to take these into account **Elevating voices of patients, carers and our community** - yes, involve them in designing the standard **Workforce priorities** - dementia awareness training
	We will mandate good quality dementia training for all 'commissioned' services	
3. Support to carers of people with dementia	We will listen to people with dementia and their 'guardians' incl. carers	**Green agenda** - yes, local listening events **EDI** - yes, views will be incorporated **Elevating voices of patients, carers and our community** - yes **Workforce priorities** - yes, engagement teams and trainers
	We will flag dementia on records and systems to enable appropriate communication to right person and care.	**Green agenda** - reduces inappropriate services care journeys **EDI** - yes **Elevating voices of patients, carers and our community** - yes as carers/ family will aid flagging
4. Relationship with key people &/or professionals along journey (e.g. navigator)	We will adopt a 'could it be dementia?' way of diagnosis	**Workforce** - yes

Strategic priority (workstream): Community based support for older and frail people

Area of focus 4(of 4): Carers (applies to all 4 areas & support systems): creation of a forum for those supporting/ enabling the well-being of older people ("guardians") in South West London

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	**The specific actions we need to take to take to achieve our enablers are…**	**This action will be achieved by the end of…** Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	**The risks or barriers that may stop us achieving this are…**
1. We need to identify them or enable them to identify themselves	We will create a carers champion		
	We will identify more on entry link care/ pathways. Nurses in hospitals proactively identifying carers. Ensuring policy & service development recognises values of carer.		
2. Value and recognise the role they play by listening to them	We will build on the existing carers week/ events/ well-being support		
	We will increase the profile of carers week (June). Promote good practice in different boroughs. Provide a range of mechanisms for views to be gathered from carers e.g. annual borough surveys.		
3. Provide relevant up-to-date easy to understand and easy to access information with rapid response	We will ensure we co-produce information about access to hubs with different communities and that we are connected with good examples e.g. Kingston/ CIL navigation + other resources.Cares Hub model in Richmond links very well to join-up services (it is VCS led).		
4. Consistent, quality respite	We will identify the amount and consistency of respite available		
	We will ensure respite is flexible, appropriate to the carer and the cared for to increase quality of life		

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Strategic priority (workstream): Community based support for older and frail people

Area of focus 4(of 4): Carers (applies to all 4 areas & support systems): creation of a forum for those supporting/ enabling the well-being of older people ("guardians") in South West London

Cross cutting themes & year 1 priorities

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	How does this action relate to our cross cutting themes/year 1 priority of workforce?
1. We need to identify them or enable them to identify themselves	We will create a carers champion	**Green agenda** - ? **EDI** - ease of access / avoid digital exclusion **Elevating voices of patients, carers and our community** - carer events, co-production **Workforce priorities** - raising the profile of carers, carers champion
	We will identify more on entry link care/ pathways. Nurses in hospitals proactively identifying carers. Ensuring policy & service development recognises values of carer.	
2. Value and recognise the role they play by listening to them	We will build on the existing carers week/ events/ well-being support	
	We will increase the profile of carers week (June). Promote good practice in different boroughs. Provide a range of mechanisms for views to be gathered from carers e.g. annual borough surveys.	
3. Provide relevant up-to-date easy to understand and easy to access information with rapid response	We will ensure we co-produce information about access to hubs with different communities and that we are connected with good examples e.g. Kingston/ CIL navigation + other resources.Cares Hub model in Richmond links very well to join-up services (it is VCS led).	
4. Consistent, quality respite	We will identify the amount and consistency of respite available	
	We will ensure respite is flexible, appropriate to the carer and the cared for to increase quality of life	

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Workstream 1: Community based support for older & frail people

Reviewing our work: Noting possible overlaps, conflicts or crossover

The community based support for older and frail people workstream spent time exploring whether there were any obvious overlaps or conflicts in the work they did, as well as whether there was any crossover between this work and the other workstreams in the session

Overlaps within the workstream work

- ➔ Dementia, falls and isolation are all linked
- ➔ Carers cards are used already in some boroughs but not others
- ➔ Integrated services
- ➔ Use of UCP for all services
- ➔ Overlap with care/support circle work but focus on dementia
- ➔ VCS as a key partner

Possible conflicts within the workstream work

- ➔ Shortage of community assets/spaces
- ➔ Limited funding and resources
- ➔ Bespoke solution needed not “one size fits all”
- ➔ Timeframes - working out priorities
- ➔ Variable digital abilities/inclusion for individuals and care homes
- ➔ No self access to UCP and limited care home access to UCP

Possible crossovers with other strategic priority workstreams

- ➔ Information and data sharing
- ➔ Workforce recruitment and retention
- ➔ VCSE sector integral to everything we do
- ➔ There is crossover between falls prevention and social isolation prevention
- ➔ Also general crossover between dementia, falls and carers

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Workstream 1: Community based support for older & frail people

The key activity this workstream chose to share with the rest of the conference in the plenary session was their proposal that South West London should strive to become a **'Dementia friendly place'.** They felt that this commitment would;

- Have a significant and sustained impact for many people
- Foster a culture of kindness and understanding that would provide a bedrock from which services could be built
- Involve everyone, from voluntary and community organisations to statutory services.

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Workstream 2: Positive focus on mental wellbeing

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Workstream 2: **Positive mental wellbeing**

This workstream was co-chaired by:

- Amy Scammell (Director of Strategy, SWL StG)
- Steph Diffey (Head of Mental Health, LB Sutton)

The co chairs started by setting some context to the workstream, including describing how today would make a difference, what patients, carers and communities had said about positive mental wellbeing.

The group started with by testing the 4 areas of focus they thought would have the most impact in supporting the delivery of this strategic priority.

The 4 areas of focus that this group agreed to prioritise were

- **Children and young people**
- **Healthy environment**
- **Mental health literacy and reducing stigma**
- **Complex needs and co-occurring issues**

They then worked together to build 4 logic models for each of these areas of focus.

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Strategic priority (workstream): Positive mental wellbeing

Area of focus 1(of 4): Children and young people

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. Increase understanding of what is effective prevention	We will build our evidence base by seeking feedback from service users & professionals; harnessing good practice; innovating and making use of pilots; and tracking outcomes and data.	Short term	Resource and capacity (both overall amount and distribution)
	Increase wraparound holistic support in schools and GPs e.g. after school family sessions		Commitment from all agencies and willingness to take forward actions.
2. Increase awareness to support self-help and early diagnosis	We will empower patients through psycho-education for them around increasing knowledge of mental health behaviours.	Short term	KPIs not aligned to focus some of the actions.
	We will build school mental health programmes and reduce stigma around the topic.		
3. Increase appropriate resource to reduce barriers to access and continued care	Increase capacity and awareness of what's available in communities through schools/VCSE/faith groups etc		Speed of mobilisation. Can providers (VCSE, NHS, LA) respond quickly enough?
	We will explore alternative funding streams e.g. lottery or community funds.		
4. Improve transition to adults and continued support through adulthood	We will target action on improved access to CAMHs services by focusing in on issues in school referrals and holistic, wider CAMHs referrals.		Recurrent and non-recurrent funding and options to mitigate this.
	We will support greater joined up working between adult and children's mental health services.	Long term	

A cross cutting risk for this area of focus was around resources

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Strategic priority (workstream): Positive mental wellbeing

Area of focus 2(of 4): Healthy environment

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. Increase understanding of what makes an environment healthy (both from a community and a services perspective)	We will incorporate co-production into service changes and developments by involving evidence from all system partners (not just NHS) into our processes e.g. business cases	Start from year 1 but continuous	Complexity of system and 'language' barriers between sectors; difficulty policing online events
2. Increase staff wellbeing and support	We will create safe spaces to enable open conversations about how things are going through training, reflection and debrief time and demonstrating tangible action on feedback.	Start from year 1 but continuous	Workload/time constraints - management culture/deflated workforce after pandemic. Current backlog, fatigue and cynicism around change. Remote working can decrease team cohesion.
	We will celebrate success by demonstrating progress, making use of quality improvement techniques, having meaningful events e.g. awards and through culture change.	Small wins from the beginning. Larger scale wins years 2-5.	Less oversight as budgets are squeezed. Competition for funds.
3. Decrease threatening environments and increase green spaces	We will make use of service user-led assessment of services/environment to check for appropriateness in terms of disability, age, cultural needs. Could combine with accreditation of services/buildings.	Year 1 - using existing auditing procedures and then build on this with new sources in years 2-5.	Competition with commercial interests/developers when trying to achieve green space
4. Increase access and transparency, consistency and continuity of services and people providing them	We will encourage honest discussion about availability of resources and prioritisation.		Managing reputations and capacity for VCSE to support this
	We will value and embed kindness and respect and try and repair the 'connection' ruptures caused by covid and post-covid ways of working (e.g. remote/digital interactions).	Start from year 1 but continuous	Stress, culture, management, workload. Supporting genuine partnership between VCSE and NHS to avoid blaming each other for underperformance and distrust.

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A cross cutting risk for this area of focus was around funding. In particular parity with physical health and equivalent spend to other parts of London

Strategic priority (workstream): Positive mental wellbeing

Area of focus 3(of 4): Mental health literacy and reducing stigma

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. Increase community co-creation, by building on existing links, networks and resources across the ICP	We will 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	Basic level - Short term (within a few months year) but more sophisticated would take longer and need updating.	Resource available to create, coordinate and update this; complexity of this when we get into the detail (i.e. Where is accountability if any issues off the back of a signposting recommendation? Do we need accreditation of services first?)
	We will develop support and training or community IAGs (Independent Advisory Groups) and empower communities to hold us to account.		
2. Increase coordination and alignment or communications and campaigns across ICP members to amplify impact	We will develop a pan SWL comms campaign including videos and online resources to differentiate mental wellbeing and mental health.		Clarity of audience and availability of existing resources.
	We will increase shared levels of literacy by improving accessibility and co-production between services		
3. Increase literacy through education, targeting key areas including schools, non-mental health providers and ensure consistency across ICP	We will co-produce literacy resources with GPs, Trusts, Police, Schools.		
	We will promote message that it's ok not to be ok and how to access help *(need a Joe Wickes style role model for mental health*).		
4. Increase the holistic nature of our approach by 'making every contact count' when engaging with people; by considering mental health when interacting with people for other reasons; and by engaging the network/family unit of any individual.	We will work with schools to embed mental health literacy in PSHE lessons and we will work on resources that engage and are accessible to the whole family unit.		

Strategic priority (workstream): Positive mental wellbeing

Area of focus 4(of 4): Complex needs and co-occurring issues

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	**The specific actions we need to take to take to achieve our enablers are…**	**This action will be achieved by the end of…** Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	**The risks or barriers that may stop us achieving this are…**
1. **Improve definition and understanding of what is complex (agreed amongst partners)**	We will co-design a single person-centred framework that describes complex needs using common language across agencies		Lack of transparency; trying to reinvent the wheel Professionals can't agree on definitions/ lack of collaborative senior leadership
2. **Increase dedicated resource that support complex needs e.g. key workers, specialists and carers**	We will review existing services and allocate according to outputs of co-production work		Resource - quantum, distribution and time horizon of allocations to enable effective planning and investment beyond short term Unsupported staff will result in burn out.
3. **Increase co-production in conversations to ensure user voice and advocacy is present**	We will co-create definitions of outcomes with people with lived experience and ensure they are person-centred		Disparity of funding structure and service user needs and aspirations. Lack of inclusive leadership. Top down approach. Lack of accountability. Lack of clear goals, values and delivery of its goals. Conscious bias is a barrier.

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A cross cutting risk for this area of focus was identified that if we don't understand the time/cost of 'complexity' we will never give it its true attention.

Workstream 2: **Positive mental wellbeing**

At the end of our time together we reviewed our work to rest whether there were any overlaps or conflicts within the workstream priorities, or any possible crossover with other workstreams

- One area of focus for this workstream was **children and young people**. There therefore could be a risk of overlap with the main 'Children and young people's workstream'. Similarly, the children and young people's workstream had one area of focus that was "mental health". Particular attention should be paid to testing these overlaps with the actions and priorities defined within these overlapping areas of focus across these two workstreams.
- **Workforce** was central to the conversations throughout, particularly the need to celebrate success in a meaningful way, build on achievements made and also increase resilience and support for staff in the face of ongoing pressures. A strong theme came through around the importance of leadership and team culture being geared towards both innovation and collaboration despite the ongoing legacy of the pandemic and continued day-to-day pressures to react to.

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Workstream 2: Positive mental wellbeing

Participants in this workstream were invited to conclude the session with a moment of individual reflection. They captured their personal top learning or message from the session on a post-it.

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"Listen to the experts by experience"

"The need to focus on all age groups and the interplay of mental health on complex conditions"

"Can see a common sense of purpose but people are run down by the struggles"

"Gaps in complex needs! Need to reach out/connect to better plan and deliver ASC/MH commissioning for Kingston"

"Resources - more than just the money! We need to be careful not to forget organisational memory."

"Improved my mental health knowledge - thank you"

"We have "power" collectively now. We need more help to connect this up between organisations and neighbourhoods"

"We need more sessions like this"

To be effective, we need to truly understand impact and outcomes and be willing to shift resources across the system irrespective of organisational boundaries"

"Getting everyone to understand mental wellbeing is more than the absence of mental ill health"

Workstream 2: **Positive mental wellbeing**

The key messages this workstream chose to share with the rest of the conference in the closing plenary session were:

Make better use of what we have: there has been huge progress to in recent years to build from and real gains we can make through coming together in partnership to deliver services and navigate the complexity we all face.

We need a common language across the system: having a shared language will support us to work in partnership more effectively

Be ambitiously realistic! We need to walk a line between being ambitious and driving services forward and being realistic about what is achievable so that we succeed.

Diversity: is a positive and adds value and we need to be more deliberate about how we harness the benefits of the diversity in our populations and services

Co-production needs to be integral to everything we do: we need to develop our services shoulder to shoulder with those who use them. We need to share stories and successes and build upon them.

We need to build resilience in individuals and organisations.

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Workstream 3: Preventing ill health, promoting self care & supporting people to manage their long term conditions

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Workstream 3: **Preventing ill health, promoting self care & supporting people to manage their long term conditions**

This workstream was co-chaired by:

- John Byrne (Chief Medical Officer, SWL ICB)
- Iona Lidington (Director of Public Health, RB Kingston)

The co chairs started by setting some context to the workstream, including describing how today would make a difference, what patients, carers and communities had said about preventing ill health, promoting self care and supporting people to manage their long term conditions.

The group started with a long list of possible areas of focus and spent their first hour together in discussing and collectively agreeing the areas of focus they thought would have the most impact in supporting the delivery of this strategic priority.

The key area of focus that this group agreed to prioritise was

- **Whole system approach to healthy weight and obesity**

With a number of key enablers e.g.

- **Digital and data**
- **Community empowerment**

The group also focused on

- **Personalised self care**

They then worked together to build 4 logic models for each of these areas.

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Strategic priority (workstream): Preventing ill health, promoting self care and supporting people to manage their long term conditions

Area of focus 1(of 4): Whole system approach to obesity

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	**The specific actions we need to take to take to achieve our enablers are…**	**This action will be achieved by the end of…** Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	**The risks or barriers that may stop us achieving this are…**
1. Healthy eating	We will roll out the SWL 'Prevention' website	12 months	Cost of healthy food higher mostly than unhealthy alternative options
	We will engage with local employers to support workforce with access to free fruit/exercise e.g. on site classes and gym passes	12 months identify employers	Economic pressure already on employers
2. Education	We will identify public role models which local communities can relate to and who can therefore be positive influencers		
	We will run social media campaigns targeted at networks rather than individuals		
3. Physical activity	"The Daily Mile" - line with workforce gap		
	Active travel to work	12 months	
4. Shared integrated strategy and resources	We will identify what is working well across our ICS and grow it by establishing a working group to decide whats in/whats out	6 months	There will be some things no one will be able to do but important we work together to figure out what is doable and who will do it

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Strategic priority (workstream): Preventing ill health, promoting self care and supporting people to manage their long term conditions

Area of focus 2(of 4): Digital and data

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. Rich data to support Population Health Management (PHM) at all levels	We will agree priority areas and develop clear plan for a PHM approach	Next 6 months	
	We will enable data access for VSCO	Next 6 months	
2. Use digital to navigate and engage in care (empowerment)	Single front door for patients to access	Next 12 months	
	We will assess and rationalise the need for different digital support for different long term conditions	Next 12 months	
3. Use digital to enable seamless working (supporting our workforce) across the ICS	We will create unified digital comms strategy	Next 6 months	
	We will undertake an assessment of digital tools to enable collaborative working	Next 12 months	
4. Address digital exclusion	We will ensure we have/can identify people who either can not or choose not to access digitally	Next 12 months	
	We will create pathways for supporting digitally excluded e.g. education	Ongoing	
	We will ensure choice of ways to access - non-digital	Ongoing	

Strategic priority (workstream): Preventing ill health, promoting self care and supporting people to manage their long term conditions

Area of focus 3(of 4): Community empowerment

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. Place based prevention model rooted in the community	We will co-produce a prevention model with the community, informed by PHM data	2 years	
2. Sustained funding for the model	We will ensure flexibility in budgets to allow/enable more services to be delivered in/via the voluntary sector	1 year	
	We will secure long term voluntary sector funding arrangement	Year 1 then ongoing	
3. Embed strong and representative community voice	We will develop a systems approach that enables the voluntary sector organisations to be heard	Year 1	
	We will share learning and good practice between Boroughs	1 year	
4. Improve communication and and better integrated working between vol/statutory sectors	We will deliver a supported programme of engagement between statutory and voluntary sector to build trust and understanding	1 year	Also needs to include interfaces within NHS esp physical and mental health

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Strategic priority (workstream): Preventing ill health, promoting self care and supporting people to manage their long term conditions

Area of focus 4(of 4): Personalised self care

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. **Patient engagement/ empowerment/ education/ shared decision making**	We will undertake competent and meaningful co-production i.e. 'What/how do you want to self-care?' to create solutions which reflect needs of specific communities	Plan: 6 months Implementation: 2-3 years with regular refresh	
2. **Access and support social prescribing**	We will improve visibility to our services/offers to achieve equity of access e.g. social media, religious and sports organisation etc)	Plan: 6 months with yearly review	
3. **Digital, Data and Information**	We will share and streamline information including digital care plans (includes: training all clinicians on how to populate and incentivising to do this; clinical access for all incl community clinicians)	Plan: 6 months Implementation: 5 years	
4. **Resources - maximise current use of funded services i.e. Make Every Interaction Count (MECC)**	We will map all activities (incl value), identify gaps to prioritise then stop/continue/start some. Then set realistic KPIs	12 months	
	We will resource our/the time to do this	12 months following on from action above (row 121)	

South West London Integrated Care System

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Workstream 3: **Preventing ill health, promoting self care & supporting people to manage their long term conditions**

The key messages this workstream chose to share with the rest of the conference in the closing plenary session were:

Willingness to work together: there was a real commitment from participants to work together and share best practice (from everyone but particularly from representatives of the voluntary and community sectors)

We need to stop doing the things that aren't working: this was a challenging conversation to have in the session, but there was strong feeling that we need to take some difficult decisions and be radical about the things we know aren't effective

We need to shift the resources to where they'll have the most impact: this needs us to map and understand resources and assets and to commit to scaling up work or services we know are having positive impact

South West London Integrated Care System

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Workstream 4: Supporting the health and care needs of children and young people

South West London Integrated Care System

KALEIDOSCOPE Health and Care

Workstream 4: **Supporting the health and care needs of children and young people**

This workstream was co-chaired by:

- Ana Popovici (Director of Children's Services, LB Wandsworth)
- Mark Creelman (Place Executive - Merton and Wandsworth)

The co chairs started by setting some context to the workstream, including describing how today would make a difference, what patients, carers and communities had said about supporting the health and care needs of children and young people and how the areas of focus had been reached. Ana explained that there was a fifth key area of focus SEND which was being picked up at a dedicated event on 14 June 2023.

The group started with by testing the 4 areas of focus they thought would have the most impact in supporting the delivery of this strategic priority.

The 4 areas of focus that this group agreed to prioritise were

- **Physical health**
- **Mental health**
- **Maternity**
- **Inequalities (with a focus on Looked After Children)**

They then worked together to build 4 logic models for each of these areas of focus, noting that SEND would be added following the upcoming system event.

South West London Integrated Care System

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Strategic priority (workstream): Supporting the health and care needs of children and young people

Area of focus 1(of 4): Physical health

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. Shared Priorities/ Commissioning	We will set out ring fenced, monitored funding for evidence based provision	Yrs 2-3	Diversity of children means individual needs might be missed
	We will co-locate and diversify experts	Yr1	Different systems and corporate "languages"
	We will build/develop systems to streamline services	Ongoing	
	We will pool budgets for NHS, social care, education (CYP centered)	Yrs 3-5	Safeguarding - possibility of children falling between cracks if responsibility not clear
2. Data - identifying disparities	We will create a shared database of intelligence to identify target populations to prioritise interventions	Yrs 2-3	Quality of information available - bad data in/bad data out
	We will pilot to test a model of data informed prioritised service with pooled resources	Yr1	Information governance/GDPR
3. Relational community expertise	We will develop community HUBS to target and allocate with expert teams contributing to decisions	Yrs2-3	lack of engagement due to communication/language barriers/trust
	We will create HUBS which feel accessible and welcoming to all	Yrs2-3	Lack of trust in "system"
	We will get it right first time so TRUST is built	Yr1	
4. Communication	We will utilise or develop technology to collate and share user information and care	Yr1 and ongoing	

South West London Integrated Care System

KALEIDOSCOPE Health and Care

Strategic priority (workstream): Supporting the health and care needs of children and young people

Area of focus 1(of 4): Physical health

Cross cutting themes & year 1 priorities

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	How does this action relate to our cross cutting themes/year 1 priority of workforce?
1. Shared Priorities/ Commissioning	We will set out ring fenced, monitored funding for evidence based provision	**EDI;** pool budgets and resources for an equality based budget - not loudest voices/lawyers **Voices;** community belief that services will help & building trust **Green Agenda;** flexible workforce reduce carbon emissions. Co-located services reduces back office need (offices etc), services closer to home reduces unnecessary drives **Workforce;** benefit of flexible working, building capacity and hope
	We will co-locate and diversify experts	
	We will build/develop systems to streamline services	
	We will pool budgets for NHS, social care, education (CYP centered)	
2. Data - identifying disparities	We will create a shared database of intelligence to identify target populations to prioritise interventions	
	We will pilot to test a model of data informed prioritised service with pooled resources	
3. Relational community expertise	We will develop community HUBS to target and allocate with expert teams contributing to decisions	
	We will create HUBS which feel accessible and welcoming to all	
	We will get it right first time so TRUST is built	
4. Communications	We will utilise or develop technology to collate and share user information and care	

Strategic priority (workstream): Supporting the health and care needs of children and young people

Area of focus 2(of 4): Mental health

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	**The specific actions we need to take to take to achieve our enablers are…**	**This action will be achieved by the end of…** Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	**The risks or barriers that may stop us achieving this are…**
1. Population Health data to support QI	We will link mental health to physical health by ensuring joined up systems/services	Yr1 and ongoing	Online safety and safeguarding Feed children breakfast! More PE in schools
	We will map all available services across SWL - NHS/VCSC etc	Yr1 and ongoing	
	We will measure the impact of support offers	Yrs 2-3	Unwell children become unwell adults
2. Understand continuum of MH challenges to prioritise	We will utilise the continuum to target resources, making sense of complexity through prioritising of services and reducing waiting times ensure there is post discharge community support	Yr1 and ongoing	
	We will create a clear pathway from universal mental wellbeing offer to acute interventions	Yrs 1-2	
	We will promote emotional wellbeing and resilience	Yr1 and ongoing	Create services that CYP want to access
3. Roadmap of services/communication including role of NHS and VS and how they intersect	We will include young carers and bespoke services	Yr1 and ongoing	
	We will create a network of all providers across system to learn from each other and share experiences	Yr1	
4. Wider lense for MH support - families and communities	We will support families and wider community to build resilience	Yr1 and ongoing	
	We will create community spaces to foster greater connection and joy	Yrs 2-3	
	We will upskill voluntary sector to ensure greater access to tiered support	Yr1 and ongoing	

General risks for this area of focus:
Risk: demand vs capacity
Barrier: if we make this all service based/medicalised
Social media - barrier and opportunity
Need to invest in early intervention
Risk: we don't listen to young people
Risk: more acute services are needed
Risk: fixed contracts for VCS - need to have consistency of funding

Strategic priority (workstream): Supporting the health and care needs of children and young people

Area of focus 2(of 4): Mental health

Cross cutting themes & year 1 priorities

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	How does this action relate to our cross cutting themes/year 1 priority of workforce?
1. **Population Health data to support QI**	We will link mental health to physical health by ensuring joined up systems/services	**EDI;** should be part and parcel of service provision. Needs a fit for purpose assessment **Green agenda;** a universal offer, walk and talk strategy **Community voices & workforce;** expertise and consideration for voluntary sector agencies **Workforce:** upskill VCSC and lived experience
	We will map all available services across SWL - NHS/VCSC etc	
	We will measure the impact of support offers	
2. **Understand continuum of MH challenges to prioritise**	We will utilise the continuum to target resources, making sense of complexity through prioritising of services and reducing waiting times ensure there is post discharge community support	
	We will create a clear pathway from universal mental wellbeing offer to acute interventions	
	We will promote emotional wellbeing and resilience	
3. **Roadmap of services/communication including role of NHS and VS and how they intersect**	We will include young carers and bespoke services	
	We will create a network of all providers across system to learn from each other and share experiences	
4. **Wider lense for MH support - families and communities**	We will support families and wider community to build resilience	
	We will create community spaces to foster greater connection and joy	
	We will upskill voluntary sector to ensure greater access to tiered support	

Strategic priority (workstream): Supporting the health and care needs of children and young people

Area of focus 3(of 4): Maternity

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	**The specific actions we need to take to take to achieve our enablers are…**	**This action will be achieved by the end of…** Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	**The risks or barriers that may stop us achieving this are…**
1. Addressing inequalities and ensuring wider provision (not just for mothers)	We will ensure there is personalised care and use patient voice to inform service design	Yr1 - this is a starting point	Eurocentric approaches
	We will listen to different voices including fathers, young parents	Yr1 - this is a starting point	Not listening to care users
2. Clear expectations for services - Information/communication joined up not just during pregnancy and birth but around it. Wider education (to include young parents/ partners/ babies)	We will use data to identify "missing cohorts"	Yr1 - this is a starting point	Misunderstanding and misuse of GDPR
	We will ensure that the continuity of care model is applied	Yr1 - this is a starting point	Services not talking to each other
3. Community wealth/champions	We will use community connectors to link with voluntary and community sectors and services and co-produce	Within 2 yrs	Wrong people/approaches used to try to reach those who don't access services they need
	We will strengthen and support the voluntary and community sector	Within 2 yrs	
4. Address priorities from failings reports such as Ockenden	We will provide clear support to reduce stigma around Mental Health	Yr1 - this is a starting point	Parent/infant interaction impacted by mental health lack of support for perinatal MH
	We will utilise robust process to deal with and respond to feedback and complaints	Yr1 - this is a starting point	Poor information sharing

General risks for this area of focus:
Risk: lack of affordable housing for key workers
Risk: staff pay
Risk: loudest voices drowning out real need
Risk: system complexity
More conferences bringing together diverse voices

South West London Integrated Care System

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Strategic priority (workstream): Supporting the health and care needs of children and young people

Area of focus 3(of 4): Maternity

Cross cutting themes & year 1 priorities

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	How does this action relate to our cross cutting themes/year 1 priority of workforce?
1. Addressing inequalities and ensuring wider provision (not just for mothers)	We will ensure there is personalised care and use patient voice to inform service design	**EDI;** voice of patients and partners/fathers/families, compassion vs clinical speak, using local workforce **Green agenda;** local services within walking distance in the community, availability of digital resources **Voices;** innovative recruitment techniques **Workforce:** Recruit locally and train as well as experienced providers
	We will listen to different voices including fathers, young parents	
2. Clear expectations for services - Information/communication joined up not just during pregnancy and birth but around it. Wider education (to include young parents/ partners/ babies)	We will use data to identify "missing cohorts"	
	We will ensure that the continuity of care model is applied	
3. Community wealth/champions	We will use community connectors to link with voluntary and community sectors and services and co-produce	
	We will strengthen and support the voluntary and community sector	
4. Address priorities from failings reports such as Ockenden	We will provide clear support to reduce stigma around Mental Health	
	We will utilise robust process to deal with and respond to feedback and complaints	

Strategic priority (workstream): Supporting the health and care needs of children and young people

Area of focus 4(of 4): Inequalities (with a focus on LAC)

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. Prevention and early intervention	We will invest in keeping families together		Wrong lead professional working with the family **There are no barriers, we are doing it!**
	We will use or create data system to identify inequalities and enable early intervention and to understand full journey through system for CYP by bringing datasets together	Yr1 - bring data sets together	
2. Systemic support - housing and employment	We will invest particularly in care leavers and transitional support	Yr1	Challenge of redistribution of funding
	We will improve quantity and quality of foster care available	Yrs 2-3	
3. Integrated working and joined up pathways	We will improve consistency of assessment	Yr1	
	We will partner with Police to address high risks of disadvantaged youth being pulled into criminal activity (there is a need to involve CYP in discussions)	Yr1	Further stigmatising those already at risk of inequalities
	We will link with VCS supporting asylum seekers	Yr1	
4. Strengthening relationships and statutory responsibilities with the voluntary sector	We will map community assets	Yr1 - this is a starting point	
	We will ensure funding is sustainable and transparent	Yr1 - this is a starting point	

Strategic priority (workstream): Supporting the health and care needs of children and young people

Area of focus 4(of 4):

Cross cutting themes & year 1 priorities

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	How does this action relate to our cross cutting themes/year 1 priority of workforce?
1. **Prevention and early intervention**	We will invest in keeping families together	**EDI;** taking in all aspects of influence, intersectionality **Voices;** get young people involved and understand how to motivate them, focus on developmental phases of youth and coping mechanisms
	We will use or create data system to identify inequalities and enable early intervention and to understand full journey through system for CYP by bringing datasets together	
2. **Systemic support - housing and employment**	We will invest particularly in care leavers and transitional support	
	We will improve quantity and quality of foster care available	
3. **Integrated working and joined up pathways**	We will improve consistency of assessment	
	We will partner with Police to address high risks of disadvantaged youth being pulled into criminal activity (there is a need to involve CYP in discussions)	
	We will link with VCS supporting asylum seekers	
4. **Strengthening relationships and statutory responsibilities with the voluntary sector**	We will map community assets	
	We will ensure funding is sustainable and transparent	

Workstream 4: **Supporting the health and care needs of children and young people**

At the end of our time together we reviewed our work to test whether there were any overlaps or conflicts within the workstream priorities, or any possible crossover with other workstreams.

Supporting the health and care needs of children and young people identified two areas of focus which could cross-over with other workstreams outputs: **mental health and inequalities (with a focus on looked after children)**. Both of these were workstreams in their own right, and it is recommended that as part of the synthesis of workshop outputs, particular attention should be paid to testing this overlap with the actions and priorities defined with both the positive mental wellbeing and reducing inequalities work streams.

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Workstream 4: **Supporting the health and care needs of children and young people**

Participants in this workstream were invited to sum up their discussions using one or two words. These are captured in the accompanying word cloud.

At the heart of their feedback was a message of inclusion and accessibility: **no decision about children and young people without children and young people in the room**

South West London Integrated Care System

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Workstream 5: Tackling and reducing health inequalities

South West London Integrated Care System

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Workstream 5: **Tackling and reducing health inequalities**

This workstream was co-chaired by:

- Catherine Heffernan, Director of Health Improvement, South West London ICB
- Imran Chaudhury, Director of Public Health at Sutton Council

The co chairs started by setting some context to the workstream, including describing how today would make a difference, what patients, carers and communities had said about tackling and reducing health inequalities.

The group started with a long list of possible areas of focus and spent their first hour together collectively agreeing which 4 areas of focus they thought would have the most impact in supporting the delivery of this strategic priority.

The 4 areas of focus that this group agreed to prioritise were

- **Embedding NHSCORE20+5 throughout the system (improving collaborative approaches)**
- **Improving outcomes for people in our most deprived areas**
- **Empowering communities by working with VCSE and local partners**
- **Improving outcomes for our most vulnerable people**

They then worked together to build 4 logic models, one for each of these areas of focus.

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Strategic priority (workstream): Tackling and reducing health inequalities

Area of focus 1(of 4): Embedding NHSCORE20+5 throughout the system (improving collaborative approaches)

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. We need communication to raise awareness, along with accessible services that are easy to navigate and digital inclusion	We will simplify the explanation of CORE20+5 by localising communications and creating a consistent message, setting expectations and clarifying rights and entitlements		
	We will embed by getting commitment from service providers through a pledge approach and through corporate objectives		
2. We need partnership working groups and co-design groups in the community to build trust and relationships, and connect people with their communities. For the community, by the community.	We will replicate today's collaborative event with wider range of stakeholders including community leaders and decision-makers		
	We will enable people to have expert/patient groups and look at how we bring together existing ones that communicate online		
3. We need accurate data, owned by local people, to allow us to invest where the need actually is where there can be maximum societal impact.	We will improve ongoing work to build Population Health Dashboards by making data more complete and ensuring ICS is data and intelligence driven (e.g. currently registered patients only)		
	We will improve accessibility of the insights and be dynamic with data by factoring in research of the ICS		
4. We need to focus on prevention, through green spaces, lifestyle, behaviours, housing, and the wider determinants of health	We will allow people to seek help and support earlier, by working with community champions to get knowledge and information		
	We will look at how we can structure the phasing in of preventative work into the planning process, including active travel and the wider green agenda		

Strategic priority (workstream): Tackling and reducing health inequalities

Area of focus 1(of 4): Embedding NHSCORE20+5 throughout the system (improving collaborative approaches)

Cross cutting themes & year 1 priorities

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	How does this action relate to our cross cutting themes/year 1 priority of workforce?
1. We need communication to raise awareness, along with accessible services that are easy to navigate and digital inclusion	We will simplify the explanation of CORE20+5 by localising communications and creating a consistent message, setting expectations and clarifying rights and entitlements	This action has an implication for Workforce
	We will embed by getting commitment from service providers through a pledge approach and through corporate objectives	
2. We need partnership working groups and co-design groups in the community to build trust and relationships, and connect people with their communities. For the community, by the community.	We will replicate today's collaborative event with wider range of stakeholders including community leaders and decision-makers	This action has an implication for Workforce
	We will enable people to have expert/patient groups and look at how we bring together existing ones that communicate online	
3. We need accurate data, owned by local people, to allow us to invest where the need actually is where there can be maximum societal impact.	We will improve ongoing work to build Population Health Dashboards by making data more complete and ensuring ICS is data and intelligence driven (e.g. currently registered patients only)	This action has an implication for Workforce
	We will improve accessibility of the insights and be dynamic with data by factoring in research of the ICS	This action has an implication for Workforce
4. We need to focus on prevention, through green spaces, lifestyle, behaviours, housing, and the wider determinants of health	We will allow people to seek help and support earlier by working with community champions to get knowledge and information	
	We will look at how we can structure the phasing in of preventative work into the planning process, including active travel and the wider green agenda	

Strategic priority (workstream): Tackling and reducing health inequalities

Area of focus 2(of 4): Improving outcomes for people in our most deprived areas

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. We need to use data and local intelligence to provide insights for SWL residents	We will specify the data relevant to each area and access local intelligence by delivering engagement events through VCSE and grass roots		
	We will test the gaps between what we think we know from the data and what people experience by engaging with residents		
2. We need inclusive community leadership (VCSE)	We will build trust between the community and the leadership by establishing a community hub to give communities a platform for their voice		
	We will provide resources to fit needs and build resilience with the voice		
3. We need anti discriminatory town planning	We will find out what the community want and need, so that town planning is reflective of need (eg more relevant affordable shops, investment in youth community)		
4. We need accessible infrastructure	We will create more transparent access to services by using local spaces to build wider knowledge of services that is accessible to all		

South West London Integrated Care System

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Strategic priority (workstream): Tackling and reducing health inequalities

Area of focus 3(of 4): Empowering communities by working with VCSE and local partners

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. We need to understand demographics of communities and what matters to them (focusing on the 'CORE20' element and understanding the bigger picture)	We will find ways to reach new people by building relationships and asking communities what matters to them, committing to keep the conversation going		
	We will collect meaningful data and triangulate socioeconomic information by presenting as "here is what we know" and engaging communities to understand why this is the case		
2. We need local communities to identify their own priorities and tell their own stories, gathering data and stories via VCSE	We will increase trust by building a virtuous cycle of engage, change, communicate back, and repeat		
	We will build VCSE capacity by committing to longer term funding for the VCSE		
3. We need to understand what are communities' strengths by building an evaluation framework	We will undertake SWOT analysis of community groups		
	We will develop community profiles		
4. We need to increase capacity of community outreach	We will enable community/VCSE to lead on grassroots engagement by utilising resources from system		

South West London Integrated Care System

KALEIDOSCOPE Health and Care

Strategic priority (workstream): Tackling and reducing health inequalities

Area of focus 4(of 4): Improving outcomes for our most vulnerable people

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. **We need to define "vulnerable people" within SWL context**	We will undertake a needs assessment by delivering a workshop inclusive of local communities and health and social representatives across SWL		
2. **We need to understand the causes of people's vulnerability**	We will undertake analysis of population health data and local intelligence and triangulate data analysis by delivering workshops with local communities and health and social care representatives		
3. **We need more resources for co-production with lived experience**	We will build on existing workshops and data analysis to co-produce service and outcomes		
4. **We need to strengthen partnerships, reduce duplication, and build on what is working, to scale up.**	We will understand what's working by mapping and then evaluating existing projects		
	We will scale up and spread what's working by using a sustainability model and Equality Impact Assessments		

South West London Integrated Care System

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Workstream 5: **Tackling and reducing health inequalities**

At the end of our time together we reviewed our work to rest whether there were any overlaps or conflicts within the workstream priorities, or any possible crossover with other workstreams. The ‘Tackling and reducing health inequalities’ group identified the following 2 themes which they felt crossed over all of their discussion on the day:

All work in this area requires involving communities in reviewing actions and progress and needs to be underpinned by a thoughtful, joined-up engagement strategy

Empowering communities and giving them voice needs to be backed up by redistribution of resources to support it

South West London Integrated Care System

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Workstream 5: **Tackling and reducing health inequalities**

The discussion within this workstream was wide ranging and complex, however there were two key messages the group shared with the rest of the conference in the closing plenary session:

Empowering our communities

We need to focus on how we empower communities to create the solutions to improve their health and wellbeing.

We should not be trying to create solutions for people, but instead giving them the skills and support to create solutions for themselves and their communities. “Listening is the main thing” and “change happens at the speed of trust”.

Scaling existing innovation

We need to use the partnership to build and scale the amazing work that is already happening in pockets across South West London.

Colleagues working in the voluntary and community sectors are already delivering community focused, impactful interventions. We should be thinking about how we can support the amplification and scaling of this work.

South West London Integrated Care System

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Workstream 6: Workforce

South West London Integrated Care System

KALEIDOSCOPE Health and Care

Workstream 6: **Workforce**

This workstream was co-chaired by:

- Una Dalton, Programme Director: Workforce and Immunisations, South West London ICS
- Sam Mason, Health and Care Programme Lead, South London Partnership

The co chairs started by setting some context to the workstream, including describing how today would make a difference, what patients, carers and communities had said about workforce.

The group started with by testing the 4 areas of focus they thought would have the most impact in supporting the delivery of this strategic priority.

The 4 areas of focus that this group agreed to prioritise were

- **Making South West London a great place to work**
- **Targeted action around difficult to recruit to roles**
- **Designing our future workforce**
- **Supporting our local people into employment**

They then worked together to build 4 logic models for each of these areas of focus.

South West London Integrated Care System

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Strategic priority (workstream): Workforce

Area of focus 1(of 4): Making South West London a great place to work

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. Health and wellbeing	Guardianship and reward scheme (every organisation to commit to this scheme, a safe space for all employees)	Year 1	Organisational buy-in, cost/funding, change in resource
	We will create and gain agreement on minimum set of standards we expect when working in South West London	Year 1-2	Agreement/consensus when it comes to minimum standards
2. Attraction and retention	We will bring the NHS and social care hubs together to advertise vacancies	Year 1	Resourcing and capacity
	We will create a SWL Talent Pool	Year 1-2	Buy-in from senior leadership, funding, resourcing, unplanned introduction of new roles
3. Pay, terms and conditions	We will ensure the passport between organisations to be in terms and conditions (willingness to accept another South West London organisation has done due diligence with hiring)	Year 3	Buy-in from senior leadership, funding, having a vested interest, capacity, legal issues and staff buy-in when it comes to passports,
	We will offer career counselling provision in South West London across all roles	Year 3	
4. Leadership and development	We will offer apprenticeships and work experiences	Year 2-3	Capacity to support

South West London Integrated Care System

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Strategic priority (workstream): Workforce

Area of focus 1(of 4): Making South West London a great place to work

Cross cutting themes & year 1 priorities

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	How does this action relate to our cross cutting themes/year 1 priority of workforce?
1. Health and wellbeing	Guardianship and reward scheme (every organisation to commit to this scheme, a safe space for all employees)	
	We will create and gain agreement on minimum set of standards we expect when working in South West London	**Green agenda:** allows for local employment so could contribute to reduction in commuter travel. **EDI:** allows equality of access to opportunities and gives a fair voice to all **Elevating voices:** Nobody has to repeat their story twice
2. Attraction and retention	We will bring the NHS and social care hubs together to advertise vacancies	
	We will create a SWL Talent Pool	**Green agenda:** staff employed locally **EDI:** focused work and targeted groups will ensure appropriate representation of community. **Elevating voices:** Involving patients, carers and communities in the development of the SWL Workforce Talent Pool
3. Pay, terms and conditions	We will ensure the passport between organisations to be in terms and conditions (willingness to accept another South West London organisation has done due diligence with hiring)	**Green agenda:** minimises travel and minimises carbon footprint of trainings etc. **EDI:** ensure access issues for people with ongoing health conditions and reasonable adjustments are made **Elevating voices:** we can learn and share knowledge across the system.
	We will offer career counselling provision in South West London across all roles	
4. Leadership and development	We will offer apprenticeships and work experiences	

Strategic priority (workstream): Workforce

Area of focus 2(of 4): Targeted action around difficult to recruit roles

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	**The specific actions we need to take to take to achieve our enablers are…**	**This action will be achieved by the end of…** Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	**The risks or barriers that may stop us achieving this are…**
1. Making entry into our sectors easier	Create a SWL workforce academy - sign posting for career development, providing support for skills development (principles are realistic, achievable, smart)	Year 2/3	Need to ensure senior endorsement from all local organisations, being sure there is a willingness for change
	Identify what are hard to fill roles across the ICS to create a joined-up approach	Year 1	Identifying who will do this, capacity, conflicting priorities
2. Strong baseline (why, what, current work arounds - design something new to move beyond rigid approaches)	Design priority career pathways	Year 1	Conflicting priorities
	Explore leadership principles of SWL (agreeing to the ambition within the ICS)	Year 1	A resistance to culture change
3. Breaking down current barriers and obstacles	Refreshed engagement approach to promoting our careers (e.g. social media platforms)	Year 3	Capacity, funding
4. Focus on competency that enables flex based on client, people, patient, service need			

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Strategic priority (workstream): Workforce

Area of focus 3(of 4): Designing our future workforce

Future workforce = work experience from school student, graduate placements, industry placements, include promotion of roles to this future workforce

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	This action will be achieved by the end of… Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	The risks or barriers that may stop us achieving this are…
1. Integrated model starting at Place	We will gather key stakeholders at Place (Voluntary, local authority, NHS, charity, MH service users)		Developing a compelling narrative
	We will design/determine what is the future service model by determining population need and levelling up community skills etc		
2. Mapping exercise	We will identify current roles, barriers within roles, contact between roles, priorities and what works well to determine the gap	Year 1	
	We will co-design with all key stakeholders to create multi-disciplinary roles (ability to prepare for a common future through fluid roles)		Govt policies
3. Collaborative working and engagement with local communities	We will run a series of joint focus groups with local communities and workforce to understand needs and forecast future needs		Senior sponsorship and buy-in
	SWL workforce academy	Year 3	Funding
4. Harmonising terms and conditions across Place	We will design flexible roles and modular courses that can be responsive in future		Buy-in and funding to make changes
	We will support development of skills around data, analytics, problem solving, innovation		Buy-in and funding to make changes

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Strategic priority (workstream): Workforce

Area of focus 4(of 4): Supporting our local people into employment

Logic model

Enablers: The high level things that we need to do to achieve our goal are…	**The specific actions we need to take to take to achieve our enablers are…**	**This action will be achieved by the end of…** Year 1 or 2 (short term) Year 3 and beyond (medium to longer term)	**The risks or barriers that may stop us achieving this are…**
1. Analysis **a) Who is unemployed locally?** **b) What are the barriers?** **c) Co-production**	We will map who is already working in the areas and form a taskforce including all stakeholders (workforce intelligence leads) to analyse current situation	Year 1 (short term)	Cost of living crisis Lack of funding Capacity to do more than day-to-day work Lack of engagement (staff and community)
2. Awareness **a) Broad campaign via local community organisations to have job opportunities more visible** **b) Work in partnership with local community groups/schools to demystify NHS jobs**	We will choose areas of focus on e.g. disability, language, long-term unemployed	Year 1 (short term)	Overwhelmed by complexity Money/funding Capacity
3. Accessible **a) Work experience (paid), apprenticeships** **b) Develop roles that are part study, part work but paid** **c) Ready for employment - locally**	We will develop placement programmes with local employers	Year 2	Lack of prioritisation Money
	We will work with local employers to mitigate barriers e.g. ensure policies are in place and the right support is available	Year 2	Working in silos Politics Resource management
4. Employment model **a) London Living wage** **b) Flexible roles** **c) Working with local community to see what roles they would be interested in**	We will introduce a workplace passport (making it easy for people to move across SWL in different roles	Year 3	Agreement, logistics
	We will work with sector employers to overcome barriers to pay/living wage	Year 3 and beyond	National policies and politics Too top down, not bringing everyone with us Lack of evaluation

Strategic priority (workstream): Workforce

Area of focus 4(of 4): Supporting our local people into employment

Cross cutting themes & year 1 priorities

Enablers: The high level things that we need to do to achieve our goal are…	The specific actions we need to take to take to achieve our enablers are…	How does this action relate to our cross cutting themes/year 1 priority of workforce?
1. Analysis **a) Who is unemployed locally?** **b) What are the barriers?** **c) Co-production**	We will map who is already working in the areas and form a taskforce including all stakeholders (workforce intelligence leads) to analyse current situation	**Green agenda:** flexible working arrangements, enabling walking to work. **EDI:** Ensuring impact of protected characteristics is taken into account.
2. Awareness **a) Broad campaign via local community organisations to have job opportunities more visible** **b) Work in partnership with local community groups/schools to demystify NHS jobs**	We will choose areas of focus on e.g. disability, language, long-term unemployed	**EDI:** looking at protected characteristics and identifying areas to improve/target.
3. Accessible **a) Work experience (paid), apprenticeships** **b) Develop roles that are part study, part work but paid** **c) Ready for employment - locally**	We will develop placement programmes with local employers	
	We will work with local employers to mitigate barriers e.g. ensure policies are in place and the right support is available	
4. Employment model **a) London Living wage** **b) Flexible roles** **c) Working with local community to see what roles they would be interested in**	We will introduce a workplace passport (making it easy for people to move across SWL in different roles	**Green agenda:** inclusive employment **EDI:** promote equity in employment **Elevate voices:** working collaboratively with patients **Workforce:** Reach people who are not reaching up
	We will work with sector employers to overcome barriers to pay/living wage	**EDI:** equal pay irrespective of location (i.e. more deprived areas)

Workstream 6: **Workforce**

The key messages this workstream chose to share with the rest of the conference in the closing plenary session were:

Making South West London a great place to work:
Our conversation had three key themes:
1) Agreeing minimum standards for working in SWL (defining the values we think are important across SWL and getting all organisations to buy-in and agree to uphold these). (This action is achieved in a short term timeline)
2) Making it easier to transfer across SWL so we can retain people, ideally through a staff passport.
3) Developing talent pools with a specific focus on EDI and underrepresented groups. This could come through a SWL workforce Academy. (Both 2 and 3 would be longer-term actions).

The key barriers to these actions are organisation buy-in, funding, having a vested interest, capacity, legal issues and staff buy-in when it comes to passports, agreement when it comes to minimum standards

Targeted action around difficult to recruit roles:
Our key focus in this area was trying to be realistic and achievable.
We had long conversations about how we make assumptions about what hard-to-fill roles actually are. When talking about designing priority career paths, we wanted to consider a cross-sector approach.

The key barriers we identified applied to all our actions: conflicting priorities that mean change can't or won't happen and resistance to culture change or the accepted 'way of doing things'. Also sometimes we just need to fail fast to know what will work and learn from that, rather than being risk averse.

Designing our future workforce:
Our conversation had three key themes: mapping, changing roles and momentum (by which we mean how will our service delivery change according to need and how will we deal with the shift in skills needed to address changes - part of which will come from sound analytics and forecasting).
We think we need to share learnings that come from data analysis more widely across SWL - not just with systems leaders, and we need to be more flexible/adaptable in our roles. We also felt there was a need to build a compelling narrative around SWL as a place people want to work. Finally, we need to make sure we're not making more work for ourselves by duplicating what's already being done elsewhere - this links back to the need for analytics.

The key barriers to designing the future workforce were government policies and changing government - these are always going to be barriers so we need to have a responsive system in place to update where needed. We need senior sponsorship and buy-in to changes are needed to make change happen. We also need buy-in from recruitment teams/leads.

Supporting our local people into employment:
Our key focus in this area was understanding the gaps: we thought there was a need to map who is already in the area to help understand gaps and that this could and should happen in year 1. This would underpin all work moving forward.
We thought we would also need to choose areas to focus on (also in Year 1 but an ongoing thing). We need to work with local employers to mitigate barriers (accessibility etc.) but also develop placement programmes. Finally we thought that the London living wage needs to be part of this work but is more likely to be Year 3+ realistically.

Key barriers to these actions include change of govt, funding, capacity, lack of prioritisation, working in silos and a lack of evaluation so change can't happen with confidence.

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Recurrent themes

There are a number of recurrent themes that arise across the workstreams. Some of the ones that frequently recur include:

- **Co-production with our communities:** throughout every workstream there was strong message around the importance of co-production to create solutions for communities which they owned and were relevant to them.
- **Commitment to partnership working:** many participants noted the strong commitment to working in collaboration and partnership in the event. This came through particularly in relation to working with the voluntary, community and social enterprise sector. The opportunity to meet colleagues and build relationships was valued and came through strongly in the post event feedback.
- **Resources:** many workstreams identified the need to revisit the way in which resources are currently distributed to align them to the activities which will have the greatest impact, including to allow more sustainable funding for VCSE partnerships
- **Scaling innovation:** several workstreams noted pockets of brilliant work happening across the partnership (often in VCSE sector). A strong theme came through of the opportunity that the partnership provides to connect these and scale these pieces of innovation across the region.

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Synthesising workstream outputs

We recommend the following to explore further as part of post event follow up to build a cohesive set of actions for the next 5 years:

- **Cross over between children and young people and positive mental wellbeing:** they both had an area of focus that covered the other's area (CYP had a MH focus, MH had a CYP area of focus)
- **Cross over between children and young people and reducing health inequalities:** Children and young people also identified inequalities as a prioritised area of focus, although with a specific focus on LAC.
- **Building on connections and maintaining momentum:** the event gave people an opportunity to connect and meet in a way which was highly valuable. Thinking about how to continue to support and build cross sector connections is clearly already a key focus for the partnership but thought should be given to considering how to maintain the momentum the action workshop has created in this space. There is a clear invitation to and opportunity for the ICP and ICB to take on a leadership role in 'convening' the system.

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Participant feedback

We closed the workshop with a commitment to share insights and an invitation to provide feedback.

What our participants thought…

86%

% of participants who responded would recommend an event like this to a colleague

Ways the event could have been better

- More patient/carer representation/voices in the workstreams
- Venue and logistics were improved (acoustics, accessibility and food options)
- More time

3 words participants used to describe the event:

- "Wonderful, collaborative and insightful"
- "Voices being heard"
- Good event
- "Excellent partnership links"
- "Informative enthusing insightful"
- "Networking, learning, creativity"
- "Well organised, energetic"
- "Collaborative, partnership, progress"
- "Partnership discussions co-design"
- "Informative, collaborative, helpful"
- "Conversations, planning, networking"
- "Energy, collaboration community"
- "Positivity, Collaboration, reality"
- "Busy, diverse, proactive"
- "Well-organised, diverse representation, time"

South West London Integrated Care System			
Name of Meeting	Integrated Care Partnership Board		
Date	Thursday, 20 July 2023		
Title	The South West London Integrated Care Partnership Governance		
Lead Director (Name and Role)	Karen Broughton, Deputy Chief Executive/Director of Transformation and People		
Author(s) (Name and Role)	Rachel Flagg, Director, Integrated Care Partnership Development		
Agenda Item No.	05	**Attachment No.**	04
Purpose	Approve ☒	Discuss ☒	Note ☐

Purpose

The purpose of this report is to ask the Integrated Care Partnership (ICP) Board to provide feedback on the proposed arrangements for sub-groups of the ICP Board to enable delivery of actions agreed as part of the ICP Strategy.

Executive Summary

The SWL Integrated Care Partnership (ICP) agreed to review its governance arrangements following the development of the ICP strategy, to ensure that we enable delivery of the actions under each of the strategic priorities.

Proposals for taking forward the ICP governance are set out in the attached paper. These would not replace or duplicate partnership groups at place, but would be there to ensure delivery of our system-wide commitments at South West London level.

All the new and existing partnership groups will need to review their Terms of Reference and membership to ensure they reflect the new requirement to drive delivery of the ICP strategy.

Key Issues for the Board to be aware of

Leadership of the workstreams

Each of the workstreams has had co-leads from local government and the NHS up to this point. These workstream co-leads will be asked if they are willing and able to continue into a Senior Responsible Officer (SRO) role for the delivery phase of the strategy. If they are not, we will work together to find suitable alternative SROs.

Each workstream will also need delivery leads from within the partnership organisations who have the support of their managers to contribute to the action plans as part of their existing role.

Ongoing engagement of the wider ICP Board membership
Several ICP Board members are already involved in the workstreams as co-leads. Delivery of the strategy would be further strengthened by the ongoing involvement of the wider ICP Board membership. As part of the review of partnership group Terms of Reference and membership we will:

- Review where ICP Board members are already part of existing sub-groups and where there are gaps in membership that would benefit from ICP Board members' input
- Invite ICP Board members to express an interest in joining one of the sub-groups.
- Consider other ways in which ICP Board members can play a role in delivery outside of formal meetings e.g. by acting as champions within their own organisations.

Recommendation

The Board is asked to:

- Comment on the proposals for ICP governance.
- Agree that Terms of Reference for the proposed sub-groups should be reviewed to ensure they are fit for purpose to oversee delivery of the ICP strategy and brought back to the ICP Board in October.
- Agree that joint Senior Responsible Officers should be confirmed for each of the workstreams.
- Comment on how the wider ICP Board membership could be involved in the delivery of the workstreams.

Conflicts of Interest

No conflicts have been identified.

Corporate Objectives This document will impact on the following Board Objectives	The governance arrangements will support the delivery of the ICP's strategic priorities by aligning sub-groups with the agreed workstreams.
Risks This document links to the following Board risks:	There is a risk that there is a lack of capacity within partner organisations to engage in the work of the sub-groups.
Mitigations Actions taken to reduce any risks identified:	All partners are asked to prioritise existing system resources towards delivery of the strategy.
Financial/Resource Implications	No financial implications have been identified.
Is an Equality Impact Assessment (EIA) necessary and has it been completed?	No
What are the implications of the EIA	None

and what, if any are the mitigations	

Patient and Public Engagement and Communication	This will be considered as part of the review of Terms of Reference for each sub-group.

Previous Committees/Groups Enter any Committees/Groups at which this document has been previously considered	**Committee/Group Name**	**Date Discussed**	**Outcome**
		Click or tap to enter a date.	
		Click or tap to enter a date.	

Supporting Documents	Annex 1: Paper on Integrated Care Partnership Governance

SOUTH WEST LONDON INTEGRATED CARE PARTNERSHIP

20 July 2023

Integrated Care Partnership Governance

1. Introduction

The South West London (SWL) Integrated Care Partnership (ICP) agreed to review its governance arrangements following the development of the ICP strategy, to ensure that we enable delivery of the actions under each of the strategic priorities. The proposal is for system-wide partnership groups that can act as (or oversee) 'task and finish' groups to deliver the strategy and report in to the ICP on progress.

We are starting from the assumption that where there is an existing system-wide partnership group, we should see if it is possible to use that as a vehicle, rather than creating a new group. We mapped the existing groups that might possibly be able to play this role – the criteria being that they need to be system level rather than place level and they need to include representation from across the ICP, rather than being single-organisation focused. We found that the South-West London-wide groups that already exist tend to be NHS focused and that most of the partnership groups made up of local government, Voluntary and Community Sector (VCS) and NHS are currently in operation are at place level, with some exceptions e.g the Children and Young People and Maternity Partnership Board.

2. Proposals for ICP sub-groups to deliver the ICP strategy

2.1 Health Inequalities

The areas of focus for this strategic priority are:

- Addressing the wider determinants of health and wellbeing
- Scaling up innovation to improve outcomes for people in our most deprived areas and our most vulnerable people
- Empowering our communities to improve their health and wellbeing

There is an existing Health Inequalities and Equality, Diversity and Inclusion (EDI) and Equalities Board. It is recommended that this group becomes a formal sub-group of the ICP and that the Terms of Reference and membership of this board are reviewed to lead the delivery of the health inequalities actions and ensure it is representative of the partnership.

2.2 Prevention, Self-Care and Long-Term Conditions

The areas of focus for this strategic priority are:

- Developing a whole system approach to healthy weight and reducing obesity
- Maximising the ability of the voluntary and community sector to support people to lead healthier lifestyles
- Developing personalised self-care for people with long-term conditions

The South West London Directors of Public Health and the ICB's Executive Medical Director have previously agreed that there is a need for a system-wide Population Health Improvement Board. Terms of reference have been drafted in the light of the emerging ICP priorities and it is recommended that this becomes a sub-group of the ICP.

2.3 Children and Young People

The areas of focus for this strategic priority are:

- Reducing health inequalities, focusing on safeguarding and looked after children
- Improving the mental health of children and young people (led from the mental wellbeing workstream)
- Improving the physical health of children and young people
- Taking a partnership approach to maternity care
- Working together to improve outcomes for children with Special Educational Needs and Disabilities (SEND)

We have an existing system-wide partnership group for children and young people and maternity co-chaired by the Director of Children's Services (DCS) who is the DCS representative on the ICP and the Integrated Care Board's Chief Nurse. The agreed priorities of this group have been used to set the areas of focus for our work on children and young people in the ICP strategy.

Each of these priorities has an agreed partnership sub-group with existing workplans that align with the actions in the ICP strategy. Therefore, the proposal is that these sub-groups (Inequalities, CYP mental health, physical health, maternity and SEND), agreed in the Terms of Reference for the existing South West London Children and Young People and Maternity System Board act as the task and finish groups for the ICP Strategy.

2.4 Positive focus on mental wellbeing

The areas of focus for this strategic priority are:

- Improving the mental wellbeing of children and young people
- Enabling healthy environments that increase mental wellbeing
- Improving mental health literacy and reducing stigma
- Understanding complex needs and co-occurring issues to better support our residents

There is currently a system-wide SWL Mental Health Transformation Board and a SWL Mental Health Partnership Delivery Group. Having consulted with leads for these groups, the Mental Health Partnership Delivery Group is recommended to oversee the delivery of the Mental Health actions on behalf of the ICP because the Terms of Reference are about the delivery of the SWL mental health strategy and the ICP actions for mental wellbeing are aligned to the strategy.

The SWL Mental Health Partnership Delivery Group is becoming more representative of the whole system and the membership is being expanded to include a Director of Adult Social Services, a Director of Public Health, representatives of the Voluntary Sector and service user voice.

The task and finish function for the ICP's actions would be carried out through a subgroup of the Mental Health Partnership Delivery Group, the SWL Mental Health Strategy Delivery Group which is under development and will be representative of the system.

2.5 Community based support for older and frail people

The areas of focus for this priority are:

- Making South West London dementia friendly
- Reducing and preventing social isolation
- Working together to prevent older people having falls
- Supporting the wellbeing of unpaid carers

There are groups in all our six Places and a number of SWL-wide groups focusing on elements of support for older people and frailty, for example:

- SWL Directors of Adult Social Services Group
- SWL Frailty Network
- Care Homes Strategic Oversight Group
- Community Provider Network
- SWL Pro-Active Care Network
- SWL End of Life Care Network

Given that these groups have different and specific areas of focus, it is recommended that we set up a focused task and finish group with system representation to drive delivery of the actions in the ICP Strategy.

2.6 Workforce

The strategic priorities already agreed by the ICP board are:

- Making South West London a great place to work
- Targeted action around difficult to recruit to roles
- Designing our future workforce
- Supporting local people into employment

There is an existing SWL Social Care Workforce Partnership Group and an existing NHS People Board, both of whom have a broader set of objectives to deliver. It is recommended that a task and finish group be pulled together with representatives from these existing groups and other system partners to drive the ICP action plan. This would link into the NHS People Board and the Social Care Workforce Group.

3. Next steps

All the new and existing partnership groups will need to review their Terms of Reference and membership to ensure they reflect the new requirement to drive delivery of the ICP strategy. The work currently under development on ways of working with the Voluntary Community and Social Enterprise Alliance will be taken into account as part of this. We know that the voluntary and community sector in South West London is well established, and we will work closely with the alliance to map and build on existing infrastructure and forums that we can align to our developing ICP workstreams.

South West London Integrated Care System

Name of Meeting	Integrated Care Partnership Board		
Date	Thursday, 20 July 2023		
Title	SWL Innovation Fund: 2022/23 Scheme Progress Report		
Lead Director Lead (Name and Role)	Karen Broughton, Deputy CEO/Director of Transformation and People, SWL Integrated Care Board.		
Author(s) (Name and Role)	Angela Flaherty, Transformation Director, SWL Integrated Care Board.		
Agenda Item No.	06	**Attachment No.**	05
Purpose	Approve ☐	Discuss ☐	Note ☒

Purpose

The following report provides information regarding the current status of the Innovation Fund 2022/23 schemes and provides detailed information on several of the completed schemes.

Executive Summary

An Integrated Care Partnership (ICP) Investment Fund was established in October 2022. It was agreed that the focus of the fund in year one would be to support winter resilience and the reduction of health inequalities.

A rapid approach was adopted for year one (2022/23) to enable funding of awards to take place before the end of the calendar year. In December 2022, the Innovation element of the Investment Fund awarded a total of £2.7m to 36 successful schemes across South West London.

The investment fund is comprised of two funding streams:

1. **The Innovation Fund** - Funding for the Innovation element of the investment fund is agreed annually by the Integrated Care Board
2. **The Health Inequalities Fund** - Funding for the Health inequalities element of the fund is funded annually through national NHS Health Inequalities funding.

This paper is focussed on the Innovation Fund element of the fund.

The Innovation Fund schemes started in January and were scheduled to conclude at the end of March 2023 however due to unforeseen delays in schemes commencing many have only finished more recently.

The following report comprises of a summary of the status of the schemes in achieving their aims and provides summaries of several of the completed schemes.

Key Issues for the Board

Many of the Innovation Fund schemes are not yet able to fully report as to whether they have fully delivered their original aims, and we will need to undertake further conversations at a later stage to understand more fully the impact of the initiatives. However, we have learnt from the responses that 25 schemes that have finished or are finishing shortly have stated they have delivered most of the anticipated benefits.

Despite delivering the benefits anticipated several schemes are currently unsure as to whether they would continue the same scheme due to various reasons. A common reason shared for not continuing is the availability of the required workforce, this learning is informing alternative models.

The quality of the progress report returns was variable, and it was often unclear from the subjective information provided as to whether the schemes had achieved the outcomes specified. We will need ensure that this is addressed in future Investment Fund schemes, this could include:

- Ensuring the bids included a clear evaluation process (utilising a recognised methodology)
- Ensuring the bids develop clear plans for data collection in their mobilisation phases
- Ensuring closer monitoring of schemes and potentially implementing stage gate progress reports to access phases of funding

We should also consider in the next phase of investment a requirement for schemes to set out options for how the schemes could continue if they have been successful and how they could be adopted more widely, enabling more rapid adoption of innovation.

Recommendation

The Integrated Care Partnership (ICP) Board is asked to:

- **Note** the progress of the Innovation Fund schemes in 2023

Conflicts of Interest
None have been identified

Corporate Objectives This document will impact on the following Board Objectives	The Innovation Fund supports the core purpose of the ICP and is aligned to planned ICP priorities.

Risks This document links to the following Board risks:	None have been identified

Mitigations	None have been identified

Actions taken to reduce any risks identified:	

Financial/Resource Implications	None have been identified

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	Not required

What are the implications of the EIA and what if any are the mitigations	None have been identified

Patient and Public Engagement and Communication	None have been identified. Specific engagement will be undertaken as part of future funds and as part of local implementation plans.

Previous Committees/Groups Enter any Committees/Groups at which this document has been previously considered	**Committee/Group Name**	**Date Discussed**	**Outcome**
		Click or tap to enter a date.	
		Click or tap to enter a date.	
		Click or tap to enter a date.	

Supporting Documents	SWL Innovation Fund: 2022/23 Scheme Progress Report

SOUTH WEST LONDON INTEGRATED CARE BOARD

20 July 2023

SOUTH WEST LONDON INNOVATION FUND

1 Introduction

The key focus for 2022/23 Innovation Fund was to support winter resilience and sustainability and to make an impact in this financial year. The shortlisting criteria had a particular focus on winter resilience and is detailed below:

Sustainability: Demonstrate how the scheme would improve sustainability across health and care over the Winter 2022/23 period, e.g. helping support people in their home and helping them to keep well.

Impact: Demonstrate how the scheme would positively impact on winter resilience (e.g. improving experience, reducing cost) on health and care in South West London.

Deliverability: Realistic delivery over winter. Potential delays to mobilisation and delivery of the scheme, e.g. recruitment processes, procurement time, workforce issues, digital engagement.

Value: Detail the value of funding required and provide a high-level breakdown of costs.

Collaboration: Describe how the scheme supports collaboration across the ICP and which teams and partners would be involved.

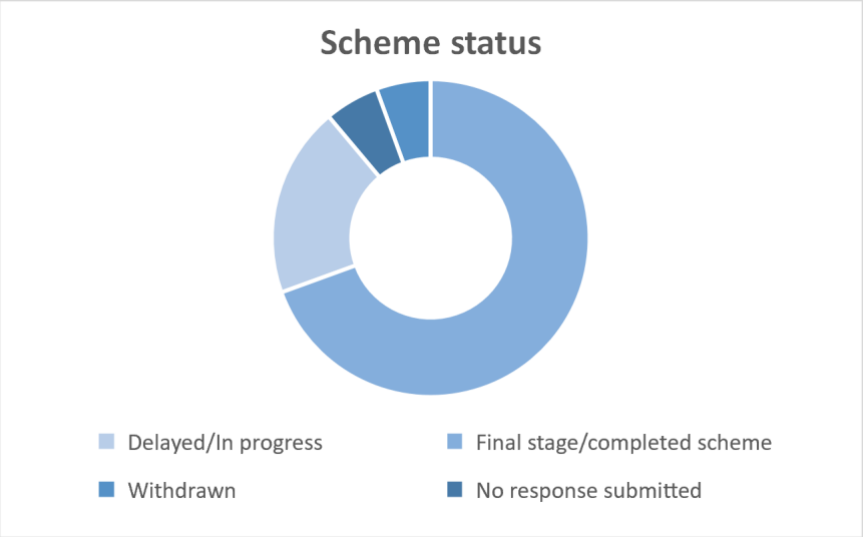
After shortlisting, 45 applications were selected (before moderation and SME review), totalling £6.6m. Following moderation, SME review and collation of any additional application information required, we agreed 29 bids totalling £3.4m to be taken to the awarding panel. The awarding panel met in November and agreed 25 bids, and post financial revisions these bids totalled c. £2.1m. The panel made three rejections and one bidder withdrew. Additional schemes were explored and a further 11 bids totalling c. £600k were awarded. This made a total of 36 bids totalling £2.7m.

The Innovation Fund schemes started in January and were scheduled to conclude at the end of March 2023 however due to unforeseen delays in schemes commencing many have only finished more recently. The following report comprises of a summary of the status of the schemes in achieving their aims and provides summaries of several of the completed schemes.

2 Delivery of schemes

To ensure schemes were supported throughout mobilisation and delivery the coordination and oversight of the schemes was undertaken either at Place or if system wide as part of an existing ICB system wide programme. Where schemes fell outside of these arrangements an ICB Director was identified to act as a point of contact. In May we formally requested a progress update on the delivery of the schemes and in particular progress against the ambitions stated in the original bid. We have had a successful number of returns with only 2 schemes not returning their progress forms. These schemes are being followed up locally. Additionally, through the responses we identified two schemes that did not proceed. Figure 1 shows the status of the 36 schemes.

Figure 1 Breakdown of scheme status



Many of the schemes are not yet in a position to fully report as to whether they have fully delivered their original aims, and we will need to undertake further conversations at a later stage to understand more fully the impact of the initiatives. However we have learnt from the responses that 25 schemes that have finished or are finishing shortly have stated they have delivered most of the anticipated benefits. Despite delivering the benefits anticipated several schemes are currently unsure as to whether they would continue the same scheme due to various reasons. A common reason shared for not continuing is the availability of the required workforce, this learning is informing alternative models.

The quality of the progress report returns was variable, and it was often unclear from the subjective information provided as to whether the schemes had achieved the outcomes specified. We will need ensure that this is addressed in future Investment Fund schemes, this could include:

- Ensuring the bids included a clear evaluation process (utilising a recognised methodology)
- Ensuring the bids develop clear plans for data collection in their mobilisation phases

- Ensuring closer monitoring of schemes and potentially implementing stage gate progress reports to access phases of funding

We should consider in the next phase of investment a requirement for schemes to set out options for how the schemes could continue if they have been successful and how they could be adopted more widely, enabling more rapid adoption of innovation.

3 Schemes in focus

To bring to life the extensive work undertaken across the Innovation Fund schemes we asked several of the completed schemes to produce a summary of the work undertaken. Please note these summaries are written from the perspective of the individual schemes;

3.1 System wide: Intensive Support Service

Our aim

This scheme was developed in response to feedback from acute discharge leads that there were a significant number of patients with behaviours that challenge that were experiencing long waits for Care Homes placement. The project sought to establish whether there is a need for a new and continuing Intensive Support Service pathway to reduce acute discharge delays and increase and improve provisional placement referral, uptake, and sustainability, longer term.

As an initial Proof of Concept (PoC) pilot, the project endeavoured to identify sufficient case studies and evidence to support any such business case or accompanying application that would be required for continued funding of an Intensive Support Service. This ranged from, the individuals who were seeking or required a care home placement; the services and teams involved in discharge referrals; compatibility assessments; and ensuring the sustainability of a care home placement.

What we did

Using three distinct pillars we established a behavioural team across South West London;

- Pillar 1: Behavioural Assessments – we carried out face to face behavioural assessments in acute hospital and care home placements, which offered stakeholders additional information and recommendations to impact on decision making processes for placements and enable care homes to make informed choices about placements.
- Pillar 2: Enhanced Positive Behavioural Support – trained staff in the basic principles of positive behavioural support.
- Pillar 3: Outreach Support & Coaching

What we have achieved

The project had a significant impact both on delayed discharges and the skill levels of staff within care across the 6 boroughs.

High-level training insights

- Positive Behavioural Support training was delivered to 70 providers, 67 of which were care homes exceeding the KPI of 45 care homes trained by over 40%. This included multi-specialism care homes, pharmacies, acute hospital ward staff.
- Total Number of staff trained was 373, exceeding the KPI of 225 staff trained by more than 60%.

High-level Assessment insights

- Number of referrals - 18
- Source of referrals - 3 from Care Homes, 15 from Hospitals
- Number of non-accepted referrals – 0
- Number of Completed Assessments – 13 (1x deferred, 1x RIP, 3x discharged)
- Number of supported discharges – 6

The feedback highlighted that there is a significant need for this to continue across the boroughs. The impact and insights of the project have been shared with the 6 boroughs to build into the 2023/24 plans.

We received the following feedback from carers/family members of patients involved in the project;

> *"Thank you so much for attending the MDT, you really helped us with my fathers case."*
>
> *"You help me understand why my mum reacts the way she does."*
>
> *"I can see a really big difference in how staff are with mum."*

3.2 System wide: Accelerate the use of universal care plans for housebound people who live with frailty and multiple long-term conditions

Our aim

The aim of this initiative was to work with a selected cohort of people (housebound, moderate or severely frail and with multiple long-term conditions) and with one Primary Care Network (PCN) in each borough in SWL and complete universal care plans (UCPs) to:

- Avoid, where possible, unplanned hospital admissions
- Provide care and support tailored to individuals' wishes
- Ensure patients' safety by ensuring health and care professionals have access to one set of digital information
- Increase resilience across health and care over the Winter period for 2022/23

Two organisations (Marie Curie and St Christopher's Hospice) were chosen to support conversations with the 279 people identified as fitting the criteria to be offered a UCP.

What we did

All 279 people were offered a Universal Care Plan. During this short-term initiative, the providers worked with a wide range of stakeholders (identified people, their families and carers,

clinical and non-clinical staff from GP Practices) to arrange discussions and complete or update the care plans. In total, 98 UCPs were completed across SWL (36% of the target cohort) within 3 months (mid-January to mid-March `23).

What we have achieved

This initiative has impacted positively the lives of people who accepted the offer. Going forward, the development of UCPs should be embedded in current practice and all health and care professionals should be involved in promoting and conducting UCPs. Below are few quotes from people and/or carers/family members who worked with the two providers to complete or update the UCPs.

"I found the care plan very useful for my father as it will reduce the amount of repetition between different healthcare professional who come to visit him"

"It is reassuring that other healthcare professionals can see my plan. I have no next of kin and I was worried that no one would be there to speak up and advocate for me"

"Living at home means I have lost my voice in what happens to me. My family can't visit a lot, but it's good to know you are interested in what I want"

"It is really nice to be thought of like this, my husband dies at St Christopher's hospice, and he had a a care plan like this, I am pleased I can make my wishes known."

3.3 System wide: Improving Digital Access for people experiencing homelessness

Our aim

SPEAR is a charity working with people who are experiencing homelessness across five SWL boroughs. Speaking to the people they work with it became apparent that one of the biggest barriers to receiving healthcare was lack of digital access. Our scheme aimed to increase access to online healthcare services by providing people with the equipment, skills, confidence, and support.

What we did

The programme had three parts; weekly 1:1 support sessions, drop-in sessions and providing digital inclusion training to 24 staff and volunteers.

Everybody participating in the support programme had access to a laptop and at the weekly sessions people were helped to register with the NHS and a digital skills course. They were also helped with basics such as using the internet for daily life, registering with a GP and ordering repeat prescriptions.

With the funding from the SWL Innovation Fund SPEAR was able to work with 16 people experiencing homelessness over 4 months to increase access to online healthcare services by providing people with the equipment, skills, confidence, and support.

What we have achieved

Of the 16 people who completed the course:

87% said their digital skills had increased

81% said they felt more confident using their devices

62% said they felt more confident about accessing health services online

87% reported that the support they had received during the course had been good or excellent

"The programme is run very well for people learning from the ground up. If I had not signed up for the programme, I would not be able to do anything digitally and would not have done it for the rest of my life." Spear client

Given the success of the project the ambition is to continue delivering digital skills support building on the learning from the first cohort.

3.4 Sutton: Cheam & South Sutton Loneliness Project

Our aim

We know loneliness has adverse effect on health outcomes, comparable to obesity and smoking. There is an increased risk of developing coronary heart disease (29%), stroke (32%), cognitive decline and dementia (50%). Loneliness accelerates the progression of frailty and increases the risk of hospital admission by 68%. The focus of our scheme was to understand loneliness and put interventions into place to reduce it.

What we did

With case identification through health professionals (GPs, community nurses and pharmacists), together with the UCLA Loneliness scale, we were accurately able to identify loneliness over 70% of the time. The scale measures different dimensions of loneliness: relational connectedness (to partner or family), social connectedness (to work/community group) and perceived self-isolation. Despite seeing their family regularly, the majority of people interviewed were still lonely, as they lacked social connectedness.

Through Innovation Funding, we recruited 2 health and well-being coordinators who interviewed 74 people over the age of 50 who were identified as lonely. Loneliness was measured to be reduced by:

- Holistic assessment and personalised care plans for all participants
- Social prescribing referrals or signposting including information on cost of living, transport and health
- Connection to local activities using neighbourhood maps showing activities within walking distance
- Digital access and training on the NHS App
- Increased awareness of alternatives to A&E and hospital admission such as MDTs, virtual ward, social care, voluntary sector, community pharmacies and additional roles now seen in General Practice

Interviews were completed from January to March'23 (Phase 1). Phase 2 of the project (April 2023 onwards) focusses on repurposing community spaces into neighbourhood hubs with the aim of proactively inviting lonely residents to volunteer or attend as guests, enabling them to form more social contacts and have a place to go outside their own home.

What we have achieved

- Ability to accurately identify residents at risk of loneliness (70% accuracy)
- Identification of unaddressed health and care needs and avoidance of admission, social care visit or GP through proactive holistic assessments. E.g., we identified physical health problems including high and low blood pressures, medication queries and mental well-being problems and referred to resident's own GP surgery or community pharmacy.
- Personalised care plans have increased awareness of different ways to access health and care, thus improving residents' control over their health and reducing anxiety over health attendances
- Increased access to care (through NHS App training or raising awareness of vulnerability to GP surgeries).
- Increased continuity of care (e.g. same clinician, same carer) through liaison with GP surgeries

3.5 Croydon: Advanced Care Planning for people attending emergency departments (ED)

Our aim

This scheme for Croydon builds upon the work undertaken by the Croydon Health Services Palliative Care team on the development of 'Pallitrigger', a tool to aid palliative care referrals from the ED front door. This focus has been undertaken based on systematic review of current tools which demonstrated limited effectiveness.

Approximately 30% of inpatients are in their final year of life. However, they can be challenging to identify. NICE recommends inclusion of a Trigger tool in end of life service delivery.

What we did

Reviewed and identified 123 people at end of life utilising the Pallitrigger tool which supports:

1. Identification of people at end of life and enable appropriate advance care planning, which is visible to all through the Urgent Care Plan (including primary care, community and LAS teams)

2. Clear care planning to provide pathways for escalation / exacerbation of illness, and ensure that, where possible community or other support is implemented. This aims to:

    - Improve the quality of life and experience for patients / carers
    - Support people to die in their place of choice
    - Reduced subsequent ED attendances and admission

What we have achieved

Reviewed and identified 123 people at end of life, and over the period of data collection:

- 36 have died and enabled appropriate advance care planning, which is visible to all through the Universal Care Plan (UCP) (including primary care, community and LAS teams).

- All patients identified by Pallitrigger and reviewed were recommended to have a UCP created
- Reduced length of stay (LOS) by 8 days (median) for patients first assessed in ED with PalliTrigger compared to usual care over the period in 2023 and reduced by 8 days compared to usual care over the same period in 2022.
- Improved the quality of life and experience for patients / carers – verbal feedback from patients and family has been positive regarding palliative care assessment In ED
- Supported people to die in their place of choice. Of the patients who have died since the start of the scheme 56% achieved their preferred place of death (PPD)
- Patients virtually reviewed with Pallitrigger demonstrated a reduced LOS of 5.5 days compared to usual care over the same time frame in 2023 and 9 days compared to usual care over the same time period in 2022.

We also identified a number of additional benefits

- Improved administration of medication for symptom management to patient receiving early palliative assessment.
- Improved transition from community to hospital palliative care for identified patients and also improved collaboration with acute medical colleagues and community services.
- Early identification of patient needs/goals of care and expediting appropriate referrals and retrieval of medical records to improve communication and transition of care
- Improved patient experience and continuity of care both as an inpatient and once discharged due to early involvement from community palliative care

3.6 Wandsworth: RISE+

Our aim

RISE + is an additional component to the RISE service which aims to transform the lives of isolated older people through a programme of care and support which respects, values and encourages independence in later life. RISE+ was a new initiative for 3 months to provide a hospital discharge programme that supports older people on the ward in hospital, on discharge and at home.

What we did

We visited individual patients, particularly those without visitors, befriend and continue to visit when they were discharged home with a visiting and practical support programme which would include a “supply box” of food on arrival home, an activity kit, a telephone help line and a dedicated person to visit on a daily basis for the first week and regularly thereafter. We liaised with care providers, pharmacists, GPs and health professionals, signposting clients to Day and other support services.

Through linking our day services, outreach and RISE+ services together, we have been able to draw in our staff and colleagues from Regenerate-RISE to ensure that the health and care of individuals would not only be sustained over this coming Winter, but throughout the year ahead. We undertook a range of activities;

- Pre-Discharge Preparation, this included
    - Clearing rooms for Hospital beds
    - Moving furniture downstairs
    - Cleaning and Tidying Up

  - Providing a Microwave
  - Providing heaters
  - Accompanying patients home for contractor meetings

- On the day of discharge, we visited patients to;
  - Provide a familiar face and help the patient to settle at home
  - Supply a food Hamper of their choice
  - Provide a gift of a Dressing Gown
  -

We also provided a visiting programme at home to befriend and signpost, to provide support and carry out practical tasks this enables the person to live safely and independently at home

What we have achieved

Over the duration of the scheme we have undertaken 267 Visits to 110 different patients living in Wandsworth and Merton at St George's Hospital, Queen Mary's Hospital and Kingston Hospital on 9 different Wards. 18 patients who were ready for discharge, were referred to us and all were visited at home on discharge. 13 received a food hamper and 12 received a dressing gown.

Prior to discharge we prepared 3 people's homes for hospital beds by moving old beds to clear a space. We also removed obvious trip hazards, moved and provided comfortable chairs and cleaned the room in preparation for the new beds. We also provided a microwave, oil-filled heaters and replaced a broken letterbox. We also provided 33 home visits.

We have received the following feedback from the Admissions and Discharge Co-Ordinator, Mary Seacole Ward.

"You and your team are providing an excellent service to our patients. I can't express how helpful you all have been since you started. You never say no to any of the requests and you go the extra mile in helping patients to be discharged safely".

Admissions and Discharge Co-Ordinator, Mary Seacole Ward.

3.7 Wandsworth and Merton: Together Children and Young (CYP) People hubs

Our aim

Together CYP (Children and Young People) Hubs, a collaborative "proof of concept" innovation aimed to reduce system pressures and support CYP in Merton and Wandsworth. The scheme aimed deliver proactive routine paediatric care to at-risk population.

What we did

The scheme has developed the Together clinics and Multi-Disciplinary Team meetings in three PCNs and set up four CYP hubs across East Merton and Wandsworth in the most deprived areas. In 2023/24, the service will scale across Merton and Wandsworth. The scheme has

improved on and built a high level of collaboration between the Trust, PCNs and individual GP practices. This has included:

- Learning/Upskilling clinicians about CYP management in all hubs, for example the identification of themes for training together days
- Sharing information about pathways for GP and Paediatricians, such as abnormal head shapes
- Promoting amongst clinicians “3 dimensional protocols”, including when to refer to primary, secondary and tertiary care.
- The sharing of resources, such as parent leaflets, the Healthier Together programme, following the lack of CYP BP cuffs to measure blood pressure

What we have achieved

The scheme has led to faster input on CYP care from paediatricians:

- An 8-month-old baby with abnormal head shape was seen the day before by their GP, then seen in TC clinic and then referred to GOSH for management. This shows how the patient was referred to paediatrics within 2 days.
- A patient with short stature was quickly assessed and investigated through Paediatrics and did not require a follow up.
- A 5-year-old patient presenting was headache was managed quickly and avoided a referral to paediatrics due to education about the pathway and these conditions in CYP (upskilling of clinicians)

We have also seen a reduction in referrals due to the pilot:

- A 3-year-old was rejected by First Fit Clinic, seen in Tertiary Care where they discovered neurodiversity issues which was impacting parenting. This was a quick referral to tertiary specialist and had a positive impact on safeguarding of patients.
- A 10-year-old patient with an irritable bladder since 4 weeks had experienced accidents in school, and through this pilot received a quick assessment, investigation and further management, demonstrating the effect of improved local access

We have also seen a reduction in follow ups with GP or paediatrics

- A 12-year-old patient presented with increased frequency of headaches and migraines due to a particular medication overuse avoided a referral to hospital and did not need a GP follow up, reassuring the parent.
- 3-year-old with faltering growth received a prompt diagnosis and investigation, avoiding a referral to paediatrics and had a clear plan with reduced follow ups needed with their GP

3.8 Wandsworth: Realigning the rehabilitation pathway

Our aim

Mary Seacole Ward (MSW) is a 42-bed older adults rehabilitation ward based at Queen Mary’s Hospital in Roehampton. The MSW Innovation Fund pilot was designed to provide a fast, intensive rehabilitation pathway through the ward with the specific aim of reducing length of stay to increase flow, reduce onward care costs and improve outcomes and experience for patients coming onto the ward.

What we did

The pilot was designed to work with 10 patients at any given time on the ward and then the therapy staff to follow up with them in the community. Ongoing care and support at home was provided by Quickstart (a health funded care bridging service) in the short-term on their discharge. A social worker was engaged for both Wandsworth and Merton to assist with removing any barriers to discharge.

Therapists are following patients out into the community and currently providing between 1 and 4 home visits both pre and post discharge to settle people at home. They are working extensively with friends, family and carers to ensure that any concerns around discharge are addressed. Patients have been highly motivated to engage in therapy on the ward, as they recognise that this will allow them to get home quicker and are managing the levels of intensive input well. Feedback from both patients and their loved ones has been extremely positive and a key piece of feedback has been that the anxieties on how people will cope at home following discharge has been managed really well.

What we have achieved

So far approximately 10 patients have completed the pathway. There had been an increase in average length of stay (LOS) on MSW up to 40 days prior to the commencement of the project. The activities of the project have now reduced that average LOS to 23 days. All patients have exhibited much lower levels of functional disability on discharge and most patients entering the programme required higher level of care assistance on admission with all showing a significant reduction in the need for support, substantially reducing the requirement for packages of care on discharge.

There has been increased collaboration with voluntary sector colleagues and anecdotal evidence suggests that these partnerships have helped significantly in reducing barriers at discharge. All patients going through the pilot so far have bypassed the need for urgent therapy on discharge with about 50% requiring some longer-term, routine therapeutic intervention from domiciliary therapy services.

Because of some of the logistics of the ward, it was necessary for all of the therapy team to be involved in the pilot, rather than just the two cited in the bid. This has had an unexpected positive outcome, as the whole therapy team are expressing higher levels of job satisfaction, principally as they are able to see rapid improvements in their patients and positive outcomes.

3.9 Kingston: Carers' Health & Wellbeing Improvement Programme

Our aim

The Kingston Upon Thames Carers' Health & Wellbeing Improvement Programme aimed to increase take-up of the holistic health and wellbeing offer that is delivered across Place by Royal Borough of Kingston Upon Thames and partners across health and the voluntary and community sector. The service was designed in direct response to the impact of a hospital admission, discharge or diagnosis on the responsibilities of carers. There is also an increased risk of hospital admission for the person being cared for in the event that the health of their carer is in decline.

What we did

The Kingston Upon Thames Carers' Health & Wellbeing Improvement Programme put in place preventative health and care interventions;

- Supporting carers' to self-identify or come to notice of statutory and voluntary sector services
- An Unpaid Carers' Awareness and Information training resource has been developed for Kingston Hospital staff through this partnership. This resource is available to be shared and scaled across other acute and PCN settings.
- Increase the resource available to both the Hospital and PCN to deliver a proactive health and wellbeing intervention that makes a bespoke assessment of carers' needs and onwards connections to support at hospital, in the community and at home. A full suite of assessment tools have been developed collaboratively through this partnership.
- Additional resources (e.g. letter templates to GPs for unpaid carers) have been developed to enable handover of essential information and assert the rights of carers in additional settings, including the workplace and employers.
- Development of collateral including service promotional posters to encourage the public to self refer and increase uptake of the new service.

What we have achieved

We have increased the early identification of unpaid carers' through increased professional awareness of the signs that someone is adopting the role of unpaid carer, support needs and services available. We identified 88 adult carers in the acute hospital setting, providing a seamless offer of support for carers between the hospital, GP surgery and Kingston Carers' Network.

We increased the efficiency of referrals to available support through greater partnership working across acute, primary and voluntary and community sectors. Of the 88 carers identified, 70 (79%) were previously unknown to the PCN, statutory or voluntary sector carers' service or provider and therefore not receiving the support they were eligible to receive as unpaid carers.

The partnership hosted over 150 carers across two dedicated events to promote the health and wellbeing of local unpaid carers. Of 130 people attending a Carers' Wellbeing Event, over half (56%) said that the event had resulted in more or significantly more confidence to make their own healthcare a priority.

The collaboration between the three providers, acute, PCN and voluntary sector has resulted in a clear carer service support pathway across the three sectors. The Carers Clinical Liaison Practitioner has supported over 217 carers with a 'Safe Transitions of Care' plan and Carer Contingency Planning since the service opened in February 2023, facilitating joined up care across acute, voluntary and PCN upon hospital discharge of a person with an unpaid carer.

For our partners (KHFT, KCN and New Malden PCN), the scheme has lead to increased take up of existing preventative health and wellbeing services as well as knowledge and insight into the needs of this population.

Our collaboration was brought to the attention of the NHS England Chief Nurse (Clinical Service Quality) Professor Siobhan Gregory and Debbie Hustings, NHSE London Region Lead for Unpaid Carers culminating in a visit to Kingston Hospital attended by our three partners. Reflecting on the day, Debbie Hustings said;

“This integrated approach extends to the New Malden & Worcester Park PCN. Today, I say how the Hospital Carer Liaison Staff use a template letter to inform primary care staff that they have supported a carer in hospital. This connectivity is what I found so exciting, and there seems to be to be enormous potential to use the GP carer SNOMED codes to map carers’ journeys through the various healthcare services so they only need to tell their story once.”

Debbie Hustings, NHSE London Region Lead for Unpaid Carers

3 Recommendations

The Integrated Care Partnership Board is asked to:

- **Note** the progress of the Innovation Fund schemes in 2023

Author: Angela Flaherty
Role: Transformation Director
Date: July 2023

South West London Integrated Care System			
Name of Meeting	Integrated Care Partnership Board		
Date	Thursday, 20 July 2023		
Title	SWL Investment Fund: Revised Approach for 2023/24		
Lead Director Lead (Name and Role)	Karen Broughton, Deputy CEO/Director of Transformation and People, SWL Integrated Care Board.		
Author(s) (Name and Role)	Angela Flaherty, Transformation Director SWL Integrated Care Board.		
Agenda Item No.	06	**Attachment No.**	06
Purpose	Approve ☒	Discuss ☒	Note ☐

Purpose

This paper proposes a revised approach to the Investment Fund 2023/24. The approach proposes the distribution of funds and outlines the award process.

Executive Summary

SWL Integrated Care Partnership (ICP) Board established an Investment Fund in September 2022 to support the delivery of ICP's Strategic Priorities. 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.

The Investment Fund is comprised of two funding streams:

- **The Health Inequalities Fund** - Funding for the health inequalities element of the fund is funded through national NHS Health Inequalities funding.
- **The Innovation Fund -** Funding for this element of the Investment Fund is agreed annually by the South West London Integrated Care Board.

The Innovation Fund approach for 2023/24 was approved by the SWL Integrated Care Partnership (ICP) Board in January 2023 and further revision approved in April 2023. This paper is focussed on both elements of the Investment Fund and describes the allocation of funding for both funding streams and also proposes greater alignment of the application processes for the two funding streams. Please note the Innovation Fund has been renamed as the ICP Priorities Fund to better reflect the purpose of the fund.

Key Issues for the Board

The Investment Fund attracted many innovative projects across the system and therefore, as agreed with the Board in January 2023, we are planning to run the process again in 2023/24.

Health Inequalities

In 2022/23, NHS England received additional funding worth £200 million for health inequalities, which was allocated to ICBs (through a needs-based approach) to support system plans developed with health and care partners.

£4.3 million is available to South West London for 2023/24. The funding should:

- Be directed towards the services and populations who face the largest inequalities in access, experience, and outcomes.
- Maintain work to reduce health inequalities, such as the NHS five priority actions, the Core20PLUS5 approach, while achieving financial balance and elective recovery.
- Systems may also wish to consider High Intensity Use programmes which can support UEC pathway pressures whilst at the same time addressing health inequalities.

The Health Inequalities fund for 2023/24 will be for existing and new projects with a distribution of funding of 75% for existing schemes and 25% for new schemes. This distribution approach applies to both Place and System wide schemes. This approach allows applications for new schemes to occur this autumn whilst the formal evaluation of existing schemes is undertaken. Successful schemes will be authorised to run until the end of March 2025.

ICP Priorities Fund for 2023-25

As agreed with the Board in January 2023, we will be running the process again this year with a confirmed budget of £5 million across the two financial years until March 2025. The new ICP Priorities Fund for 2023-25 will be targeted to support delivery of the Integrated Care Partnership's strategic plan and priorities.

In considering the allocation of the fund we are proposing the creation of two categories with the following distribution of the fund.

- Category 1: ICP Workforce priority focussed with an 80% allocation of funding
- Category 2: Remaining ICP priorities and cross cutting themes focussed (excluding HI) with an allocation of 20% of the funding

Successful schemes will be authorised to run until the end of March 2025.

Application and Award Process

To improve alignment of the approaches for both funding streams we have redesigned the awards process, in essence the funding streams would follow a similar process until the awards panel stage. Each funding stream will have its own shortlisting criteria to reflect the requirements of the funds, however we will where possible strive to ensure common criteria across the funding streams.

Recommendation **The Integrated Care Partnership (ICP) Board is asked to:** • **Approve** the approach for the Health Inequalities Fund for 2023/24 • **Approve** the approach for the ICP Strategic Priorities Fund for 2023-25 • **Review** and **support** the process for 2023/24.

Conflicts of Interest: None have been identified

Corporate Objectives This document will impact on the following Board Objectives	The Innovation Fund supports the core purpose of the ICP and is aligned to planned ICP priorities.
Risks This document links to the following Board risks:	None have been identified
Mitigations Actions taken to reduce any risks identified:	None have been identified
Financial/Resource Implications	None noted
Is an Equality Impact Assessment (EIA) necessary and has it been completed?	This is not required at this stage
What are the implications of the EIA and what if any are the mitigations	None have been identified
Patient and Public Engagement and Communication	None has been identified. Specific engagement will be undertaken as part of future prospective applications and as part of local implementation plans.

Previous Committees/Groups Enter any Committees/Groups at which this document has been previously considered	**Committee/Group Name**	**Date Discussed**	**Outcome**
	The Integrated Care Partnership Committee	12/01/2023	Approved
	The Integrated Care Partnership Committee	19/04/2023	Approved

Supporting Documents	Innovation Fund 2023/24: Proposed approach

South West London Integrated Care System

SOUTH WEST LONDON INTEGRATED CARE BOARD

20 JULY 2023

SOUTH WEST LONDON INVESTMENT FUND REVISED APPROACH FOR 2023/24

1. Introduction

SWL Integrated Care Partnership (ICP) Board established an Investment Fund in September 2022 to support the delivery of ICP's Strategic Priorities. 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.

The Investment Fund is comprised of two funding streams:

- **The Health Inequalities Fund** - Funding for the health inequalities element of the fund is funded through national NHS Health Inequalities funding.
- **The Innovation Fund** - Funding for the innovation element of the investment fund is agreed annually by the South West London Integrated Care Board.

The Innovation Fund approach for 2023/24 was approved by the SWL Integrated Care Partnership (ICP) Board in January 2023 and further revision approved in April 2023. This paper is focussed both elements of the Investment Fund and proposes options for the use of the fund and also suggests greater alignment of the application processes for the two funding streams. Please note the Innovation Fund has been renamed as the ICP Priorities Fund to better reflect the purpose of the fund.

2. Revised approach for the Investment Fund 2023/24

2.1 Health Inequalities

In 2022/23, NHS England received additional funding worth £200 million for health inequalities, which was allocated to ICBs (through a needs-based approach) to support system plans developed with health and care partners.

£4.3 million is available to South West London for 2023/24. The funding should:

- Be directed towards the services and populations who face the largest inequalities in access, experience and outcomes.
- Maintain work to reduce health inequalities, such as the NHS five priority actions, the Core20PLUS5 approach, while achieving financial balance and elective recovery.
- Systems may also wish to consider High Intensity Use programmes which can support UEC pathway pressures whilst at the same time addressing health inequalities.

The Health Inequalities fund for 2023/24 will be for existing and new projects with a distribution of funding of 75% for existing schemes and 25% for new schemes. This distribution approach applies to both Place and System wide schemes (full details of the allocation can be found in Appendix A.) This approach allows applications for new schemes to occur this autumn whilst

the formal evaluation of existing schemes is undertaken. Successful schemes will be authorised to run until the end of March 2025.

Both new and existing schemes will be required to meet the Health Inequalities Fund criteria, full details can be found in Appendix B.

2.2 ICP Priorities Fund (formerly Innovation Fund) Process

The Innovation Fund in 2022 attracted many innovative projects across the system and therefore, as agreed with the Board in January 2023, we will be running the process again this year with a confirmed budget of £5 million across the two financial years until March 2025. The new ICP Priorities Fund for 2023-25 will be targeted to support delivery of the Integrated Care Partnership's strategic plan and priorities.

In considering the allocation of the fund we are proposing the creation of two categories with the following distribution of the fund;

- Category 1: ICP Workforce priority focussed with an 80% allocation of funding
- Category 2: Remaining ICP priorities and cross cutting themes focussed (excluding HI) with an allocation of 20% of the funding

A breakdown of the funding can be found in Appendix c.

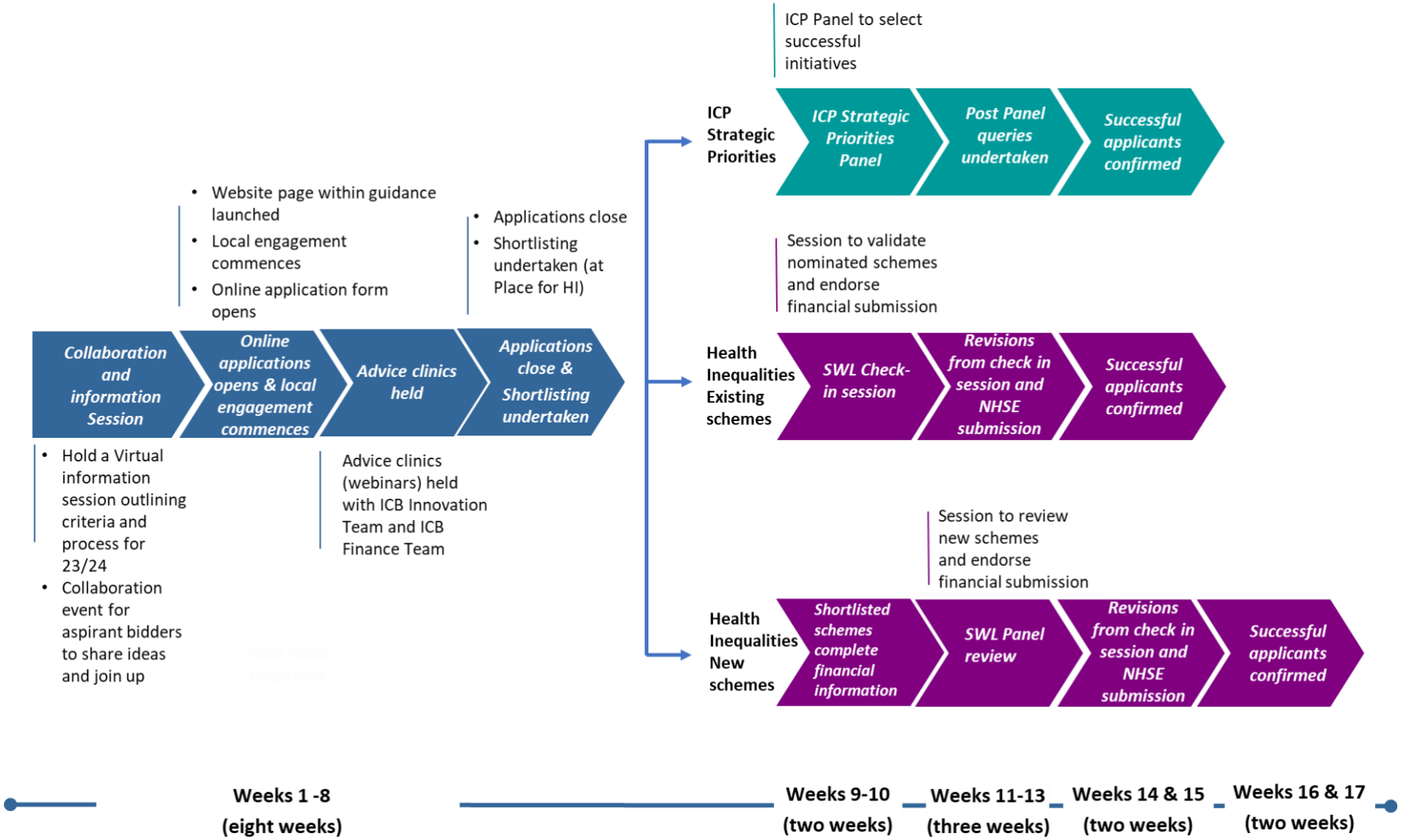
Both categories of the fund will have a number of common shortlisting criteria and some that are unique to the category.

Successful schemes will be authorised to run until the end of March 2025.

3. Revised award process for 2023/24

To improve alignment of the approaches for both funding streams we are proposing the adoption of the following process. The streams would follow a similar process until the awards panel stage. These proposed changes to the approach are reflected in Figure 1 below:

Figure 1. Investment Fund Approach: Health Inequalities and ICP Strategic Priorities Funds



3 Encouraging and supporting applications

To ensure we receive a broad range of high quality innovative applications we need to provide sufficient information and opportunities for engagement and collaboration over the coming months. Key to this are our local voluntary and community sector organisations, in the first year of the Investment Fund, we recognise that our Places were able to involve the local voluntary and community sector organisations in the process. This year the SWL VCSE Alliance has been newly established and will further enable the sector to be involved at the early stages of developing local bids to ensure they are able to collaborate fully in the process and play a role in local decision making.

As referenced in the April 2023 Board paper there are number of supporting activities that will be undertaken before and during the application process;

Information and Collaboration Event

We are designing an information and collaboration event for all stakeholders across SWL to provide an opportunity to come together to discuss emerging ideas in groups to foster collaboration and innovation. At this event we will also provide advice and guidance on how to approach applications including finance and data information.

Support for applications

We are finalising the design of the application forms for both streams for this year's process and we will include worked examples of completed bids, and a detailed financial template to reduce follow-up queries.

In addition, we will be holding advice clinics during the application period to answer questions and provide support and guidance where possible.

4 Recommendations

The Integrated Care Partnership Board is asked to:

- **Approve** the approach for the Health Inequalities Fund for 2023/24
- **Approve** the approach for the ICP Strategic Priorities Fund for 2023-25
- **Review** and **support** the process for 2023/24.

Author: Angela Flaherty
Role: Transformation Director
Date: July 2023

Appendix A: Health Inequalities Funding allocation

	Funding allocation	Amount	Description	Existing projects (75%)	New projects (25%)
System	System projects and programmes	£1,040,000	Collective projects and programmes delivered SWL wide	**System allocation** £780,000	**System allocation** £260,000
Place	Wider health inequalities projects and programmes **Place based** Core20 population - **Place based** PLUS population – **Place based**	£774,000 £1,591,000 £645,000	Weighted for each Place using ONS 2021 population size estimate percentages Weighted for each Place using SWL Core20 population percentages from Core20 infographics Weighted for each Place using needs based scoring tool - using sources e.g. Core20 infographics, IMD, JSNA, ONS data, SWL Health Insights, Trust for London data, PHE Fingertips	**Place allocation** Kingston - £135,354.80 Richmond - £176,006.14 Merton - £283,979.70 Wandsworth - £485,655.99 Croydon - £886,395.89 Sutton - £290,107.48	**Place allocation** Kingston - £45,118.27 Richmond - £58,668.71 Merton - £94,659.90 Wandsworth - £161,885.33 Croydon - £295,465.30 Sutton - £96,702.49
System Support	Support and coordination costs	£250,000	• To provide leadership, support, coordination and management of the fund • Provide support for progress reporting • Provision of SME to support award and review process	N/A	N/A
Total	**Total**	**£4,300,000**			

Appendix B: Criteria for Health Inequalities funded projects

Criteria	Existing projects 22/23
Core 20 Population	Adults Children and Young People (CYP)
PLUS Groups	Black, Asian and minority ethnic communities Physical disabilities Learning disabilities and autism Homeless and rough sleeping communities Refugee and asylum seekers Care leavers
5 Clinical areas	SMI and wider mental health (adults) Maternity (adults) Cancer (adults) Long Term Conditions (including co-morbidities), including Hypertension and lipid optimal management Respiratory (adults – vaccinations)
Other areas	Fuel poverty CYP Sickle cell disease Menopause Carers Social prescribing CYP Oral Health Cost of living - food poverty, fuel poverty
NHS five priority actions	Addressing digital exclusion Accelerating preventative programmes e.g. healthy weight, physical activity Strengthen leadership and accountability (Fellowship)

Suggested areas for new projects (23/24)

- Children & Young People Core20PLUS5
  - Epilepsy
  - Mental Health
  - Asthma
  - Diabetes
- PLUS group
  - Those in contact with the justice system
  - Other protected characteristics e.g. Sexual orientation
- Women's Health – *aligning with the Government Strategy*
- High Intensity Use services
- NHS five priority actions
  - Restore NHS services inclusively e.g. elective recovery
  - Ensure datasets are complete and timely e.g. improved ethnicity data collection

Based on NHS England priorities and operational planning guidance 2023/24

Appendix C: ICP Priorities Fund Funding allocation

Funding category	Amount	Description
Workforce priority	£3,800,000	Schemes to support delivery of the ICP workforce strategic priority
Wider ICP strategic priorities and cross cutting themes	£950,000	Schemes to support delivery of ICP strategic priorities and cross cutting themes (Preventing ill health, children and young people, mental health and well being, older and frail people, equality, diversity and inclusion and Green)
Support and coordination costs	£250,000	• To provide support, coordination and management of the fund • Provide support for progress reporting
Total	**£5,000,000**	

Appendix D: Similarities and differences between the funding streams

Process stages	Innovation Fund	Health Inequalities Fund
Launch	Both processes will have an application launch with opportunities for engagement and collaboration	
Financial governance	Value for money will be assessed as part of the application process	Scheme will require internal CFO approval and schemes over £25,000 require NHS England approval (this will be managed centrally)
Panel	Both processes will have a SWL awarding panel *Note that local Health Inequalities project applications will be shortlisted by Place*	
Shortlisting	System only	Place only
Criteria	ICP strategic priorities	As specified
Funding source	SWL ICB	NHS England
Funding allocation method	See options	Defined method for Places and System (see appendix B)

South West London Integrated Care System			
Name of Meeting	Integrated Care Partnership Board		
Date	Thursday, 20 July 2023		
Title	The Voluntary, Community and Social Enterprise (VCSE) Alliance in the Partnership		
Lead Director (Name and Role)	Charlotte Gawne, Executive Director of Stakeholder & Partnership Engagement and Communications		
Author(s) (Name and Role)	Sara Milocco, SWL VCSE Alliance Director		
Agenda Item No.	07	**Attachment No.**	07
Purpose	Approve ☐	Discuss ☒	Note ☐

Purpose

An update on the work of the South West London Voluntary, Community and Enterprise Sector (VCSE) Alliance.

Executive Summary

The community and voluntary sector is crucial to the ICP's vision for the future of health and social care. It can offer flexibility, creativity, professionalism and closeness to our diverse communities, with a real focus in areas of health inequalities – those people most at risk or have the poorest health and wellbeing. South West London has more than 5,500 voluntary sector organisations; approximately half of them are registered charities and the others are constituted community groups of different legal structures.

The community and voluntary sector offers the following to the partnership:

Community-led approaches

- Rich in assets (e.g. skills, knowledge of its community, capacity, resources, experience, creativity, flexibility)
- Asset Based Community Development (ABCD) approach, coproduction and codesign

Data, insight and intelligence

- The sector holds both quantitative and qualitative

Commissioning, service design and delivery

- Involved as partners in planning services
- As service providers

Reducing health inequalities

- Prevention - ranging from community-based support, discharge, avoiding social isolation
- Reaching our diverse communities.

This paper outlines how the Integrated Care Partnership can genuinely work in partnership with the voluntary sector to provide integrated health and social care.

Community and voluntary sector (CVS) organisations across the system suggested how they see themselves working with ICP partners through the SWL VCSE Alliance. The key ways of working and values include:

Collaboration

- Authentic communication in both directions, with a real willingness to hear from the VCSE, including its knowledge, needs and challenges
- Continuous and early conversations that focus on prevention and community-based solutions
- Linking with local community groups through CVSs and voluntary sector infrastructure networks

Trust

- Relationships based on honesty and transparency
- Active listening – being solution focused in difficult conversations and finding common ground
- Learning approach

Equity

- Equal voice and influence
- Considering Voluntary Sector as a “must have” partner. Key to prevention.
- Sharing data both sides routinely

Pragmatism

- Keeping sense of SWL pound
- Facilitating contract/funding arrangements that are sustainable for small organisations

Key Issues for the Board to be aware of:

The Voluntary Sector Alliance is at the start of a journey, the VCSE Leadership Group has been working closely together for the past year. Sara Milocco – Director of VCSE Alliance has been in post since April 2023 and is supporting increased collaboration with the VCSE sector to ensure the VCSE voice and perspective is heard.

VCSE sector is a diverse and vast landscape – the leadership group are working through ways to ensure the sector is meaningfully represented within the Alliance.

Recommendation

The ICB Board is asked to:

- Note the update on the VCSE Alliance and discuss how we can achieve for our partnership real and equal collaboration with the voluntary sector at both place and system level.
- Consider what we could do together that would help partners increase meaningful partnerships with voluntary and community groups?
- Consider how we can work together to ensure that all partners fully understand the complexity of the voluntary and community sector to increase opportunities for successful outcomes?

- Consider what practical steps we can take to build trust?

Conflicts of Interest None.

Corporate Objectives This document will impact on the following Board Objectives	Integration of the voluntary sector in the ICS will make sure the Board achieves the following corporate objectives: • Reduction of health inequalities. • Ensuring the voice of people and communities is central to all levels of its work. • Prevention across the all the ICS priorities. Discussion is ongoing with VCSE Alliance to focus the first year on three of the priorities below (tbc). - workforce - mental health - children and young people - community based support for older and frail people - ill health and long-term conditions.

Risks This document links to the following Board risks:	N/A

Mitigations Actions taken to reduce any risks identified:	N/A

Financial/Resource Implications	N/A

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	N/A

What are the implications of the EIA and what, if any are the mitigations	N/A

Patient and Public Engagement and Communication	The presentation was put together in collaboration with the Leadership group of the SWL VCSE Alliance and ICB Engagement leads.

Previous Committees/Groups Enter any Committees/Groups at	**Committee/Group Name**	**Date Discussed**	**Outcome**
		Click or tap to enter a date.	

which this document has been previously considered		Click or tap to enter a date.	
		Click or tap to enter a date.	

Supporting Documents	SWL VCSE Alliance July 2023 Power Point presentation

South West London Integrated Care System

South West London Voluntary, Community and Social Enterprise Alliance

20 July 2023

Sara Milocco
SWL VCSE Alliance Director

What does the sector offer?

South West London Integrated Care System

Primary purpose is **to create social impact rather than profit**. Often called the **third sector, civil society** or **the not for-profit sector**. Charities are the largest single category. Others include community benefit societies and co-operatives, not-for-profit community businesses or community interest companies (CICs), credit unions and small informal community groups.

Community-led approaches

- Rich in assets (e.g. skills, knowledge of its community, capacity, resources, experience, creativity, flexibility)
- Asset Based Community Development (ABCD) approach, coproduction and codesign

Data, insight and intelligence

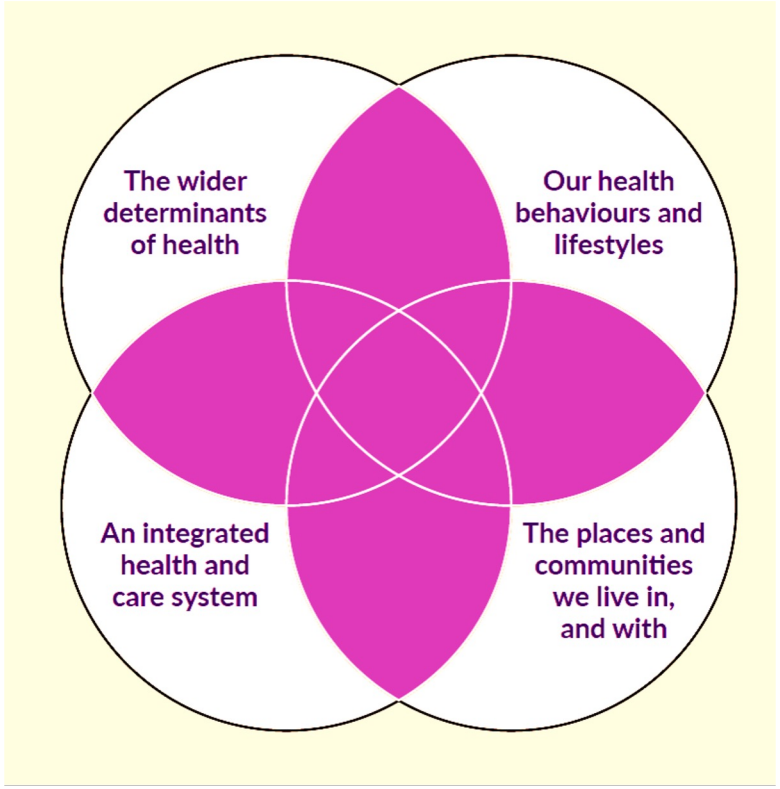
- Hold both quantitative and qualitative

Commissioning, service design and delivery

- Involved as partners in planning services
- As service providers

Reducing health inequalities

- Prevention - ranging from community based support, discharge, avoiding social isolation
- Reaching our diverse communities.



King's Fund (2022) – A population health system

… and in South West London?

5,565 organisations

Croydon	1,900	Kingston	575
Wandsworth	1,390	Merton	400
Richmond	800	Sutton	400

1.56 million residents

£448,276,797

external funding

Reference - 2021/22, threesixtygiving.org

Helmar Care and Community Services

Keeping elderly independent and at home:

Kingston upon Thames

Small registered charity with a very diverse staff base delivering home care services in Kingston, whether it's practical support with activities of daily living, socialization, medication support, or comprehensive 24 hour live-in care.

Social isolation: Drop-in centre offering activities, and access information and support to combat loneliness and isolation and improve mental wellbeing.

Resilience: Access to training and education, peer support groups, and respite care services for carers.

Challenges: flexibility/adaptability within contracting arrangements to adapt to place's geography, minimise staff travelling time and maximise number of residents supported by covering travel expenses. Access to affordable accommodation for staff.

> Our team of compassionate and skilled healthcare workers are dedicated to delivering the best possible care to our residents.
>
> (Helmare Care's CEO)

https://www.helmarcare.com/

Alzheimer’s Society

A chance to talk about memory worries:

Merton

Large national charity with local presence delivering a Metronome café’ in Morden.

Resilience: Many people have concerns about their memory but aren’t sure where to turn - which is the idea behind the cafe. People worried about their memory, or that of a friend or family member, can pop into, Morden’s Metronome café to talk to the experts - or just enjoy a free cup of tea or coffee and a chat. The project is part of the Health on the High Street initiative, jointly funded by NHS South West London and Merton Council, which seeks to bring wellbeing services into communities by working with businesses, libraries and other facilities.

> Our aim is to get people to drop in for a coffee, so they can chat about anything that’s bothering them. People have questions about dementia – what exactly is it, how you get it, what you should do if you’re worried?
>
> Bill Gibbons of Alzheimer’s Society

Alzheimer's Society (alzheimers.org.uk)

New Addington Good Samaritans:
A space for independency in older age

Croydon

Well established, small community organisation offering a “Pop in”, a space for social interaction and food to New Addington older residents.

Social isolation: Community, Food, and Social Interaction for local elderly with poor mobility and living by themselves. They have a mini-bus service that supports residents attending. The jumble room where residents sell their wool and can buy clothes at a discount has been a lifeline to those who lack the means and capacity to make trips to shops in their surrounding area.

Resilience: Residents: A place of Friendship. can engage with anything from Bingo to getting their haircut.

Health inequalities: One of the most deprived wards in Croydon. Seeing 70-100 residents per week, with some coming back 5 times a week.

Challenges: Diversifying income, too small to compete in competitive tenders, local health focus.

> I would see nobody if it weren’t for this Pop in. It kept me sane through the death of my husband.
>
> Resident

https://tinyurl.com/3m8knhht

SWL VCSE Alliance so far

South West London Integrated Care System

Business case developed for VCSE Alliance model
June 2022

SWL ICB agreed funding
July 2022

VCSE Engagement events in each
October 22 to March 23

SWL VCSE Alliance Director appointed
April 2023

Terms of Reference
May 2023 onwards

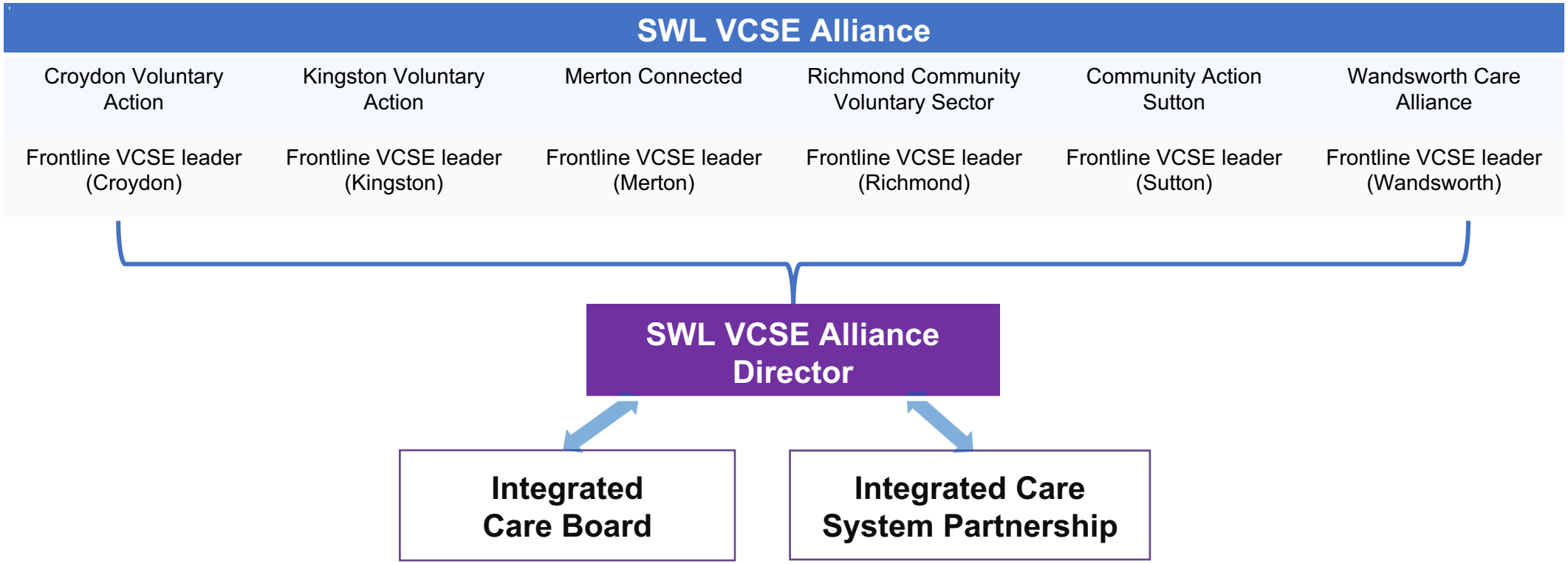
VCSE representatives remuneration policy
June 2023

Planning workshop between ICB and VCSE leads to inform MOU
July 2023

Event to develop delivery plans for ICP priorities
October 2023 TBC

Building the SWL VCSE Alliance

South West London Integrated Care System



VCSE organisations have come together around a common set of aims or principles. A VCSE alliance provides an ICS with a single point of contact for communication, engagement and reach into the many VCSE sector organisations across the ICS footprint at system and place level. We want to enable the sector to work in a co-ordinated way and be better positioned within the ICS to maximise its contribution and impact. (King's Fund, 2023)

How do we work in partnership?

South West London Integrated Care System

Collaboration

- Authentic communication in both directions, with a real willingness to hear from the VCSE, including its knowledge, needs and challenges
- Continuous and early conversations that focus on prevention and community based solutions
- Linking with local community groups through CVSs and VS networks

Trust

- Relationships based on honesty and transparency
- Active listening – being solution focused in difficult conversations and finding common ground
- Learning approach

Equity

- Equal voice and influence
- Considering Voluntary Sector as a “must have” partner. Key to prevention.
- Sharing data both sides routinely

Pragmatism

- Keeping sense of SWL pound
- Facilitating contract/funding arrangements that are sustainable for small organisations

How can the ICP genuinely work in partnership together?

South West London Integrated Care System

- What could we do together that would help partners increase meaningful partnerships with voluntary and community groups?
- How can we work together to ensure that all partners fully understand the complexity of the voluntary and community sector to increase opportunities for successful outcomes?
- What practical steps can we take to build trust?

South West London Integrated Care System

Thank you

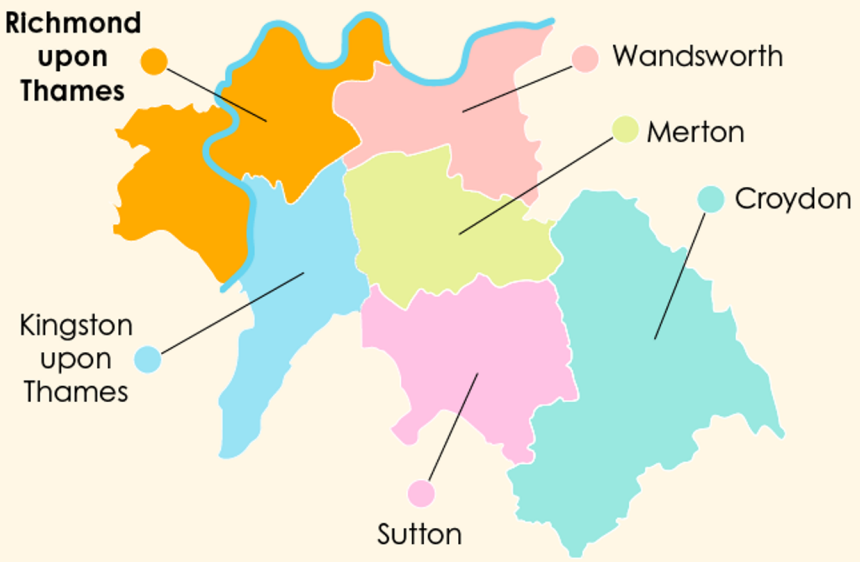
sara.milocco@cvalive.org.uk
07540 720 103

Further case studies below

11

Tackling health inequalities with Ruils

South West London Integrated Care System



Proud to be working together to create healthier communities

Partners involved

NHS South West London
Ruils

Find out more
Learn more about our work and get involved at www.southwestlondonics.org.uk

How we're making a difference

Richmond charity, Ruils, has identified three Core20PLUS areas in the borough where health inequality is most pronounced. South West London ICB and Ruils are working together to advise and support residents with a particular focus on those living with hypertension, diabetes, depression, impacted by the cost of living crisis and the isolated and lonely.

Ruils has organised health and wellbeing events and Ruils Connectors are carrying out basic health checks and surveys with residents to better understand how they view their health, how they engage with primary care, how the cost of living crisis is impacting their health and welllbeing and their levels of regular physical and nutritional intake.

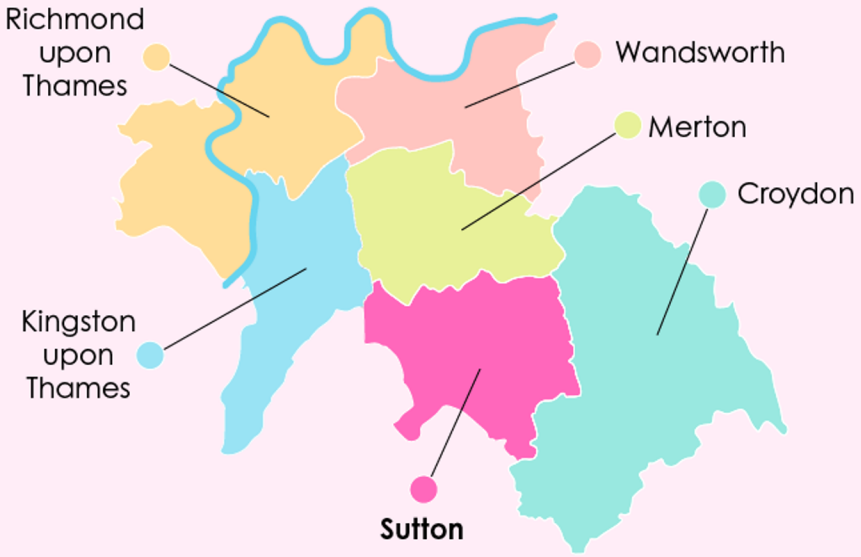
Wellbeing Coordinators aim to meet members of the community in a variety of ways, from visiting local community centres, organising health fairs and meeting people in public spaces not linked with GP surgeries and knocking on doors.

www.ruils.co.uk/news/community-conversations

So far, Ruils has carried out 26 health checks, referred 10 people to other services, issued health and wellbeing advice to 21people and supported 24 residents in filling out surveys around their health and wellbeing.

Shanklin Village Estate in Sutton

South West London Integrated Care System



Proud to be working together to create healthier communities

Partners involved

NHS South West London
GPs, pharmacists, health coaches, social prescribers, Community Connectors
Sutton Council

Find out more
Learn more about our work and get involved at www.southwestlondonics.org.uk

How we're making a difference

After asking Shanklin Estate residents what matters to them, we worked with our partners to run a programme of community health and wellbeing activities. Not only is this making residents feel more connected to each other, but it is also positively affecting their physical and mental health.

These activities have included GPs, community pharmacists, health coaches, social prescribers and local Community Connectors coming together to start building trust with Shanklin Estate residents, by providing information and advice about local health and care services.

We've also been running a weekly chair exercise class and a Happy Eaters healthy eating session to discuss diet and weight. As a result, residents have told us their mobility has improved. Similarly, by encouraging people to 'bring a neighbour', new friendships are forming across the estate, improving their sense of connection and community.

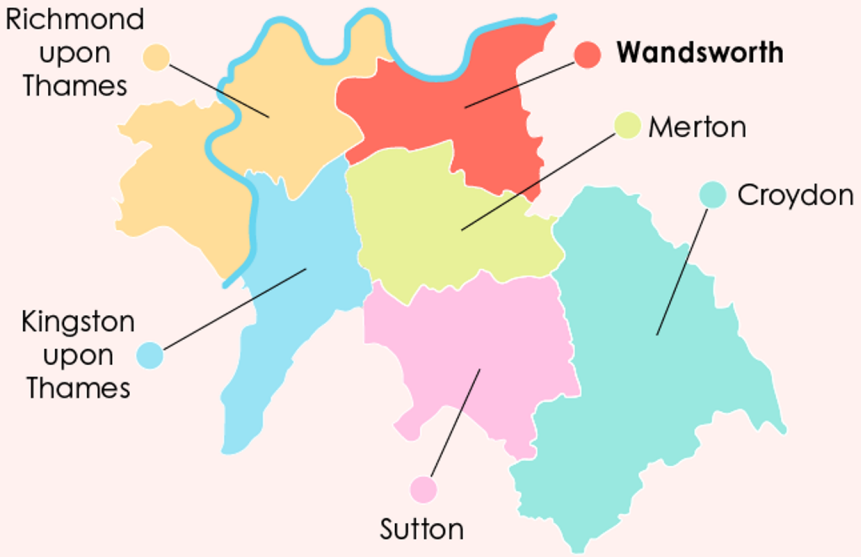
Given the success of this project, we're working with the voluntary sector and the local authority to take this approach to three other estates in Sutton where local people are facing deprivation and health inequalities.

"I have seen a significant improvement in everyone's willingness to take part and their positive attitude to receiving the benefit of the workshops and exercises that will make a massive difference in their lives. Now that they are willing to stand, I can do standing strength exercises and seated. All are gentle but will all help to improve balance and prevent falls."

Chair Exercise Instructor

Building a better future in Roehampton

South West London Integrated Care System



Proud to be working together to create healthier communities

Partners involved

Wandsworth Borough Council
Estate Art
NHS South West London

Find out more
Learn more about our work and get involved at www.southwestlondonics.org.uk

How we're making a difference

An ambitious community project is addressing health inequalities on the Alton Estate in Roehampton by empowering local people.

Around 13,000 people live on the estate. Local residents are more prone to high blood pressure, diabetes and heart disease than people in more affluent areas nearby - and less likely to be fully vaccinated against Covid-19.

The Roehampton community health champions project aims to change this by recruiting a network of volunteers to share information with their neighbours through existing relationships and special events. The scheme is supported by NHS South West London and Wandsworth Borough Council – after it was shown to work well in other areas during the pandemic.

Lynne Capocciama, who is leading the project through her not-for profit company, Estate Art, said: "We live in a community full of big-hearted and talented people and I believe they deserve the best in health care and life opportunities."

"Covid was a tough time for local people but I'm proud of what we achieved in that time. I want us to grab hold of all that purpose and passion and turn it into something permanent. I think the community health champions project could be our chance to own our own future."

Lynne Capocciama, Estate Art