Public Document Pack

Health & Wellbeing Board

To:

Councillor Yvette Hopley (Chair)
Councillor Margaret Bird (Vice-Chair)
Councillor Tamar Barrett
Councillor Janet Campbell
Councillor Humayun Kabir
Councillor Joseph Lee
Annette McPartland, Corporate Director Adult Social Care & Health (DASS)
Rachel Flowers, Director of Public Health - Non-voting
Edwina Morris, Healthwatch
Jon Northfield, South London and Maudsley NHS Foundation Trust
Yemisi Gibbons, Croydon Health Services NHS Trust - Non-voting
Steve Phaure, Croydon Voluntary Action - Non Voting
Matthew Kershaw, NHS Croydon Clinical Commissioning Group (CCG)
Debbie Jones, Corporate Director for Children, Young People and Education

A meeting of the **Health & Wellbeing Board** will be held on **Wednesday, 18 October 2023** at **2.00 pm** in **Council Chamber, Town Hall, Katharine Street, Croydon CR0 1NX**

Katherine Kerswell
Chief Executive
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk, Croydon CR0 1EA

Michelle Ossei-Gerning
michelle.gerning@croydon.gov.uk
www.croydon.gov.uk/meetings
10 October 2023

The agenda papers for all Council meetings are available on the Council website www.croydon.gov.uk/meetings

If you require any assistance, please contact Michelle Ossei-Gerning
020 8726 6000 x84246as detailed above.

AGENDA – PART A

1. Apologies for Absence

To receive any apologies for absence from any members of the Committee.

2. Minutes of the Previous Meeting (Pages 5 - 16)

To approve the minutes of the meeting held on 18 January 2023, 21 March 2023 and 28 June 2023 as an accurate record.

3. Disclosure of Interests

Members are invited to declare any disclosable pecuniary interests (DPIs) and other registrable and non-registrable interests they may have in relation to any items(s) of business on today's agenda.

4. Urgent Business (if any)

To receive notice of any business not on the agenda which in the opinion of the Chair, by reason of special circumstances, be considered as a matter of urgency.

5. Public Questions

Public Questions should be submitted before 12 noon on Friday 13 October 2023 to democratic.services@croydon.gov.uk. Any questions should relate to items listed on the agenda. 15 minutes will be allocated at the meeting for all Public Questions that are being considered.

6. Better Care Fund 2023-25 - Letter from NHS England (Pages 17 - 24)

In response to the Better Care Fund plan submission by Croydon the Chair of the Health and Wellbeing Board received the attached letter of approval from NHS England.

7. Update on South West London ICS Strategy

[To Follow]

8. NHS Joint Forward Plan

[To Follow]

9. South West London Mental Health Strategic Plan (Pages 25 - 74)

The South West London Mental Health Strategic Plan report is attached.

10. Croydon Dementia Strategic Plan (Pages 75 - 114)

The Croydon Dementia Strategic Plan report is attached.

11. Croydon Mental Health Summit Update (Pages 115 - 136)

The update report for the Croydon Mental Health Summit is attached.

12. Croydon Joint Local Health and Wellbeing Strategy Refresh: October Update (Pages 137 - 150)

The Health and Wellbeing Board have agreed to refresh the current strategy in March 2023. This report provides updates on progress to date and details next steps.

13. CUH Update on improvement plan following CQC rating

[To Follow]

14. Exclusion of the Press and Public

The following motion is to be moved and seconded where it is proposed to exclude the press and public from the remainder of a meeting:

"That, under Section 100A(4) of the Local Government Act, 1972, the press and public be excluded from the meeting for the following items of business on the grounds that it involves the likely disclosure of exempt information falling within those paragraphs indicated in Part 1 of Schedule 12A of the Local Government Act 1972, as amended."

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Health & Wellbeing Board

Meeting of Health & Wellbeing Board held on Wednesday, 18 January 2023 at 2.02 pm in Room 1.01 and 1.02 - Bernard Weatherill House, Mint Walk, Croydon CR0 1EA

MINUTES

Present: Councillor Yvette Hopley (Chair);
Councillor Margaret Bird (Vice-Chair);
Councillor Amy Foster
Annette McPartland, Corporate Director Adult Social Care & Health (DASS)
Edwina Morris, Chair of Healthwatch, Croydon
Hilary Williams, South London and Maudsley NHS Foundation Trust
Steve Phaure, Croydon Voluntary Action - Non Voting
Yemisi Gibbons, Croydon University Hospital, Chair

Also Present: Councillor Janet Campbell
Councillor Tamar Nwafor
Jack Bedeman (Public Consultant)
Emma King (Public Consultant)
Shelley Davies (Director of Education)
Carolyn Castle (Interim Manager Transformation Lead)
Jonathan McShane (Associate for Local Governance Association)
Jack Edge (Head of Primary and Community Care – Croydon South SWL ICB)
Ima Miah (ARCC)
Lisa Broderick (Croydon BME)
Yusuf Osman (Service User Representative)

Apologies: Councillor Maria Gatland;
Rachel Flowers (Director of Public Health);
Matthew Kershaw (Chief Executive and Place Based Leader for Health)
Debbie Jones (Corporate Director for Children, Young People and Education)

PART A

29/22 Minutes of the Previous Meeting

RESOLVED that the minutes of the meeting held on

- Wednesday 18 October 2022
- Friday 17 November 2022
- Thursday 15 December 2022

were agreed as an accurate record

30/22 **Disclosure of Interests**

There were no disclosures at this meeting.

31/22 **Urgent Business (if any)**

There was none.

32/22 **Public Questions**

There were none.

33/22 **LGA Review Update**

The Health and Wellbeing Board received a verbal update from a member of the Local Government Association (LGA), Jonathan McShane, who informed that their service offered support to all Health & Wellbeing Boards in England.

With the changes within the NHS structures, establishments of ICS, place-based arrangements and an oversight of Health and Social Care delivery, the LGA was keen to work together with the Croydon Health & Wellbeing Board as they build a new strategy following the new changes in administration.

The approach to this work would include workshops for how the Board would work in the future and its focus, in addition, the Public Heath Team to review the development of the new Health & Wellbeing Strategy and its deliverance; also addressing how the new joint Health & Wellbeing Strategy would be developed; reflection from partners, forward planning and agenda setting.

The Chair welcomed the support from the Local Government Association which was supporting the Health & Wellbeing in Croydon following the new changes in Croydon.

34/22 **Adult Social Care Discharge Fund/Winter Pressures**

The Health and Wellbeing Board received a verbal update from the Head of Primary and Community Care – London South, Jack Edge in relation to the discharge fund and winter pressures.

In summary, the Board heard that:

- In November 2022, there was an initial fund of £500 million pounds to support the discharge into social care, which was divided into two pots: 60% within the health sector and 40% to the local authorities. The distribution of the ICB share and the Adult Social Care discharge fund

to local areas, saw Croydon with £2.687 million pounds which was split into £1.5 million pounds from the NHS and £1.16 million pounds from the local authority.

- The funding was to be used on activities that reduced flow pressure on hospitals by enabling discharge to appropriate settings. This was not to be used to prevent admissions. Funding was also to be streamed into the Better Care fund.
- Croydon provided twenty-six schemes. The projects put forward would be monitored fortnightly to address the spending. The service was on track on their second return having completed and signed off their first return in spending.
- There was also funding for eleven stepdown beds which had been purchased.
- Discharges had been increased into pathway discharges by thirty per week, i.e. path one: would see the patient return to their original place of residence with a care package.
- Support for seventeen housing spots was provided to mental health patients.
- Recruitment across all roles were taking place to provide care capacity, inside and outside of hospitals though roles were filled with existing staff.
- Additional support such as drivers, IT support and equipment had also been used from the funding.
- The GP rapid response provision had increased, also additional equipment to ensure all packages within the community through the rapid response had increased.
- A flow hub had been set up to facilitate discharge and prevent discharge at the front door in hospitals. This had been successful.
- Additional mental health treatment had also been established with support for discharge at home.
- Working with local authority and South West London (SWL) to best spend the £200 million pounds that was allocated within the NHS to facilitate the discharges, with the guidance around increasing bed capacity and activities contributed to supporting the beds, before 31st March 2023.

The Board welcomed the update from officers.

In response to queries raised by the Board, Jack Edge and Annette McPartland clarified the following:

- In relation to the work of the projects and feedback from the first return completed, the Board heard that the first report took a lot of time away from implementing the projects and assessments within the community, the hospitals were now providing daily reports on discharging. This had shown great impact to the health and commissioning leads. The first report highlighted no queries, though some areas received queries on specific projects to understand impact. There were no queries raised with the Croydon specific projects as information provided was thorough and succinct. Through the learning,

from a mental health perspective, staff were able to move patients quickly, though there were still delays with those ready for discharge and the home provision was to be revised. The provision commissioned for this short period of time,

- In relation to the short-term money and beds, the Board heard that the preference of Home First was to be the ultimate pathways such as Pathway Zero and Pathway One; and the service would be reviewing the spending to assist the local needs and to not merely increase the bed base. The spending of the money would be assessed for purpose within Croydon. Further, the Board heard that with the voluntary sector there was a big project around Pathway Zero that helped the innovation fund through South West London.

- In relation to what support there was for families where patients returned home causing huge challenges on the family, and those patients with no recourse to public funds, the Board heard that the network for support was included within the package as family were deemed the primary carers, though this was different in most cases.

The Chair thanks all officers for the update.

35/22 **Family Hubs**

The Health and Wellbeing Board considered the Family Hubs report which was an overview of the Family Hub and 'Start for Life' grant assigned to Croydon by the Department of Education.

The Board received an overview from the Head of Education, Shelley Davies who summarised that Croydon Council had been selected to receive Family Hubs. Section 8 of the report outlined the funding to this development and what the grant would be used for. The development would provide a great opportunity to reshape the services for babies, children and young people with a Start for Life offer at their core. The Family Hub model and purpose was to have a place for families to receive universal services in outreach spaces alongside a robust virtual offer, additionally, to provide a gateway to services for older children, young people (up to 25 years with Special Education Needs and Disabilities) and their families. It was noted that during the pandemic, families were able to access services virtually.

The Interim Manager Transformation Lead, Carolyn Castle, further added that the delivery plan was scheduled for December and that by March 2025 the service would be able to fully implement the Start of Life as proposed in bold within the report on page 4. Services were working together and building strong communication on engagement.
The Chair was pleased to hear of the upcoming projects coming forward.

In response to queries raised by the Board, Shelley Davies clarified the following:

- In relation to the £4.3 million over three years (£1.3 million a year) and whether the funding was sufficient, the Board heard that the priorities were rig-fenced and the service had to deliver what was set out to be spent on.
- In relation to supporting parents with parenting especially with a child with disability, the Board heard that it was important for parents to engage with others with similar needs and a parent partnership was set up for this.
- In relation to Hubs and what it means, the board heard that though there were a lot of hubs, the National policy was to provide a family hub that had information enabling family to access families. Family hubs were different to community hubs, and it was important to understand what was offered in the hubs. It was proposed for the hub to be physically opened in summer of 2023 in an existing place within the borough.
- In relation to staffing, the Board heard that money had been invested to train frontline staff. There was no impact on retention as staffing was in partnership and therefore retention and recruitment would remain in the same respective areas. The family hubs did not require brand new practitioners as when in partnership staff would become family hub practitioner which would range across a number of different services contributing with skills and multi-workforce development.

The Board **RESOLVED**:

To support the provisional approach within the 'Family Hub and Start for Life' grant.

36/22 **Croydon Mental Health Summit - November 2022**

The Health and Wellbeing Board considered the Croydon Mental Health Summit: November 2022 report which was held to deliver with Croydon Citizens the Mayor's Business plan 2022-2026 to improve resident health and reduce health inequalities.

The Board received an overview from the Public Consultant, Jack Bedeman who summarised that the Mental Health summit was a success with a variety of different organisations in attendance from different community groups. Croydon citizens were also keen in working and supporting the work proposed. The summit provided lots of conversations and feedback relating to ensuring better utility in the programme. The key aspects for the future was to take the learning gathered to address how services could develop further the care plan amongst other proposals.

The Board discussed the little feedback received following the summit and comments were made on the disproportionality in the black community, though there was a lot of work happening in the background following review on the information collated.

The Chair thanked all staff involved in the summit which had captured a lot of information and noted that the Board were now reviewing the outcomes of what could be achieved from the information collated.

37/22 **Exclusion of the Press and Public**

This was not required.

The meeting ended at 4:04pm

Signed: ....

Date: ....

Health & Wellbeing Board

Meeting of the Health and Wellbeing Board held on Tuesday 21 March 2023 at 2:10pm in Town Hall, Council Chambers

MINUTES

Present: Councillor Yvette Hopley (Chair)
Councillor Margaret Bird (Vice Chair)
Councillor Tamar Barrett

Rachel Flowers, Director of Public Health - Non-voting
Annette McPartland, Corporate Director Adult Social Care & Health (DASS)
Hilary Williams (South London and Maudsley NHS Foundation Trust)
Mathew Kershaw (Chief Executive and Place Based Leader for Health)
Yemisi Gibbons (Croydon University Hospital, Chair Croydon University Hospital, Chair)
Edwina Morris (Chair of Healthwatch, Croydon)
Steve Phaure (Croydon Voluntary Action)

Also Present: Councillor Amy Foster
Councillor Janet Campbell
Shelley Prince (Head of Commissioning and Procurement CYP&E);
Hana Ally (Principal Public Health Analyst)
Jack Bedeman (Public Health Consultant)
Gordon Kay (Healthwatch Croydon Manager)
Rachel Flagg (Joint Director of Transformation and Commissioning, South West London Integrated Care Board (Croydon) and Croydon Health Services NHS Trust)
Benjamin Jolly (Addington Station Commander, London Fire Brigade)

Apologies: Councillor Maria Gatland
Yusuf Osman (Service User Representative)

PART A

38/23 **Disclosure of Interests**

There were no disclosures at this meeting.

39/23 **Urgent Business (if any)**

There was none.

40/23 **Public Questions**

There was one public question received from Councillor Michael Neal:

Constituents that I meet often highlight the fact that it is difficult to obtain Health services for example GP Surgeries, appointments at Hospitals etc, they believe this is due to the many new builds around our District Centres and in particular in our Town Centre / East Croydon area in which there are several hundred new residents.

My question was around data, do you have data determining where new Health Services should be placed? And how do we mitigate that demand to ensure Health Services are spread evenly in the Borough.

In response to the question, Matthew Kerswell addressed that Croydon was a growing borough and in the planning of that growth health did receive dispensation in that the budget was based on population size, and so the bigger the population the bigger the allocation of the budget. There was further investment required for Croydon and progress had been made in some areas for this request. Further, the Board were to continue to identify the needs which helped start conversations to ensure the needs were addressed; this included influencing and persuading, to ensure the borough received the resources required.

41/23 **Healthwatch Croydon Annual Report 2021-2022**

The Health and Wellbeing Board considered the Healthwatch Croydon Annual Report 2021-2022 report, which summarised the work undertaken by Healthwatch Croydon between 1st April 2021 and 31st March 2022. It also set out the priorities and plans for work in 2022-2023 as identified at the beginning of that year.

The Board received an overview from the Healthwatch Croydon Manager, Gordon Kay, who highlighted three of the themes covered in the year:

- Urgent and Emergency Care: Healthwatch Croydon were to provide patient and resident insight on the choice of pathways and their experience of using urgent and emergency care. This survey was undertaken in July 2021 where 1038 completed responses were received. Recommendations included fully integrating pharmacies and GP Hubs into the pathway and support with positive communication; Define NHS111 as the single reliable point of access to direct care to other services; and Understanding services from a user perspective.

- Experienced of Non-English speakers in accessing services: a Croydon version of the Healthwatch England’s wider report “Lost for Words” was recently published and was shared with local stakeholders to consider their current services and how they may improve service to those who do not speak English.

- Dentistry: There was a report of Croydon resident's experiences of accessing and using NHS dental services in 2021, which followed the survey that took place between January and June 2021, and had received 150 responses. The recommendations and follow ups included that access needed to be less variable; to undertake a local needs assessment as commissioning has not been reviewed since 2006; to understand the perception of the regular dentist; to prioritise urgent need with regular dentist over check-ups; to provide better information to manage expectations; to communicate costs better and engage with patients

The Chair welcomed the report and the recommendations highlighted within the presentation. It was important for work to be supported.

In response to queries raised by the Board, the Healthwatch Croydon Manager, Gordon Kay clarified the following:

- In relation to the consideration of dentistry and whether the pandemic had an impact, the Board heard that the timing of the survey was not part of the pandemic. The challenges had existed prior, and though not unique Croydon were the most affected due to the commissioning requirements. Rachel Flowers also highlighted the inequalities within the dentistry. Matthew Kershaw highlighted a change within the responsibility of dentistry which currently sat with NHS England would be delegated down to an ICS level focus for dentistry to benefit the services for Croydon.

The Board welcomed the emergency care project which heard the voices of patients of the services provided, to better outcomes which would make a difference to patients.

The Chair thanked the officers for all their work.

The Board **RESOLVED**:

To note the Annual Report of the work of Healthwatch Croydon in 2021-2022, which was attached as an Appendix to this report.

42/23 **Health and Wellbeing Board Annual Report 2021-2022**

The Health and Wellbeing Board considered the Health and Wellbeing Board Annual Report 2021-2022 report, which provided an opportunity to celebrate all the hard work that had been achieved over the past year by everyone in the Croydon Borough right across the health and social care system, as well as looking ahead to some of the opportunities for the coming year.

The Chair thanked the officers for their hard work over the municipal year.

The Board **RESOLVED**: To

1.1. Report to Full Council the outcome of the Board's monitoring of the delivery plans in fulfilment of the Health and Wellbeing Strategy as part of its annual report; and

1.2. Note the contents of the Annual report in the Appendices Report.

43/23 **Update on Croydon's JSNA**

The Health and Wellbeing Board considered the Update of Croydon's Joint Strategic Needs Assessment (JSNA) report, which was a collection of information relating to the health and wellbeing needs of our population. The report was an update of content that had been added to the JSNA since the topic last came to the Health & Wellbeing Board in October 2021 and a summary of the challenges faced.

The Board received a presentation from the Principal Public Health Analyst, Hana Ally, highlighting the challenges and current view.

The Chair thanked officers involved with this work and acknowledged the challenges and communication outlined in the presentation which required further review and accurate information.

The Director of Public Health, Rachel Flowers, added that a lot of work had been undertaken in Public Health and more improvement was to include more partnership work. The narrative within the data was also important to provide and interpret its meaning.

In response to queries raised by the Board, the Director of Public Health, Rachel Flowers, clarified the following:

- In relation to what further work was required for the joint partnership, and whether the JSNA fit and supported the forward plan and other consistent messages and themes, the Board heard that the challenges included for better multi-agency work in partnership to provide all information in one place. The Head of Commissioning and Procurement CYP&E, Shelley Prince, added that the JSNA was welcomed within their service which was used to utilise information to inform evidence-based commissioning. With a number of strategies refreshed locally the JSNA was the opportunity to feed into the areas, additionally in the way it was engaged, shared and communicated with communities.

The Chair highlighted that there was a lot of initiatives where partners needed to join and support the residents needs and aspirations for better services; this included conversations of taking ownership and resourcing. Additionally, the Chair noted a lot of change was taking place, which hoped for better outcomes and understanding to the residents.

The Board **RESOLVED**:

1.1. To approve the update to JSNA content

To note the challenges and, if deemed necessary by the Board, discuss how to overcome these

44/23 **Croydon Health and Wellbeing Strategy Refresh**

The Health and Wellbeing Board considered the Croydon Health and Wellbeing Strategy Refresh report, which was published in 2019 with the vision: “Croydon would be a healthy and caring borough where good health was the default not the exception and those that experience the worst health improved their health the fastest.” The report provided a review and refresh of the Strategy and proposed an approach through which this could be achieved in 2023.

The Board received an overview from the Consultant in Public Health, Jack Bedeman who highlighted shared that the key rationale was that the health and care system were all relevant to the strategy. This followed the Covid 19 pandemic which had highlighted health inequalities and health crisis in cost of living, also the wider health issues including mental health and wellbeing.

The Board welcomed the new joint strategy where services would be able to connect together to add value. There was thought in finding ways to engage with the local community partnership and build into the work and development undertaken to reflect the needs of the community.

The Board **RESOLVED**:

To agree on the process for the review and refresh of the Health and Wellbeing Strategy to cover the years 2024-2029.

45/23 **South West London Integrated Care Partnership Strategy and Joint Forward Plan**

The Health and Wellbeing Board considered the South West London Integrated Care Partnership Strategy and joint Forward Plan report, which South West London were required to produce two plans, a system-wide plan ‘the Integrated Care Partnership Strategy’ and an NHS plan ‘the Joint Forward Plan (JFP)’.

The Board received an overview from the Joint Director of Transformation and Commissioning, South West London Integrated Care Board (Croydon) and Croydon Health Services NHS Trust, Rachel Flagg, who highlighted that the first part of the plan, the Integrated Care Partnership Strategy, had been discussed at One Croydon Health and Care Board. Some of the discussions

included reducing health inequalities. The second part of the plan was the Joint Forward Plan that described how Integrated Care Boards and their partner NHS trusts intended to meet the health needs of their population through arranging or providing NHS services. It would include delivery plans for the integrated care strategy and align with joint local health and wellbeing strategies. The plan was for the priorities of the health and wellbeing to be reflected in the joint forward plan of the NHS.

The Chair noted that there were a lot of strategies which should be based on the public needs, and suggested that all the priorities within the streams would need to align to see where the synergy was.

The Board discussed ideas to the development of the strategies, how it collaborated and delivered with other strategies with other partners.

The Board **RESOLVED**:

1.1. To note the development of the Integrated Care Partnership Strategy for South West London and the process for agreeing the Croydon place response to the draft.

1.2. To provide input to the development of the draft NHS Joint Forward Plan for SWL in terms of the Croydon Health and Wellbeing Strategy priorities that should be reflected.

1.3. To receive a further update on the development of the NHS Joint Forward Plan when it had been drafted.

46/23 **Exclusion of the Press and Public**

This was not required.

The meeting ended at 3.44 pm

Signed: ....

Date: ....

LONDON BOROUGH OF CROYDON

REPORT:		**HEALTH AND WELLBEING BOARD**
DATE OF DECISION		**18th October 2023**
REPORT TITLE:		**BETTER CARE FUND 2023-25 – Letter from NHS England**
CORPORATE DIRECTOR / DIRECTOR:		**Annette McPartland** **Corporate Director** **Adult Social Care & Health Directorate** **Matthew Kershaw** **Chief Executive / Place Based Lead for Health** **Croydon Health Services NHS Trust**
LEAD OFFICER:		**Daniele Serdoz, Deputy Director for Primary and Community care, SWL ICB (Croydon) Email: daniele.serdoz@swlondon.nhs.uk** **Telephone: 02039239524**
LEAD MEMBER:		**Cllr Yvette Hopley, Chair of Health and Wellbeing Board, Cabinet Member for Health and Adult Social Care**
KEY DECISION? [Insert Ref. Number if a Key Decision] ***Guidance***: *A Key Decision reference number will be allocated upon submission of a forward plan entry to Democratic Services.*	**No**	REASON: [N/A] or The Better Care Fund (BCF) is an annual grant and is one of the Government's national vehicles for driving health and social care integration. It requires the South West London Integrated Care Board (ICB) and Croydon Council to agree a joint plan on how the grant will be used, aligned to the BCF Policy Framework. The plan enables use of pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006)
CONTAINS EXEMPT INFORMATION? ***(* See guidance)***	**NO**	Public
WARDS AFFECTED:		**All**

1 SUMMARY OF REPORT

1.1 In response to the Better Care Fund plan submission by Croydon the Chair of the Health and Wellbeing Board received the attached letter of approval from NHS England.

2 RECOMMENDATIONS

For the reasons set out in the report, the Health and Wellbeing Board is recommended:

2.1 to note the letter received from NHS England

3 REASONS FOR RECOMMENDATIONS

3.1 For the Board to acknowledge the response from NHS England and the successful approval of the Better Care Fund plan submission.

4 BACKGROUND AND DETAILS

4.1 *The Board signed off the Better Care Fund Plan 2023-35 submission on 28th June 2023. The Letter in Appendix A is the response from NHS England approving the Plan and outlining Better Care Fund Conditions for financial year 2023/24*

5 ALTERNATIVE OPTIONS CONSIDERED

5.1 *This report is to note correspondence from NHS England in response to a submission on behalf of the Board.*

6 CONSULTATION

6.1 *The 2023-25 plan was developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care. The One Croydon Governance was used to agree and implement the schemes as planned.*

6.2 *The One Croydon Senior Executive Group approved the plan on 13th June 2023.*

6.3 The Timetable for agreeing BCF Plans and NHSE assurance process are set out below:

Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	28/6/2023-28/7/2023
Regionally moderated assurance outcomes sent to BCF team	28/7/2023
Cross- regional calibration	3/8/2023
Approval letters issued giving formal permission to spend	From 3/9/2023

All Section 75 agreements need to be signed and in place	31/10/2023

7. CONTRIBUTION TO COUNCIL AND ONE CROYDON PRIORITIES

7.1 We will live within our means, balance the books and provide value for money for our residents.

7.2 We will focus on providing the best quality core service we can afford. First and foremost, providing social care services that keep our most vulnerable residents safe and healthy

7.3 We will focus on prevention and proactive care: supporting people to stay well, manage their own health and maintain their wellbeing by making sure they can get help early

7.4 We will unlock the power of communities: connecting people to their neighbours and communities, who can provide unique support to stay fit and healthy for longer.

7.5 We will develop services in the heart of the community: giving people easy access to joined up services that are tailored to the needs of their local community

8. IMPLICATIONS

8.1 FINANCIAL IMPLICATIONS

8.1.1 This report confirms NHS England's approval of Croydon's 2023-25 Better Care Fund plans, which were reviewed and signed off by this Board on 28 June 2023. It does not impact current budgets.

8.2 LEGAL IMPLICATIONS

8.2.1 The BCF enables the allocation of grant funding between the Council and SWL, with a minimum SWL contribution to the Council for ASC of £11.8M in 23/24 (year 1) and £12.5M in 24/25 (year 2). The grant funding sits within the Care Act 2014 and within the revised 2023-25 BCF policy framework, which requires a signed section 75 agreement between the Council and SWL. The agreement must be signed and submitted to NHS England by 31st October 2023.

8.3 EQUALITIES IMPLICATIONS

8.3.1 There are no changes proposed to existing schemes in this report that affect people, policies, facilities, or processes. An equality impact assessment therefore has not been carried out.

8.3.2 For any new scheme implemented over the course of the next two years, equality impact assessments will be undertaken as part of the business case development.

9. APPENDICES

9.1 *A BCF Approval Letter Croydon*

NHS England

NHS England
Wellington House
133-155 Waterloo Road
London,
SE1 8UG
E-mail:
england.bettercarefundteam@nhs.net

To: *(by email)*
Cllr Yvette Hopley, Chair, Croydon
Matthew Kershaw, Integrated Care Board Chief Executive or Representative(s)
Katherine Kerswell, Chief Executive, Croydon Council

22 September 2023

Dear Colleagues,

BETTER CARE FUND 2023-25

Thank you for submitting your Better Care Fund ("**BCF**") plan for regional assurance and approval. I am pleased to let you know that following this process, your plan has been classified as '**approved**'. You should now proceed to finalise your section 75 agreements with a view to these being signed off by 31 October 2023.

We are grateful for your commitment to developing and producing your agreed plan and we recognise that there are many pressures on local system colleagues, despite the early publication of the planning requirements.

The BCF is the only mandatory policy to facilitate the integration of health, social care and housing funding. This is the second time that the BCF Policy Framework covers two financial years to align with NHS planning timetables and to give areas

the opportunity to plan more strategically.

BCF Conditions for financial year 2023/4

The BCF funding from NHS England for the financial year 2023/24, which includes additional discharge funding, can now be formally released subject to compliance with the following conditions (referred to as "the **BCF Conditions**"):

- The BCF funding is used in accordance with your final approved plan.
- The national conditions ("the **National Conditions**") set out in the BCF Policy Framework for 2023-25 and further detailed in the BCF Planning Requirements for 2023-25 continue to be met.
- Satisfactory progress is made towards meeting the performance objectives specified in your BCF plan.
- Reports on your area's progress and performance are provided to NHS England in accordance with relevant guidance and any requests made by NHS England and governmental departments. This includes quarterly reporting on the BCF overall and fortnightly reporting on use of the Additional Discharge Funding, as set out in the Planning Requirements document.

Escalation

The BCF Conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006. This means that if the BCF Conditions are not complied with NHS England can, under section 223GA:

- withhold any payment, if any of the BCF Funding has not already been made available to the ICB;
- recover any of the funding (either from the current financial year or a subsequent financial year); and/or
- direct the ICB or ICBs in your Health and Wellbeing Board area as to the use of the funding.

Where an area is not compliant with one or more BCF Conditions or there is a material risk that a BCF Condition will not be met, an area may enter into escalation, as outlined in the BCF Planning Requirements 2023-25. This could lead to NHS England exercising the powers outlined above. Any intervention will be proportionate to the risk or issue identified.

Local authority funding for financial year 2023/4

Grants to local government (improved Better Care Fund, Additional Discharge Fund

and Disabled Facilities Grant) will continue to be paid to local government under s31 of the Local Government Act 2003, via the Department of Levelling Up, Housing and Communities, with a condition that they are pooled into one or more pooled funds under section 75 of the NHS Act 2006 and spent in accordance with your approved BCF plan.

Reporting and compliance

Ongoing support and oversight regarding the spending of BCF funding will continue to be led by your local Better Care Manager ("**BCM**"). Following regional assurance, we are asking all BCMs to feed back to local systems where the process identified areas for improvement in plans, including where systems may benefit from conversations with other areas. Nationally, we will also be reflecting on the data and what further support we can consider in the future.

Reporting on the overall BCF programme for 2023-25 will resume in September with quarterly reporting and an end of year return. In preparation for winter and to ensure ongoing alignment with urgent and emergency care recovery plans, the Quarter 2 report will include a check that your Intermediate Care Capacity and Demand plans are still fit for purpose as we enter months where capacity is often stretched. Your refreshed Intermediate Care Capacity and Demand plan needs to be submitted by 31 October 2023. All templates and guidance will be published on the Better Care Exchange. Further information on quarterly and end of year reporting will be confirmed in due course.

You will be aware that there are additional reporting requirements for the Additional Discharge Fund. The Government maintains a strong interest in improving timely discharge of patients; details of additional reporting on this part of the fund have been published. NHS England also requires a monthly return on packages provided to date, spend to date and forecast spend data on an ICB footprint. There is a commitment to review these reporting arrangements for 2024-25.

BCF Conditions for financial year 2023/24

As explained above, the BCF Policy Framework covers the financial years 2023/24 and 2024/25. NHS England expects that before any BCF funding for 2024/25 is made available it will write to areas to notify them that the BCF Conditions for 2023/24 set out in this letter will also apply to 2024/25.

If your area is in breach of its BCF Conditions or there is a material risk that it will breach a BCF Condition, then further conditions may be applied to BCF funding for

NHS England

2024/25.

Once again, thank you for your work and best wishes with implementation and ongoing delivery.

Yours sincerely,

Nicola Hunt

Senior Responsible Officer for the Better Care Fund
NHS England

Copy (by email) to:

Caroline Clarke, Regional Director, NHS England
Rosie Seymour, Programme Director, Better Care Fund team, Better Care Fund Programme, NHS England
Andre Lotz and Nicole Valenzuela-Sotomayor, Better Care Managers, Better Care Fund Programme, NHS England

LONDON BOROUGH OF CROYDON

REPORT:	**HEALTH & WELLBEING BOARD**	
DATE OF DECISION	18 October 2023	
REPORT TITLE:	South West London Mental Health Strategic Plan	
CORPORATE DIRECTOR / DIRECTOR:	**Hilary Williams** Interim Joint Director of Transformation and Commissioning South West London Integrated Care Board (Croydon) and Croydon Health Services NHS Trust	
LEAD OFFICER:	**Wayland Lousley** Head of Mental Health Commissioning (Croydon) South West London ICB, Croydon	
KEY DECISION? [Insert Ref. Number if a Key Decision]	**No**	**Key Decision** NA
CONTAINS EXEMPT INFORMATION?	**NO**	Public
WARDS AFFECTED:	**All**	

1. SUMMARY OF REPORT

1.1 Mental health is a priority for south west London and the SWL Integrated Care System (SWL ICS) has developed a mental health strategy. The SWL MH strategy identifies priorities, responds to challenges (including those around access, variation and fragmentation), drives forward transformation and addresses population health needs.

2. RECOMMENDATIONS

2.1. The Health & Wellbeing Board is recommended:

- to note the SWL ICS Mental Health Strategy has been developed and is providing the future direction for MH transformational work across the six boroughs.

3. REASONS FOR RECOMMENDATIONS

3.1. The SWL ICS Mental Health Strategy has been through the required ICS governance process and is being presented to the Health & Wellbeing Board so that they can be aware of the identified themes and priorities.

4. BACKGROUND AND DETAILS

4.1 **Vision:** "In SWL we want everyone to have access to early support for their emotional wellbeing and mental health, recognising many influences on health and wellbeing come from outside health care, including factors such as education, employment, housing, and community. We want services to work effectively together to meet people's needs and ensure everyone receives the support they need in the most appropriate setting."

4.2 **Aims**

- Increase equity of access, experience and outcomes for all SW Londoners – reducing unwarranted variation and ensuring a fair and sustainable allocation of resources.

- Prioritise prevention and early support as we know this promotes good recovery and reduces burden of Ill-health.

- We will better support and equip our CYP to manage their mental health in future given 75% of MH diagnosed by age 24.

- Design a new model for mental health workforce including voluntary and community sector and peer support to tackle mental health recruitment and retention issues.

- Expand bio-psycho-social care to address the mortality gap and the opportunity to increase years of quality life.

- Co-produce this strategy and delivery with service users/ residents in SWL, putting partnership with those who use services and those in our communities at the heart of everything we do.

4.3 Themes

- Prevention and early support
  - Children, young people and family support
  - Health environments
  - Mental health literacy and reducing stigma
- Bio-psycho-social model
  - Physical healthcare for people with mental illness
  - Neighbourhood teams and integration
  - Complex needs and co-occurring issue
- Inequalities
  - Unwarranted variation
  - At risk communities
- Timely access
  - Least restrictive care and recovery
  - Waiting times
  - Transitions
  - Discharge

5. GOVERNANCE SIGN OFF

5.1 The final draft of the MH Strategic Plan was presented to the Mental Health Programme Board on 14 March 2023. The Board members were happy to sign off the strategy.

5.2 The Strategic Plan has subsequently been approved by the Senior Executive Group on 11 April 2023, and by the Croydon Health and Care Board on 19 July 2023.

6. OWNERSHIP OF THE STRATEGY

6.1 Strategic ownership is with the South West London Integrated Care Board.

6.2 Delivery of the actions within the Strategic Plan will be owned by the Mental Health Team of the SWL ICB. For local actions, the Croydon Mental Health Programme Board will oversee the delivery of resources. This reports to the Senior Executive Group and ultimately into the Croydon Health and Care Board.

7. MONITORING & REPORTING

7.1 Monitoring and reporting will be co-ordinated through the Croydon Mental Health Programme Board through to the SWL MH PGD.

7.2 A year 1 delivery plan has been developed and will require set up and enabling actions in the main to prepare delivery shifts in year 2.

7.3 Year 1 delivery plan inclusions:

Year 1 of the strategy delivery will require set up and enabling actions in the main to prepare delivery shifts in year 2. Enabling actions include:

- **Funding and efficiency:** strategic financial and delivery review and model completed, return on investment (RoI) approach agreed and pathway review programme agreed.
- **Effectiveness:** Outcomes and evaluation approach agreed and outcomes measures approach implemented in initial service areas; review of public MH work to identify initiatives for development.
- **Resourcing:** Mental health leadership and resourcing in place to support system working; strategy delivery group formalised

Foundation work to identify proposals for delivery in each theme within the strategy will be progressed during year 1. However, there will also be a core delivery focus in each theme:

1. **Prevention and early support:** South London Listens – begins the focus on community action/ involvement.
2. **Bio-psycho-social model:** SMI health checks & community transformation – tackles core area and maximises investment to support MDT working.
3. **Inequalities:** EMHIP – extends and develops programme around race and ethnicity.
4. **Timely access:** Waiting list, discharge and length of stay initiatives – provides solid foundation for change.

A mental health workforce plan will also be developed to support across all areas.

Next Steps:

There have been a number of actions and deliverables to progress; we are currently at step 8:

1. Narrative elements of the Strategy were iterated and drafted via the SWL MH Partnership Delivery Group – Jan/ Feb 2023
2. Discussions of progress and inputs at the SWL place meetings – Feb 2023
3. Strategy presentation at SWL ICB Senior Management Team meeting – 23rd Feb 2023
4. Next and final versions reviewed and agreed at the SWL MH PDG – Feb and March 2023
5. SWL places and providers to agree Strategy – March/ April 2023
6. SWL ICB Board meeting to approve strategy – May 2023.
7. Year 1 work underway – May 2023.
8. **Set up SWL MH structures (including SWL MH Partnership Delivery Group) for Strategy delivery – Sept 2022**

Governance: PDG embedded, accountability agreement in place, cases for change developed and initial areas delegated.

8. OUTCOMES

5 year outcomes have been drafted for review – see below. These will further iterate:

Our 5 year outcomes. By 2027/28 we will have:	
Improvements for our population	Service improvements
• **Improved our recovery rates for SMI and mild to moderate mental health conditions** • **Improved quality of life for people with SMI** • **Increased the number of SMI service users maintaining independence and wellbeing without regular SMI team input** • **Reduced rates of detention people from black ethnic backgrounds** • **Improved levels of access to services across different communities** • **Reduced restrictive practices of all types** • **Increased understanding of mental health issues and wellbeing amongst key communities** • **Reduced suicide and self-harm rates** • **Improved outcomes of physical health conditions for people with SMI** • **Improved mental health, wellbeing and support to carers of people with SMI**	• Reduced waiting times for services – with greater reduction for CYP • Eradicated out of area placements for acute mental health provision • Implemented mental health advice and wellbeing support across all boroughs • Implemented effective parenting programmes and education wellbeing services for all school age children • Trained residents, VCSE partners, wider health, education and care professionals and employers in mental health support • Improved positive feedback around transitions and discharges from services • Increased peer support levels available across all boroughs • Implemented pathways for those with complex needs including rough sleepers, co-occurring substance misuse, learning disabilities and autism • Integrated mental health care with primary care, social care and education partners • Improved workforce retention, wellbeing and morale • Implemented outcomes measurement and evaluation of services • Developed measurement approaches of population wellbeing • Redistributed resources across boroughs to ensure investment reflects mental health population need • Increased levels of mental health care provided within community settings • Delegated the commissioning of community mental health services to place • Improved system collaboration around population-wide prevention and early intervention

10 year outcomes have been drafted for review – see below. These will further iterate:

Our 10 year aspirations By 2032/33 we will have:

Achievements for our population	Service achievements
• **Population mental wellbeing increased** • **Mortality gap between those with SMI and the general population reduced** • **Improved mental health for people with long term physical health conditions** • **No person known to mental health services presents to A&E unless for physical health issue** • **Zero restrictive practices** • **Zero suicide** • **Self-harm significantly reduced** • **Zero out of area placements for SWL residents** • **Acute inpatient beds closed as unneeded** • **Service access mirrors community demographics with no unwarranted variation in outcomes**	• Fully integrated mental health care in place for people with SMI and physical health needs, social care needs (including supported living), LDA, homelessness and substance misuse • Allocation of resources equitably across all 6 SWL boroughs • Majority of mental health spend and provision in primary care, VCSE and community services • Funding in mental health increased • Fully staffed services with new roles in our workforce • Research and evaluation of services and initiatives standardised into practice (inc assessment of operational delivery models) • Services responsive to population health needs and flexibly delivering changes

9. ALTERNATIVE OPTIONS CONSIDERED

10. CONSULTATION

10.1 In October 2022 open reflective sessions were held with SWL stakeholders, service users and carers and those working in mental health services to consider the vision, aims and themes and offer any further elements.

11. CONTRIBUTION TO COUNCIL PRIORITIES

11. FINANCIAL IMPLICATIONS

11.1 There are no existing commitments within the Strategic Plan for the council.

This table below is a requirement unless the Head of Finance for your directorate confirms it is not needed.

	Current Year	Medium Term Financial Strategy 3 year forecast

	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000
Revenue Budget Available				
Expenditure Income				
Effect of decision from report				
Expenditure Income				
Remaining Budget				
Capital Budget available				
Expenditure Income				
Effect of decision from report				
Expenditure Income				
Remaining Budget				

Insert at the end of the section: Comments approved by [Officer title] on behalf of the Director of Finance. (Date DD/MM/YYY)

8.2 LEGAL IMPLICATIONS

8.2.1 Xxxx

Insert at the end of the legal section: Comments approved by the Head of [XXX] on behalf of the Director of Legal Services and Monitoring Officer. (Date DD/MM/YYY)

8.3 EQUALITIES IMPLICATIONS

8.3.1 An Equality Analysis has been undertaken for the strategic plan.

8.3.2 The outcome of the analysis was - No major change – the Analysis shows that the policy is robust and the evidence shows no potential for discrimination and all opportunities to advance equally have been taken;

Insert at the end of the Equalities section: Comments approved by XXX, or by XXXX on behalf of the Equalities Manager or by XXX, the Equalities Manager. (Date DD/MM/YYY)

9 APPENDICES

9.2 South West London ICS Mental Health Strategic Plan.

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

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

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

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

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

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

NHS
South West London

DRAFT

Our Mental Health Strategy:

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

Executive Summary

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

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

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

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

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

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

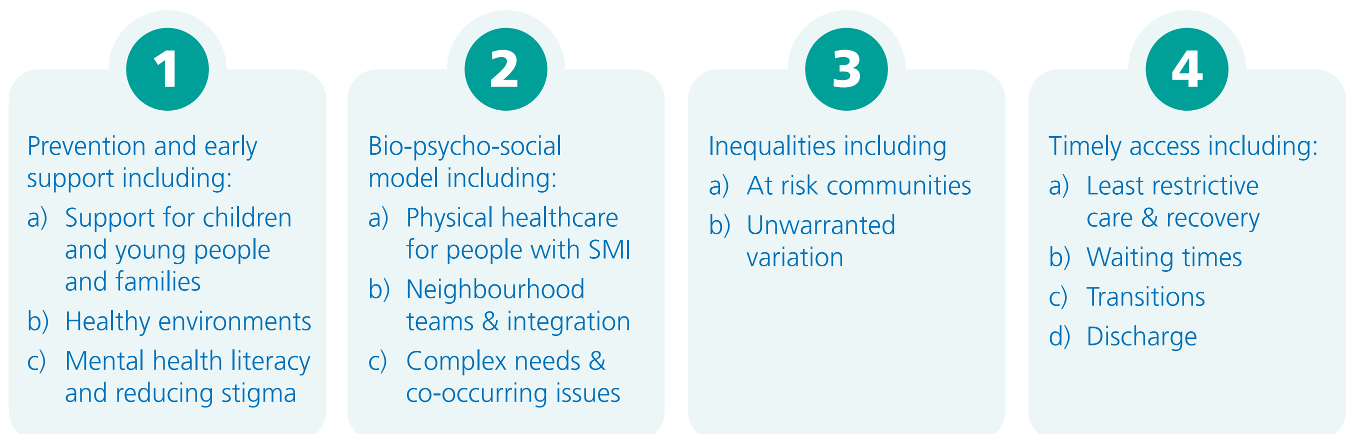
The aims of this strategy are to:

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

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

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

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



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

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

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

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

1. Introduction

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

The importance of mental health

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

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

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

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

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

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

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

2. National context

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

The importance of mental health

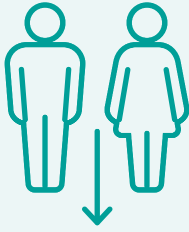
It's hard to overstate the importance of mental health for us in the 21st century. The facts speak for themselves.

From an individual perspective:

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

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

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



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

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

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

At a societal level:

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

£26 billion

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

Whilst the majority of NHS spending is on physical health, estimates suggest that the cost of treating mental health problems could double over the next 20 years.

More than £2 billion is spent annually on social care for people with mental health problems. In 2003 estimates put the costs of mental health problems in England at £77 billion; in 2022 this figure was estimated at nearly £101 billion. And these figures do not include costs related any exacerbation of physical health issues, reduced performance at work, costs to housing or criminal justice sectors, suicide and self harm or alcohol substance misuse.

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

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

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

The strategic environment

Mental health is a national health priority in England.

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

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

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

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

Current pressures

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

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

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

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

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

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

3. The SWL landscape

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

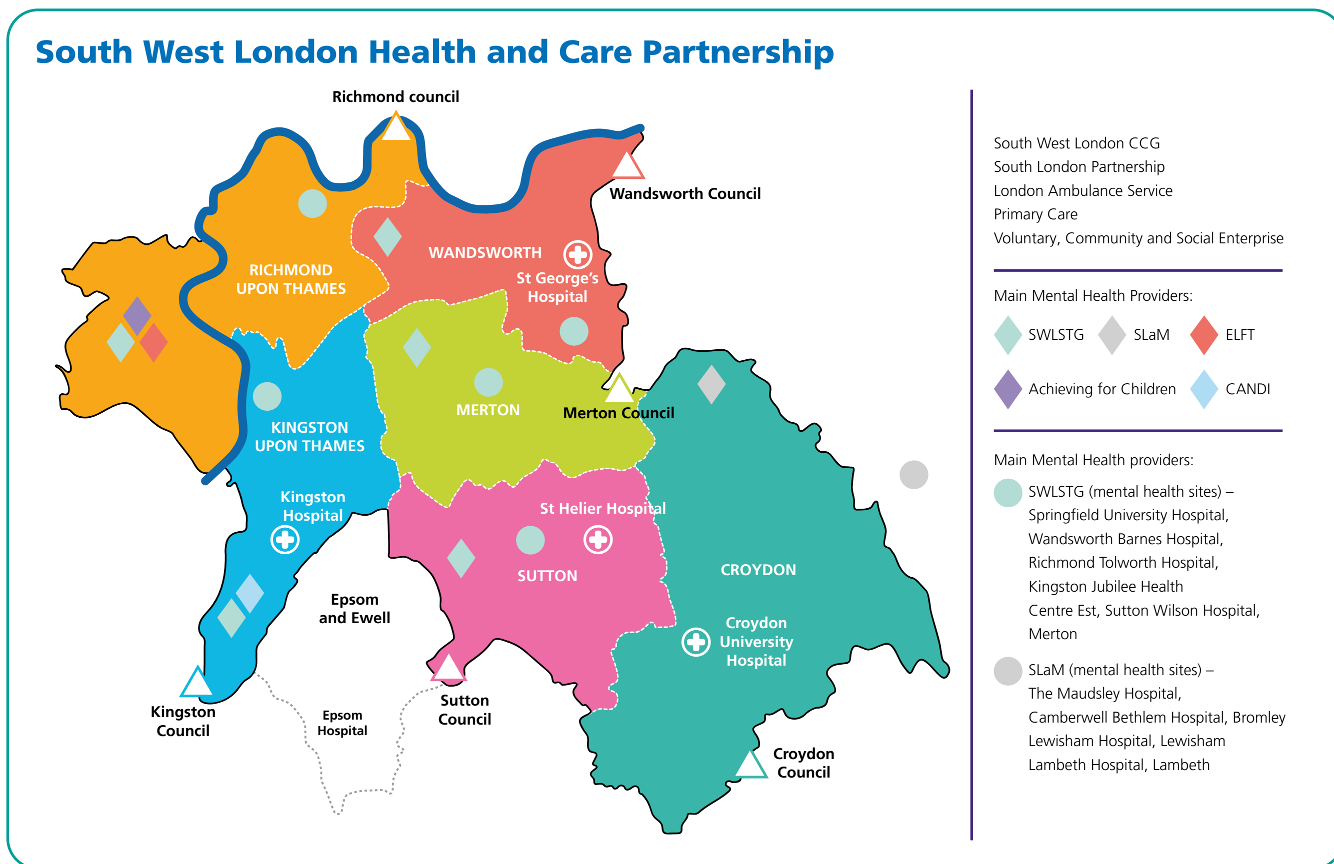
Our mental health services

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

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

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

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



Our population and their needs

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

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

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

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

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

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

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

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

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

In terms of mental health needs data show us that:

- CYP in SWL have a high level of need for mental health support. A higher proportion of under-18s access NHS community mental health services compared to other London ICSs.
- For CYP there are also some distinct population groups with particular needs which cross boroughs boundaries – for example CYP living in poverty or CYP at high performing schools experiencing eating disorders.
- In CLA emotional wellbeing is a cause for concern for approximately a third of children across London, rising to 37% nationally. In Richmond, Merton and Kingston this is a concern for half of all CLA.
- Across SWL, 16% of CYP have special educational needs (SEN). The number is increasing with the fastest growth in Kingston and Richmond. The proportion of pupils with SEN in SWL with a primary need for social, emotional and mental health support is above the London and national averages with highest rates in Wandsworth and Merton. Additionally, both the proportion of pupils with SEN with an autistic spectrum disorder or with a learning difficulty are both above the London and national averages.
- Self harm is a key issue. For adults Kingston, Richmond and Sutton have the three highest rates of admission for self-harm of all London boroughs and for CYP these three boroughs along with Wandsworth and Merton are in the top ten London boroughs for admission to hospital for self-harm. In Kingston, self harm admission rates for CYP and adults are twice as high as the London average.
- SWL has the lowest level of SMI in London yet there is a higher prevalence of depression in working age adults and high suicide rates compared to the London average in 5/6 SWL boroughs (excepting Wandsworth and Merton respectively). In addition, there are high levels of physical health conditions in our SMI population with over 50% of people with SMI have co-morbid diabetes. There is some variation in prevalence of mental health conditions which can in part be linked to demographic variation. For example, Croydon has a higher prevalence of SMI (e.g. bipolar disorder, psychosis) than Richmond.

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

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

Meeting population needs

Mental health is a clear priority for SWL partners.

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

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

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

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

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

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

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

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

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

Our starting point

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

Strengths	Weaknesses
• Effective collaborative working • High quality existing services • Rich and varied mental health provider landscape including VCSE partners including prevention initiatives within local authorities. • Strong, longstanding mental health leaders • Committed and resilient workforce • Embedded ethos of co-production and involvement	• Lower historic levels of mental health investment compared to other areas • Unwarranted variation in investment levels, access, activity, outcomes and services provided between boroughs • Clear ethnic inequalities in service access • High vacancy rates and competition for staff • Lack of provision for complex individuals

Opportunities	Threats
• Passion and enthusiasm for mental health amongst a range of stakeholders • Increasing evidence base of mental health prevention initiatives • New mental health environments at Springfield, Barnes and Tolworth integrated with local housing, wider services and new green space • Population health management intervention development and testing • Digital delivery of care and support • Research and education expansion • Community organisation and asset mobilisation through South London Listens • Green agenda driving sustainable models of care	• Focus on physical healthcare elective recovery effectively deprioritises mental health • Deficit financial position within the SWL ICS NHS partners • Local authority funding pressures and forecasts and s114 notice from Croydon • Continuing rises in mental health demand, acuity and complexity • Changes to policy direction and the existing political landscape • Lack of long-term workforce model

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

4. How we developed our strategy

We developed our Strategy in three stages:

1

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

2

Engagement with our local population (including service users and carers) and professional stakeholders with an online survey, virtual and face-to-face discussions and reflective discussion sessions.

3

Synthesis of data and information into key content.

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

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

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

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

2. Public and partner engagement

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

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

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

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

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

3. Synthesis of data and information into key content

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

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

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

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

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

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

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

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

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

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

5. Vision, aims and outcomes

Vision

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

Aims

The aims of this strategy are therefore to:

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

Outcomes

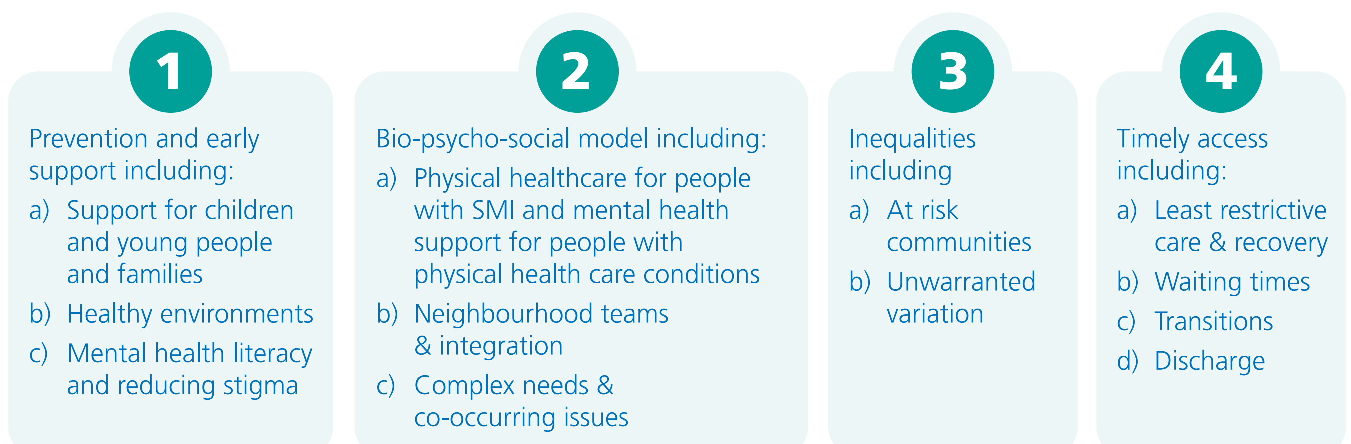
We have high aspirations for the mental health and wellbeing of our SWL residents and communities. To reflect these we have set ourselves ambitious goals over a ten year period:

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

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

Themes

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



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

6. Theme 1: Prevention and early support

Including:

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

What we know

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

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

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

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

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

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

What people told us

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

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

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

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

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

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

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

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

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

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

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

What we need to do

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

Outcomes we expect to deliver

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

7. Theme 2: Bio-psycho-social model

Including:

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

What we know

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

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

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

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

What people have told us

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

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

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

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

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

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

"Placing mental health workers in General Practice."

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

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

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

"MIND and Samaritans were fantastic."

What we need to do

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

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

Outcomes we expect to deliver

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

8. Theme 3: Inequalities

Including: • At risk communities • Unwarranted variation

What we know

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

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

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

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

What people have told us

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

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

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

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

What we need to do

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

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

Outcomes we expect to deliver

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

9. Theme 4: Timely access

Including:

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

What we know

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

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

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

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

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

What people have told us

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

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

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

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

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

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

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

What we need to do

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

Outcomes we expect to deliver

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

10. Enabling programmes

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

1. Population Health Management

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

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

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

2. Workforce

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

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

3. Digital

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

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

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

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

11. Implementing our Strategy

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

Our delivery structure

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

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

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

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

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

Measuring success and progress

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

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

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

Year 1 focus

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

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

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

This will include:

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

12. Glossary

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

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May 2023

LONDON BOROUGH OF CROYDON

REPORT:		**HEALTH & WELLBEING BOARD**
DATE OF DECISION		**18 October 2023**
REPORT TITLE:		**Croydon Dementia Strategic Plan**
CORPORATE DIRECTOR / DIRECTOR:		**Hilary Williams** Interim Joint Director of Transformation and Commissioning South West London Integrated Care Board (Croydon) and Croydon Health Services NHS Trust
LEAD OFFICER:		**Wayland Lousley** Head of Mental Health Commissioning (Croydon) South West London ICB, Croydon
KEY DECISION? [Insert Ref. Number if a Key Decision]	**No**	**Key Decision** NA
CONTAINS EXEMPT INFORMATION?	**NO**	Public
WARDS AFFECTED:		**All**

1. SUMMARY OF REPORT

1.1 The Croydon Dementia Strategic Plan has been developed as an integrated health and care approach, to directing shared resources enabling best impact on the wellbeing and independence of people living with dementia.

1.2 It sets out a borough wide direction of travel, focussed on tackling inequality and making sure no-one is left behind. This is especially important given the disproportionate national impact the Covid-19 pandemic has had on people living with dementia and their carers; this was identified in the 2021 Alzheimer's Society report 'Worst Hit'.

1.3 The Strategic Plan aims to provide clarity to our residents, carers, workforce, providers and partners, on the core dementia care offer and services provided by statutory and non-statutory partners in the borough.

1.4 The primary objectives of the Strategic Plan are to enable strategic and operational improvement and transformation within the available budget and to meet legislative statutory requirements.

1.5 It should be read alongside other strategic plans such as the Mayor's Business Plan, Adult Social Care and Health Strategy and the Croydon Health and Care Plan.

2. RECOMMENDATIONS

2.1. The Health & Wellbeing Board is recommended:

- to support the Council to the strategic and operational integration partnership arrangements required to successfully deliver the plan and relevant actions.

3. REASONS FOR RECOMMENDATIONS

3.1. There are legislative requirements for health and care statutory partners in relation to Dementia; further there are relevant interdependencies within Equality Act protected characteristics, including age, disability, gender and race.

3.2. Developing an integrated Strategic Plan is the recommended enabler for system partners to deliver both their fiduciary and legislative responsibilities.

3.3. The partnership approach taken has also framed responding to the challenges of Dementia as a borough responsibility; beyond just health and social care boundaries.

4. BACKGROUND AND DETAILS

4.1. During 2022 Croydon's health and care partners, through the Mental Health Transformation Programme re-established the Croydon Dementia Action Alliance and developed a Dementia and Older Adults Steering Group. They focussed on:

- developing a Croydon Dementia Strategic Plan; and
- ensuring that Croydon achieved Dementia Friendly status (a key Mayoral pledge).

The Croydon Dementia Action Alliance

2.1 The Croydon Dementia Action Alliance will promote all aspects of the Croydon Dementia Strategic Plan, from Preventing Well to End of Life Care.

2.2 The Alliance brings together local organisations, business, and groups across multiple sectors, alongside individuals with lived experience. Facilitated by a Communities Coordinator from the Alzheimer's Society, the aim is that all organisations in the Alliance play a proactive role in making the borough more dementia friendly, both as individual members and collaboratively as an alliance.

2.3 Organisations represented include the voluntary sector, community groups, retail and business, faith groups, the arts, culture and leisure sector and health and social care. This enables a borough wide response to dementia. This also includes work with organisations representing black and minority ethnic communities such as the BME Forum and the Asian Resource Centre. A list of organisations who play an active role in the Croydon Dementia Action Alliance can be found in the appendix B of the Strategic Plan.

The Croydon Dementia Steering Group

2.4 The Steering Group is formed of senior representatives from both commissioning and provider organisations to develop and drive the strategic work around dementia.

2.5 The primary purpose is to develop and oversees the work the Croydon Dementia Action Alliance including supporting the work of the Dementia Friendly Communities Coordinator. The Group involves people with dementia and their carers in its meetings and work programmes.

2.6 Membership of the Croydon Dementia Steering Group can be found in Appendix C of the Strategic Plan.

Strategy development

2.7 Following a survey run by Healthwatch Croydon, the Strategic plan development was initially facilitated by the National Alzheimer's Society who collated together the information on the current dementia services within the borough and produced a first draft of the strategy in December 2022.

2.8 Developing versions of the plan have been reviewed and discussed by both the Dementia and Older Adults Steering Group and Croydon Dementia Action Alliance. They have provided comment and direction on the themes and actions, ultimately leading to the document being presented.

2.9 Building on the first draft, the South West London Integrated Care Board's, Croydon Place Mental Health Commissioning Team, took over the development of the strategy incorporating the provided comments and taking an updated draft version for discussion at a Professionals workshop in February 2023.

Governance sign off

2.10 The final draft of the Strategic Plan was presented to the Mental Health Programme Board on 9 May. The Board members provided some helpful suggestions on the document and were happy to sign it off as a complete document.

2.11 The Strategic Plan has subsequently been approved by the Senior Executive Group on 13 June 2023, and by the Croydon Health and Care Board on 19 July 2023.

2.12 The Strategic Plan is being presented for the approval of the Mayor in Cabinet on 25 October 2023. This will complete the Croydon heath and care system level strategic governance for the Strategic Plan.

Ownership of the strategy

2.13 Strategic ownership is with the Croydon Health and Care Board, co-Chaired by the Borough's Executive Mayor and Health's Place Based Lead.

2.14 Delivery of the actions within the Strategic Plan will be owned by the Croydon Mental Health Programme Board. This reports to the Senior Executive Group and ultimately into the Croydon Health and Care Board.

2.15 There is also expected to be a call to present progress against actions to the Croydon Health and Social Care sub-committee.

Monitoring and reporting

2.16 Monitoring and reporting will be co-ordinated through the Dementia and Older Adults Steering Group, through to the Mental Health Programme Board.

2.17 A development plan is being finalised and is expected to be signed off by Steering Group and in progress from October 2023.

2.18 Each partner organisation would ultimately be responsible for their individual deliverables. In particular enabling the ambitions and the outcomes of the dementia strategy action plan to be costed in the context of efficiencies/other system pressures and with realistic timescales for future service model developments.

2.19 All current and future actions will be supported through development of full business cases progressed through the governance routes described, and with decisions supported where necessary by equality impact assessments.

5. ALTERNATIVE OPTIONS CONSIDERED

5.1. There are legislative requirements for health and care statutory partners in relation to Dementia; further there are relevant interdependencies within Equality Act protected characteristics, including age, disability, gender and race.

5.2. Developing an integrated Strategic Plan is the recommended enabler for system partners to deliver both their fiduciary and legislative responsibilities.

5.3. The partnership approach taken has also framed responding to the challenges of Dementia as a borough responsibility; beyond just health and social care boundaries.

6. CONSULTATION

6.1. The strategic plan has been developed by the Alzheimer's Society, primarily in collaboration with members of the Croydon Dementia Strategy Steering Group and Croydon Dementia Action Alliance.

6.2. The views and experiences of people affected by dementia in Croydon have been sought through face-to-face conversations, online surveys, and focus groups.

6.3. Healthwatch Croydon conducted three surveys to see:

- How people affected by dementia experienced receiving a dementia diagnosis.
- Whether they feel supported to manage their dementia.
- How they have experienced services within Croydon.
- What they feel could be improved to make Croydon a good place to live with dementia.

6.4. From these surveys, and further engagement work with people living with dementia, there were responses from 75 residents who have received a dementia diagnosis, are an informal carer for someone living with dementia, or are a family member/friend of someone living with dementia.

6.5. A summary of the findings can be found in appendix D of the Strategic Plan.

7. CONTRIBUTION TO COUNCIL PRIORITIES

7.1. The Strategic Plan will contribute to the following Council priorities cited in the Mayor's Business Plan:

- The council balances it's books, listens to residents and delivers good sustainable services.
- People can lead healthier and independent lives for longer.

8. FINANCIAL IMPLICATIONS

8.1. There are no existing commitments within the Strategic Plan to deliver services beyond the existing budgets. This strategic policy will ensure cohesive support for people with Dementia and their families which should result in the delay or prevent the need for care in a formal setting.

8.2. The governance model will enable strategic partners to map and understand and negotiate the financial system impacts of existing and new proposals.

8.3. Each partner organisation would ultimately be responsible for their individual deliverables. In particular enabling the ambitions and the outcomes of the dementia strategy action plan to be costed in the context of efficiencies/other system pressures and with realistic timescales for future service model developments.

Comments approved by Mirella Peters on behalf of the Director of Finance. (06.08.2023)

9. LEGAL IMPLICATIONS

9.1. The Care Act 2014 provides the legal framework for adult social care and places a duty on councils to promote individuals well being. Under the Care Act, councils must support and promote the wellbeing and independence of working age disabled adults and older people, and their carers; provisions of the Care Act 2014 include:

- Section 1, Promoting individual well being
- Section 2, Preventing needs for care and support
- Section 3, Promoting integration of care and support with health services etc
- Section 18 – Duty to meet needs for care and support
- Section 20 – Duty and power to meet a carer's needs for support

The proposed service will contribute to the fulfilment of these duties.

The Public Sector Equality Duty as set out in section 149 of the Equality Act requires the Local Authority, in the exercise of its functions, to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity between different groups and foster good relations between different groups.

Comments approved by Doutimi Aseh, Head of Legal Services on behalf of the Director of Legal Services and Monitoring Officer. (14/08/2023)

10. EQUALITIES IMPLICATIONS

10.1. Under the Public Sector Equality Duty of the Equality Act 2010, decision makers must evidence consideration of any potential impacts of proposals on groups who share the protected characteristics, before decisions are taken. This includes any decisions relating to how authorities act as employers; how they develop, evaluate and review policies; how they design, deliver and evaluate services, and also how they commission ad procure services from others.

10.2. Section 149 of the Act requires public bodies to have due regard to the need to:

- Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it; and

- Foster good relations between people who share a protected characteristic and people who do not share it.

10.3. The strategic plan will provide clarity to our residents, carers, workforce, providers and partners, on the core dementia offer and services provided by statutory and non-statutory partners in the borough. The highest risk factor for Dementia is age, predominantly affecting 5% of people aged 65 years and over and 20% of those aged over 80 years. Dementia however is not an inevitable part of ageing. Not everyone who is old has Dementia and not everyone who has Dementia is old. In Croydon there are an estimated 3,597 of people living with dementia; of which 2,692 people over the age of 65 who have received a dementia diagnosis.

10.4. An EQIA has been carried out and shows predominantly positive impact on all protected characteristics. However, there is a need to collect better data of service users for some protected groups.

10.5. Comments approved by Naseer Ahmad, Interim Senior Equalities Officer on behalf of the Equalities Manager. (Date 01/08/2023).

11. HUMAN RESOURCES IMPLICATIONS

11.1. There are no direct human resources implications arising from this report for Council employees, and if there were, the Council's HR policies and procedures will be observed, and HR advice would be sought at an early stage.

Comments approved by: Debbie Calliste, Head of HR for Adult Social Care and Health on behalf of the Chief People Officer

12. APPENDICES

12.1. Croydon Dementia Strategic Plan

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One Croydon

Your Health and Care partnership

Croydon Dementia Strategic Plan

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Croydon GP Collaborative

NHS South London and Maudsley NHS Foundation Trust

VCS

Croydon South West London Integrated Care System

NHS Croydon Health Services NHS Trust

Contents

Foreword	**4**
Our Vision for Excellence in dementia Care	**4**
Background	**5**
What is dementia?	5
Local context	6
The Croydon Dementia Action Alliance	6
The Croydon Dementia Steering Group	7
Wider Croydon Governance Structure	7
Development of the Croydon Strategy	7
Context	**8**
National context	8
Croydon context	10
National Well Pathway for dementia	11
National Strategy for dementia	11
What does the strategy mean for Croydon organisations?	12
Preventing Well	**14**
Strategic Plan: Preventing Well	15
Diagnosing Well	**16**
Strategic Plan: Diagnosing Well	17
Supporting Well	**18**
Strategic Plan: Supporting Well	19
Living Well	**20**
Strategic Plan: Living Well	21
Ending Life Well	**22**
Our Strategic Plan: Ending Life Well	23
What to expect in the first 18 months	**24**
Appendixes	**25**
Appendix A: Current dementia support and services in Croydon	25
Appendix B: Croydon dementia Action Alliance Group Members	26
Appendix C: Croydon dementia Steering Group Membership (August 2023)	27
Appendix D: Croydon Governance Structure	28
Appendix E: Recommendations taken from Health Watch survey report	29
Appendix F: Figure from the 2020 Lancet report showing potentially modifiable risk factors for dementia that could affect people over the course of their lifetime	30

Foreword

As the Executive Mayor of Croydon and co-Chair of the Croydon Health and Care Board, I am delighted to launch this Dementia Strategic Plan for Croydon. In my Mayoral Business Plan, I have made it a priority to ensure that people can lead healthier and independent lives for longer. I also committed to collaborating with partners to make Croydon a Dementia Friendly Borough, and through the fabulous work of the Croydon Dementia Action Alliance and with support from Alzheimer's Society, Croydon achieved Dementia Friendly Borough status in June 2023.

This strategic plan is now about delivering on the pledges made to achieve Dementia Friendly status. It sets out a clear direction for all the partners of the Croydon Dementia Action Alliance to work together, to maximise our impact on the wellbeing and independence of people with dementia living in our borough. It is an opportunity to tackle inequality and make sure no one is left behind. This is especially important given the disproportionate impact the Covid-19 pandemic has had on those with dementia and their carers as identified in a report by the Alzheimer's Society in 2021 entitled 'Worst Hit'

I know all partners will work together to deliver the desired outcome for those living with dementia.

Mayor Jason Perry, Executive Mayor of Croydon

Our Vision for Excellence in dementia Care

As a system (Health, Social Care, Voluntary Community and Social Enterprise (VCSE) providers) we will provide dignified, compassionate, clinically effective, and safe person-centred care for our patients living with dementia. This will be delivered by staff who are appropriately trained and who work in partnership with families and carers. This care will be provided in environments which promote safety, wellbeing, and independence.

We aim to increase early diagnosis and promote living well with dementia, transforming the patients' journey through, reduced length of stay and prevention of admission, early and safe discharge, good mental health liaison as well as ensuring the recognition of the need for palliative and end of life care.

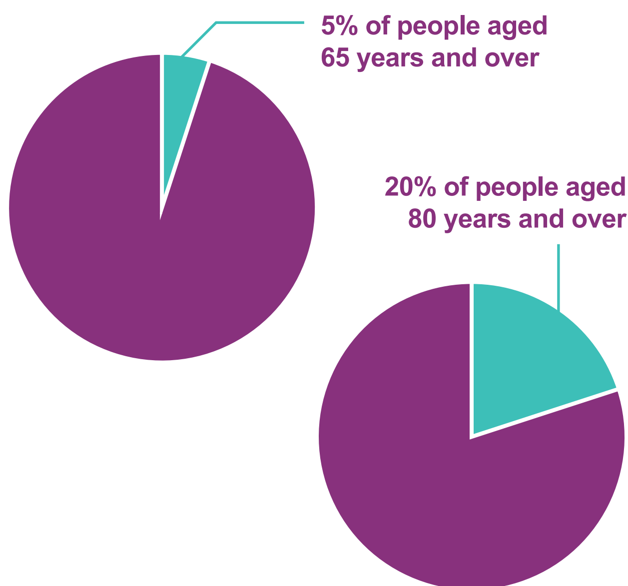
We aim to provide comprehensive and specialist assessments and services at the level required for each individual. We will work across our multi-agency partners to keep the length of in-patient stay as short as possible and enable safe and supported discharge.

Our care and services will demonstrate best practice principles by promotion of research and development in the fields of ageing and dementia studies and through co-production with people with dementia and their carers.

Background

What is dementia?

'Dementia' is a condition where several areas of thinking and memory are impaired. A person with dementia will have difficulties carrying out their activities of daily life. There are many causes of dementia. Alzheimer's disease, brain injury due to strokes, and Parkinson's disease are the three most common types. A person with dementia may experience progressive decline in multiple areas of function, such as memory, reasoning, planning and communication skills.



The highest risk factor for dementia is age. It affects 5% of people aged 65 years and over and 20% of those aged over 80 years. These figures are twice as high for people with a learning disability and greater still for people with Down's syndrome where dementia can start from an earlier age. Dementia is not an inevitable part of ageing. Not everyone who is old has dementia and not everyone who has dementia is old. Two thirds of people with dementia are supported at home by some of the 670,000 unpaid carers throughout the country.

Dementia is potentially preventable. Improving physical and mental health in mid-life can reduce the chances of people getting dementia.

Although there is no known cure, some medications can help with some of the symptoms. There is increasing evidence that improving physical health in people with dementia can also improve outcomes. Most importantly, non-medical interventions such as psychological treatments and personalised care can improve dramatically the quality of life of people with dementia and those who care for them.

Although there are common symptoms, each person is unique and experiences dementia in their own way.

Local context

Dementia is a complex condition which impacts primary, secondary, community, acute and social care. The integration of health services is an important opportunity for people affected by dementia to experience better joined-up care across several service providers.

A list of the current Croydon services for dementia is included in Appendix A.

Recognising that dementia is a collective responsibility for organisations within the Borough, two key groups have been developed to proactively drive the dementia work.

The Croydon Dementia Action Alliance

The Croydon Dementia Action Alliance is the vehicle through which local organisations, businesses, groups and individuals across multiple sectors are committed to enabling people with dementia and carers to live well by taking action to contribute to a more Dementia Friendly Borough. The work is facilitated by a Communities Coordinator employed by Alzheimer's Society, and the aim is that all organisations who are a part of the Croydon Dementia Action Alliance play a proactive role in making the borough more Dementia Friendly, both as individual members and collaboratively as an alliance.

There are a wide variety of organisations represented including from the voluntary sector, community groups, retail and business, faith groups, the arts, culture and leisure sector and health and social care. This enables a borough wide response to dementia. This also includes work with organisations representing black and minority ethnic communities such as the Croydon BME Forum and the Asian Resource Centre of Croydon. A list of organisations who play an active role in the Croydon dementia Action Alliance can be found in the appendix B.

The Croydon Dementia Action Alliance plays a practical role in promoting all aspects of the Croydon dementia strategy, from Preventing Well to End of Life Care, as outlined through the course of this strategy.

The Croydon Dementia Steering Group

The Croydon Dementia Steering Group brings together senior representatives from both commissioning and provider organisations to develop and drive the strategic work around dementia. The Steering Group also oversees the work the Croydon Dementia Action Alliance including supporting the work of the Dementia Friendly Communities Coordinator. The Group involves people with dementia and their carers in its meetings and work programmes.

Members of the Croydon Dementia Steering Group can be found in Appendix C.

Wider Croydon Governance Structure

The Croydon Dementia Steering Group is a working group of the Croydon Mental Health Programme Board (MHPB) and provides updates and documents for scrutiny and approval through an agreed process. There are different levels of Governance and the diagram in Appendix D shows the committees and Boards who have approved the Croydon Dementia Strategy.

Development of the Croydon Strategy

The strategy has been developed by the Alzheimer's Society, in collaboration with members of the Croydon Dementia Strategy Steering Group and Croydon Dementia Action Alliance.

Throughout its development, the views and experiences of people affected by dementia in Croydon have been sought through face-to-face conversations, online surveys, and focus groups.

Healthwatch Croydon conducted three surveys to see:

- How people affected by dementia experienced receiving a dementia diagnosis;
- Whether they feel supported to manage their dementia;
- How they have experienced services within Croydon; and
- What they feel could be improved to make Croydon a good place to live with dementia.

From these surveys, and further engagement work with people affected by dementia, we heard from over 75 people who have either received a dementia diagnosis, are an informal carer for someone living with dementia, or are a family member/friend of someone living with dementia.

A summary of the findings can be found in appendix E.

Context

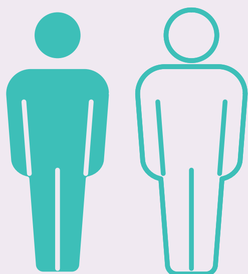
National context

Dementia is a high-level priority for all local authorities, health partners, Integrated Care Systems, and social care services. There are approximately 900,000 people living with dementia in the UK, which is predicted to rise to over 1 million people by 2025.

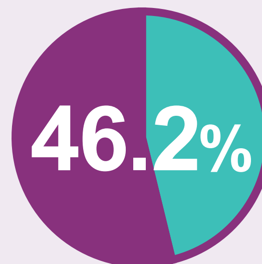
The case for dementia care integration is overwhelming. Current estimates put the cost of dementia to the UK at £34.7bn a year increasing to £94.1bn by 2040. Out of the total cost, £5.1bn is currently incurred within health care settings.

Dementia crosses NHS directorates (older people's mental health, ageing well, frailty etc.), has a huge impact on social care and is often accompanied by multi-morbidities. It places significant pressure on primary and acute services due to a lack of community care and high thresholds for people affected by dementia looking to secure social care support. This in turn places a huge burden on the unpaid carers of people with dementia due to the lack of integrated support.

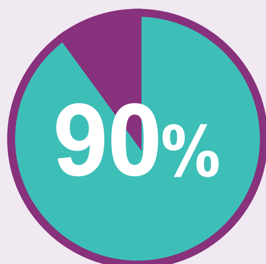
For example:



In 2019-20, half of all people with dementia were hospitalised at least once that year, a trend that has been consistent since 2016-17.

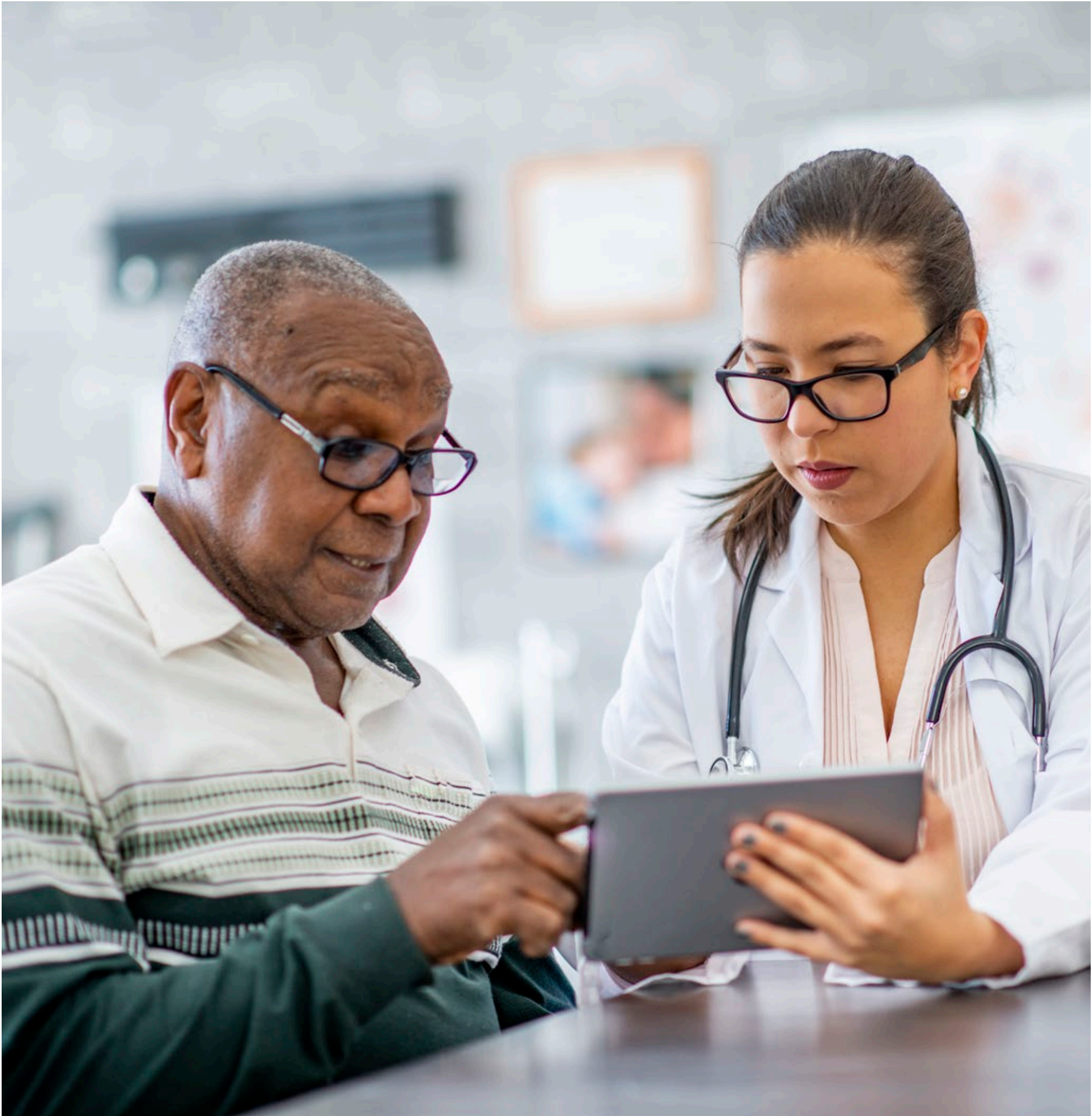


Recent data shows that just 46.2% of people with dementia had a care plan initiated or reviewed, despite these often being peoples only formal methods of support.



90% of the 2019-20 admissions were as an emergency, with almost a third for stays of one day or less, suggesting better care in the community could have identified problems experienced by people with dementia earlier and prevented these admissions.

In 2021 one fifth of people with dementia also had diabetes, 10 per cent had had cancer in the last five years, 23% had a heart condition and 40% had arthritis.



Person living with dementia

"At the dementia day centre the staff are very friendly and capable -I think they have a really good understanding of dementia and are very well trained. They seem dementia friendly. The place here is really nice and has lots of space, a quiet room and different people to talk to and things to do. I think dementia training is very important and I worry about people elsewhere where staff may not be as good."

Carer

"Support for both of us is important, respect for the person in this situation and mindfulness of how this is affecting the person and the family."

Croydon context

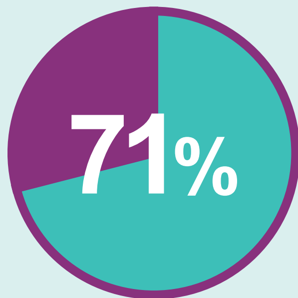
Croydon is part of NHS South West London Integrated Care System (ICS). Within this ICS area, there are currently:

9,732
people over the age of 65 have received a recorded diagnosis of dementia;

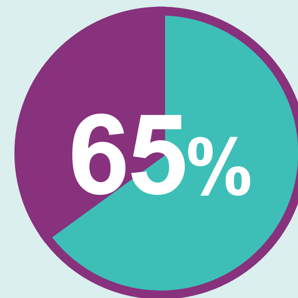
13,808
people over the age of 65 estimated to be living with dementia; and

45%
of people have reported having a dementia care plan review in the last 12 months.

In addition:



NHS South West London ICS currently has a dementia diagnosis rate of 71%[1]; and



Across NHS South West London ICS approximately 65% of people die at their usual place of residence.

On a more local level, currently in Croydon borough there are[2]:

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

3,597
people estimated to be living with dementia[3]

5,471
predicted number of people who will be living with dementia by 2030

75%
diagnosis rate

51.7%
of residents are from a BAME background, as described in the Health and Care plan for Croydon 2019

21%
As part of the NHS Personal Social Services Survey 2021/22, **21%** of all carers who responded to the survey reported caring for a person living with dementia.

21%
In the same survey, **21%** of respondents who had used social care in the last 12 months reported being either dissatisfied, very dissatisfied, or extremely dissatisfied with the services received.

80%
Over **80%** had not accessed day centres or day activities in the last 12 months

1 Not everyone with dementia has a formal diagnosis. Since 2012, the NHS has been seeking to ensure that patients suffering from dementia are given a formal diagnosis so that they can receive appropriate care and support. The national target is for two thirds of people with dementia to be formally diagnosed. The Dementia 65+ estimated diagnosis rate indicator tracks this ambition by comparing the number of people thought to have dementia with the number of people diagnosed with dementia, aged 65 and over.

2 https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia/data

3 https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses

National Well Pathway for dementia

The national Well Pathway for dementia is recognised as the focus to support patients, carers and families on their journey and reduce variation in health and care services.

The Well Pathway for dementia concentrates on five themes

- **Preventing Well**
- **Diagnosing Well**
- **Living Well**
- **Supported Well**
- **Ending Life Well**

These themes have been used to set the priorities within the strategic objectives linking to the key objectives of the national dementia five year strategy. The aim is to provide a comprehensive framework to deliver better care and support from patients and carers from prevention through to end of life and bereavement care.

Family & Friends

"Simplify processes. Join up information. Help carers to get help. Stop people feeling isolated. Help GPs to see people in their own homes. Have one place to access info."

National Strategy for Dementia

Dementia is a key priority for both NHS England and the Government. In February 2015 the Prime Minister launched his Challenge on dementia 2020, which set out to build on the achievements of the Prime Minister's Challenge on dementia 2012-2015 (https://www.england.nhs.uk/mental-health/dementia/).

The guidance 'Dementia: applying all our help' (updated in February 2022) is a part of "All Our Help", a resource to help health and care professionals in preventing Ill Health and promoting wellbeing. It sets out the actions which can be taken in each stage of the dementia Pathway. The

strategic actions in the section have been aligned to the suggested actions as part of this guidance.

All Our Help: https://www.gov.uk/government/publications/all-our-health-about-the-framework

In May 2023, NHS England published the guidance 'Intercultural dementia care: A guide for health and care workers'. The aim of the guide is to help health and social care workers, to provide dementia care, which corresponds to the needs and wishes of people from a wide range of ethnic groups, especially minority ethnic groups.

(https://www.england.nhs.uk/wp-content/uploads/2023/05/intercultural-dementia-care-guide.pdf)

What does the strategy mean for Croydon organisations?

The proposals co-produced within this document describe how we will:

- Work together.
- Further develop local services where possible.
- Enhance staff skills in dementia awareness and management.
- Measure the impact of the strategy on people with dementia and their carers.
- Update key stakeholders on the implementation of this strategy.

This high level strategy will be used to develop annual deliver plans where actions and action owners will be specified, with clear timelines and measures of success identified. A refreshed delivery plan each year will enable a collaborative approach across health and care and across sectors and build on the previous year to achieve the best possible outcomes within our budgeting constraints.

Person living with dementia

"For everyone to be nice and understanding. For staff everywhere to treat you with respect and understanding. I was a nurse and I treated people as individuals. Everyone with dementia needs to be treated as an individual not a group. People need to be active and need help to do this. It is difficult to stay active. I would like there to be more ways to do this."

It is vital that we assess whether this strategy is making a demonstrable difference to the experience of people living with dementia and their family and friends as well as carers. We know that to really meet the needs of the individual, it is important to listen to them. We will therefore involve people living with dementia and their families in helping us achieve the aspirations set out in this strategy and will continue to re-visit our vision to ensure the voice of lived experience not only remains central to the strategy but helps to measure the impact of it.

Learning from our previous dementia strategy tells us that it is imperative we have systems in place for decision-making and accountability. The Croydon Dementia Steering Group and Croydon Dementia Action Alliance will be key groups to monitor the progress of this strategy, identify gaps and work together to help find solutions. To help achieve this, representatives have committed to continue to 'Listen Well' as we implement this strategy over the next three years. The groups will continue to meet regularly and hold the system to account for delivery of the work.

Carer

"Treat us like human being, don't use unpaid labour to prop up services, older people with mental problems should be cared for properly and their families free to choose how to live their lives."

Preventing Well

What do we mean by the theme of Preventing Well?

Activity around prevention of ill health is not specific to dementia and includes messages around preventing cardiovascular disease, diabetes and other long term conditions. This provides an opportunity to look at the wider prevention strategy and to see what role awareness of dementia prevention could play as a driver for behaviour change in several areas of health awareness. By potentially influencing the population to:

- be more physically active
- eat healthily and maintain a healthy weight
- drink less alcohol
- stop smoking
- be socially active
- control diabetes and high blood pressure

there is the opportunity to improve outcomes in several health areas. It could be beneficial for professionals to provide support and advice on dementia risk reduction as part of their daily contact with individuals. 'Making Every Contact Count' is an opportunity public-facing workers during their contact with patients, service users or the public to support, encourage or enable them to consider health behaviour changes such as stopping smoking or improving their sense of wellbeing.

In 2017, the Lancet published "Prevention and management of dementia: a priority for public health" which identified 12 modifiable risk factors which could prevent or delay 40% of dementia cases (informatic shown in appendix F) (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31756-7/fulltext).

Dementia Friendly Communities and Preventing Well

Examples of practical actions:

- Incorporate messages around prevention into all activities where possible, including all communications, events, awareness talks, provision of information to ensure a wide reach across the borough.
- Encourage local authority and NHS partners to include relevant actions as part of their bespoke dementia friendly action plans, such as: including messages about prevention and dementia in their communications and campaigns and including dementia as part of NHS health checks.
- Establish strong partnerships with organisations across Croydon that work with people from minoritised communities who are at an increased risk of dementia.
- Seek awareness raising opportunities with younger people and with the wider Croydon community, to help increase the reach of prevention messages.

What Croydon residents told us in 2022:

"Very important for people to understand dementia in Alzheimer's is an illness but not contagious... public awareness of life and the best support for the carer/s and family."

"Information campaign. Encouraging local people to look out for people who may be alone and not managing."

"For there to be understanding of people with Alzheimer's, they can still give a lot to society. Places they can go and feel safe."

Strategic Plan: Preventing Well

Key Challenge / Opportunities	Year 1	Year 2+	What success will look like
Address the 12 modifiable risk factors which could help prevent / delay dementia diagnosis: 1) Less Education 2) Hearing Loss 3) Traumatic Brain Injury 4) Hypertension 5) Alcohol >21 units per week 6) Obesity 7) Smoking 8) Depression 9) Social Isolation 10) Physical Inactivity 11) Air Pollution 12) Diabetics	Explore including preventing dementia messages at both strategic and delivery levels in all commissioned programmes Understanding of how current services such as Livewell, Occupational Therapists etc. are helping to prevent dementia through their interactions Where possible, encourage the use of the lines like "what is good for the heart is good for the head" and "dementia is preventable" at each opportunity when other prevention work is discussed. Ensure risk factors for dementia are identified and treated adequately in middle age, especially for high risk groups (people from poorer socioeconomic groups, non-white people, people with severe mental illness, non-English speakers Investigate the possibility of Health and care professionals providing support and advice on dementia risk reduction as part of their daily contact with individuals	Explore having specialist community dementia champions who can liaise with community leaders and groups to raise awareness in face-to-face sessions that are sensitive to cultural needs. Investigate opportunities to promote the uptake of community-based interventions to support health and wellbeing and address social isolation and loneliness Where possible, encourage that any new/developed community locations are both age-friendly and dementia-friendly, to make healthier choices easier	Local commissioned programmes, where appropriate, include preventing dementia messages Increased awareness within the Croydon population as to the 12 risk factors for dementia Better informed front line workforce who are thinking about ways to discuss preventing dementia
Alignment between the dementia strategy and other Health & Social Care strategic Plans	Encourage links between strategy development groups and the dementia Steering group to ensure alignment between strategic documents and future planning.		Coherence between the different Croydon strategic documentation with a clear joined up vision for dementia prevention and awareness of the risk factors
Raise awareness of dementia prevention within High Risk groups for early onset	Explore possible alignment between the dementia strategy and the Community Learning Disability Health Services strategies Embed the dementia strategy into the Ethnicity and Mental Health Improvement Project (EMHIP) including the mobile hub	Explore opportunities to raise the awareness of the risk factors associated with early onset dementia and uncontrolled vascular disease in those under 65	Coherence between the different Croydon strategic documentation with a clear joined up vision for dementia prevention and awareness of the risk factors
NHS Health checks for those aged between 40 – 74	When an NHS Health Check is taking place consider including information on how individuals can reduce their risk of dementia and, for those aged over 65, the signs and symptoms of dementia to look out for.	Investigate if the service could embed dementia risk reduction for all attending the NHS Health Check, making use of the range of resources available through the NHS Health Check website, which has links to associated leaflets, e-learning and online resources	NHS Health Checks including information on reducing the risk of dementia / signs and symptoms of dementia

Diagnosing Well

What's included in the theme of Diagnosing Well?

Everyone with dementia should have their diagnosis delivered in a timely and compassionate way. The time between symptoms developing and receiving a formal diagnosis should be as short as possible.

Receiving a dementia diagnosis can be a life-changing experience. As there is no cure for dementia, a diagnosis is essential in supporting people to live well as it opens the door to emotional, legal and financial advice as well as practical care and support services to allow people to live well for longer.

At the time of writing the strategy (2023), Croydon has a dementia diagnosis rate of 74.1% which is above the England average diagnosis rate of 62.2% and above the national target of 67%.

Dementia Friendly Communities and Diagnosing Well

Examples of practical actions:

- Prioritise building connections with community groups, including those who work at grass roots level, and organisations who are likely to engage with people pre-diagnosis, to increase awareness of dementia and what to do if concerned about potential signs and symptoms.
- Work alongside GPs to support them to become dementia Friendly Practices, such as: Dementia Friends sessions for non-clinical staff who work face to face with the public; connecting surgeries to examples of dementia Friendly Signage and the dementia Friendly Environments audit; support awareness raising of the benefits of a diagnosis, based on Alzheimer's Society research with people with lived experience; supporting GPs to explore other dementia Friendly actions through the sharing of existing good practice.
- Promote messages around living well with dementia throughout all communications to help reduce the fear and stigma around dementia and therefore encourage more people to access a timely diagnosis (for instance through the dementia Friends sessions).
- Build strong connections with organisations who work with minority ethnic groups to include information about dementia, diagnosis and living well.

What Croydon residents told us in 2022:

Although Croydon is performing well with its diagnosis rate, engagement with people affected by dementia, health and social care professionals, providers and memory service colleagues have revealed the following challenges in making sure that people receive a timely and compassionate diagnosis:

- "Difficulty in getting the GP to consider dementia as a diagnosis and difficulty getting a referral to the memory service".
- "Difficulty in securing scans for diagnosis".
- "Slow diagnosis times and often had to chase for a diagnosis".
- "GPs more likely to focus on physical health needs rather than looking into possible dementia".
- Lack of follow up dementia checks after being diagnosed with a Mild cognitive impairment (MCI).

Carer of person living with dementia

"They diagnosed quickly but didn't take it very seriously, they acted like he wasn't very far along, but he was deteriorating quickly; his license was taken away and this was horrible for him. He had been having accidents and getting lost while driving for a while before his diagnosis."

Strategic Plan: Diagnosing Well

Key Challenge / Opportunities	Year 1	Year 2	Year 3+	What success will look like
Individuals attending General Practice (GP) with concerns around dementia symptoms	Awareness raising of dementia symptoms with GPs (aligning with Preventing Well actions) Raise awareness in community settings for individuals to approach GPs if they think somebody's memory is becoming a problem	Investigate other opportunities to raise awareness with those vulnerable individuals such as during fire service checks, hairdressing, housing visits, delivery services etc.	Explore involvement of agencies within ICN+ huddles to support integrated working	More individuals approaching general practice with dementia symptoms at an early stage
Opportunity to follow up after a Mild cognitive impairment diagnosis to look for possible dementia symptoms	Awareness raising with GPs around the benefits of proactive / early case finding for dementia diagnosis	Options for proactive case finding for dementia is considered including dementia screening for those newly registered with practices	Explore including dementia screening into clinics for long term conditions that are considered as risk factors for dementia	Potential reduction in late referral for dementia diagnosis
Waiting times for a dementia diagnosis with an average waiting time in 2022 of 118 days	Trajectory agreed to look to reduce the average waiting time from 118 to 42 days by end of year 1	Individuals are ideally not waiting more than 42 days from referral for a diagnosis		Better experience for individuals in receiving a diagnosis in a timely manner
Correct pathway for referrals into dementia diagnosis services	Awareness raising with GP and referrers pathways about who's going to benefit from diagnosis service and when other services may be more appropriate for the person's needs			Better experience for individuals accessing the most appropriate service first
Maintain the national dementia diagnosis target of 67%	Ensure there remains a focus on maintaining the national dementia diagnosis rate target			Croydon will be above the national dementia diagnosis target of 67% on the quarterly reporting
Increase the level of referrals from those in minority ethnic groups early in the course of their dementia	Guidance to GP practices around ethnicity data collection, including identifying additional resource requirements	Commitment to links between EMHIP mobile hub and dementia services to ensure that dementia services are fully culturally accessible		Increase in people accessing diagnostic services from the minority ethnic groups population
Understanding of the diagnosis path and which elements may be included	Communicate the diagnosis path to individuals effectively so that there is understanding of when tests/scans may/may not be required			Better understanding by individuals of the pathway to diagnosis with a reduction in anxiety around access to brain scans / testing

Supporting Well

What's included in the theme of Supporting Well?

Initial post-diagnostic support is vital to help people come to terms with their diagnosis and manage their condition. Given the variety of symptoms that people experience, post-diagnostic support is essential to facilitate access to the right services.

This period following on from diagnosis looks at a person's immediate support needs, up to approximately one year after diagnosis.

After receiving a diagnosis, we would expect to see the following information and support offered to a person with dementia:

- What their dementia subtype is and the changes to expect as the condition progresses;
- Which health and social care teams will be involved in their care and how to contact them;
- How dementia affects driving and the need to notify the Driver and Vehicle Licensing Agency of their diagnosis;
- Discussion on legal rights and responsibilities including the right to reasonable adjustments under the Equality Act 2010; and
- How to contact local support groups, online forums, national charities, financial and legal advice services, and advocacy services. Signposting and contact information including hours, how to

Person with a dementia diagnosis

"They just told me it's dementia. They didn't tell me any more than this. I had a form to fill in an assessment form from Croydon Council. I had to do some research myself on some cost issues." -

Dementia Friendly Communities and Supporting Well

Examples of practical actions:

- Through quarterly Croydon dementia Action Alliance meetings, provide a networking space for organisations to share information and knowledge with one another, as well as encouraging opportunities for partnership working.
- As part of communications with health and social care staff, increase awareness of the importance to access correct training.
- Connect staff of non health and social care organisations to information about dementia and dementia Friends sessions.

What Croydon residents told us in 2022:

The experiences of people with a dementia diagnosis and carers in Croydon is inconsistent, with some people feeling satisfied with the level of information and support offered after diagnosis, but many are left feeling overwhelmed, abandoned, or unsure on what to do next and what help is available.

Person with a dementia diagnosis

"We had to find everything out by ourselves about help. I get financial entitlements, but I didn't get told about this or available support services. For financial help we had to go to a tribunal."

Strategic Plan: Supporting Well

Key Challenge / Opportunities	Year 1	Year 2	Year 3+	What success will look like
Dementia Training and awareness for health and social care professionals	Promote 'becoming a Dementia Friend' to local organisations	Explore providing online dementia awareness training for staff	Explore providing NHS- backed dementia training for Health and Social Care professional directly supporting people with dementia	A more informed workforce around dementia awareness and how to incorporate this into their work environment
Information at the point of diagnosis regarding available help and support options	Review current information (online and paper form) and update as required	Investigate creating a single source/one stop shop to provide information, links to advice and support services and areas such as financial support		Patients report feeling supported at point of diagnosis and know where to access information and support
Coordination of support upon diagnosis to help navigate the health and social care system	Explore Colocation of memory services with related dementia services	Explore the option that every person with a dementia diagnosis has an automatic referral to the dementia adviser service	Explore everyone with a dementia diagnosis having a named care coordinator from diagnosis to death	Patients and carers report feeling better supported as to the options available within the health and social care system during the course of their dementia pathway
Dementia Advice services providing in person sessions after diagnosis	Map unmet need for dementia adviser service to understand level of capacity required	Explore increasing capacity of the dementia adviser service to have at least one at each of the Integrated Community Networks (based on demand mapping)	Investigate options for a stepped up model of post diagnostic support to include different levels of support as needs change	Patients and carers report that they have been supported by the dementia adviser service, as required, after their diagnosis. The capacity of the services are able to meet the demands of the rate of dementia diagnosis
Availability of post diagnostic support services	Map service capacity across dementia advisers and Age UK PICS to identify pathway challenges Explore providing post-diagnostic information and education support in languages other than English, as well as in non-written resources, to reduce health disparities.	Investigate options for evidence based post-diagnostic support interventions which are appropriate to age, ethnicity, religion, gender and sexual orientation. Looks at different options for the provision of transportation to services for people affected by dementia	Explore offering equitable access to non-pharmacological interventions, such as cognitive stimulation therapy	
Duplication in providing personal information to different health professionals	Promote the Universal Care Plan (UCP), shared care record to help join up the care pathway	Promote the use of the dementia template within the UCP (being developed in 2023)		The UCP is the shared care record of choice for clinicians across the pathway

Living Well

What's included in the theme of Living Well?

Living as well as possible with dementia is an aspiration for many people.

This section of the pathway looks at people with dementia living in safe and accepting communities.

It covers consistency of follow-up, care coordination and care plan reviews. It also looks at support for carers, assessment of need as someone's dementia progresses and the impact increasing care needs have on health and care services.

Carers in this section refer to anyone, including children and adults who looks after a family member, partner or friend who needs help because of their dementia. This includes those family members who may not formally call themselves a carer.

Dementia Friendly Communities and Living Well

Examples of practical actions:

- Supporting organisations in the borough to pledge Dementia Friendly actions to enable their activities and premises to be more inclusive and accessible to people affected by dementia.
- Encouraging organisations to include activities that help people to stay mentally and physically active as part of their dementia Friendly action plan (where this is part of their remit).
- Promoting messages around "Living Well" in all communications and events within the community, such as through dementia Friends sessions, written communications, and events.
- Develop the reach of the Croydon dementia Action Alliance to include organisations such as community groups, faith groups, arts and culture, leisure, retail and other businesses to help improve the day to day experiences of living with dementia as they go about their daily lives.
- Build strong links with organisations that support people from minority ethnic groups to encourage them to be part of Croydon dementia Action Alliance, connect them to information about dementia (in different languages where possible), provide dementia awareness and support them to explore dementia Friendly actions.

What Croydon residents told us in 2022:

During engagement with local people as part of the development of this strategy, people with a dementia diagnosis and carers of a person with a dementia diagnosis, have highlighted some of the following challenges in living well after diagnosis:

- Lack of awareness of what help is out there for people with and a diagnosis and for carers.
- No central place of information on help and support
- People are left to pay for their own modest modifications to make a house dementia friendly, such as grab rails etc.
- Difficult to book respite care and often this can only be done at very short notice so no long-term planning.
- Not enough community support to keep people in their own homes.
- Inconsistent follow-up from health professionals, including patchy provision of annual care reviews.
- Referral to the day centre support service is too slow and the service is too costly.
- Lack of diverse community support groups and a lack of carer specific support groups.

Carer of person living with dementia

"I've been offered groups, but I've not found that helpful. I've asked for respite care, but none has been forthcoming."

Strategic Plan: Living Well

Key Challenge / Opportunities	Year 1	Year 2	Year 3+	What success will look like
Dementia Friendly Borough status for Croydon	Ensure that we obtain the Dementia Friendly Borough Status Ensure key health and care services (e.g. GP, dentistry, social care, Live Well etc) achieve dementia Friendly status Explore how the work of the CDAA in raising dementia awareness could be highlighted		Review the pledges and status for the Dementia Friendly Borough status	Croydon continues to be recognised as a Dementia Friendly Borough The CDAA continues to meet and drive forward the dementia agenda
Follow up support to monitor if dementia symptoms and support needs have changed		Explore options for cognitive stimulation therapy or similarly structured group work for people with dementia to provide both support and social interaction	Explore providing an annual dementia review for all people diagnosed with dementia	Patients and carers report that they are supported through their dementia journey and are aware where to access support as their symptoms change
Recognising the progression of an individual's dementia journey and the different needs of carers throughout	Explore options for structured support for those in at high need at the time of diagnosis. Explore ways that services can effectivity respond to crisis points in the individual's journey and provide the support needed	When commissioning interventions, where possible, try and ensure that they support the individual's journey, identifying requirements at possible crisis points	Explore conducting a pilot using a risk stratification tool at the time of diagnosis. Additional interventions are then offered according to need.	Carers report that they feel supported and aware of the services available to them Services recognise the importance of support to carers during the dementia pathway and can assess where there might be possible crisis points
Support for Carers of people living with dementia	Explore how we are providing information to carers both printed and digital Raise awareness with health and social care staff that people may not identify as a carer but could still need carer support	Explore how we might provide structured evidence based support for carers to manage their own health needs including their mental health		Carers report that they can access culturally appropriate support as required
Diverse support services for carers and people with a dementia diagnosis from a minority ethnic background	Where possible, ensure communications produced are personalised and jargon free, tailored, and accessible to diverse communities	Explore how Social Care services could consider future population trends to ensure that language, communication, and cultural needs are met		Dementia Day Centres are operating to an efficient model with appropriate referral pathways in place
Dementia Day Centres operating efficiently to meet the needs of the Croydon population	Investigate the referral pathways to see if there are options for greater efficiency		Investigate expanding the day centre service to include some possible weekend services	The UCP is the shared care record of choice for clinicians across the pathway
Hospital admission for a mental health related crisis point	Map where there might be points for people to recognise signs of deterioration (timely support to access early help could possibly avoid admission)	Ensure use of the UCP within the Trust to update details on information and treatment during a hospital stay Where appropriate, individuals who are admitted are referred to the Trust Dementia Lead to assist them through the journey until they are discharged		
Hospital admission for a physical health issue	Explore if the Admission Pathway could formally consider impact of dementia during a physical health hospital admission			Carers report that they feel supported and aware of the respite services available to them
Availability of appropriate respite services for both emergency and long-term services	Check process for carers to understand options for respite care services including timescales from referral		Investigate options for a simplified way to book overnight and day respite care from recommended local care services	
Support for independent living within own home is considering as well as options for entering formal care settings	Where appropriate, check if Housing Plans consider the needs of people living with dementia in Croydon	Explore the options for dementia grants to provide timely house adaptions including living aids and assistive technology to enable people to remain in their own home		Where patients wish to remain within their own home, they are supported to be able to live independently
Staying physically and mentally active following a dementia diagnosis	Promote health messages to support the physical, mental, and oral health of people living with dementia and their carers Provide information for people living with dementia to choose from a range of activities tailored to their preferences to promote wellbeing	Explore how we commission support services for people living with dementia to choose from a range of activities tailored to their preferences to promote wellbeing		Patients and carers report that they are aware of the activities available locally to help them stay physically and mentally active The capacity of the services are able to meet the demands of the rate of dementia diagnosis

Ending Life Well

What's included in the theme of Ending Life Well?

Everyone diagnosed with dementia will have the condition at the end of their life. People living with dementia should die with dignity in the place of their choosing.

This part of the dementia pathway looks at the care people receive at the end of life, including access to palliative care and advance decisions. It also looks at where people with dementia are dying, which is a frequently used quality marker.

Dementia Friendly Communities and Ending Life Well

Examples of practical actions:

- Planning for the end of life is important for anyone who has a life-limiting condition. For a person with dementia, it's important to try and have these conversations early, while it's still possible to make shared decisions.
- Having an up-to-date care plan for the person. This plan should include end of life plans and should be shared with those involved in the person's care.
- The person's spiritual needs, practices and traditions will be individual to them. These needs should be addressed and respected as much as the medical aspects of care. Personal or religious objects, symbols or rituals (including prayer or readings) may provide comfort, both for the person and those close to them. These could also include music, pictures, smells or tastes.
- Palliative care may be offered, especially in the later stages of dementia.

What Croydon residents told us in 2022:

What have people affected by dementia told us?

Some of the challenges highlighted by people living with dementia about end-of-life care are as follows:

- Lack of awareness about the need for advance care planning;
- People were not sure who to talk to about end-of-life care;
- Concerns over appropriateness of end-of-life care services for people who may not speak English or have reverted to their primary language through the course of their dementia; and
- Worries over whether care homes and home care services are appropriate for someone with dementia and if they are dementia friendly.

Carer of person living with dementia

"I heard about a carers support group but didn't access it. I didn't know there was anything else."

Our Strategic Plan: Ending Life Well

Key Challenge / Opportunities	Year 1	Year 2	Year 3+	What success will look like
Provide dementia appropriate palliative care services		Where accreditation is available, consider if commissioned services could meet the National Gold Standards Framework for end-of-life care		Palliative Care Services are provided which are sensitive to the needs of people with dementia
Effective advance care planning to realise the benefits of early planning	Explore how conversations around end-of-life decisions are made during post diagnosis support when the individual can express their wishes and have the capacity to make decisions	Promote the use of the UCP to record advance care plan and including end-of-life planning		Individuals with dementia and carers better informed during post diagnosis support to be able to plan effectively for end-of-life
Support for family and carers around end of life planning	Investigate how we could prepare carers and families for what end-of-life may look like and how to access support			Families and carers report they are better informed about what end-of-life may look like
Recognition of dementia as a terminal condition		Undertake a review of the management of mental capacity and access to palliative care in care homes, including training needs	Explore options for training for other chronic and terminal illness services around dementia awareness	Services are provided which are sensitive to the needs of people with dementia

What to expect in the first 18 months

Aug 2023

Draft development plan for the implementation of the Croydon Dementia Strategy

Oct 2023

Publish Croydon Dementia Strategy

Aug 2024

Review progress of development plan and update documentation if required

Dec 2024

Repeat Health Watch survey to test progress of strategy against desired measures of success

Appendixes

Appendix A: Current dementia support and services in Croydon

Memory Tree Cafes: Currently running in 2 locations across Croydon and are focused on providing a safe space for stimulating activities in a friendly and understanding environment.

A separate Age UK Croydon healthier lifestyles service focuses on physical health promotion and exercise to older people in care homes, and some community work in Croydon which is beneficial in living well with dementia and preventing or delaying certain aspects of the disease.

dementia Advisor Service: The dementia Advisor (DA) provides a one-to-one service for people affected by dementia from the point of diagnosis. They provide information, support and signposting for people in all matters related to their dementia and their journey with the dementia.

A dementia Advisor will usually visit the clients in their own home although occasionally a family member/carer may request a meeting away from the home, so that they may talk more freely about their situation.

Alzheimer's Society Singing for the Brain group: The Alzheimer's Society provides one 2 hour 'Singing for the Brain' session per week in Croydon for people affected by dementia.

Day Services for People Affected by dementia: Day services for individuals with dementia to reduce social isolation, increase engagement and enhance wellbeing. In addition to support carers via day respite. Support, and sign posting and advocacy for those with dementia and their carers. dementia Friends training for carers. This council-funded service operates out of two sites within the borough of Croydon and is means tested, requiring referrals to go through a financial assessment to become eligible to attend.

Croydon Care Home Intervention Team (CCHIT): The intervention team is a multi-professional team who work with people aged 65 and above living in residential or nursing care homes in Croydon and are displaying behaviours that staff find difficult to manage.

The team also works with people under the age of 65 with a confirmed diagnosis of dementia living in residential or nursing care homes in Croydon, and specialises in understanding the behavioural and psychological symptoms of dementia, providing intervention and support to residents, their families and care home staff to better understand the person's behaviour and any unmet needs.

Age UK Croydon (AUKC) Personal Independence Coordinator (PIC) Service: This service works with older people (aged over 50) to help them identify their own personal goals so they can retain and regain their independence. The team often works with people who have a complex range of support needs or who are frail or vulnerable, and also works with people who have long-term or multiple health and social issues. The aim is to help people become better informed about how to manage their own health and to help them live independently for longer, as well as to help minimise any unplanned hospital visits.

Carers Information Service: The Carers Information Service provides information, advice and support to carers in Croydon who are looking after someone who needs their help due to illness, disability or older age.

Appendix B: Croydon dementia Action Alliance Group Members

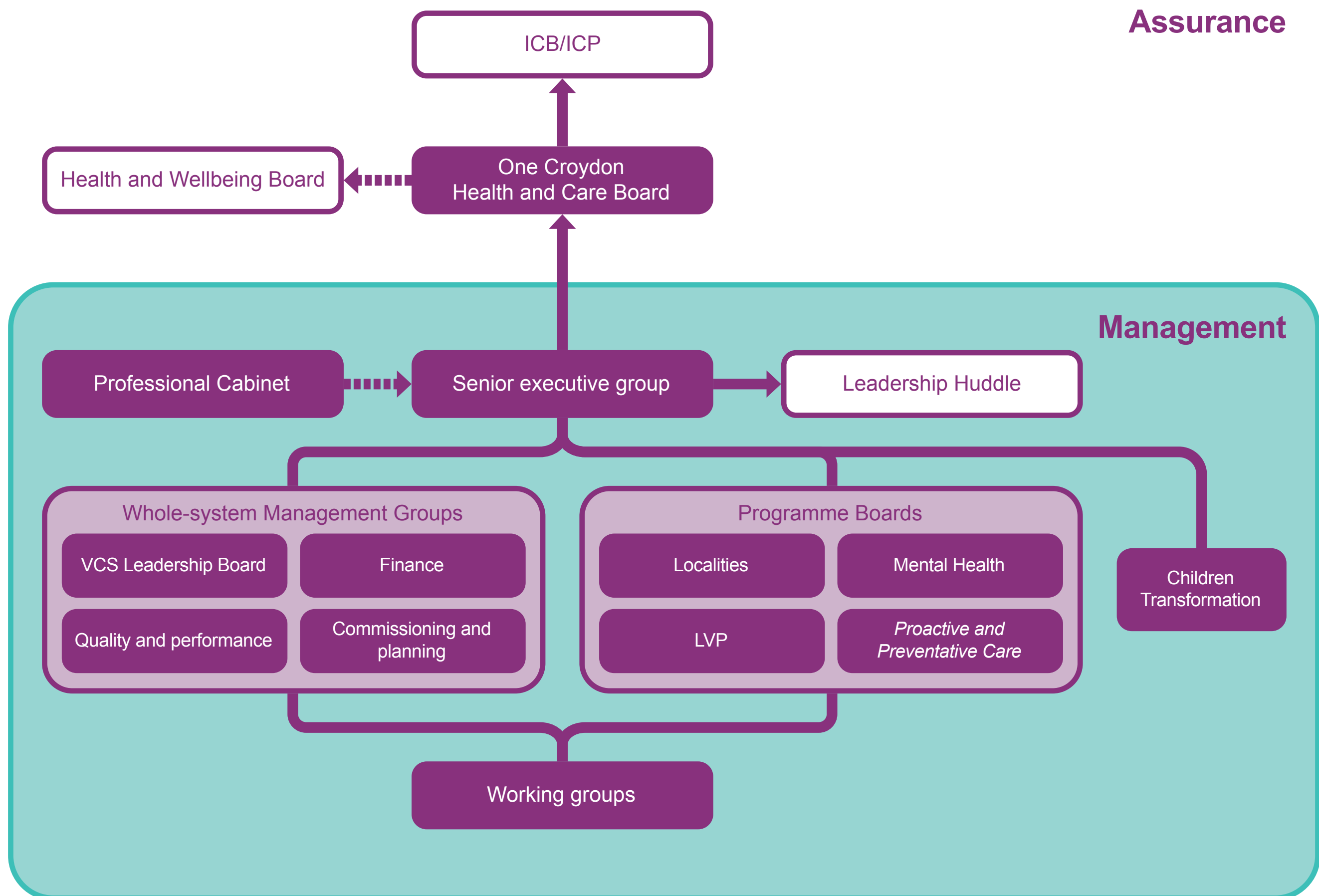
- A Place to Be drop in
- Age UK Croydon
- Alzheimer’s Society
- Asian Resource Centre
- BME Forum
- Carer representatives
- Carers Information Service
- Croydon BID
- Croydon Communities Consortium
- Croydon Council
- Croydon Neighbourhood Care Association
- Croydon University Hospital
- Croydon Voluntary Action
- David Lean Cinema
- Fairhand Visiting Physiotherapists
- Healthwatch Croydon
- Home Instead Croydon
- Integrated Care Board (Croydon Place)
- London Mozart Players
- Methodist Homes Association
- Museum of Croydon
- Pension Protection Fund
- Printwell
- Purley Bid
- Right at Home
- SLaM
- The Met Police
- Thornton Heath Leisure Centre
- United St Saviours
- Woodside Baptist Church

Appendix C: Croydon dementia Steering Group Membership (August 2023)

Core Members

Representative	Job title, Organisation
Cllr Yvette Hopley	Cabinet Member Adult Social Care and Health
Cllr Margaret Bird	Deputy Cabinet Member Adult Social Care and Health
Cllr Janet Campbell	Shadow Cabinet Member Adult Social Care and Health
Richard Eyre	Head of Improvement, Adult Social Care & Health Directorate, Croydon Council
Claire Fletcher	Strategic Commissioning Manager (Older People and Carers), Croydon Council
Sasha Lindsay	Older Adults Commissioning Manager, Croydon Council
Denise Malcolm	Senior Communications Officer, Croydon Council
Sean Oliver	Head of Service for Older Adults Social Care, Croydon Council
Ami Patel	Senior Commissioning and Contract Officer (Older People and Carers), Croydon Council
Dr Jack Bedeman	Consultant in Public Health, Croydon Council
Tracy Dumbarton	Mental Health Transformation Programme Manager (Croydon), SWL ICB
Wayland Lousley (Chair)	Head of Mental Health Commissioning (Croydon), SWL ICB
Dr Emily Symington	Croydon GP, Clinical Lead for dementia for SWL ICB
Olu Odukale	Transformation Programme Manager for community care in Croydon (responsible for care homes), SWL ICB
Rosalyn Tuerk	Older Adult Community Services Lead, SLAM
Sharling Bovell	Lead Nurse for dementia Care, Croydon University Hospital
Andrew Brown	CEO, Croydon BME Forum
Shelly Bardouille	BME Mental Health Community Development Worker (Older Adults), Croydon BME Forum
Ima Miah	CEO, Asian Resource Centre, Croydon
Sue McVicker	CEO, Croydon Neighbourhood Care Association
Abeline Greene	PIC Service Manager Age UK Croydon
Rebecca Stebbings	Healthier Lifestyle Service Manager, Age UK Croydon (includes Memory Tree Café)
Susan Underhill	Programmes Director, Age UK Croydon
Luke Symonds	Regional Public Affairs and Campaign Officer, Alzheimer's Society
Melanie Cressey	Dementia Friendly Communities Coordinator – Southwark and Croydon, Alzheimer's Society
James Whynacht	NE Yorkshire Regional Public Affairs and Campaign Officer, Alzheimer's Society
Pat Knight	Person with Lived Experience, Croydon
Daisy Anderson	Person with Lived Experience, Croydon

Appendix D: Croydon Governance Structure



***Senior Executive Group**

The Council's Corporate Director Adult Social Services (DASS) is a member of the Senior executive Group (SEG). Relevant papers go to the DASS's Adult Social Care and Health Directorate Management Team (DMT) meeting prior to SEG to enable Council governance mechanisms, in particular briefings to the Council Corporate Management Team (CMT), briefing the Directorate Cabinet Member and the Executive Mayor.

Appendix E: Recommendations taken from Health Watch survey report

Communications and information

- Better information needed on legal and financial entitlements and improved communication on support services and after diagnosis.
- Greater awareness or access to GP follow up appointments, advanced care planning and dementia and care need assessments.

Diagnosis, care planning and reassessments

- Improve the time it takes to see a specialist Issues around diagnosis. Increased carers support • Discuss more about support and care needs with carers.
- Improve the awareness and communication of carers support and information services.
- Find ways to increase confidence of patient and carers to manage the condition.

Understanding needs and preferences

- Coproduce services to understand needs and preferences and align services accordingly.
- Understand concerns about care homes and sheltered accommodation, particularly around their understanding about dementia, quality of service, staff training, a person-centred approach with residents, access and support with finances.

Hospitals

- Design a dedicated pathway if going into hospital ensuring they have the specialist support they need with these issues considered.

Ensure carers can be easily identified as advocates

- Make sure patients are discharged with the right support is also an important priority.

Suggested improvements from residents

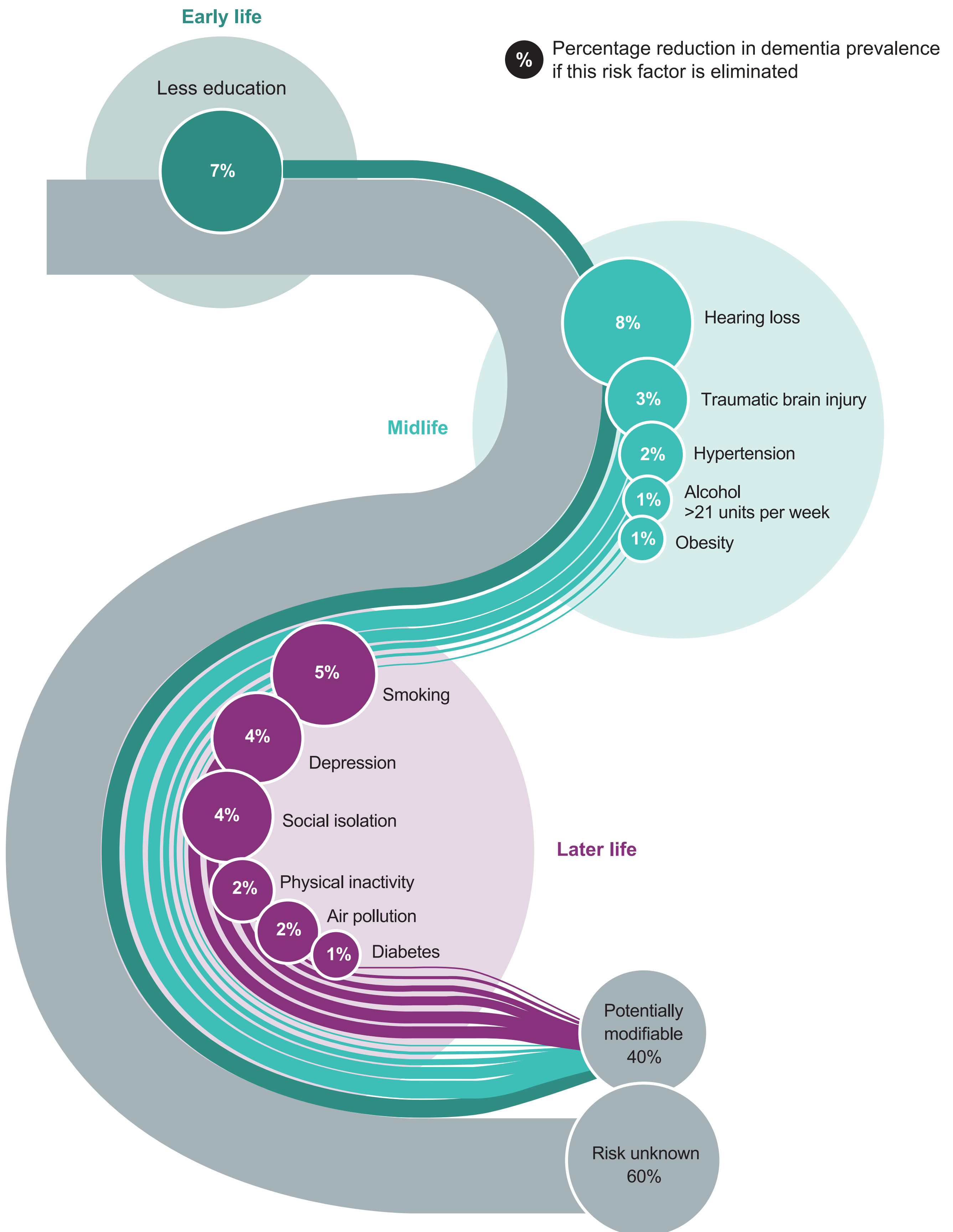
- More support, quality of care, information and wayfinding.

What makes Croydon dementia friendly

- Ensure effective support and increase awareness.

Link to full report: https://www.healthwatchcroydon.co.uk/wp-content/uploads/2023/06/Dementia-Services-Pathway-Experience-in-Croydon-Final-report-June-2023.pdf

Appendix F: Figure from the 2020 Lancet report showing potentially modifiable risk factors for dementia that could affect people over the course of their lifetime



One Croydon

Your Health and Care partnership

LONDON BOROUGH OF CROYDON

REPORT:		**HEALTH AND WELLBEING BOARD**
DATE OF DECISION		**18th October 2023**
REPORT TITLE:		**Croydon Mental Health Summit Update**
CORPORATE DIRECTOR / DIRECTOR:		**Rachel Flowers, Director of Public Health**
LEAD OFFICER:		**Jack Bedeman, Consultant in Public Health** **Email: jack.bedeman@croydon.gov.uk Telephone: 22616**
KEY DECISION? [Insert Ref. Number if a Key Decision] ***Guidance****: A Key Decision reference number will be allocated upon submission of a forward plan entry to Democratic Services.*	**No**	N/A
CONTAINS EXEMPT INFORMATION? ***(* See guidance)***	**NO**	Public
WARDS AFFECTED:		**All**

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1 SUMMARY OF REPORT

1.1 The Croydon Mental Health Summit was held at Braithwaite Hall on the 18th November 2022, 9.45am-1pm.

1.2 The event was held to deliver a Mayoral campaign commitment to hold a summit with Croydon Citizens and delivers against the Mayor's Business plan 2022-2026 Outcome 5, People can lead healthier and independent lives for longer, Priority 2, work closely with health services and the Voluntary Community and Faith Sector (VCFS) to improve resident health and reduce health inequalities.

2 RECOMMENDATIONS

The Health and Wellbeing Board is recommended:

2.1 to note the report.

3 REASONS FOR RECOMMENDATIONS

3.1 To share the work ongoing within the Mental Health space following the Mental Health Summit

4 BACKGROUND AND DETAILS

4.1 The Mayor made a campaign promise to hold a Summit around mental health and primary care with Croydon Citizens

4.2 Nearly one year has passed following the Summit and this report is an update to the Board on the activity within the mental health space that relates to the feedback heard at the summit contained in the report and slides discussed at the January 2023 Health and Wellbeing Board meeting

4.3 The Summit provided an opportunity to explore experiences around barriers to accessing support within the community as well as feeding into the development of local health strategies

4.4 The Summit provided feedback for the development of the South West London Mental Health Strategy and an update on this overarching strategy for South West London is coming to this Board.

4.5 The Summit also provided feedback that was used to inform the development of the refresh of the Croydon Self-harm and Suicide Prevention Strategy, which will come to the Board in January 2024.

4.6 The Summit was developed with the Croydon citizens and gave an opportunity to discuss and reflect on the opportunities around the Be Well Hubs being developed as part of the South London Listens work.

4.7 The feedback from the Summit has been utilised in the early development work for the refresh of the Croydon Joint Local Health and Wellbeing Strategy and will inform the development of priorities within this in the coming months.

4.8 A major theme within the conversations within the summit was the challenges around cultural competency and cultural appropriateness of current mental health and wellbeing services. This was recognised as a significant challenge that requires more

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and different approaches. The Croydon Ethnicity Mental Health Improvement Programme (EMHIP) work is significant in starting to address some of these challenges, and the Mental Health Programme Board has also started the process of becoming and actively anti-racist Board and now has a working group exploring what this means for the work of the Board, and for future commissioning.

4.9 The presentation in Appendix A covers the feedback from the Summit aligned to the action that is being taken. It also contains slides outlining the Mental Health Transformation work, which gives context to most of this work, and an outline of the Croydon Ethnicity Mental Health Improvement Programme that was given as part of the Mental Health Summit.

5 ALTERNATIVE OPTIONS CONSIDERED

5.1 *N/A*

6 CONSULTATION

6.1 Members of the public were consulted as part of the Mental Health Summit

6.2 The South West London Mental Health Strategy, Croydon Dementia Strategy and the development of the Croydon Joint Local Health and Wellbeing Strategy all have their own consultation and updates are coming to the Health and Wellbeing Board separately.

7. CONTRIBUTION TO COUNCIL PRIORITIES

7.1 The summit was the delivery of a Mayoral commitment and delivers against the Mayor's Business plan 2022-2026 Outcome 5, People can lead healthier and independent lives for longer, Priority 2, work closely with health services and the VCFS to improve resident health and reduce health inequalities.

8. IMPLICATIONS

8.1 FINANCIAL IMPLICATIONS

8.1.1 There are no direct financial implications as a result of this report. Any future financial impact will be fully considered as part of subsequent reports as they arise.

8.1.2 Comments approved by Lesley Shields, Head of Finance for Assistant Chief Executive and Resources on behalf of the Director of Finance. 09/10/2023

8.2 LEGAL IMPLICATIONS

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Under Section 195 of the Health and Social Care Act 2012, a Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area, to work in an integrated manner. In addition, the Board may encourage health-related services to work closely with the Board, and may encourage health and social care services, and health-related services to work closely together. The Croydon Mental Health Summit, and the development of the strategies referred to in this report, demonstrate how the Board is discharging these functions.

Comments approved by the Head of Litigation & Corporate Law on behalf of the Director of Legal Services and Monitoring Officer. (Date 06/10/2023)

8.3 EQUALITIES IMPLICATIONS

8.3.1 The Council has a statutory duty, when exercising its functions, to comply with the provisions set out in the Sec 149 Equality Act 2010. The Council must, in the performance of its functions, therefore have due regard to:

eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

8.3.2 The Mental Health summit crosses all equality characteristics in that mental heath concerns may impact all members of the community. As such the development of a strategy will also benefit all characteristics in the Croydon community.

8.3.3 The invitation to the Mental Health Summit was shared widely through community groups including an emphasis on minoritized groups and experts by experience. The summit also had a focus on improving mental health outcomes for racialised groups.

8.3.4 Development of the Health and Wellbeing Strategy will include an equalities impact assessment which will identify equality implications for all characteristics.

Comments approved by Naseer Ahmand, on behalf of the Equalities Manager. 06/10/2023

OTHER IMPLICATIONS

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9. APPENDICES

9.1 *A* Croydon Mental Health Summit – Activity

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Croydon Mental Health Summit – Activity

Summit Feedback	What action is happening
Support in the community following diagnosis	Peer Support Workers
More support needed for the family affected by mental health issues	Increased focus on carers/families
Signposting people correctly- need more support.	Mental Health Wellbeing Hub
Breaking cultural barriers within mental health	Ethnic Minority Focused Services (Ethnicity Mental Health Improvement Programme, EMHIP) work Mental Health Local Voluntary Partnership – Grant funded initiatives
Culturally appropriate and informed mental health services	Ethnic Minority Focused Services (EMHIP) work Mental Health Programme Board – Task and Finish Group established on ensuring commissioning and services are anti-racist
Supporting individual carers	Increased focus on carers/families
People not being able to come together for support	Mental Health Wellbeing Hub Community Mental Health First Aid Training
GP's aren't getting the information they need	MH advice Line for GPs – 20/21 Local commissioned scheme for SMI Health Checks and Longer Appointments Mental Health Personal Independence Co-ordinator workers in GP Huddles and Integrated Care Network Multi-disciplinary Teams
More training for frontline (clinical and non-clinical) staff	Health Education England training for care coordinators
Financial strain on the individual seeking care	Policies are being explored
Empower local communities/organisations to help	Stabilising voluntary sector – longer contracts
Information around services needs to be more accessible and advertised	Mental Health Wellbeing Hub
Lack of suitable emergency housing once discharged from wards	Intermediate supported accommodation for step down (Shared Lives – implementation started in 20/21, enhance crisis pathway in 21/22)
Lack of alternatives for the police when dealing with a person in crisis	Establishment of Recovery Space (crisis café
Ordinary people are unable to access information about services available	Mental Health Wellbeing Hub
Links with GP and mental health service and eHealth/ social prescribing	Mental Health Personal Independence Co-ordinator workers in GP Huddles and Integrated Care Network Multi-disciplinary Teams

Co-production

Recurring themes: services feel fragmented, hard to access, poorly-tailored to different Ethnic Minority communities, too focused on crisis and reactive treatment not well-being and prevention. There is a need to rebalance this and ensure there are new roles to support people, mental health 'champions' to be embedded in community groups, third sector and peer support, enabling self-care and opportunities to improve well-being through work, social activities and exercise.

A summary of the engagement that took place to support the development of the original business case for Mental Health Wellbeing Hubs:

Engagement and Co-production events:

- Transformation Workshop (MHPB) – June 2018
- All MHPBs transformation is a standing item – monthly 2018
- Grassroot events – July 18 & November 18
- Community Hub Delivery Group 17 September 18
- Enhanced Primary Care Delivery Group 14 September 18
- Community Hub Delivery Group 1 October
- Croydon MH Forum (Hear Us) - February 2019
- Healthwatch Croydon. Meet the Changemakers Mental Health - July 2018
- With Public Health - Thrive London Borough wide event - July 2018
- Other Grass roots events
- with South-west London Association for Pastoral Care in Mental Health - Sept 2018
- With AGE UK & ASKI BME Elders - MH prevention - March 2017 & May 2018
- Croydon College - LGBT group - June 2018
- Engagement will continue with design and development based on principles of co-production

Local reviews echoed the issues raised through co-production events, emphasising:

- Long waiting times and delays in hospital admission.
- Voluntaries disenfranchised from decision making & strategic thinking with Commissioners working in silos

All the Woodley review and Co-produced recommendations have informed and underpin the Croydon Mental Health Transformation Programme. Co-production has continued throughout service design, building community capacity & ensuring a focus on BAME communities at every organisational level of the decision making process

Additional Service User, CCG, LA, Voluntary Sector engagement:

- Hear Us Presentation 7th May 2019
- Governance discussions with LA and One Croydon Apr-May 2019
- Public Health discussions with LA Mar-May 2019
- Discussions with MIND to repurpose contract Apr-May 2019
- BAME Workshop June 2019
- LMC Engagement June 2019
- Discussions with Autism Carers Group Apr 2019
- On-going discussions with CCG Clinical Lead

Vision

Well co-ordinated mental health care and support in the most appropriate setting, which is truly person-centred and helps people to maintain their independence

The Challenge: The existing Model of Care is disproportionately provided in Acute settings particularly for people from Ethnic Minority backgrounds. There not being enough alternative provision in Primary Care and Community settings, provided by GPs, health and voluntary sector professionals, and peer support workers. Evidence demonstrates that patients spend too long in hospital, past the point of clinical effectiveness, and health professionals are spending a significant proportion of their working day providing support on non-health related social matters. Mental health patients report feeling support is over-medicalised, and they are not receiving the support they need to prevent poor mental health, self-manage their illness, and avert mental health crises. The current system of support for mental illness is both expensive and inefficient. The challenge is to provide alternative appropriate support – social as well as health related – in accessible settings at convenient times to avert crises, prevent admissions which includes appropriate alternative provision in community settings that promote well-being and recovery. The Model of Care therefore must be transformed to meet the need of the individual in the right place at the right time.

Objectives

The following are objectives of this business case:

- enable people to take responsibility for managing their own health and wellbeing in the most appropriate setting for them;
- deliver a Model of Care that ensures people are at the centre of their care, enabling them to achieve the outcomes that are important to them and promotes a shift in focus from dependency and ill health to independence and wellbeing;
- incentivise effective partnerships, providing care and support in and through the community;
- engage, empower and grow community networks and assets so they are responsive, timely and flexible to individual needs;
- reduce health inequalities and improve health and well-being outcomes across the borough;
- deliver transformation across the system in order to achieve optimum value for money and economies of scale and efficiency by leveraging resources and capabilities across the system.

Principles

- Acknowledging that the existing Model of Care is not optimum and is not supporting people to stay healthy in the community;
- And is not empowering people to look after themselves,
- Acting in accordance with the needs of people in Croydon, recognising the cultural diversity, the existing health inequalities, stigma and engrained attitudes;
- being collaborative, co-operative and timely in our approach to system transformation and decision making;
- invest, transfer funding appropriately to different settings of care to change the Model of Care;
- continuing to operate to principles of co-design and co-production through engagement with the people of Croydon and other key stakeholders, seeking their views and facilitating their involvement;
- committing to a culture that promotes innovation and transformation across the system, and organisational boundaries; making best use of available resources.
- The Model of Care and the Delivery Landscape will be based on that of the ICN+ and there will be close joint working.

Major Themes

Major themes and threads that run through the transformation work include but are not limited to:

- Tackling Inequalities
- Improving the transition from CAMHs to Adult MH Services
- Making the most of Digital Innovation
- Prevention and Public Health Mental Health: Education & Training
- Intervening 'up-stream' and averting crises
- Providing appropriate community-based alternatives to inpatient treatment / Depots in the community
- Social prescribing and emphasis on social support to prevent clinical crises
- Modelling the impact of increasing acuity and specialised support in secondary care settings
- Working in 'alliance', with outcome based commissioning and capitated budgets

Strategic Context – Phased Delivery of Vision

Our 'Blueprint' for delivering the 'vision': 'what good looks like'…

Phase 1: Meeting the Ambitions of the Five Year Forward View (FYFV)

2019/20 – 2020/21 (Covid delayed starts)

Funding source: NHSE Crisis Transformation Fund

Strategic Aim: Meeting the ambitions set-out in the 5yr Forward View (FYFV)

- Establishment of a Recovery Space (crisis café)
- Local Commissioned Scheme for SMI Health Checks and Longer Appointments
- MH Advice Line for GPs
- MH PIC workers in GP Huddles & ICN+ MDT's
- Peer Support Workers
- CMHT Restructuring
- Stabilising Voluntary sector – longer contracts
- MH Local Voluntary Partnership – Grant funded initiatives
- strong focus on improving care for people with learning disabilities and autism
- Strong focus on carers / families
- IPS Wave 2
- Health Education England training for care coordinators

Phase 2: Meeting the Ambitions of the NHS Long Term Plan

2021/22 – 2022/23

Funding source: Mental Health Investment Standard and Spending Review Allocation

Strategic Aim: Meeting ambitions in NHS Long Term Plan

- Establish a Pilot MH Wellbeing Hub (Croydon Health & Wellbeing Space) – Open Access in Central area 2021/22, 2nd Hub North area 2023
- Intermediate supported accommodation for step down (Shared Lives – implementation started in 2020/21, Enhanced Crisis pathway in 2021/22)
- MHW Hubs to work closely with each of the 6 ICN+ Localities & Talking Points (MHPICs)
- Autism adapted support – Autism Strategy
- Managing transition from CAMHs to Adult MH
- Further support in workplace (awareness / resilience)
- Ethnic Minority Focused Services - Ethnicity in Mental Health Improvement Programme (EMHIP)

Phase 3: Shifting Settings of Care (Cultural Change; Workforce; Thresholds)

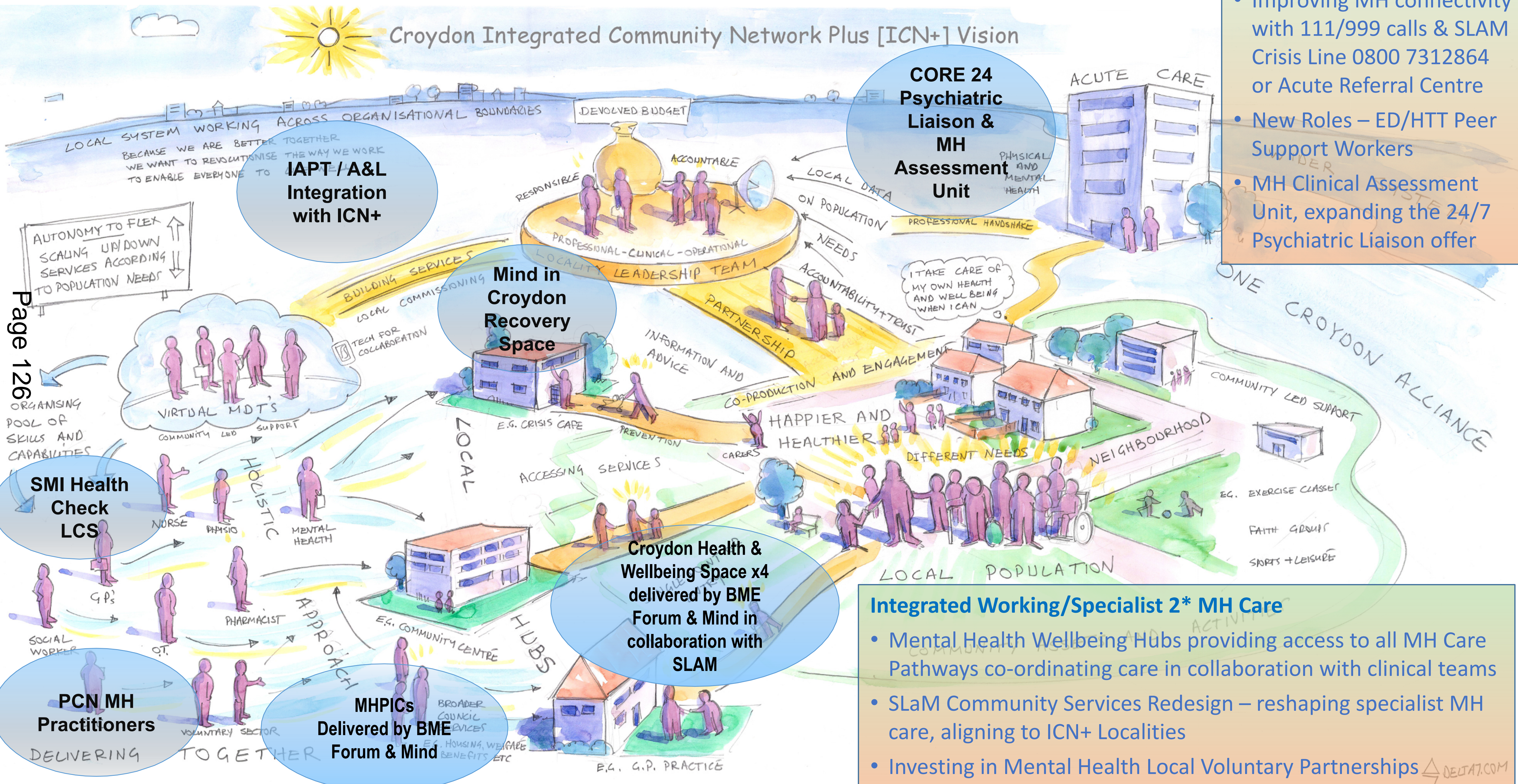
2023/24 – 2024/25

Funding source: Mental Health Investment Standard / Shifting Settings of Care (i.e. transferring resource and activity from secondary care to community and primary care)

Strategic Aim: meeting ambitions in NHS Long Term Plan / funding social care and housing

- 3rd Health & Wellbeing Space in South area 2024 (may require 2 smaller hubs to cover the geography)
- Benefits Realisation from phases 1 & 2 – Begin to see improved access, experience, and outcomes especially for Ethnic Minority Communities
- Delivering a Modern Acute Mental Health Hospital
- Shifting activity and resource from secondary care to primary care and communities
- Enhancing primary care and community support further
- Improved psychological support
- Improved social care support

Where we are….. Mental Health Transformation – Improving Outcomes



Reshaping the Crisis Offer

- Improving MH connectivity with 111/999 calls & SLAM Crisis Line 0800 7312864 or Acute Referral Centre
- New Roles – ED/HTT Peer Support Workers
- MH Clinical Assessment Unit, expanding the 24/7 Psychiatric Liaison offer

Integrated Working/Specialist 2* MH Care

- Mental Health Wellbeing Hubs providing access to all MH Care Pathways co-ordinating care in collaboration with clinical teams
- SLaM Community Services Redesign – reshaping specialist MH care, aligning to ICN+ Localities
- Investing in Mental Health Local Voluntary Partnerships

Case Study- Mind “Recovery Space”

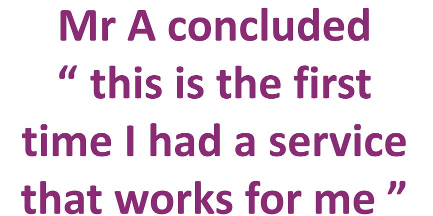
One Croydon
Your Health and Care partnership

Background

- Mr A was referred by the MH Liaison Team at CUH for Emotional Support, Psychological Intervention, Social Inclusion, Information, Activities to Assist Daily Living
- A phone call assessment by Recovery Space staff happened whilst Mr A was waiting for an ambulance to go to the Emergency Department again. The assessment resulted in Mr A cancelling the ambulance and going to the Recovery Space instead

What did we do?

- The HTT were able to provide Mr A with his medication whilst at the Recovery Space
- Checked if Mr A had been referred to Turning Point ensuring he was
- Agree to reduce alcohol consumption
- Refer Mr A to Employment Services, Active Minds, Social Networking Service and a Carers Service



As a result of the Recovery Space involvement Mr A is now…

- engaged with other services.
- able to focus and feels motivated to action his personal recovery plans.
- not drinking alcohol or calling for an ambulance when anxious.
- supported to achieve & engage with services to continue to work on the reasons for referral.
- self reporting on the Recovery Star as learning or being self reliant in 9 out of the 10 areas e.g. managing his mental health, trust and hope, which is a marked difference from when he started, scoring 1 or 2 e.g. feeling stuck or struggling to accept help.

Before & After Case Study – Croydon Health & Wellbeing Space

Amy is 37. She has had a diagnosis of Schizophrenia for 15 years and has been living very stably for the last decade when she presented to her GP distressed, feeling paranoid and like she was losing control of her life. Having lost one of her two part-time jobs, she has fallen into arrears with her Housing Association. She ignored the last two letters, but on Friday received a letter threatening her with eviction should she fail to respond to this final notice. She is also being depressed about the weight she's gained on her medication, and she admits to skipping doses and to smoking cannabis to help her relax, due to the stress.

BEFORE

Amy's GP is very concerned about her mental state and welfare. She feels that a medication review is essential and agrees to refer her back to her old CMHT for this. The waiting time to be seen is roughly 10 weeks, she is told, and they will contact Amy directly at her address. Amy is at imminent risk of losing her tenancy, which doesn't meet the criteria as an urgent referral.

Her GP then advises her about a Citizen's Advice service run by the Council and suggests she goes there to get support with her flat and suggests they may also be able to give her debt advice. They can also be accessed on-line.

She asks Amy if there are other ways to relax that she enjoys, rather than relying solely on cannabis. She used to enjoy yoga but got out of the habit and now feels unsure about how she could afford to attend a class and feels that people would talk about her.

They agree to meet again in a week, but Amy doesn't attend that appointment. Four months later the GP gets a letter to say that she has just been discharged from an in-patient ward and is moving in to supported accommodation for a year.

AFTER

Amy's GP sends a 'task' via EMIS to the CHW Space, a one-stop shop for mental health and well-being, requesting a same-day call back with a Psychiatrist to discuss Amy's medication. A full review is agreed, considering options that have fewer cardio-metabolic side effects to take place at the New Addington GP Huddle.

At the same time the GP updates Amy's "Well-Being Plan" with the latest information following their consultation. Amy identifies from the 'CHW Space' website when the next Housing Advice session is running and arranges to see a Support/Peer Worker later that day. They agree to meet the Housing Association together.

In notes, her GP advises that Amy is feeling socially isolated and would likely benefit from some time with the Support/Peer Worker to access weekly yoga or mindfulness sessions near where she lives. When Amy is meeting the Support/Peer Worker in the CH & Wellbeing Space café area, she recognizes someone she once knew well from Rehab who's also going to yoga. She agrees to pick Amy up so they can walk there together.

The Support Worker updates Amy's "Well-Being Plan" on EMIS, so it is available when Amy's GP sees her in a week's time to review.

Health and Care Plan Priorities 2021 – 2023

One Croydon
Your Health and Care partnership

Improve the Community Mental Health pathway (Underpinned by Prevention & Early Intervention)

- Deliver Mental Health Wellbeing Spaces for Croydon in Central, North, South-East and South-West Localities
- Re-establish the Dementia Action Alliance
- Strengthening Mental Health and Substance Misuse Pathways

Improve the Crisis Mental Health Pathway (Underpinned by Prevention & Early Intervention)

- Establish a Mental Health Assessment Unit at Croydon University Hospital
- Strengthen both the non-clinical / clinical provision and care pathways for those experiencing a mental health crisis

Provide greater Mental Health support in primary care (Underpinned by Prevention & Early Intervention)

- Introduce new clinical & non-clinical roles focused on mental health
- Strengthen the care pathways for mental health

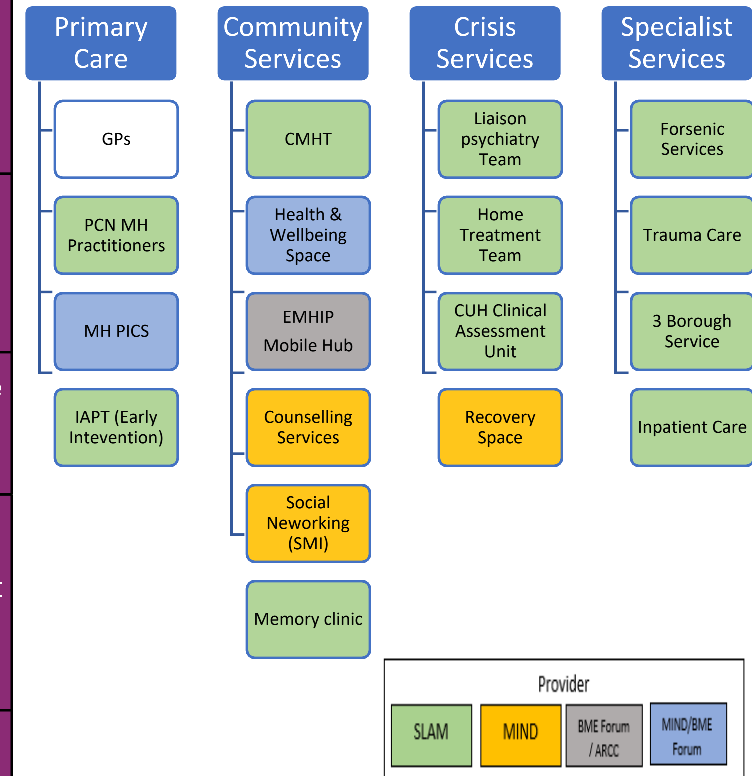
Establish a clear pathway for people with a serious mental illness to facilitate step down to more independent living

Enhance Partnership Working – Moving to an Integrated Care System (ICS)

- Establish a Mental Health & Learning Disability Joint Commissioning Boards to develop our commissioning plans, review current provision and market relations, and to ensure our collective resource is being used appropriately to support individuals with health and social care needs with a focus on prevention and early intervention

Address the Health Inequalities for Mental Health across Croydon (Underpinned by Prevention & Early Intervention)

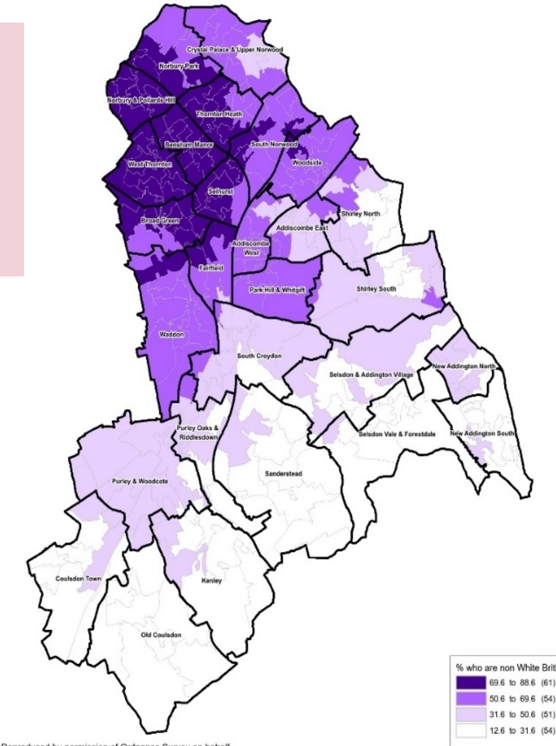
- Implement the Ethnicity Mental Health Improvement Programme



The Mental Health Programme aims to prevent mental health problems and ensure early intervention for those with mental illness by improving access to services and providing care closer to home where appropriate. Despite the negative impact of the pandemic causing delay's in delivery, progress has been made. The pandemic and lockdown restrictions have negatively impacted on people's mental health and as restrictions were lifted we have seen a significant increase in demand and acuity through all of our services.

Improving Outcomes for Ethnic Minority Communities

The Croydon transformation workstreams have initially focused on establishing the new infrastructure and roles e.g. Recovery Space, MHPICs hosted by Voluntary Sector in the Community to shift the emphasis from Acute inpatients to prevention and early intervention in the Community. Including enabling mental health services to further integrate with physical health developments e.g. ICN+ Localities. **Diversity has underpinned each step,** building on the engagement events. Co-production of design, recruitment of staff with Croydon BME Forum in Partnership with Mind to deliver MHPICs and Health & Wellbeing Hubs, and establishing Ethnic Minority champions to change practice, enable culturally sensitive service provision, and inform operational and commissioning decisions.



Ethnic Minority Interventions:

- Establish a Recovery Space (crisis café) with robust statutory referral links. Oct' 2020
- Recovery Space increased referral sources e.g. GP's, CMHT's (Q4 2020/21) and targeting specific under-represented communities (from Q2 2021/22)
- Establishing new community based Health & Wellbeing Space. Contract awarded to Croydon BME Forum in partnership with Mind in Croydon. Started (Q4) 4th Jan 2022.
- New MH Personal Independence Coordinators (MHPICs) roles from April 2021. Specifically recruited to ensure diversity, developing as Ethnic Minority champions and will work closely with the EMHIP Mobile MH Wellbeing Hub to target hard to reach communities.
- MH Local Voluntary Partnership Grant – the successful initiatives provide essential community development roles as spokes to the MH Wellbeing Hubs. Mar' 2021.
- Peer Support workers in Crisis Pathway initiatives e.g. MH Assessment Unit, HTT
- Right Care, Bed Flow and reshaping of SLaM MH Services enables better alignment with the Health & Wellbeing Space and new roles. Enabling the appropriate changes in practice to take place and creating culturally sensitive service environments.
- Ethnicity Mental Health Improvement Programme (EMHIP) – is a clinically-led partnership with a specific objective to reduce ethnic inequalities in access, experience and outcome of mental health care and aligns with SLaM's Patient Carer Race Equality Framework (PCREF) development.

NEXT STEPS:

- Ensure effective reporting of Ethnic Minority outcomes to further inform operational and strategic decision making across the health and care system.
- 'Test and Learn' approach to implementation allows for quick adjustments to service provision
- Robust local governance and commitment to ensuring a focus on Ethnic Minority communities at every organisational level of the decision making process.

Ethnicity Mental Health Improvement Programme

The Ethnicity and Mental Health Improvement Project (EMHIP) is a system-led partnership with a specific objective to reduce ethnic inequalities in access, experience and outcome of mental health care and will link to SLaM's Patient Carer Race Equality Framework (PCREF) development.

A collaborative partnership:

- South West London CCG
- South London & Maudsley NHS Trust
- Local network of BME voluntary, faith and community groups, organised by Croydon BME Forum in collaboration with Wandsworth Community Empowerment Network (WCEN)

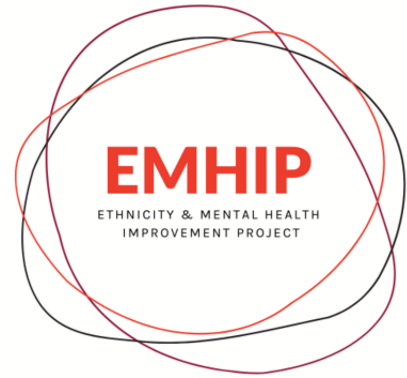
Aims of the project:

- Achieve a more detailed and granular understanding of the extent and nature of ethnic disparities in mental health care in Croydon
- Develop a bespoke whole-system intervention programme to reduce ethnic disparities in access, experience and outcome in mental health care in Croydon
- Implement this intervention within the local mental health systems
- Monitor and evaluate the process and outcomes

Phase 1:

- Establish a BME Expert Oversight Group & Approve Project proposal
- Establish a project team
- Project development:
  - ✓ mobilisation and alignment of local resources / assets including key partner agencies
  - ✓ Mapping and analysis of BME mental health / points of inequality in care pathway – Croydon
  - ✓ Identify and mobilise BME community assets / networks
  - ✓ Ethnicity audit process finalised
  - ✓ Key stakeholder engagement events – iteration / adaptation / "what good looks like"
  - ✓ Co-develop and agree key interventions delivering a business case for implementation of Phase 2

Ethnicity Mental Health Improvement Programme – Next Steps



- **Approval of EMHIP Phase 1 report – Proposed Key Interventions**

Phase 2:

- Report feedback and stakeholder consultation
  - ✓ It is important that stakeholders who contributed to the report can see that their views are considered, and they have an opportunity to comment on the proposals (interventions) and for further iteration.
- Develop Full Business Cases and costings - Five Key Interventions
- Develop a High-level Implementation Plan (incl. Scoping existing provision)
  - ✓ Anchoring each intervention in the system, in partnership with services and clinicians
  - ✓ Establish Service Implementation Groups (SIG) – identify processes, barriers, facilitators
  - ✓ Ensure BME community and Lived Experience involvement
  - ✓ Data alignment and audit – monitoring and outcomes
  - ✓ Governance and project management

- **EMHIP Phase 3 – Implementation**

MILESTONES

- 2021
- 2021 — EMHIP Project Launch
- 2022 — Phase One Complete
- 2022 — Launch of EMHIP Report and Feedback
- 2022 — Phase Two Begins
- 2022 — Recruitment of ICB/BME Programme Managers
- 2023 — Intervention One Begins
- 2024 — Evaluation and Review
- 2024 — Intervention Two Begins
- 2025 — Evaluation and Review

5 KEY INTERVENTIONS

EMHIP
ETHNICITY & MENTAL HEALTH IMPROVEMENT PROJECT

1. **MOBILE HEALTH & WELLBEING HUB**
2. IMPROVING CRISIS CARE AND CHOICE
3. REDUCE RESTRICTIVE COERCIVE PRACTICES
4. ENHANCING CARE FOR PEOPLE WITH SMI
5. CULTURALLY CAPABLE WORKFORCE

Community at the Heart

Mental Health & Wellbeing Hub

- First intervention / Adaption to a mobile model
- Bid for Health Inequalities Fund
- Whole-family approach
- Non-clinical service, supported by a psychologist
- Linked to the Health and Wellbeing Spaces
- Linked in with specialist care pathways (*DASV, perinatal mental health, family hubs, mental health teams)* – priority is to **bring everything together to the community.**
- Plans to fully integrated with LTC health care pathways and physical clinics *(diabetes, respiratory and cardiovascular)* supporting communities by linking the mind and the body
- Launching 2023

Systemic Family Therapy Training

- Training up our local faith and community leaders
- Level 6 Accredited Course, Two Year Commitment, commenced from Sept 2022
- 19 Students Registered, range of ages
- Students from Black Caribbean, Black African and South East Asian backgrounds
- From the Christian and Muslim faiths
- Weekly sessions held at the BME Forum
- Building community champions: the aim is to provide local residents with the skills to support their own communities
- Mental Health and Wellbeing Hub Psychologist will also support these students within their communities

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LONDON BOROUGH OF CROYDON

REPORT:		**Health and Wellbeing Board**
DATE OF DECISION		**18 October 2023**
REPORT TITLE:		**Croydon Joint Local Health and Wellbeing Strategy Refresh: October Update**
CORPORATE DIRECTOR / DIRECTOR:		**Rachel Flowers, Director of Public Health**
LEAD OFFICER:		**Dr Jack Bedeman, Consultant in Public Health** **Email: jack.bedeman@croydon.gov.uk** **Telephone: 22616**
LEAD MEMBER:		**Councillor Yvette Hopley**
DECISION TAKER:		**Health and Wellbeing Board**
AUTHORITY TO TAKE DECISION:		**Constitution of the London Borough of Croydon - Part 4.L It is a function of the Health and Wellbeing board to encourage, for the purpose of advancing the health and wellbeing of people in Croydon, persons who arrange for the provision of any health or social care services in Croydon.**
KEY DECISION? [Insert Ref. Number if a Key Decision] ***Guidance**: A Key Decision reference number will be allocated upon submission of a forward plan entry to Democratic Services.*	**No**	**N/A**
CONTAINS EXEMPT INFORMATION? ***(* See guidance)***	**No**	**Public**
WARDS AFFECTED:		**All**

1 SUMMARY OF REPORT

1.1 The Health and Wellbeing Board have agreed to refresh the current strategy in March 2023.

1.2 This report provides updates on progress to date and details next steps.

2 RECOMMENDATIONS

The Health and Wellbeing Board is recommended:

2.1 To note progress to date.

2.2 To agree on the next steps regarding strategy development.

2.3 To confirm attendance at the partnership planning workshop organised for Thursday, 9th November 2023, 10:00-13:00.

3 REASONS FOR RECOMMENDATIONS

3.1 There is a statutory requirement for the Health and Wellbeing Board to produce a 'Joint Local Health and Wellbeing strategy' to improve the health and wellbeing of the local community and reduce inequalities across the life course.

3.2 With the implementation of the Health and Care Act 2022, Health and Wellbeing Boards continue to be responsible for the development of the joint local health and wellbeing strategy. However, the Act notes that the Boards 'must now have regard to the integrated care strategy when preparing their joint local health and wellbeing strategies in addition to having regard to the NHS Mandate.'[1]

3.3 Croydon's current Joint Local Health and Wellbeing Strategy was published in 2019. Since then, the public health landscape in Croydon, like many other places, have seen important shifts.

3.3.1 The health and care system has seen significant developments such as the creation of the Integrated Care Boards (ICBs) and Integrated care partnerships (ICPs) following the Health and Care Act 2022.

3.3.2 In addition, the Covid-19 pandemic has shone a light on existing, and in some cases widening, health inequalities and their structural causes.

3.3.3 More recently, the impact of the war in Ukraine and the current cost-of-living crisis continue to pose significant challenges not only to health and social care services but also to the health and wellbeing of Croydon residents.

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[1] More information is available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1099832/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf.

3.4 With the support of the Local Government Association, the Health and Wellbeing Board is currently undertaking a review to ensure it is best able to deliver within the new landscape of ICBs and ICPs.

3.5 In March 2023, the Board have agreed to review and refresh the Joint Local Health and Wellbeing Strategy to ensure alignment with Board development work as well as meeting the following goals:

- the Strategy is fit for purpose in the changing context in which health and social care services are operating,
- outcomes and priorities identified in the Strategy address new and emerging local health and wellbeing needs, and
- the updated Strategy can continue to effectively inform relevant strategies and action plans in the area.

4 BACKGROUND AND DETAILS

Background to the Croydon Joint Local Health and Wellbeing Strategy

4.1 Croydon Health and Wellbeing Board is a formal committee established under the Health and Social Care Act 2012 with a statutory duty to produce a Joint Strategic Needs Assessment and Joint Local Health and Wellbeing Strategy.

4.2 The Joint Strategic Needs Assessment (JSNA) is a continuous, systematic process through which local data and intelligence are analysed and interpreted. Within Croydon, since 2017, the JSNA is published digitally at https://www.croydonobservatory.org/jsna/.

4.3 Croydon's digital JSNA is a collection of key datasets and statistical bulletins that are updated as new data become available to ensure timely and up-to-date data and insights on Croydon's overall population, their general health and wellbeing and key factors that affect health and wellbeing. This digital JSNA aims to identify current and future health and social care needs of the local community which in turn inform outcomes and priorities to be considered for the joint local health and wellbeing strategy.[2]

4.4 The Joint Local Health and Wellbeing Strategy is the local strategy developed by the Health and Wellbeing Board that addresses the needs and priorities identified in the JSNA. It sets out the shared vision, principles and priorities for actions.

4.5 The current Croydon Health and Wellbeing Strategy[3] was published in 2019 with a clear vision 'Croydon will be a healthy and caring borough where good health is the default not the exception and those that experience the worst health improve their health the fastest' underpinned by three key principles:

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[2] More information about the JSNA process in Croydon can be found at https://croydonobs.wpenginepowered.com/wp-content/uploads/2021/11/The-JSNA-in-Croydon.pdf

[3] The Croydon Health and Wellbeing Strategy can be found online at https://www.croydonobservatory.org/strategies-for-health-and-social-care/.

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

4.6 The Strategy has eight priorities:

Priority 1 – A better start in life

Priority 2 – Strong, engaged, inclusive and well-connected communities

Priority 3 – Housing and the environment enable all people of Croydon to be healthy

Priority 4 – Mental wellbeing and good mental health are seen as a driver of health

Priority 5 – A strong local economy with quality, local jobs

Priority 6 – Get more people more active, more often

Priority 7 – A stronger focus on prevention

Priority 8 – The right people, in the right place, at the right time

4.7 Since the publication of the Croydon Health and Wellbeing Strategy in 2019, the health and wellbeing landscape in Croydon, like many other local authorities in the UK, has undergone substantial changes.

4.8 In March 2023, the Board have agreed to review and refresh the current Strategy to ensure it can continue to effectively inform collective aiming to improve the health and wellbeing of the local population and to reduce health inequalities across the life course.

Progress to date

4.9 The Strategy refresh process has been guided by three core principles: evidence-based decision making, co-production and partnership working. These guiding principles are pivotal in ensuring that the refreshed Strategy reflects the health and wellbeing needs of Croydon and that there is a genuine sense of shared ownership for the refreshed priorities and outcomes among the diverse partners and stakeholders in Croydon, including our local population.

4.10 In light of these principles, a number of activities have been undertaken since March 2023 to inform the Strategy refresh. This section will summarise key findings from these activities under the following headings: Review of local, regional and national strategies; JSNA review, LGA HWB Development Workshop, Review of previous engagement activities in the Borough, Engagement workshop with the Preventative and Proactive Care Board, Planning Public Engagement with Healthwatch Croydon.

4.11 **Review of local, regional and national strategies and policies since the publication of the current Strategy**

Changes in the local, regional and national health and care landscape since the launch of the current Strategy were reviewed through a desktop exercise and a series of meetings with local and regional partners. This was done to establish a good understanding of the current landscape and identify opportunities for streamlining efforts to improve population health and wellbeing and reduce inequalities.

Key strategies and policies are summarised below. Please note this is not an exhaustive list and for brevity only high-level strategies and policies relevant to the Joint Local Health and Wellbeing Strategy are listed.

- NHS Long Term Plan (January 2019): This long-term plan sets out a plan for the NHS to improve the care for patients over the next ten years and introduces a new service model for the 21st century, including a stronger focus on out-of-hospital care that aims to enable patients to get ‘more options, better support and properly joined-up care at the right time in the optional setting’. Uniquely, the plan highlights the importance of prevention and health inequalities.
- The creation of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) following the Health and Care Act 2022. Croydon is now one of the six places that make up the South West London Integrated Care System (ICS). South West London ICS brings together partner organisations, including NHS, local authorities, community and voluntary organisations, to plan and deliver joined up services to improve the health and wellbeing of the residents who live and work in South West London.
- Publication of Croydon Mayoral Business Plan for 2022-2026 (May 2023): this Business Plan sets the key outcomes and supporting priorities for Croydon Council between 2022 and 2026. The key outcomes identified in the Plan have close synergies with the health and wellbeing of Croydon’s residents.
- Publication of the SWL Joint Forward Plan (June 2023): this 5-year plan describes how the NHS in SWL will work with partners to improve local services.
- Development of SWL ICS Strategy: This Strategy is developed accounting for the JSNAs and Joint Local Health and Wellbeing Strategies of the six local authorities making up the SWL Integrated Care System. It sets out the direction and priorities for health and care services across the six borough to improve people’s health and wellbeing and tackle health inequalities.
- The following strategies are also under development or review: SWL Mental Health Strategy, Croydon Dementia Strategy, Croydon Autism Strategy and Croydon’s Self Harm and Suicide Prevention Strategy, Croydon Early Years Partnership Strategy.

4.12 JSNA Review

Providing up-to-date data, intelligence and insights on the health and wellbeing outcomes and factors affecting these outcomes, Croydon’s digital JSNA provides a first port-of-call for understanding the state of health and wellbeing alongside relevant gaps and needs in Croydon. The current JSNA is structured as themed sections covering the following:

- Population overview: focusses on Croydon's overall population and their general health and wellbeing
- Population groups: provides data and intelligence on specific populations, covering specific localities, various demographic groups and vulnerable population groups.
- Wider determinants: focusses on factors that shape health and wellbeing including education, environment, housing and employment.
- Healthy behaviours: focuses on individual actions impacting health and wellbeing, ranging from physical activity, sexual health, oral health, smoking, and alcohol and substance use.
- Health conditions: focuses on specific diagnosed conditions, including mental health, self-harm and suicide prevention and the Pharmaceutical needs Assessment.

Croydon's JSNA was reviewed to identify common cross-cutting themes and key challenges relevant to health and wellbeing.

Below are some key cross-cutting themes identified from the JSNA review. Please note this is not an exhaustive list and does not cover all drivers of health and wellbeing, including healthy behaviours and wider determinants such as education, income, housing, neighbourhood and environment.

- **Croydon has the highest population among all London boroughs.** According to Census 2021, Croydon is now home to 390,719 people with more than half of the population being from Black, Asian or Minority Ethnic backgrounds, making it the largest and one of the most diverse boroughs in London. Croydon's population is expected to increase to just under 500,000 by 2050.
- **Croydon has a relatively high proportion of older and younger people.** In 2021, one in seven residents in Croydon were over 65 years of age while around a quarter of Croydon's population was under 18 year of age. As people live longer with more complex needs, the demand on the health and care services will be impacted. The relatively large population of children and young people would have impact on children's services, including provision of education and other services.
- **Health inequalities remain a challenge in Croydon.** In 2021, males born in the most deprived areas are expected to live 9.2 years less than their fellow residents born in the least deprived areas. In the same year, the gap in life expectancy for females was 6.5 years. The gap between residents living in the most- and the least-deprived areas were even wider for healthy life expectancy, with a 16.5-year gap for males and 21.3-year-gap for females.
- **Poverty remains an important issue in Croydon.** Around 10,000 residents in Croydon live in areas among the 10% most deprived areas of the country. Around 1 in 4 children and young people in Croydon live among the 20% most deprived areas in England. We know that residents living in less well-off neighbourhoods are likely to face multiple disadvantage, often lacking the right

building blocks for good physical and mental health. This is likely to be particularly exacerbated by the ongoing cost-of-living crisis.

- **Croydon's residents have diverse backgrounds, affecting their health and wellbeing needs.** It is important to recognise Croydon's diversity and its implications on health and wellbeing needs. For example, the latest census showed that over half the residents come from Global majority backgrounds, while 84% of Croydon's population spoke English as their main language. The same census showed that one in thirteen residents provide some form of unpaid care. Other resources show that Croydon has the largest number of Looked After Children in London, particularly impacted by the high numbers of unaccompanied asylum-seeking children looked after by the borough (550 in March 2022).

4.13 Engagement workshop with the Preventative and Proactive Care Board

One of the cornerstones of the current Health and Wellbeing Strategy, 'a stronger focus on prevention', has formed one of the principles through which the Strategy has been delivered. Indeed, following the launch of the current Strategy, the Proactive and Preventative Care Board, a partnership board functioning under the Health and Care Board, had developed Croydon's current Prevention Framework. This Framework underpinned many of the proactive and preventative care initiatives across the Borough, particularly in the areas of healthy weight, immunisations, mental health and trauma and falls and frailty.

In May 2023, the Public Health Team and the Proactive and Preventative Care Board led a joint session to review the Prevention Framework to reflect on the achievements and lessons learned from implementing the Prevention Framework and to discuss how prevention work across the Borough could continue to be effective. Findings from this workshop were discussed at the Proactive and Preventative Care Board in September 2023. These insights will be incorporated into the Joint Local Health and Wellbeing Strategy refresh process.

4.14 HWB Development Workshop in partnership with LGA

In collaboration with LGA, the Health and Wellbeing Board held a Board Development Workshop in June 2023. One of the main sessions in this workshop focussed on the Joint Local Health and Wellbeing Strategy Refresh. This session allowed participants to review the current Strategy in light of local priorities and discuss the co-production of the new Strategy with partners and residents. Findings from this workshop have been instrumental in shaping the Strategy refresh.

Key achievements and learning points from the current Strategy

Several positive aspects of the current Strategy were highlighted, including and not limited to:

- The Strategy document was praised for its brevity and readability, making it accessible to a wide audience.

- The Strategy covered a broad set of service and sector priorities under the Health and Wellbeing Board's umbrella, ensuring comprehensiveness.
- Partners across the board agreed on the Strategy, indicating consensus.
- Most participants found the current priorities to be well-aligned with local needs.

However, few learning points were noted for consideration in the review and refresh process:

- Some participants recommended a sharper focus of priority outcomes, concentrating efforts on fewer priorities to achieve tangible results.
- There was a call for more publicity to increase awareness of priorities and ways for the public to get involved.
- A desire for greater public engagement was expressed, emphasising that it should be inclusive of all age groups and diverse communities of Croydon.
- It was felt that action planning and delivery oversight needed to be more robust.

Review of current priorities

While many participants affirmed the relevance of the current priorities, there was a general agreement that refreshed priorities needed to be more specific for maximum impact. Members agreed that having fewer priorities focusing on major root causes, including a strong focus on prevention and health inequalities, would enable effective action planning, delivery and monitoring of outcomes. The importance of addressing the cost-of-living crisis in the refreshed Strategy and ensuring the priorities reflected residents' voice were also stressed. The workshop emphasised that co-production is vital for ensuring that the Joint Local Health and Wellbeing Strategy truly reflects the needs and aspirations of the local community, fostering a sense of ownership among all stakeholders.

4.15 Review of engagement activities in the Borough

Croydon's longstanding commitment to community engagement to understand health and wellbeing needs was prominently demonstrated in the recent desktop exercise that reviewed relevant engagement activities in the borough between 2018 and 2023. The aim was to gain a comprehensive understanding of residents' views on their health and wellbeing needs and identify gaps in engagement. This review provided a wealth of insights on what we already know about resident priorities and how we can address any gaps in engagement in the Strategy refresh process.

A total of 45 reports, representing a diverse array of engagement activities were reviewed. These events ranged from routine resident drop-ins to outreach activities as well as online and in person health and wellbeing surveys, in-person workshops, routine local community partnership events and wider one-off events such as the recent Mental Health Summit. In the past five years, these engagement efforts reached Croydon's diverse residents, hearing from residents of all age groups, spanning school pupils to young people, parents and older adults, as well as various communities with diverse needs, such as Black, Asian and Minority Ethnic communities, asylum seekers

and refugees, non-English speakers, individuals experiencing homelessness, and care home residents.

The review identified important cross-cutting themes, shedding light on overarching challenges and opportunities. The impact of the cost-of-living crisis and the need to focus on mental health and wellbeing across all ages were specifically highlighted. In terms of mental health and wellbeing, the need to ensure accessible support and reduce stigma were particularly prominent. The review also highlighted the need for better access to primary care, importance of intercultural training of staff so they are able to sensitively address diverse needs of different communities.

One significant theme was the importance of communication and information accessibility across various engagement initiatives. Whether it was addressing vaccine confidence, promoting mental health support, or enhancing primary care access, effective communication and reliable information were identified as fundamental pillars. Finally, collaboration between the VCSE sector and statutory services was specifically valued, and the theme of community collaboration and inclusivity ran consistently through the engagement activities, emphasising the need for grassroots involvement, community-driven initiatives, and the recognition of diverse voices.

4.16 Planning Public Engagement in Collaboration with Healthwatch Croydon

As highlighted earlier in this report under the engagement review section, Croydon has a longstanding commitment to community engagement through which we have gained valuable insights into the health and wellbeing needs of our residents. Building upon this foundation, we would like to hold a specific public engagement workshop on the Joint Local Health and Wellbeing Strategy ahead of the formal consultation process. The aims of this workshop are three-fold:

1. To familiarise our residents with the Health and Wellbeing Board and the Joint Health and Wellbeing Strategy in view of the various recent changes in the health and care landscape.
2. To feedback the findings of public engagement activities in the past five years in the Borough and demonstrate how these views were incorporated in the Strategy refresh process.
3. To seek feedback on the refreshed Strategy's vision, guiding principles and priority outcomes in an informal setting.

Planning is currently underway in partnership with Healthwatch Croydon for a workshop scheduled for November 2023.

Next steps

4.17 The following table shows suggested steps and indicative timelines for the different phases of work required for the review and refresh.

Task	Description	Date
Health and Wellbeing Strategy Refresh Partnership Workshop	This workshop will bring together members of the Health and Wellbeing Board and key partners to review identified health and wellbeing needs and undertake a shared prioritisation exercise for the refreshed Strategy	9 November 2023
Public Engagement Event	This workshop will be open to all those who live, work or study in Croydon. The main aim will be to sense check the identified health and wellbeing needs and priorities with our local population and collate their thoughts and feedback.	November 2023, (Exact Date TBC)
First draft ready for consultation with partners and stakeholders	First draft of the refreshed Strategy ready for review	December 2023
Public consultation period	Formal public consultation	Allow 4-6 weeks (January-February 2024)
Final draft ready for review and agreement	Final draft prepared incorporating feedback from the public consultation.	February 2024
Review and agreement by HWB Board	Final draft reviewed and approved by the Health and Wellbeing Board	March-April 2024
Review and agreement by full Council	Strategy approved by Full Council.	May 2024
Publication of updated Strategy	New Strategy published.	Expected June 2024

5 ALTERNATIVE OPTIONS CONSIDERED

5.1 The responsible local authority and its partner integrated care boards need not prepare a new joint local health and wellbeing strategy if, having considered the integrated care strategy, they consider that the existing joint local health and wellbeing strategy is sufficient.

6 CONSULTATION

6.1 This report outlines a partnership approach to refreshing the Health and Wellbeing Strategy for the next five years. No direct consultation was undertaken for this specific

report. However, the proposed approach considers feedback from previous stakeholder and public engagement activities in the Borough and takes a co-production approach to refreshing the Strategy.

7. CONTRIBUTION TO COUNCIL PRIORITIES

7.1 Croydon Health and Wellbeing Strategy supports the delivery of a number of key council priorities, including the following outcomes in Mayor's Business Plan (2022-26)

- Outcome 5. People can lead healthier and independent lives for longer
  - Priority 1. Work with partners and the VCFS to promote independence, health and wellbeing and keep vulnerable adults safe.
  - Priority 2. Work closely with health services and the VCFS to improve resident health and reduce health inequalities.
  - Priority 3. Foster a sense of community and civic life.

7.2 The Strategy will also have crosscutting links with several other outcomes in the Mayor's Business plan, including:

- Outcome 3. Children and young people in Croydon have the chance to thrive, learn and fulfil their potential
- Outcome 4. Croydon is a cleaner, safer and healthier place, a borough we are proud to call home.

8. IMPLICATIONS

8.1 FINANCIAL IMPLICATIONS

8.1.1 There are no direct financial implications as a result of this report. Any future financial impact will be fully considered as part of subsequent reports as they arise.

Comments approved by Lesley Shields, Head of Finance for Assistant Chief Executive and Resources on behalf of the Director of Finance. 05/10/23

8.2 LEGAL IMPLICATIONS

8.2.1 The establishment, composition and functions of the Health and Wellbeing Board are set out in the Health and Social Care Act 2012, sections 194-196. Section 196(1) provides that the functions of a local authority and its partner integrated care boards under section 116 and 116A of the Local Government and Public Involvement in Health Act 2007 (the 2007 Act) are to be exercised by the Health and Wellbeing Board established by the local authority.

8.2.2 Section 116A of the 2007 Act, provides that where the responsible local authority and each of its partner integrated care boards receive an integrated care strategy, they must prepare a strategy ("a joint local health and wellbeing strategy") setting out how the assessed needs in relation to the responsible local authority's area are to be met by the exercise of
functions of—

(a)the responsible local authority,
(b)its partner integrated care boards, or
(c)NHS England.

8.2.3 The responsible local authority and its partner integrated care boards need not prepare a new joint local health and wellbeing strategy if, having considered the integrated care strategy, they consider that the existing joint local health and wellbeing strategy is sufficient.

8.2.4 In preparing a strategy under this section, the responsible local authority and each of its partner integrated care boards must, in particular, consider the extent to which the assessed needs could be met more effectively by the making of arrangements under section 75 of the National Health Service Act 2006 (rather than in any other way). In addition, the responsible local authority and each of its partner integrated care boards must have regard to the integrated care strategy prepared under section 116ZB, of the 2007 Act, the mandate published by the Secretary of State under section 13A of the National Health Service Act 2006, and any guidance issued by the Secretary of State. In this regard the current statutory guidance is the Department of Health guidance "Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies". There is also published non-statutory guidance "Health and Wellbeing Boards- guidance" dated 22 November 2022 which is of relevance.

8.2.5 In preparing a strategy under this section, the responsible local authority and each of its partner integrated care boards must—(a)involve the Local Healthwatch organisation for the area of the responsible local authority, and (b)involve the people who live or work in that area.

8.2.6 The responsible local authority must publish each strategy prepared by it under this section.

8.2.7 The Health and Wellbeing Board continues to be responsible for the development of joint strategic needs assessments under Section 116 of the 2007 Act and joint local health and wellbeing strategies. However, the Local Health and Wellbeing Strategy is part of the Policy Framework under Article 4 of the Council's constitution, and therefore the approval process is as set out in the Budget and Policy Framework Procedure Rules, and the function of approving the Strategy is a matter reserved to Full Council

Comments approved by Sandra Herbert, Head of Litigation & Corporate Law, on behalf of the Director of Legal Services and Monitoring Officer 06/10/2023.

8.3 EQUALITIES IMPLICATIONS

8.3.1 The Council has a statutory duty to comply with the provisions set out in the Sec 149 Equality Act 2010. The Council must therefore have due regard to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act.
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it

- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

8.3.2 The Health and Wellbeing Strategy crosses all equality/protected characteristics, since it places improving health and wellbeing and reducing inequalities in these outcomes at its core. The refresh of the strategy will aim to benefit all equality and protected characteristics among Croydon residents.

8.3.3 There are a number of Health and wellbeing challenges which may impact particular characteristics such as instances of mental health illness in males, LGBT+ community, racial trauma in the Global Majority and the over representation of the Global Majority in mental health institutions.

8.3.4 The council is a pilot organisation on the Chief Executive London Councils Tackling Racial Injustice Programme. The programme requires each local authority to understand, acknowledge and support racial trauma as an issue affecting the Global Majority in workplaces.

8.3.5 The development of the Health and Wellbeing Strategy will include an equalities impact assessment which will identify and explore equality implications for all characteristics.

Approved by: Naseer Ahmad for the Equality Programme Manager 03/10/2023.

9. APPENDICES

9.1 Not applicable.

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