NHS South West London
Integrated Care Board

Meeting Pack

South West London Integrated Care Board

01 July 2022
10:00 – 13:00pm

Middle Hall, The Chaucer Centre,
Canterbury Road, Morden, SM4 6PX

NHS
South West London

NHS South West London Integrated Care Board

Friday 1 July 2022
10:00am – 13:00pm
Location: The Chaucer Centre, Canterbury Road, Morden, SM4 6PX

The ICB has four core purposes. These are to:
- Improve outcomes in population health and healthcare;
- Tackle inequalities in outcomes, experience and access;
- Enhance productivity and value for money; and
- Help the NHS support broader social and economic development.

No.	Time	Agenda Item	Sponsor	Enc
1.	10:00am	**Welcome, Introductions and Apologies**	Chair	
2.		**Declarations of Interest** *All members and attendees **may** have interests relating to their roles. **These interests should be declared in the register of interests.** While these general interests do not need to be individually declared at meetings, interests over and above these where they are relevant to the topic under discussion should be declared.*	All	02
3.	10:05am	**Chair's welcome to the ICB**	Millie Banerjee	Verbal
4.	10:20am	**CEO report**	Sarah Blow	04

5.	10:25am	**South West London Governance & procedures process**
		A)
		• South West London ICB Constitution & Standing Orders.
		
		B)
		• ICB Core Policies
		  ○ Scheme of Reservation and Delegation
		  ○ Scheme of Delegation
		  ○ Standing Financial Instructions (SFIs)
		  ○ Standards of Business Conduct
		  ○ Conflicts of Interests policy
		• Other SWL policies
			Karen Broughton & Ben Luscombe	05 (P1-P5)

		C)
		• ICB Committee Terms of Reference & Committee membership
		
		D)
		• Appointment of:
		  ○ Conflicts of Interest Guardian
		  ○ Freedom To Speak Up Guardian
		  ○ Non-Executive Member for Emergency, Preparedness, Resilience and Response
		  ○ ICB's Founder member of the ICP
		
		E)
		• CCG Close down and ICB Establishment		

6.	10:40am	**The next steps for Primary Care Integration: The Fuller stocktake**	Mark Creelman	06
	10:55am	**Comfort break**		
7.	11:05am	**Improving Care through Population Health Management**	Sam Green & Sayanthan Ganesaratnam	07
8.	11:25am	**Reducing Health Inequalities (Core 20+5)**	Gloria Rowland	08
9.	11:45am	**Committee Updates & reports** • Performance report • Quality Report • SWL ICB Finance report	 Jonathan Bates Gloria Rowland Sarah Blow	 09a 09b 09c
10.	12:30pm	**Public Questions - by email** Members of the public are invited to ask questions, in advance by email, of the Board relating to the business being conducted today. Priority will be given to those received in writing in advance.		

11.	12:40pm	**Review of the Board meeting**	All	
12.	12:45am	**Any Other Business**	All	

NHS SOUTH WEST LONDON INTEGRATED CARE BOARD - REGISTER OF DECLARED INTERESTS - JULY 2022

Name	Current position (s) held in the ICB .	Do you have any interests to declare? (Y or N)	Declared Interest (Name of the organisation and nature of business)	Financial Interest	Non-Financial professional Interest	Non-Financial Personal Interest	Indirect Interest	Nature of Interest	From	To	Action taken to mitigate risk
Millie Bannerjee	**Chair of SWL Integrated Care System** Chair of the ICB Board Joint Chair of the ICP Board Member of the Remuneration and Nominations Committee	Y	Compass Well-Being	1				1 Paid Chair of Compass Well-being a social enterprise wholly owned by East London Foundation Trust with a mission to support the citizens	12.05.2021	Present	1 Internet declared. Compass does not operate in SWL. If that changes I will take appropriate action
Mercy Jeyasingham	**Non Executive Member** ICB Board Member Chair of the Quality Oversight Committee Member of the Remuneration and Nominations Committee	N	Nil Return								
Dick Sorabji	**Non Executive Member** ICB Board Member Chair of the Finance & Planning Committee Member of the Audit and Risk Committee	N	Nil Return								
Ruth Bailey	**Non Executive Member** ICB Board Member Chair of the Remuneration & Nominations Committee Member of the Audit and Risk Committee	Y	1 Expert advisor to Boston Consulting Group in the Middle East on a public sector project that is not healthcare related. 2 Associate HR Consultant for 3XO. Not engaged on any healthcare related projects. 3 Husband is Director in UK Health Protection Agency. 4 Non-Executive Member on Hertfordshire and West Essex ICB	1 2	4		3	1 Expert advisor to Boston Consulting Group in the Middle East on a public sector project that is not healthcare related. 2 Associate HR Consultant for 3XO. Not engaged on any healthcare related projects. 3 Husband is Director in UK Health Protection Agency. 4 Non-Executive Member on Hertfordshire & West Essex ICB	1. October 2021 2. June 2022 3. October 2016 4. July 2022	1-4 Present	Declared and discussed where relevant with Conflicts of Interest Guardian
TBC	**Non Executive Member** ICB Board Member Chair of the Audit & Risk Committee	*tbc*	to follow								
Sarah Blow	**Chief Executive** ICB Board Member Attendee of the Remuneration and Nominations Committee	Y	1. LAS				1	1. My son is a band 3 call handler for LAS outside of SWLondon	Jan-22	Present	Individually determined
Karen Broughton	**Deputy Chief Executive / Director of People & Transformation** ICB Board Member Attendee of the Remuneration and Nominations Committee	N	Nil Return								
Dr Gloria Rowland	**Chief Nursing and Allied Professional Officer and Director for patient outcomes** ICB Board Member Attendee of the Quality Oversight Committee Attendee of the Finance and Planning Committee	Y	1. Nursing and Midwifery Council 2. Care Embassy Consultancy & training Ltd - Director 3. Grow Nurses & Midwives Foundation 4. NHSE&I (London Region) 5.Turning the Tide	2	1 4 5	3		1 Associate Council Member (2 days a month) 2. Director (Husband owns the Company) 3. Chair of Trustee for a charity 4. Chair of Maternity & Neonatal critical review implementation programme 5. Report Author and founder	1. 08.12.20 2. 21.01.17 3. 15.11.21 4. 15.11.21 5. 15.11.21	1-5 Present	Ensure Board dates do not conflict
John Byrne	**Executive Medical Officer** Member of ICB Board Attendee of the Quality Oversight Committee Attendee of the Finance and Planning Committee	N	Nil Return								

Name	Current position (s) held in the ICB .	Do you have any interests to declare? (Y or N)	Declared Interest (Name of the organisation and nature of business)	Financial Interest	Non-Financial professional Interest	Non-Financial Personal Interest	Indirect Interest	Nature of Interest	From	To	Action taken to mitigate risk
Helen Jameson	**Chief Finance Officer** Member of the ICB Board Attendee of the Finance and Planning Committee Attendee of the Audit and Risk Committee	N	Nil Return								
Dame Cally Palmer	**Partner Member Specialised Services** Member of the ICB Board	Y	1. Chief Executive The Royal Marsden NHS Foundation Trust 2. NHS England/Improvement (national)	1				1. CEO of a Provider Trust in SWL 2. National Cancer Director	1. 2. April 2015	Present	Declared and discussed where relevant with Conflicts of Interest Guardian
Vanessa Ford	**Partner Member Mental Health Services** Chief Executive SWL & St. Georges Mental Health NHS Trust Member of the ICB Board	Y	1. Chief Executive SWL & St Georges Mental Health NHS Trust 2. Co-Chair of NHS Confederation Mental Health Digital Group 3. Senior Responsibile Officer (SRO) of ICS Digital Programme 4. Merton Place Convenor 5. SRO for Regional NHS 111 programme for Mental Health	1	02-May			1. CEO of Provider Trust in SWL 2. Co-Chair of NHS Confederaiton MH digital group 3. SRO of ICS digital programme 4. Merton Place Convenor 5. SRO for Regional NHS 111 programme for Mental Health	1 August 2019 2. August 2018 3.January 2021 4.July 2022 5.August 2021	Present	Declared and discussed where relevant with Conflicts of Interest Guardian
Jo Farrar	**Partner Member Community Services** Member of the ICB Board	Y	1. Chief Executive Kingston Hospital NHS Foundation Trust	1				1. CEO of Provider Trust in SWL	1 2019	Present	Declared and discussed where relevant with Conflicts of Interest Guardian
Jacqueline Totterdell	**Partner Member Acute Services** Member of the ICB Board	Y	1 Group Chief Executive Officer St George's, Epsom and St Helier University Hospitals and Health Group	1				Group Chief Execuitve Officer of Provider Trust in SWL	01-Aug-21	Present	Declared and discussed where relevant with Conflicts of Interest Guardian
Dr Nicola Jones	**Partner Member Primary Medical Services** Member of the ICB Board	Y	1. Managing Partner Brocklebank Practice, St Paul's Cottage Surgery (both PMS) and The Haider Practice (GMS) 2. Joint Clinical Director, Brocklebank PCN 3. Brocklebank PCN is part of Battersea Healthcare (BHCIC) 4. Convenor, Wandsworth Borough Committee 5. Primary Care Representative, Wandsworth 6. Co-Chair Cardiology Network, SWL ICS 7. Clinical Director Primary Care, SWL ICS	1 3 4 5	2 6			1. Practices hold PMS/GMS contracts. Dr Nicola Jones holds no director post and has no specific responsibilities within BHCIC other than those of other member GPs.	1. 1996 2. 2020 3. 2018 4. 2022 5. 2022 6. 2022 7. 2022	1-7 Present	Adherence to COI policy
TBC	**Partner Member Local Authorities**	*tbc*	to follow								
Matthew Kershaw	**Place Member Croydon** Member of the ICB Board	Y	1. Chief Executive of Croydon Healthcare Services NHS Trust	1				Chief Executive of a provider Trust in SWL	1. 19/10/2019	Present	Declared and discussed where relevant with Conflicts of Interest Guardian
Dr Annette Pautz	**Place Member Kingston** Member of the ICB Board	Y	1 Holmwood Corner Surgery 2 Kingston General Practice Chambers Ltd. 3 NMWP PCN	1 2 3				1 Partner at Holmwood Corner Surgery 2 Member of Kingston General Practice Chambers Ltd. 3 Board Member NMWP PCN	1 01.04.21 2 01.04.21 3 01.04.21	1-3 Present	Declared and discussed where relevant with Conflicts of Interest Guardian
Dr Dagmar Zeuner	**Place Member Merton** Member of the ICB Board	Y	1. Director of Public Health, LBM In this role potential / perceived conflict of interest re any decision about future of St Helier's Hospital. 2. Partner is owner of ZG publishing (publishes the magazine: "Outdoor Swimmer"). 3. Honorary senior lecturer at the London School of Hygiene and Tropical Medicine. 4. Research advisor (occasional) for University of London/Institute of Child Health.	1 3			2		1. Feb 2016 2. Feb 2011 3. Apr 2006 4. Apr 2010		1. Not being a member of the CIC, being excluded from any decision making on the future of St Helier, which includes circulation of related unpublished papers.
Ian Dodds	**Place Member Richmond** Member of the ICB Board	N	Nil Return								
TBC	**Place Member Sutton**	*tbc*	to follow								
TBC	**Place Member Wandsworth**	*tbc*	to follow								

Name	Current position (s) held in the ICB .	Do you have any interests to declare? (Y or N)	Declared Interest (Name of the organisation and nature of business)	Financial Interest	Non-Financial professional Interest	Non-Financial Personal Interest	Indirect Interest	Nature of Interest	From	To	Action taken to mitigate risk
Jonathan Bates	**Chief Operating Officer** Participant of the of the ICB Board Attendee of the of the Quality Oversight Committee Attendee of the of the Finance and Planning Committee	Y	1. Spouse provides primary care consultancy and interim support to a range of organisations.				1	Spouse provides primary care consultancy and interim support to a range of organisations.	Autumn 2020	Present	Highlighted potential conflict to the Accountable Officer
Charlotte Gawne	**Executive Director for Communications, Engagement and strategic stakeholder relations** Participant of the of the ICB Board	N	Nil Return								
Ben Luscombe	**Chief of Staff** Participant of the of the ICB Board Attendee of the of the Audit and Risk Committee Attendee of Remuneration and Nominations Committee	N	Nil Return								

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board	
Date	Friday, 01 July 2022

Document Title	CEO report		
Lead Director (Name and Role)	Sarah Blow, Chief Executive Officer, SWL ICB		
Author(s) (Name and Role)	Jitendra Patel, ICB/ICP Secretary		
Agenda Item No.	4	**Attachment No.**	04

Purpose (Tick as Required)	Approve	Discuss	Note ✓

Executive Summary

The report highlights items of interest to members of the Board and the Public which are not discussed in detail in the rest of the agenda.

Background:

At each public Board meeting the Chief Executive Officer will provide a brief verbal and written update regarding matters of interest to members of the Board and members of the Public.

Purpose:

The report is provided for information to keep the Board updated on key issues not covered in other substantive agenda items.

Recommendation:

The Board note the contents of the report.

Key Issues for the Board to be aware of:

1. ICS Transition.
2. Planning update.
3. NHS support for Ukrainians coming to the UK.
4. The Messenger Review.

Conflicts of Interest: None
Mitigations for Conflicts of Interest: N/A

Corporate Objectives This document will impact on the following Board Objectives:	Overall delivery of the ICB's objectives

Risks This document links to the following Board risks:	N/A
Mitigations Actions taken to reduce any risks identified:	N/A

Financial/Resource Implications	N/A

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	**N/A**
What are the implications of the EIA and what, if any are the mitigations	N/A

Patient and Public Engagement and Communication	N/A

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

Supporting Documents	None

NHS South West London
Integrated Care Board

South West London Integrated Care Board
Meeting Paper 01 July 2022

Chief Executive Officer's Report

Introduction

1. The following report highlights items of interest to members of the Board and the public which are not discussed in detail in the rest of the agenda.

Items to note from the Chief Executive Officer

ICS Transition

2. Today is the first day of South West London Integrated Care System. Over the past year, the ICS has been designed in partnership by system leaders across South West London and I want to formally record my thanks for tremendous effort and commitment shown by all and for the support they and their organisations have shown. I look forward to our continued work together as we work to improve health and care services, and experiences and outcomes for the people in South West London.

Planning update

3. We have worked as a system to develop our plans for 2022/23 and have shared these with NHS England. These reflected our local priorities as well as national planning guidance which had been shared at the end of December. The key areas of focus are:

    - Recovery to pre-pandemic levels for elective activity as well as recovery of cancer and diagnostic services;
    - Reducing ambulance handover and Emergency Department waiting times;
    - Mental Health investment commitments; and
    - Continued focus on reducing health inequalities.
    - Staff wellbeing;

4. We have submitted a balanced plan for the system but the year ahead will be extremely challenging. We will continue to work as a system to mitigate the financial risk in our plans to ensure that we can achieve a break-even position.

NHS support for Ukrainians coming to the UK

5. As part of the UK's offer to Ukrainians coming to the UK, the Government has guaranteed free access to NHS healthcare. This includes hospital services, GP and nurse consultations, urgent care centres and injury units. Covid-19 vaccines and medical screenings have also been offered.

6. We have worked with partners locally to ensure Ukrainians arriving in South West London boroughs can access the support they need. More information on the support in each borough is available on the Council websites in Croydon, Kingston, Merton, Richmond, Sutton ad Wandsworth.

The Messenger Review

7. Sir Gordon Messenger, was commissioned by the Secretary of State in October 2021 to undertake a review of leadership and management in the health and social care sector. His report, co-written with Dame Linda Pollard, was published on the 8 June 2022.

8. Whilst the report acknowledges the challenges faced in the health and care sector, it highlights inadequacy in the way that leadership and management is trained, developed and valued. It found that this then had an impact on behaviours in the workplace, poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance.

9. The report proposes a number of key interventions to strengthen leadership and management in health and care as follows:
    1. Targeted interventions on collaborative leadership and organisational values;
    2. Positive equality, diversity and inclusion (EDI) action;
    3. Consistent management standards delivered through accredited training;
    4. A simplified, standard appraisal system for the NHS;
    5. A new career and talent management function for managers;
    6. Effective recruitment and development of non-executive directors (NEDs); and
    7. Encouraging top talent into challenged parts of the system.

10. The new ICB People Committee will review the report and agree actions to respond to it so that managers and leaders in SWL are supported and developed to create a fairer and more inclusive workforce experience. To read more access the report via the following link.

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board	
Date	Friday, 01 July 2022

Document Title	Establishing South West London Integrated Care Board		
Lead Director (Name and Role)	Sarah Blow Chief Executive Officer		
Author(s) (Name and Role)	Ben Luscombe – Chief of Staff Steve Crocker – Deputy Director Governance & Corporate Services		
Agenda Item No.	5	**Attachment No.**	05 (P1-P5)

Purpose (Tick as Required)	Approve ✓	Discuss	Note ✓

Executive Summary

The Health and Care Bill was published in July 2021. The Health and Care Act 2022 (the Act) received Royal Assent on 28 April 2022.

The Act dissolves Clinical Commissioning Groups and establishes Integrated Care Boards (ICB) on 1 July 2022.

To deliver the change to the new Integrated Care System (ICS):

a. A comprehensive ICS Transition Programme was put in place.
b. A Governance Oversight Group was created to ensure strong oversight and assurance on the transition to the South West London Integrated Care Board.
b. A Due Diligence process and plan, assured by internal audit, were put in place to support a safe transition to the new ICB.

SWL CCG has undertaken a process to meet the requirements of the NHSE guidance; to ensure that all due diligence is completed in closing the CCG and establishing the ICB; that the new organisation was in alignment with the ICS framework; and that the Readiness to Operate statement has been submitted to NHSE.

The Constitution for SWL ICB has been approved and a suite of Governance documents, covering Committee Structure, Terms of Reference and Policies have been prepared.

Purpose:

The papers that make up the governance report (papers 1 to 5) provide South West London ICB Board (the Board) with an update and overview of the work that has been undertaken, along with seeking certain necessary approvals from the Board and approval of certain Appointments, Terms of Reference and Policies:

- **Governance Paper 1** – Provides the Board with an overview of the ICS and governance processes undertaken to establish the ICB;

- **Governance Paper 2** – provides the Board with SWL ICBs final Constitution and Standing Orders together with NHS England's guidance notes.
- **Governance Paper 3** – Provides an overview of the Boards membership, and lists a number statutory and best practice roles that the ICB are required to appoint named members of the Board to undertake.
- **Governance Paper 4** – Provides an overview of the phased development of the ICB Committee structure and their Terms of Reference.
- **Governance Paper 5** – Provides an overview of the ICB Transition and the work due diligence completed in closing the CCG and establishing the ICB and the completion of the Readiness to Operate statement.

Recommendation:

The Board are asked to:

- **Note** the ICBs Constitution and Standing Orders and **approve** the remaining documents and policies set out in **Paper 2;**
- **Note** the membership and **approve** the appointments listed in **Paper 3**;
- **Approve the** Committee Structure and Terms of Reference in **Paper 4**;
- **Note** the due diligence and Readiness to Operate process that has been undertaken to abolish the CCG and create the ICB **Paper 5**.

Key Issues for the Board to be aware of:

In closing the SWL CCG and establishing SWL ICB a number of milestones have been met:

- On 1 June SWL CCG Accountable Officer submitted letters to both the ICB Chair (designate) and London Regional Director that South West London CCG has followed a robust due diligence process to prepare for closedown and for the safe transfer of staff and property (in its widest sense) to South West London ICB on 1 July 2022.
- On 1 June London Regional Director wrote to the SWL ICB Chair (designate) confirming NHS England's approval of SWL ICBs Constitution.
- On 10 June 2022 the ICB CEO (designate) signed the Readiness to Operate Statement (ROS), the ROS was ratified by the Regional Director by 19 June 2022 for submission to the national team.

Conflicts of Interest:
Where the Board is being asked to provide approval to the appointment of individuals those individuals concerned should not take part in these discussions.

Mitigations for Conflicts of Interest:
That the relevant individuals do not take part in that part of the discussion.

Corporate Objectives This document will impact on the following Board Objectives:	The establishment of the ICB helps to deliver the overall policy objectives of the Health and Care Act 2022.

Risks This document links to the following Board risks:	N/A
Mitigations Actions taken to reduce any risks identified:	N/A

Financial/Resource Implications	N/A

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	Yes, as part of the Staff Consultation Process
What are the implications of the EIA and what, if any are the mitigations	No

Patient and Public Engagement and Communication	As part of the process to establish the ICB we have engaged widely with our system colleagues, including other NHS organisations; Local Authorities; Health Watch and The Voluntary, Community and Social Enterprise Sector (VCSE)

	Committee/Group Name:	Date Discussed:	Outcome:
Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	South West London CCG Audit Committee	Tuesday, 08 March 2022	The Audit committee noted the process that was underway with regard to Due Diligence.
	South West London CCG Governance Oversight Group	Click here to enter a date.	The group have been providing oversight and guidance on the establishment of the ICB since September 2021
	South West London CCG Governing Body	Wednesday, 22 June 2022	Governing Body have received updates on ICS transition and completion

			of Due Diligence and Readiness to Operate.

Supporting Documents	**Paper 1** • Paper 1 Annex A Governance Oversight Group Terms of Reference **Paper 2** • Paper 2 Annex A SWL ICB Constitution and Standing Orders • Paper 2 Annex B NHSE Guidance notes • Paper 2 Annex C ICB Model Constitution • Paper 2 Annex D Submission letter SWL ICB Constitution • Paper 2 Annex E Letter from NHSE Approving SWL ICB Constitution • Paper 2 Annex F Scheme of Reservation and Delegation • Paper 2 Annex G SWL ICB Functions and Decisions Map • Paper 2 Annex H Standing Financial Instructions (SFIs) • Paper 2 Annex I Standards of Business Conduct Policy • Paper 2 Annex J Conflict of Interest Policy • Paper 2 Annex K Policy for Public involvement and Engagement • Paper 2 Annex L ICB Detailed Scheme of Delegation • Paper 2 Annex M SWL ICB Policies. **Paper 3** • Paper 3 Annex A Letter seeking approval to appoint the Board Partner Members • Paper 3 Annex B Letter confirming appointment of the Board Partner Members **Paper 4** • Paper 4 Annex A Remuneration & Nominations Committee Terms of Reference • Paper 4 Annex B Audit and Risk Committee Terms of Reference • Paper 4 Annex C Finance and Planning Committee Terms of Reference • Paper 4 Annex D Quality and Oversight Committee Terms of Reference • Paper 4 Annex E Place Committee Terms of Reference **Paper 5** • Paper 5 Annex A SWL CCG AO Due Diligence Assurance Letters • Paper 5 Annex B Due Diligence Assurance letters • Paper 5 Annex C Readiness to Operate statement

NHS South West London
Integrated Care Board

South West London Integrated Care Board
1 July 2022

ESTABLISHING SOUTH WEST LONDON INTEGRATED CARE BOAD - An overview of the SWL ICS and governance processes undertaken to establish the Integrated Care Board

INTRODUCTION

1. In 2019, NHS England and NHS Improvement (NHSEI) were asked to identify legislative changes that would help the NHS to deliver the ambitions of the Long-Term Plan. A key recommendation from NHS England was to transform the '*system architecture of the NHS to increase coordination of services through the creation of integrated care systems'*.

2. In February 2021, the Government published the White Paper 'Integration and Innovation: working together to improve health and social care for all' and announced it would be followed by a Health and Care Bill.

3. The Health and Care Bill was published in July 2021. The Health and Care Act 2022 (the Act) received Royal Assent on 28 April 2022.

4. The Act establishes Integrated Care Systems (ICSs) as partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. On 1 July 2022, the Act abolishes Clinical Commissioning Groups (CCGs) and establishes Integrated Care Boards (ICBs) as statutory organisations.

5. To enable the transition from CCGs to ICBs, NHS England & Improvement issued guidance on the design of the new organisation, the due diligence process to be completed when closing down the CCG and establishing the ICB and the process of reporting and assuring progress to confirm that the ICB was Ready to Operate.

6. This paper and its constituent parts provide an overview of the ICS; the ICB's constitution and Standing Orders; core policy documents; all ICB policies; the ICB Board Membership; the ICB committee structure and Terms of Reference; and finally the due diligence and establishment process we have undertaken to abolish the CCG and create the ICB.

7. The papers are ordered as follows:

   - **Governance Paper 1** – Overview of the ICS and governance processes undertaken to establish the ICB;
   - **Governance Paper 2** – South West London ICB's Constitution, Standing Orders and Core Policies.

- **Governance Paper 3** - South West London ICB Board Membership and Appointments.
- **Governance Paper 4** - Committee Structure and Terms of Reference.

- **Governance Paper 5** – CCG Close down and ICB Establishment

SOUTH WEST LONDON INTEGRATED CARE SYSTEM

8. ICS's have been established with four core principles. To:

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

9. South West London (SWL) Integrated Care System (ICS) consists of three parts: SWL Places; SWL Provider Collaboratives; SWL level; and is made up of two boards:

    - **Integrated Care Partnership (ICP):** the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.
        - The SWL ICP is being established at system level by the NHS and local government as equal partners and is a statutory committee of the SWL Integrated Care System.
        - The South West London Integrated Care Partnership (ICP) will bring together organisations and representatives to reduce health inequalities and improve the care, health and wellbeing of the people in South West London.
        - SWL ICP is responsible for the development of an 'integrated care strategy' for the whole population to improve system-wide health and care outcomes and experiences, and influence the wider determinants of health, including healthier environments and inclusive and sustainable economies. The ICP will champion inclusion and transparency and challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It will support place- and neighbourhood-level engagement, ensuring the ICP is connected to the needs of every community.

    - **Integrated Care Board (ICB**) brings the NHS together locally to improve population health and care.
        - The SWL ICB is the statutory NHS organisation responsible for developing a plan for meeting the health needs of the population,

managing the NHS budget and arranging for the provision of health services in South West London.

- The ICB brings the NHS together locally to deliver shared priorities, with an emphasis on collaboration and shared responsibility for the health of the local population, and collective accountability for whole-system delivery and performance.

THE ICS TRANSITION PROGRAMME

10. To deliver the transition from the CCG to the new ICS, the ICS Transition Programme was created. Led by Karen Broughton, ICS Transition Programme Senior Responsible Officer, the programme has overseen all aspects of the abolition of the CCG and creation of the ICS, including the work to establish the ICB's governance structure.

11. In order to oversee the transition between SWL CCG and the new ICB, the CCG and ICB established a joint Governance Oversight Group (GoG). The group was chaired by Sarah Blow, as the current Accountable Officer of the CCG and ICB CEO (designate), with the following membership:

- Millie Banerjee (ICB Chair (designate));
- Andrew Murray (SWL CCG Clinical Chair);
- David Smith (CCG Deputy Chair and Chair of the Finance Committee);
- Paul Gallagher (CCG Audit Committee Chair);
- Mike Bell (representing the NHS Trust Chairs);
- Nick Atkinson (CCG Head of Internal Audit);
- James Murray (CCG Chief Financial Officer);
- Karen Broughton (as the SRO for the ICS transition);
- Ian Thomas (Local Authority Representative) and
- Ben Luscombe (due diligence and Governance lead).

12. The GoG was not a decision-making body but provided guidance and oversight regarding the creation of a new, best practice, governance framework for the Integrated Care Board, and delivery of the due diligence workstream. It considered:

- The effectiveness of the proposed Constitution, providing insight into best practice and suggested additions/amendments;
- The appropriate structures for the ICB, committees and sub committees of the ICB's Board;
- The constitutional impact of conflicts of interest and its effective management within the new organisational structure;
- The transitional governance arrangements required to ensure the continued effective operation of existing systems and controls (the due diligence process).

13. The groups Terms of Reference are attached at **Annex A.**

14. As part of the final process to approve the governance arrangements for the ICB the following papers provide the ICB Board with an overview of the ICB's governance structure and ask the Board either to note or approve certain elements of this.

RECOMMENDATION

15. The Board are asked to:

- **Note** the ICBs Constitution and Standing Orders and **approve** the remaining documents and policies set out in **Paper 2;**
- **Note** the membership and **approve** the appointments listed in **Paper 3**;
- **Approve the** Committee Structure and Terms of Reference in **Paper 4**;
- **Note** the due diligence and Readiness to Operate process that has been undertaken to abolish the CCG and create the ICB **Paper 5**.

June 2022

NHS South West London
Integrated Care Board

South West London Integrated Care Board
1 July 2022

ESTABLISHING SOUTH WEST LONDON INTEGRATED CARE BOAD - South West London ICB's Constitution, Standing Orders and Core Policies

INTRODUCTION

1. As part of the process to establish Integrated Care Boards (ICBs) the Health and Care Act 2022 (the Act) sets out that each ICB must have a Constitution.

2. This paper provides the ICB Board with SWL ICB's final Constitution and Standing Orders (**Annex A**) and accompanying NHS England guidance notes (**Annex B**). it also provides the Board with the ICB's core policies for approval.

OVERVIEW

3. The Act sets out that each ICB must have a Constitution in order to be established. Clause 14Z25, Sub Clause 5 states *'An order establishing an integrated care board must provide for the constitution of the board, either by setting out the constitution or by making provision by reference to a published document where it is set out.'*

4. The Act goes on to set out the statutory requirements as to what must be included in the Constitution. It also allows for Secondary Legislation to be published, providing more detail on what the Constitution must include. The Act also sets out, at 14Z26 (2) that *''The relevant clinical commissioning group or groups for an initial area must propose the constitution of the first integrated care board to be established for that area.'*

5. In late summer 2021, NHS England created a model Constitution (**Annex C)** and guidance notes for all ICBs (**Annex B**). Although the model Constitution itself borrows heavily from the CCG template, the majority of the Constitution is prescribed and cannot be altered locally. Local discretion has been allowed for areas such as the appointment process for Board members and areas related to patient and public involvement.

6. In order to oversee the transition between SWL CCG and the ICB, we established a Governance Oversight Group (GoG). Although not a decision-making group, one of its key responsibilities was to oversee the effectiveness of the proposed

Constitution, providing insight into best practice and suggested additions/amendments. The Group has been involved with the drafting of the Constitution from the beginning and has had in-put into all of the amendments as they have been proposed and made. *Paper 1 - An overview of the SWL ICS and governance processes undertaken to establish the Integrated Care Board* provides more detail on the remit of the GoG.

7. Throughout the development of the Constitution, NHS England have regularly updated the model constitution and reviewed our progress. We have liaised closely with NHS England and incorporated their comments and suggestions into our drafting.

8. The draft Constitution was circulated in December 2021 to all of our key stakeholders as part of our *'Creating South West London Integrated Care System'* engagement exercise and input from this has been included in the final version.

9. As part of the assurance and sign-off process to agree the final constitution, South West London CCG, had to 'propose' the draft constitution to NHS England. SWL CCG agreed to propose the draft constitution at its meeting on 2 March 2022. On the 20th of May 2022, Sarah Blow as the CCG Accountable Officer and ICB CEO (designate), submitted the draft Constitution to Andrew Ridley, Regional, Director, NHS England London Region (**Annex D**). Andrew Ridley wrote to Millie Banerjee on 1 June 2022, confirming NHS England's approval of SWL ICBs Constitution (**Annex E**)

CORE POLICIES AND SUPPORTING DOCUMENTS

10. Section 1.7 of the South West London ICB's Constitution sets out a number of documents which support the Constitution, including:

    - The Scheme of Reservation and Delegation (SoRD) – (**Annex F**);
    - Functions and Decision map (**Annex G**); and
    - Standing Financial Instructions (**Annex H**).

11. In addition to this, the Constitution sets out that the ICB must have the following core policy documents:

    - Standards of Business Conduct Policy (**Annex I**);
    - Conflicts of interest policy and procedures(**Annex J**);

- Policy for Public involvement and engagement (**Annex K**);
- In addition to the above, also included are the ICB's Detailed Scheme of delegation (**Annex L**).

12. As with the Constitution and Standing Orders, the GoG have reviewed and recommended all of the above documents and the **ICB are asked to approve the documents listed above.**

13. A comprehensive register of all South West London ICB Policies is contained at **Annex M.** Over the past months all of these policies have been reviewed by the relevant Executive Directors and their teams.

14. The majority of policies have simply been updated to reflect the transition between CCG and ICB. The Evidence Based Interventions policy has been additionally updated to so that the ACT/Fertility Preservation Policy is now integrated within the core EBI policy. Its 2022 review and refresh was undertaken to clarify certain criteria within the pre-existing policy for the benefit of the SWL patients seeking support for fertility treatment and fertility preservation. No change to the policy criteria has been made and as such, the policy is not required to undergo consultation prior to publication.

15. The policy has also been updated to include an additional Ovulation Induction section which will formalise existing clinical practice across SWL and has been developed in collaboration with and agreed by the four acute providers and the SWL Fertility Network Group.

16. If any member of the Board would like to review these polices, please contact the Governance Team who will provide copies.

17. Relevant policies will be published on the South West London ICB Website and intranet.

RECOMMENDATION

18. The Board are asked to:
    - **Note** the ICBs Constitution and Standing Orders.
    - **Approve** core policies and supporting documents transferring to the ICB.
    - **Approve** the amendments to policies, as set out above.

June 2022

NHS South West London
Integrated Care Board

South West London Integrated Care Board
1 July 2022

ESTABLISHING SOUTH WEST LONDON INTEGRATED CARE BOARD
South West London ICB Board Membership and Appointments

INTRODUCTION

1. As part of the Programme of work to create Integrated Care Boards (ICB), NHS England issued detailed guidance on the governance documents and arrangements that needed to be put in place for the first day of operation of the ICB. With specific reference to the creation of the ICB's Board, NHS England issued a 'Model ICB Constitution' and supporting guidance.

2. Among other things, the Constitution sets out the Board's membership and the governance arrangements for the ICB. Large parts of the Model Constitution are prescribed, with certain elements left for local discretion.

OVERVIEW OF THE BOARD'S MEMBERSHIP

3. Paragraph 2.1.3 of the Model Constitution sets out that the Board will consist of:

    - A Chair;
    - A Chief Executive;
    - At least three Ordinary members.

4. Paragraph 2.1.5 sets out that the Board must have the following ordinary members:

    - Three executive members, namely:
        i. Chief Financial Officer;
        ii. Executive Medical Director;
        iii. Chief Nursing Officer;
    - At least two [*SWL ICB has agreed it will have four*] non-executive members;

5. The model Constitution then goes on, at paragraph 2.1.6, to set out that the Ordinary Members will include:

    - …at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following, and appointed in accordance with the procedures set out in Section 3 below**:**

I. NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description;
II. the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description;
III. The local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

6. Taking into account the minimum numbers of prescribed roles, SWL ICB has determined locally, that the Board will have the following membership (this is set out at paragraphs 2.2.1 – 2.2.3 of the SWL ICB Constitution):

- 2.2.1 The ICB has six Partner Members:

  a) Four Partner Members – NHS Trusts and Foundation Trusts;
  b) One Partner Member – Primary Medical Services; and
  c) One Partner Member - Local Authorities.

- 2.2.2 The ICB has also appointed the following further Ordinary Members to the Board:

  a) Six Place Members; and
  b) Deputy CEO.

7. **In summary, paragraph 2.2.3 of the constitution sets out that the SWL Integrate Care Board is constituted of the following members:**

- **Chair;**
- **Chief Executive;**
- **Four Partner Members - NHS and Foundation Trusts;**
- **One Partner Member - Primary Medical Services;**
- **One Partner Member - Local Authorities;**
- **Four Non-Executive Members;**
- **Chief Finance Officer;**
- **Executive Medical Director;**
- **Chief Nursing Officer;**
- **Six Place Members; and**
- **Deputy CEO**.

8. In addition to the above, the Constitution sets out that the Board may invite specified individuals to be Participants or Observers. Participants will receive advanced copies of the agenda. They will be invited to attend any or all of the Board meetings and will be able to address the meeting and ask questions but may not vote. The Constitution lists the following as participants:

- All Executive Directors of the ICB who are not appointed members of SWL the Board; and
- A Local Authority Representative

9. The Constitution goes on to set out the nominations, selection and appointments criteria for different Board members, along with eligibility criteria for each of the roles. In appointing to the Ordinary Member roles, the ICB has ensured that all of the conditions of the constitution have been met and that all of the members meet these eligibility criteria. This includes, where appropriate, the joint nomination of roles.

10. On the 10th of June 2022, the SWL ICB CEO (designate) wrote to the SWL ICB Chair (designate) following the selection and appointment panel for Partner Members. The letter sought approval to appoint the Partner Members listed at paragraph 11 to the respective roles. (A copy of the letter is attached at **Annex A)**. On the 17 June 2022, the ICB Chair (designate) confirmed approval of all of these appointments (a copy of the letter is attached at **Annex B**).

11. Therefore, the ICB Board is made up of the following members:

- **The ICB Chair**: Millie Banerjee
- **The ICB Chief Executive Officer**: Sarah Blow
- Four members from NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description:

    i. **Partner Member – Acute Service**: Jaqueline Totterdell (Chief Executive Officer, St George's University Hospitals NHS Foundation Trust (FT), and Epsom and St Helier University Hospital NHS Trust);
    ii. **Partner Member – Mental Health**: Vanessa Ford (Chief Executive Officer, South West London and St George's Mental Health NHS Trust);
    iii. **Partner Member - Community Services**: Jo Farrar (Chief Executive Officer, Hounslow and Richmond Community Healthcare NHS Trust);
    iv. **Partner Member – Specialised Services**: Dame Cally Palmer (Chief Executive Officer, The Royal Marsden NHS FT).

- One member from Primary Medical Services (general practice) providers within the area of the ICB and are of a prescribed description:

    i. **Partner Member - Primary Medical Services**: Dr. Nicola Jones, GP Partner in Wandsworth.

- One member from Local Authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

i. **Partner Member - Local Authorities**: TBC

- **Four Non-Executive Members**:

  i. Mercy Jeyasinham;
  ii. Ruth Bailey;
  iii. Dick Sorabji;
  iv. The fourth Non-Executive Member is yet to be appointed.

- **The Chief Financial Officer**: Helen Jameson.
- **The Executive Medical Director:** Dr. John Byrne.
- **The Chief Nursing Officer**: Dr.Gloria Rowland.

- **Six place based members**:

  i. **Place Member for Croydon**: Matthew Kershaw (Chief Executive Officer, Croydon Health Services and Place-based Leader for Health);
  ii. **Place Member for Kingston**: Annette Paultz (GP Partner in Kingston and Kingston Place Provider Lead for Primary Care);
  iii. **Place Member for Merton**: Dagmar Zeuner (Director of Public Health, London Borough of Merton);
  iv. **Place Member for Richmond**: Ian Dodds (Director of Children's Services, Royal Borough of Kingston upon Thames and London Borough of Richmond of Thames);
  v. **Place Member for Sutton**: TBC
  vi. **Place Member for Wandsworth**: TBC

- **The Deputy CEO**: Karen Broughton

ADDITIONAL APPOINTMENTS

12. **Founder Member of the ICP**: The Board is required to appoint the ICB Founding member of the ICP. As Chair of the ICB and Joint Chair of the ICP, Millie Banerjee will fulfil this role.

13. In addition to the above, there are a number of statutory and best practice roles that the ICB are required to appoint named members of the Board to undertake.

14. **Conflicts of Interest Champion**: Section 6.1.6 of the South West London ICB Constitution sets out the requirement for a Conflict of Interest Guardian and that this will be the ICB's Audit Chair. Their role is to:

    - Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;

- Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
- Support the rigorous application of conflict of interest principles and policies;
- Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation; and
- Provide advice on minimising the risks of conflicts of interest

15. Upon appointment, the Audit Chair will be asked to undertake this role.

16. **Freedom to Speak Up Guardian**: The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015).

17. The Freedom to Speak Up Guardian supports staff to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken.

18. SWL ICBs Freedom to Speak up Guardian will be Ruth Bailey.

19. All NHS Organisations must have an Emergency, Preparedness, Resilience and Response (EPRR) function in place to respond to critical incidents. We will provide the Board with more background and information on the ICB's arrangements for this function in the future. However, NHS England guidance sets out that we must have a Non-Executive Member to provide oversight and assurance to the Board on this function. This role will be undertaken by Dick Sorabji.

20. South West London ICB's Senior Information Responsible Officer (SIRO) is Karen Broughton and the ICB's Caldicott Guardian is Dr.Gloria Rowland.

RECOMMENDATION

21. The Board are asked to **note** the appointments listed under paragraphs 11 and 20 and **approve** the appointments listed in paragraphs 12 – 19, in this paper.

NHS South West London
Integrated Care Board

South West London Integrated Care Board
1 July 2022

ESTABLISHING SOUTH WEST LONDON INTEGRATED CARE BOAD
Committee Structure and Terms of Reference

INTRODUCTION

1. Section 4.6.1 of the South West London (SWL) Integrated Care Board's (ICB) Constitution provides for the Board to appoint committees and arrange for its functions to be exercised by such committees.

2. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees. The Board may also create Task and Finish Groups to undertake specific, time limited, pieces of work.

3. Each committee, sub-committee or Task and Finish Group, established by the ICB operates under Terms of Reference, which must be either approved by ICB Board or the relevant Committee, as appropriate.

4. The Board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference.

COMMITTEE STRUCTURE

5. In order to facilitate the safe and effective delivery of its work the ICB has established a number of committees. Development of these committees and their Terms of Reference is taking place in three phases, as outlined below.

PHASE ONE

6. **Phase one - Statutory, Oversight and Place Committees**: Committees that need to be operation from the commencement of the ICB.

7. The Health and Care Act 2022 sets out that ICB will have at least two, statutory Committees, these are:

a. **Remunerations and Nominations Committee –** Chaired by Ruth Bailey. The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. The Committee is responsible for the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including Board Members) and Non-Executive Members, excluding the Chair (Terms of Reference are attached at **Annex A**).

b. **Audit and Risk Committee –** Chair to be confirmed: The committee provides oversight and assurance to the ICB on the adequacy of governance, risk management and internal control processes within the ICB. The duties of the Committee will be driven by the organisation's objectives and associated risks (Terms of Reference are attached at **Annex B**).

8. Further to the statutory Committees listed in paragraph 7, the ICB will also establish the following committees:

9. **Finance and Planning Committee –** Chaired by Dick Sorabji. The Committee is responsible for ensuring that there is both a robust financial strategy and planning framework in place and to oversee the system planning and broader financial management (Terms of Reference are attached at **Annex C**).

10. **Quality and Oversight Committee** – Chaired by Mercy Jeyasingham. The Committee is responsible for ensuring that the ICB secures continuous improvement in the quality of services, This includes reducing inequalities in the quality of care. The Committee will also ensure that there is system oversight of Performance including at Place and Collaborative level (Terms of Reference are attached at **Annex D**).

11. **Place Committees**: Place Committees are responsible for the planning, coordination and delivery of shared objectives and Health and Care Plans. The Committees focus on improving health and wellbeing outcomes for the population, prevention of ill health and addressing health inequalities that exist in the boroughs. SWL ICB has six Place Committees:

    a. **One Croydon Committee**
    b. **Merton Health and Care Together Committee**

c. **Kingston Place Based Partnership Committee**
d. **Richmond Place Based Partnership Committee**
e. **Sutton Place Partnership Committee**
f. **Wandsworth Health and Care Partnership Committee**

12. A standard Terms of Reference has been completed for all these committees and is attached at **Annex E.**

PHASE TWO

13. **Phase two:** These committees are already in place and meeting but need their Terms of Reference amending to reflect the new ICB Governance structure. These Terms of Reference will come to the next ICB Board.

14. **Urgent and Emergency Care Committee:** the UEC Committee provides oversight and assurance on urgent and emergency care across SWL. It ensures that UEC pathways deliver safe, high quality, responsive care for the SWL population.

15. Provider Collaborative Committees: Provider Collaboratives work together to continuously improve quality, efficiency and outcomes, and proactively address unwarranted variation and inequalities in access and experience across their different providers. They collaboratively lead the transformation of services and the recovery from the pandemic, ensuring shared ownership of objectives and plans across the collaborative's members**:**

- South London Partnership Committee;
- South West London Acute Provider Collaborative Committee;
- Royal Marsden Partners Committee.

PHASE THREE

16. Phase three: Phase three of this work constitutes committees which report to both the ICB and the ICP. As these are joint committee their Terms of Reference need to be co-designed. This will be taking place over the coming months and we will bring back the final Terms of Reference to a future ICB Board meeting for approval.

17. People and Communities Engagement Assurance Committee provides assurance to the both the SWL ICB, and Integrated Care Partnership that the

duty to involve has been met. It will provide advice on engagement plans and activities to ensure they meet best practice and are inclusive of those that are seldom heard, experience health inequalities and/or have protected characteristics.

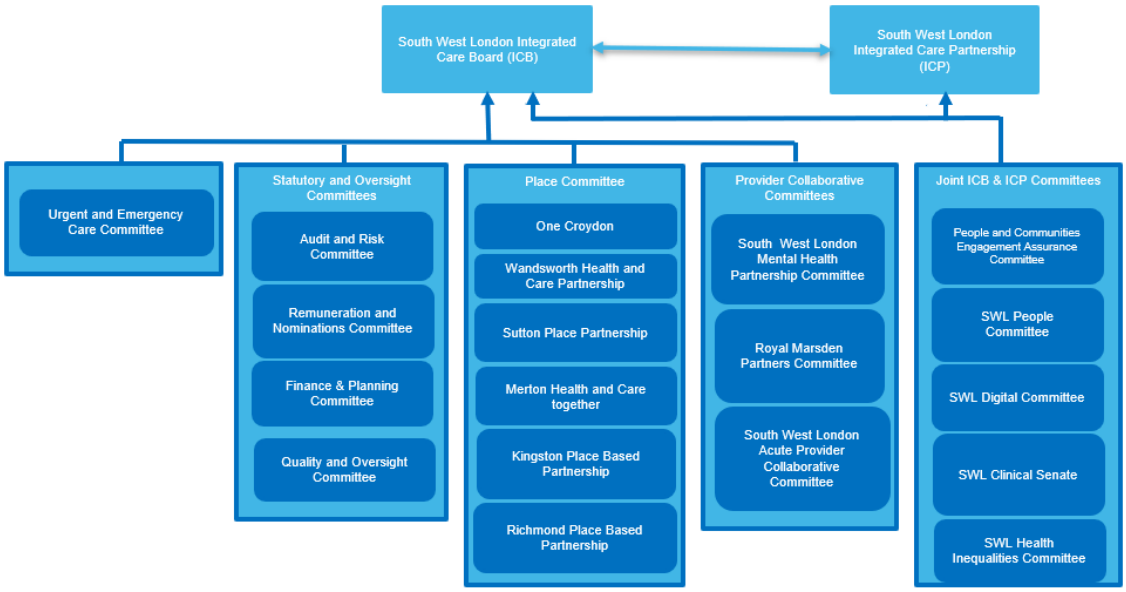
18. **SWL People Committee** brings partners together to assess the Integrated Care System (ICS) people issues and challenges. It ensures that SWL meets the NHS National People requirements. It oversees the development of the ICS People Strategy and Priorities and agrees, oversees and drives the delivery of SWL ICSs people actions. It is responsible for ensuring a fit for purpose data collection and analytical capability is in place to assess improvement opportunities at sufficient level of granularity to design focussed objectives and workstreams**.**

19. **SWL Digital Committee** is responsible for developing the Digital Strategy for the ICS and setting key focus workstreams, investment prioritisation, funding approach, stakeholder engagement and supplier strategy.

20. **SWL Clinical Senate** the Clinical Senate is responsible for setting the clinical strategy for South West London. The Senate reviews progress towards the SWL Five-Year Plan, sets clinical priorities, shares good practices and brings working groups together to assure delivery and consider cross-working group issues. The Senate explores clinical innovation opportunities and where agreed, will commission a small number of clinical reviews each year to improve care**.**

21. **SWL Health Inequalities Committee** The role of the SWL Health Inequalities Committee is to set the strategic vision and goals for the health disparities programme across the ICS. It provides oversight on the implementation of the London Equity strategy and local key workstreams which will support work to reduce health inequalities. The Committee provides leadership and steering to the Equality, Diversity and Inclusion delivery group for matters escalated to the Board and embeds system partnership and community-centred approaches to health and wellbeing at Board level

22. The diagram below provides a visual representation of SWL ICB's governance structure.



RECOMMENDATION

The ICB Board are asked to:

- **Approve** the establishment and proposed terms of reference of the phase one committees
- **Note** the on-going work in regard to the development of other ICB and joint ICB/ICP committees.

June 2022

South West London Integrated Care Board
1 July 2022

ESTABLISHING SOUTH WEST LONDON INTEGRATED CARE BOAD
CCG Close down and ICB Establishment

INTRODUCTION

1. As part of the transition from Clinical Commissioning Groups (CCG) to Integrated Care Boards (ICB), NHS England & Improvement issued guidance on the design of the new organisation. This guidance included: the ICB Design Framework; the Due Diligence process to be completed when closing down the CCG and establishing the ICB; the process of reporting and assuring progress to confirm that the ICB is Ready to Operate and that:

    a. All legally required and operationally critical elements are in place ready for the establishment of the ICB as a statutory body on 1 July 2022; and
    b. Arrangements are in place for the ICB to fulfil its role within the wider ICS, including establishing the Integrated Care Partnership (ICP) with the relevant local authorities.

2. The five relevant documents for CCG Close down and ICB Establishment were (these are available on request):

    1. ICS Design Framework
    2. ICS Implementation Guidance; Due Diligence, transfer of people and property from CCGs to ICBs
    3. CCG Close Down and ICB Establishment Due Diligence (DD) checklist;
    4. ICB Establishment Timeline;
    5. Readiness to Operate Statement (ROS).

ICS design framework

3. As part of the ICS Transition Programme, SWL CCG responded to all areas of the ICS design framework and the range of guidance documents that were published by NHSE:

    a. **Provider collaboratives**: our provider collaboratives have developed their plans reflecting the expectations of the ICS design framework and '*Working together at scale: guidance on provider collaboratives*.'
    b. Place: our six SWL places have all refreshed their two-year Local Health and Care Plans. Place governance arrangements have been agreed and leaders (including Place Convenor, Executive lead) have been appointed.

c. **People function:** we have developed our people plans and revised our governance arrangements for the People Committee. These were agreed at the Recovery and Transition Board in May 2022.
d. **Engaging with our communities:** our engagement strategy was signed off by our Recovery and Transition Board and our SWL Programme Board in February 2022.
e. **Clinical and care professional leadership:** we have drafted our clinical and care professional leadership framework and have had our pay and remuneration proposals for clinical leads approved by the SWL CCG Remuneration Committee. Appointments are underway for ICB Place clinical leads.
f. **Quality and safety:** SWL has established its System Quality Group, the SWL System Quality Council. Terms of reference has been developed and ratified by the SWL CCG's Quality and Performance Committee and by the System Quality Council.

Oversight

4. Guidance has been received from NHSE regarding completion of new Memorandum of Understanding (MOU) which is intended to document the relationship/operating model between NHSE and ICBs, including arrangements for oversight and performance. The completion of the MOU will support the establishment of ICBs as statutory bodies and their expected relationships with NHSE. The MOU is being finalised and will be agreed with NHSE by 1 July 2022. The expected MOU will build on the local SWL ICS oversight framework which has previously been agreed at the Recovery and Transition Board.

5. Work is also in process to develop a Place based accountability agreement with the aim of having this agreed on or near the 1 July. Place based agreements will be aligned to the new proposed MOU between NHSE and the ICS as well as reflecting local agreements. Shadow accountability agreements are also being developed for Provider Collaboratives.

Emergency Preparedness, Resilience and Response

6. We have shared our updated Emergency Preparedness, Resilience and Response (EPRR) readiness self-assessment with NHSE who commended us for the quality of the work undertaken.

Finance and planning

7. Principles for financial delegation were agreed by the system in December 2021 with the detailed financial envelopes being finalised now that the planning process has been completed.

8. Place and SWL ICB budgets are currently being created in line with the functional review.

9. System Leaders came together to address the financial gap that emerged during the initial planning phases. Their work has closed the financial gap and they are now turning their attention to delivering the financial requirements. As part of the ROS we are required to provide assurance that planning for 22/23 has been completed in line with national requirements. NHSE have issued further guidance which states that, 'the joint System Transformation and Finance position should be rated as complete (blue) where the region is assured by the system that the planning process has been undertaken satisfactorily and the ICB's infrastructure for financial management and planning is robust. This may apply even in cases where there is a planned deficit position at the point of conducting the ROS assessment in June.' On this basis SWL is rated blue on its ROS (complete) for finance and planning.

Communications and engagement

10. In addition to developing our engagement strategy we have developed our websites for ICB and ICP, which will go-live on 1 July 2022.

11. A new brand for NHS SWL ICB has been developed and we are working to 'evolve' and refresh the current South West London Health and Care Partnership branding, that has been in use for the last four years, to become branding for South West London Integrated Care System.

12. Funding has been agreed for a shared working model which supports greater SWL collaboration across our six Healthwatches. Healthwatches will now be resourced in addition to their local roles to: coordinate their work to better inform SWL priorities; more closely align work plans across SWL; and provide SWL informed representation on ICS boards and committees. This SWL work will be carried out by a SWL HW executive coordinator post and non-exec HW influencer role – hosted through an existing Healthwatch organisation.

Due Diligence Process

13. NHSE defined three starting points and corresponding levels of complexity for CCGs in the ICS implementation programme and specified that the level of due diligence to be undertaken should reflect these starting points. **SWL CCG was in level 1**:

    a) **Level 1**: Where the boundary of a CCG is coterminous with its existing ICS, due diligence will involve listing all staff, property and liabilities so that this information is available to the new ICB.

       The listing is not required for legal purposes for the transfer scheme, as this scheme will simply make provision for all CCG staff, property and liabilities to transfer to the ICB in a straightforward 'lift and shift' arrangement.

    b) **Level 2**: Where there will be no ICS boundary changes but there are multiple CCGs within an ICS there will be additional complexity and a need for co-

ordination, with consideration of the processes to bring together the staff, property and liabilities from multiple CCGs. Whilst each CCG is accountable for their own staff, property and liabilities, further joint work may be required between CCGs to consider how organisational policies, processes, assets and liabilities may be consolidated and to ensure that arrangements are fit for purpose for a single ICB.As for level 1, the transfer scheme will make provision for the legal transfer of all people, property and liabilities of the CCGs to the ICB.

c) **Level 3**: Where there will be changes to existing ICS boundaries, particularly any which involve CCGs being 'split' between ICBs, there will be further complexity as multiple CCGs will be involved in the development of the new ICB configurations and, where any ICS boundary change cuts across an existing CCG boundary, a full CCG 'lift and shift' arrangement cannot apply. In such circumstances, comprehensive lists will be required to confirm the specific people, property and liabilities to be transferred from each CCG to each ICB, and the lists will need to be included in a schedule to the transfer scheme. There will need to be joint working and information sharing between CCGs and existing ICSs to ensure the accuracy of the lists and that there are no gaps or duplication

14. SWL CCG utilised work previously undertaken when we merged SWL's six CCGs into the current single CCG, to provide a holistic view of all the due diligence work that needed to be completed. Using all of these documents we created a comprehensive due diligence checklist which our Internal Auditors also cross checked against other organisations for best practice.

15. As part of the due diligence process, the CCG's Accountable Officer was required to provide assurance, both to the new CEO of the ICB and the NHS England Regional Director, on 1 June that our due diligence process has met these requirements. The Governance Oversight Group (GoG) agreed at its meeting on 23 May 2022 that, as the CCG's Accountable Officer (Sarah Blow) is both the outgoing AO and the incoming ICB CEO (designate), this would not be appropriate for SWL and that, instead, the CCG's Accountable Officer should write to the ICB Chair (designate) and the NHS London Regional Director to provide assurance. (**Annex A**)

Due Diligence delivery

16. The due diligence process commenced on 1 November 2021. It was initially due to complete on 1 April 2022. However, due to delays in the passage of the Health and Care Bill 2022 (now Act) the final establishment of ICBs was moved to 1 July. It is worth noting that, as the 1 June deadline was a month before the formal closure of the CCG and establishment of the ICB, there were a number of actions that could not be completed on 1 June, or, in the case of some finance actions, until later in the year. We have clearly identified these actions and will continue to track progress against delivery.

17. SWL CCG took a three-stage approach to the completion of the due diligence process:

- **Stage 1** – Nomination of an SRO and Workstream leads to review the due diligence checklist and timeline, and lead the creation of a project plan;
- **Stage 2** – Completion the relevant tasks in the due diligence checklist, monitoring progress against plan through fortnightly workstream progress updates and workstream leads meeting; and
- **Stage 3** – Provisions of written evidence of completion of tasks.

Stage 1 (complete)

18. James Murray (SWL CCG CFO) was nominated as SRO for the project and the checklist was broken down into the following workstreams:

    - Governance;
    - Communications;
    - Workforce & HR;
    - Finance; Estates & Contracts;
    - Quality; and
    - ICT

19. The relevant Executive Directors were asked to lead each workstream, with day-to-day delivery being undertaken at Director or Deputy Director level. Each line item for the individual workstreams was treated as a deliverable and assigned a start and finish date along with a responsible owner. Following this, an overall plan was built in Microsoft Project to track delivery.

Stage 2 (Workstreams continue delivering their planned activity)

20. A Task and Finish Group (T&FG), chaired by the CCG's Chief of Staff, with the relevant workstream leads was established to oversee the process. The group has met on a two-weekly basis since November to track progress against plan and flag any exceptions. To support the T&FG, by-weekly reporting was putting in place with regular updates being provided to the T&FG, GoG and SWL SMT. (The latest update can be seen in **Annex H**)

21. Stage two will continue to deliver up to and past the transition date on 1 July due to:

    - A number of tasks which cannot be completed until prior to transfer (for example, final and up-to-date lists of complaints, Freedom of Information requests, contracts etc);

    - Some tasks within the Finance workstream in relation to CCG final accounts being delivered after transition (for example, finalisation of the accounts for months 1-3).

22. We have agreed that the T&FG will continue to meet until the end of July. At which point any outstanding actions, for example those relating to the final close-down the CCG's account, will be explicitly transferred to the responsible Executive Director for completion.

Stage 3

23. We have undertaken multiple levels of assurance to ensure delivery:

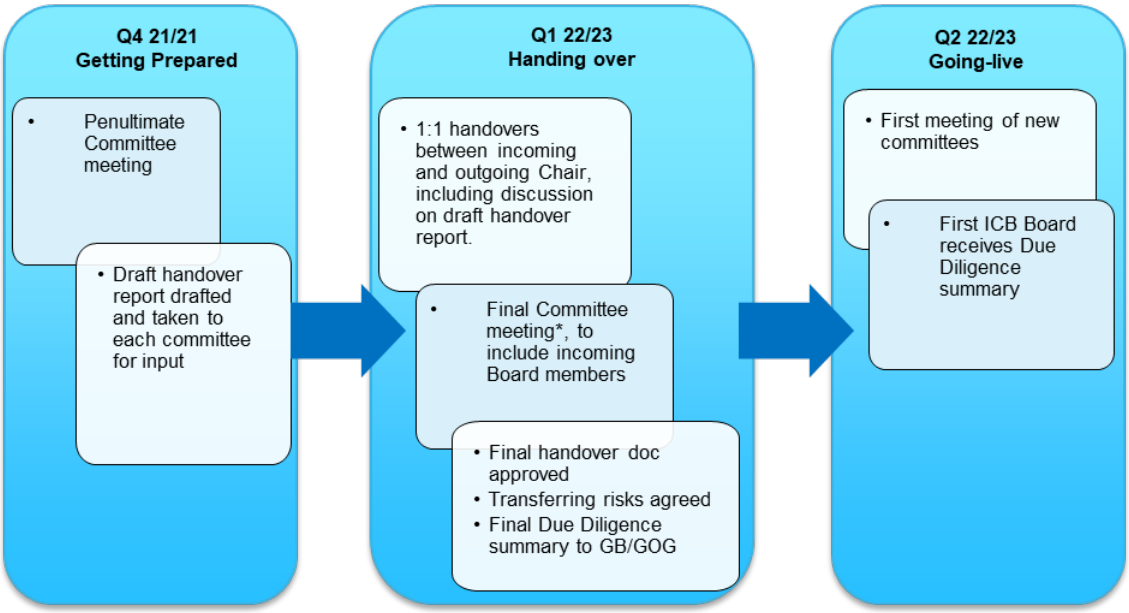
- As noted above, a T&FG was established to monitor progress against plan on a regular basis and provide feedback to the GoG and the Senior Management Team (regular reporting has been provided to both groups).
- As tasks have been completed these have been marked against plan and leads have been asked to provide evidence of their completion. We created a SharePoint site for storage of all of this evidence so that it was available centrally.
- The Audit Committee was updated on due diligence progress on the 8 March 2022.
- At the beginning of May, the CCG's Chief of Staff wrote to the relevant Executive Directors asking them to assure themselves that each workstream had completed the necessary deliverables to date and, where these did not complete before 1 June, that there was a plan in place for completion. A template letter was provided for the Executive Directors to reply to the CCG's Accountable Officer providing this assurance. These letters are provided at **Annex B.**
- In addition to the above, the CCG's Internal Auditors were asked to undertake an advisory audit across the entire due diligence process. This has been split into three phases to match the stages of the programme. The first two phases of the audit have now been undertaken. These audits have confirmed that the processes in place have been sufficiently robust to ensure delivery and have not produced any significant management actions. We have completed the first two phases of the audit, receiving positive assurances on both.
- The overall process and evidence was reviewed by the Chairs of CCG's Audit and Finance Committee together with the Head of Internal Audit on 27 May.
- On the 31st of May we held an extraordinary GoG, chaired by the CCGs Director of Strategy and Transformation (and ICB Deputy Chief Executive (designate) to go through the due diligence process. That meeting made a recommendation to the CCG Accountable Officer that the due diligence letters providing assurance to London Regional Director and ICB Chair (designate) could be submitted.

24. On 1 June SWL CCG Accountable Officer submitted letters to both the ICB Chair (designate) and London Regional Director that South West London CCG has followed a robust due diligence process to prepare for closedown and for the safe transfer of staff and property (in its widest sense) to South West London ICB on 1 July 2022.

Committee Handover

25. To ensure a smooth and comprehensive transition and handover between the CCG's governance structures and the future ICB Governance Structures, the GoG agreed the committee handover process. That process built on the process used when abolishing the former six SWL CCGs and creating the new single CCG and consisted of:

    a. Committee handover reports;
    b. 1:1's between incoming and outgoing Chairs (due to be scheduled in June/July where new ICB Committee Chairs have been identified).



26. The written handover process has taken place, draft handover documents will be considered in the penultimate committee meeting, with a final handover paper presented to the final meeting of each committee. Details of each committee handover were provided to the final Governing Body meeting 22 June 2022.

Readiness to Operate Statement (ROS)

27. The ICB CEO (designate), signed the ROS on 10 June 2022 and this was ratified by the Regional Director on 19 June 2022 for submission to the national team (A copy of the Ready to Operate Statement can be seen at **Annex C**)

28. NHSE provided guidance to enable us to rate our position:
29.

R	*Delivery is not achievable by 1 July*	*Comments to be provided; including route for further action post-establishment. It may be appropriate for red-rated issues to be highlighted in the ROS (the statement itself) and to highlight to the NHSE Chief Executive Officer*
A	*Delivery is at risk but mitigation plan in place for delivery by 1 July*	*Comments to be provided, including further action prior to 1 July*
G	*On target for delivery by 1 July 2022 (only to be used in exceptional circumstances i.e. where it is expected that action will be **complete** by 1 July 2022)*	*Examples could be amendments to documents to be made before 1 July, appointments to be fully confirmed by 1 July or the ICB Board meeting to take place on 1 July to ratify governance documents*
N/A	*Not applicable - applies to prompt 3.8 only*	
C	*Completed*	*No further action required prior to ICB establishment - ready for 1 July (NOTE: this does not preclude further development beyond this point)*

30. The SWL Recovery and Transition Board have assessed our progress against the ROS as 'blue' (completed) across the majority of areas with the following exceptions:

    a. Arrangements for the **Memorandum of Understanding with NHSE**. GREEN rated – received from NHSE on 30 May 2022, expected to be completed by 1 July 2022.
    b. Activities as outlined in the **NHS SBS finance reconfiguration programme plan** as due by 1 July 2022. GREEN rated – work is on track as planned with overall programme expected to be complete by 1 July 2022.

Further development of the ICS

31. **First day plans:** In addition to our inaugural Integrated Care Board which will meet on 1 July we have also developed a communications plan for our first day as an ICS. This plan builds on communications and engagement work across South West London Health and Care partnership over the last 6 months, and will also continue beyond 1 July 2022. For example, monthly 'Message from Millie and Sarah', King's Fund leadership films, Team Talk and staff briefings.

32. **Development of the Integrated Care Board five-year forward plan and Integrated Care Partnership Integrated Care Strategy**: During early summer work will commence with the ICP to develop the strategic ambitions and priorities of the ICP which will support the creation of the Integrated Care Board five-year forward plan. The creation of the ICB five year development plan will be an early focus for the new ICB. During its first year the ICP will focus on developing an integrated care strategy as well develop ICS wide ambitions and plans to integrate care and improve health and wellbeing outcomes for our population.

33. **Creation of the ICS first 100 days plan**: Work has commenced on the creation of a plan for the first 100 days of the ICS aimed at co-designing what the key areas of focus for the new organisation and staff. The plan will focus on key activities in relation to strategy, delivery, governance, and oversight as core elements of a 100-day plan.

34. **ICS Organisational Development**: A second ICS wide simulation event is planned for mid-July which will focus on potential key challenges the new ICS might face as it moves forward as well as several topic areas and priorities we will look to explore in more detail. Further discussions will take place with ICS partners to identify these issues.

Conclusion and Recommendations

35. A paper was presented to South West London CCG Governing Body on 22 June 2022 for them to note the successful delivery due diligence in closing South West London CCG and the assurance that South West London ICB is Ready to Operate and that there will be a safe and smooth transition on 1 July 2022.

36. The ICB Board is asked to note the successful completion of this work.

June 2022

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board	
Date	Friday, 01 July 2022

Document Title	Next Steps for Integrating Primary Care: The Fuller Stocktake		
Lead Director (Name and Role)	Mark Creelman Primary Care SRO		
Author(s) (Name and Role)	Andrew McMylor Director of Primary Care		
Agenda Item No.	6	**Attachment No.**	06

Purpose (Tick as Required)	Approve	Discuss	Note ✓

Executive Summary

Next Steps for Integrating Primary Care: The Fuller Stocktake is a nationally commissioned stocktake review of integrated primary care. It primarily focusses on general practice but is not exclusive to all pillars of primary care. The review has 15 shared actions, 8 of which apply to ICSs. In the attached report we set out the ICS actions and a high level SWL position/progress against them.

Purpose:

To provide the Integrate Care Board with a summary of the national review of Integrating Primary Care, Next Steps for Integrating Primary Care: The Fuller Stocktake, and the 15 shared actions that have been identified. The Report also provides a high level summary of SWL action against the ICS recommendations and outlines the next steps to take the recommendations forward in SWL.

Recommendation:

The Board is asked to note that:

1. A national review of Integrating Primary Care has been undertaken and that 15 shared actions have been identified.
2. The Primary Care Transformation Group will review the ICS recommendations from the Stocktake Review, together with the current SWL primary care transformation plan, to create an ICS Primary Care Transformation Delivery Plan which will be brought back to a future meeting of the ICB for approval.

Key Issues for the Board to be aware of:

Next Steps for Integrating Primary Care: The Fuller Stocktake sets out clear aims in:

- Streamlining access to care;
- Providing more proactive, personalised care; and
- Helping people to stay well for longer.

Although many of the required actions set out in the stocktake are already in development, or in place, in South West London it is likely that the ICB will be required to report against the actions at some point in the future.

Conflicts of Interest: None
Mitigations for Conflicts of Interest: None

Corporate Objectives This document will impact on the following Board Objectives:	The Fuller review and associated actions will assist the ICS achieve: • integrated primary care services, • improved access and urgent care access • supporting and improving care for our most vulnerable patients, improving health outcomes • providing preventative, proactive care

Risks This document links to the following Board risks:	Key risks highlighted in the report are: • access to urgent and non-urgent care • quality and consistency of care As we consider the actions more systematically, there may be financial risks to achieve the new models of care
Mitigations Actions taken to reduce any risks identified:	SWL progress will be monitored through the Primary Care Transformation Group and reported to the ICB and the relevant sub-committees such as Finance and Planning or Quality and Oversight.

Financial/Resource Implications	No financial implications are known at this point

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	No
What are the implications of the EIA and what, if any are the mitigations	n/a

Patient and Public Engagement and Communication	The review undertook a wide-ranging consultation process. Locally where we would consider service change, the appropriate consultation will be undertaken

	Committee/Group Name:	Date Discussed:	Outcome:
Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Primary Care Transformation Group	Wednesday, 20 July 2022	To be confirmed
		Click here to enter a date.	
		Click here to enter a date.	

Supporting Documents	None

NHS South West London
Integrated Care Board

SOUTH WEST LONDON INTEGRATED CARE BOARD
1 JULY 2022

NEXT STEPS FOR INTEGRATING PRIMARY CARE: FULLER STOCKTAKE REPORT AND SWL PROGRESS

Background

- In November 2021 Amanda Pritchard asked Dr Claire Fuller, GP and CEO designate Surrey Heartlands ICS, to undertake a stocktake of integrated primary care to look at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry) across systems. The remit excluded the partnership model, the GP contract and the funding formula.

- The Stocktake team engaged with almost 1,000 people through workstreams, roundtables and one-to-one meetings, and had over 12,000 individual visits to a dedicated engagement platform and over 1.5 million Twitter impressions.

- The engagement reached a consensus that what is not working in primary care is access and continuity, with frustrations shared by both patients and staff alike. What also emerged was a consensus on what to do differently with 15 areas of shared action identified. This report will consider these recommendations and where South West London is against each identified ICS action.

- At the heart of this report is a new vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers:

    - **Streamlining access to care** and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
    - **Providing more proactive, personalised care** with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
    - **Helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

- The Stocktake Report acknowledges a number of challenges to deliver the vision, and notes local leadership at Primary Care Network (PCN), place and system level will be the difference between success and failure in integrating primary care.

Framework for shared action

- The Stocktake Report outlines 15 core actions, shared between ICSs, NHS England, Health Education England and the Department of Health & Social Care. The actions for ICS' are outlined below, alongside a brief commentary of SWL progress. The full

range of actions are outlined in appendix A. Further direction from NHSE is expected with regards to specific actions and any national changes.

Actions for ICSs

- **Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices.** This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face.

  SWL progress
  - The new Integrated Urgent Care provider commenced in June 2022 (including GP Out of Hours, i.e. after 6.30pm Mon-Fri and 24 hours Sat/Sun along with 111) and as part of the procurement process, SWL were clear the successful provider needs to work to better integrate with GP services and to ensure seamless handoffs back to GPs during core hours. This work is in its early stages and a detailed programme of work is in place to achieve better integration.
  - We have successfully implemented weekend telephony for patients to contact primary care rather than 111 throughout December and January and other bank holidays since the pandemic.
  - From October, all Primary Care Networks (PCNs) will be delivering as part of the PCN Direct Enhanced Service (DES), additional capacity between 6.30pm-8pm Mon-Fri and 9am – 5pm Saturday. This is expected to include the broader skill mix of GP teams and clinics will be designed around local population needs, for example some PCNs will wish to establish 7am-8am commuter clinics and other PCNs will establish dedicated paediatric clinics.
  - As the national PCN DES requirement does not specify Sunday and Bank Holiday provision, we are working with PCNs on their plans throughout July to understand, and mitigate any possible gaps.

- **Enable all PCNs to evolve into integrated neighbourhood teams, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors.**

  SWL progress
  - There are 39 PCNs in SWL across our six boroughs and have been in place since 2019.
  - Since their creation PCNs in SWL have recruited nearly 500 additional roles covering a multitude of professions, ranging from pharmacists, social prescribers and first-contact physiotherapists.
  - PCNs for the last 2 years have been actively engaged, and leading multidisciplinary teams (MDTs) with their local care homes in order to promote better personalised support for patients. This work will be broadening in the coming months around anticipatory care, i.e. to identify people before

they need hospitalisation and through collaborative work reduce the chances of an emergency admission.
- For SWL this will build on many successful examples of primary care working with other system partners in pro-active MDTs.

- **Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams**, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates. Specifically put in place sufficient support for all PCN clinical directors and multi-professional leadership development, and protected time for team development. Baseline the existing organisational capacity and capacity for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions.

  SWL progress:
  - Each borough has a dedicated primary care team who work with PCNs and general practice to support both the day-to-day work alongside leading on implementing a range of primary care transformational programmes.
  - There is a SWL centralised team who are responsible for managing primary care (specifically GP) contracts alongside leading on a number of once for SWL transformation programmes.
  - The SWL central team also has a workforce lead, responsible for working across the ICS to create and share workforce development opportunities.
  - The SWL finance team work increasingly closely with local teams as primary care (non-core contract) budgets continue to be evolved to place.
  - A number of PCNs have embraced recent technological innovations to help manage their resources so they can focus on patients who need their support. For example, eHubs have allowed one PCN to run various long-term conditions clinics through a dedicated clinical and admin team, without which each practice within the PCN may have struggled to staff and deliver.
  - As part of the innovative, ongoing Population Health Management programme in SWL, PCNs in Sutton are developing a range of initiatives to help them better understand their population and in turn re-design services.
  - SWL CCG, via NHSE funding invested over £1m in development for PCNs enabling PCNs clinical directors undertake a range of leadership and development programmes and these will remain available throughout 2021/22.
  - Furthermore, GP Federations (a membership of all practices in a borough which are aligned with PCNs) are well established and have the benefit of organisational infrastructure. Further work is planned with Federations and PCNs on building organisational capacity.

- **Develop a primary care forum or network at system level**, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place-based boards.

SWL progress

- Each place-based committee has a primary care lead representative, and they are supported by primary care development leads alongside a range of pathway-specific clinical leads.
- Each place as a primary care forum and multiple forums exist, for example there is a very active primary care nurses forum and other forums are being set up to support other staff groups.
- Additionally, the SWL Primary Care Transformation Group is an opportunity for senior leads to meet monthly to ensure consistency of delivery against key programmes, this will include PCN Clinical Director representatives.

- **Embed primary care workforce as an integral part of system thinking, planning and delivery.** Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.

  SWL progress

  - Workforce data has improved over the past 2 years and is reported monthly and we track numbers, and type of staff and working with Training Hub and HEE colleagues are able to target workforce interventions where they are most needed.
  - There are IT facilitators across all boroughs who are working with practices to improve coding and data mapping across a variety of indicators, e.g. appointment data.
  - The SWL Training Hub, working with SWL ICS has run a number of workforce recruitment and retention initiatives. This covers everything from workforce fares to explore the barriers to working in the NHS, through to running long-term conditions training qualifications for practice nursing.
  - A large part of the work in the past 2 years has focused on workforce well-being as a central enabler to retention. The Training Hubs and local GP Federations have, and continue to run, both 1:1 and team sessions to support the well-being of our primary care workforce.
  - A number of good practise models of training and supervision have been in place for SWL, which typically sees a PCN taking a lead for a certain type of workforce to build expertise in this area.
  - We are in the process of implementing a new Clinical and Care pay framework which has in its design access to certain NHS Terms and Conditions.
  - A proportion of national HEE funding is focussed on primary care workforce development. There is also a SWL leavers and returners initiative.

- **Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care**, taking a ‘one public estate’ approach and maximising the use of community assets and spaces.

  SWL progress

  - Each borough has, or is establishing, a local Estates Forum which will include primary care along with community and acute partners. As the report

acknowledges, and SWL is no different, there are a number of estate challenges.
- Throughout the rest of 2022, there will be opportunities for PCNs to work with external specialists in developing their local estate strategy. Acknowledging actions from NHSE on this, the ICS will continue to work with practices and PCNs in maximising our available estate.
- Despite the challenges there have been a number of success stories to create additional capacity in some practices, from innovative partnerships with other sectors through to making best use of technology to ensure clinical services are prioritised on-site with admin duties being conducted elsewhere.

- **Create a clear development plan to support the sustainability of primary care and translate the framework provided by *Next steps for integrated primary care* into reality, across all neighbourhoods.** Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.

  SWL progress
  - We have a good quality of general practice in SWL which is a reflection of how local primary care works to meet the needs of their community. Working at place and SWL we are pro-active in our approach to quality surveillance with all boroughs meeting regularly to understand and analyse data to reduce unwarranted variation.
  - Increasing access to appointments has been a feature of our work over the past six months with a focus on increasing the number of overall appointments and the percentage of face-to-face appointments within general practice. For example in March 2022 there was a total of 718,000 appointments delivered in general practice compared to 527,000 in March 2019. Face to face appointments were also at their highest level since the pandemic began.
  - We are developing a primary care quality surveillance dashboard which will bring together all core data sets available to us into one easy to interpret dashboard that will help us identify where a particular practice (or PCN) may require support.

- **Work alongside local people and communities** in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.

  SWL progress
  - Whilst this action pertains to implementing the recommendations in the future, there are a number of recent examples of engagement by primary care in co-designing local services.

- A key focus in 2022/23 is for PCNs to tackle health inequalities and all 39 have identified a local group, currently experiencing issues with regards to access and throughout the year will be proactively working with the groups to address barriers to access.

Summary and Next steps for SWL

- In November 2021 Amanda Pritchard asked Dr Claire Fuller, GP and CEO designate Surrey Heartlands ICS, to undertake a stocktake of integrated primary care. The Next Steps For Integrating Primary Care: Fuller Stocktake Report outlines 15 share actions to address the findings from the stocktake. This report outlines those actions and our initial assessment of SWL's progress against them.

- The Stocktake Report outlines both the challenges and opportunities for primary care as we move into Integrated Care Systems. It also acknowledged there are a range of actions that need to be undertaken at a national level to help unlock local opportunities for change locally.

- Good progress has been made in SWL over the past 2 years in delivering;

  - Improved access, increasing the number of appointments being delivered in general practice along with an increase in face-to-face appointments.
  - Recruiting almost 500 new people across 12 new job roles in primary care and integrating them into the work of general practice and PCNs. This has seen a large number of personalised care services developed, for example in supporting access for patients into community and voluntary self-help groups.
  - Embracing technology to improve access, for example around online consultations so patients can swiftly access the right care for them by the right person at the right time.
  - Every PCN participating or leading multidisciplinary team meetings for care home residents, which will be expanded over the coming months to include patients at risk of an emergency admission.
  - Supporting our workforce, both to focus on well-being and resilience but also in developing leaders for the future.

- Whilst this represents a strong start in delivering the actions of the Stocktake Report, we recognise there is a significant amount of work to still be achieved. Through the collaboration of place and SWL teams, led by our local clinicians, we believe the building blocks are in place to comprehensively deliver the vision of the report.

- The Primary Care Transformation Group will review the ICS recommendations from the Stocktake Review, together with the current SWL primary care transformation plan, to create an ICS Primary Care Transformation Delivery Plan which will be brought back to a future meeting of the ICB for approval.

Action for the Integrated Care Board

The integrated Care Board is asked to note that:

1. A national review of Integrating Primary Care has been undertaken and that 15 shared actions have been identified.
2. The Primary Care Transformation Group will review the ICS recommendations from the Stocktake Review, together with the current SWL primary care transformation plan, to create an ICS Primary Care Transformation Delivery Plan which will be brought back to a future meeting of the ICB for approval.

Appendix A

15 shared actions outlined in NEXT STEPS FOR INTEGRATING PRIMARY CARE: FULLER STOCKTAKE REPORT

1	Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices. This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face.	ICSs
2	Assist systems with integration of primary and urgent care access, specifically looking at the role of NHS 111, and considering the development of new metrics and standards on urgent and routine access, and introduce as planned, the new patient-reported experience measure for access to general practice.	NHS England
3	Enable all PCNs to evolve into integrated neighbourhood teams, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams. With teams collocated within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests. At place level, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams. Focus on community engagement and outreach, across the life course. Proactively identify and target individuals who can benefit from interventions in neighbourhoods, committing to delivering neighbourhood teams first for Core20PLUS5 populations. Co-ordinate vaccinations, screening and health checks at place level, in accordance with national standards.	ICSs
4	Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates. Specifically put in place sufficient support for all PCN clinical directors and multiprofessional leadership development, and protected time for team development. Baseline the existing organisational capacity and capacity	ICSs

	for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions.	
5	Develop a primary care forum or network at system level, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all placebased boards.	ICSs
6	Embed primary care workforce as an integral part of system thinking, planning and delivery. Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.	ICSs
7	Include primary care as a focus in the forthcoming national workforce strategy to support ICSs to deliver this report (NHS England). Recognising this is not currently funded, commit to future rollout of the NHS Staff Survey in primary care. Examine further flexibilities, and better communicate existing flexibilities, in the Additional Roles Reimbursement Scheme. Specifically consider, with DHSC and HEE, how the scheme should operate after March 2024, including the role of ICSs in working with national colleagues and PCNs in delivering it. Review the GPs Performers List to enable other appropriately qualified clinicians to contribute more easily as part of the primary care workforce.	DHSC with NHS England and HEE
8	Pivot to system leadership as the primary driver of primary care improvement and development of neighbourhood teams in the years ahead. Move to greater financial flexibility for systems on primary care. Bring together existing national primary care funding wherever practicable. Beyond 2023/24, maximise system decisionmaking on any future discretionary investment, beyond DDRB and pay uplifts.	NHS England
9	Improve data flows including by (i) solving the problem of datasharing liability, issuing a revised national template; (ii) working with system suppliers on extract functionality; (iii) improving data to support access (actions 1 and 2 above), and (iv) helping to identify population cohorts to be targeted by neighbourhood teams.	NHS England
10	Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care, taking a ‘one public estate’ approach and maximising the use of community assets and spaces.	ICSs
11	DHSC and NHSE should provide additional, expert capacity and capability to help offer solutions to the most intractable estates issues, and practical support to work through them, as well as building ICS estates expertise. DHSC and NHSE should consider what flexibilities and permissions should be afforded to systems to allow shaping and influencing of the physical primary care estate, including through reviewing	DHSC and NHS England

	the Premises Cost Directions. DHSC DHSC and NHS England should ensure that primary care estate is central in the next iteration of the Health Infrastructure Plan.	
12	Create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods. Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.	ICSs
13	Work alongside local people and communities in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.	ICSs
14	In support of systems, set out how the actions highlighted for NHS England will be progressed.	NHS England
15	15 DHSC and NHS England should rapidly undertake further work on the legislative, contractual, commissioning, and funding framework to enable and support new models of integrated primary care. This work should also consider how to improve equity in distribution of resource and ultimately improve health outcomes.	DHSC and NHS England

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board	
Date	Friday, 01 July 2022

Document Title	Population Health Management: Roadmap and Implementation Plan		
Lead Director (Name and Role)	Dr Andrew Murray, SRO for Population Health Management, SWL ICS		
Author(s) (Name and Role)	Dr Andrew Murray & Sam Green, Head of Population Health Management Programme, SWL ICS		
Agenda Item No.	7	**Attachment No.**	07

Purpose (Tick as Required)	Approve ✓	Discuss	Note

Executive Summary

The SWL Population Health Management (PHM) Roadmap sets out the context (captured in our "Stocktake" which describes the existing SWL system position on PHM) and the steps needed to create the capability and capacity to deliver a Population Health Management approach. This will allow us to use our collective resources more effectively to add most value to our residents and tackle inequity. The Roadmap was approved at the final ICS Recovery and Transition Board in early June; the draft Implementation Plan sets out the timelines to deliver the Roadmap recommendations and has not yet been through any governance forum.

Purpose:

To inform the board of the progress and plans for PHM in SWL. To gather feedback on the Implementation Plan and to allow discussion of the risks identified in the Roadmap and Implementation Plan.

Recommendation:

ICB to further approve the PHM Roadmap.
ICB to consider and approve the draft PHM Implementation Plan.

Key Issues for the Board to be aware of:

- PHM capacity and capability in SWL is in the early stages of development but there is much good practice to build on.
- In the midst of significant operational pressures and financial challenge there is a risk that PHM does not get the focus required, yet it is critical to help deliver a sustainable value-based health system and to reduce health inequity.
- The most critical interdependency is with the development of SWL system intelligence capability, with significant risks existing around data and analytics.

Conflicts of Interest:

None noted.

Mitigations for Conflicts of Interest: N/A

Corporate Objectives This document will impact on the following Board Objectives:	The roadmap and plan addresses all four ICB objectives: • Improve outcomes in population health and healthcare • Tackle inequalities in outcomes, experience and access • Enhance productivity and value for money • Help the NHS support broader social and economic development. The first three explicitly and the fourth indirectly through a holistic approach to improving health as part of PHM improvement cycles delivered at place and in PCNs.

Risks This document links to the following Board risks:	Key risks relate to failure to achieve the potential of PHM to improve care for our most needy residents, to reduce health inequity and ultimately to create a sustainable health system (by reducing future need and maximising the value of care). These risks include the potential failure to carve out adequate time for system organisational development; a continued focus on immediate operational priorities over the more planned and proactive interventions that come through a PHM approach; failure to develop an effective Intelligence Function (data and analytics).
Mitigations Actions taken to reduce any risks identified:	The recommendations in the plan deal with these risks but ultimately it will be for the ICP, ICB and SWL Executive to ensure that PHM is given the focus and resource (principally time and attention) that is required.

Financial/Resource Implications	In year 1 (2022/23), the PHM Roadmap saves money against provisional budgets. In year 2 there is a call for increased financial resource, the main cost being to increase the number of analysts (this can be phased). This would not just serve PHM but would support all system activities that need good system intelligence.

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	No formal EIA has been carried out but the entire Roadmap focusses on how to reduce health inequity.
What are the implications of the EIA and what, if any are the mitigations	N/A

Patient and Public Engagement and Communication	The PHM Roadmap is being circulated electronically to the SWL Community Engagement Steering Group and we would be very pleased to take this to the new SWL People and Communities Engagement Committee in due course.

	Committee/Group Name:	Date Discussed:	Outcome:
Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	SWL Senior Management Team	Thursday, 26 May 2022	Some minor changes and added some explanatory sections to appendix. Request for implementation plan with timelines.
	SWL PHM Programme Board	Tuesday, 31 May 2022	Approved
	SWL ICS Recovery and Transition Board	Wednesday, 08 June 2022	Approved

Supporting Documents	SWL Population Health Management Roadmap SWL Population Health Management Implementation Plan

SWL PHM Roadmap 2022

JUNE 2022

SOUTH WEST LONDON HEALTH & CARE PARTNERSHIP

Authored by: Dr Andrew Murray & Sam Green

South West London Health & Care Partnership

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Introduction

There are five problems found in almost every health service in the world:

- Unwarranted variation in quality and outcome
- Harm to patients
- Waste, and failure to maximise value
- Health inequalities and inequities
- Failure to prevent disease.[1]

Many previous NHS re-organisations, plans and initiatives have sought to address these problems and (particularly in the context of population health management) to increase the focus on population health, the prevention of disease and early intervention but have failed to have the scale of impact required.

The COVID-19 pandemic has highlighted the impact of preventable diseases and health inequalities and has once again shown the importance of the social determinants of health. At the same time, it has brought to the fore the strength of our borough-based partnerships and system relationships and has driven innovative practice of population health management focused on some of our most vulnerable residents (perhaps best evidenced by the work on COVID vaccination).

The shift into new Integrated Care Systems (with the ICS Partnership Board a genuine joint endeavour between NHS and non-NHS system partners) presents an opportunity to create an aligned approach to improving population health across NHS providers, Local Authorities, the Voluntary Sector and our residents. It allows us to re-appraise our local and system priorities and encourages us to use the increasingly rich data available to target those in our communities with the greatest need, much of which is unmet. It also allows us to thoughtfully allocate resources to maximize value, in every sense.[2] This is what is meant by "Population Health Management" (PHM).

This "Roadmap" has been developed following a South West London (SWL) "PHM Stocktake" which involved multiple partners across the system and captured examples of excellent existing practice, valuable distributed assets, high levels of aspiration for a

[1] How to build healthcare systems, J. A. Muir Gray, Offox Press 2011
[2] See definition of "value" in Definitions section (p.9)

range of uses of PHM as well as a variety of development needs. The Roadmap sets out the current context in South West London and the next steps required to improve our capability and capacity to enhance Population Health across our geography.

There is action required to improve the tools and skills available to those already working in our system, to target resource to support PHM but most importantly to change the way we think and behave across our system to move away from a predominantly reactive approach to those presenting at the doors of our services to a more reflective, proactive way of working that actively seeks unmet need across our population, reduces unwarranted variation, maximizes value and plans for the future.

"It's not just what you have that is important. It's what you do with what you have" Prof Sir Michael Marmot

Executive Summary

Population Health Management (PHM) is not a new concept. Understanding the needs of our population and working with them to improve their health has been the core business of public health teams, NHS planners, local authorities and many other key partners in South West London for very many years. What has changed is the imperative (with stark inequities manifest clearly through the COVID pandemic), the political and policy support (with clear requirements set for the new Integrated Care Partnerships and Systems) and the tools available to understand both need and the impact of change (with better quality data and access to data than ever before). Now is the time to take decisive action.

> ***"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."***
> ***Martin Luther King Jr***

We have already come a long way in SWL since engaging with the National PHM Development Programme and creating the right leadership and support to launch and develop PHM. This roadmap sets out that context (captured in our "Stocktake") and the steps we now need to take together, from individuals in communities to SWL system leaders, to create the capability and capacity to use our collective resources more effectively to add most value to our residents and tackle inequity.

These steps include:

1. **Learning by doing** – continuing to roll out PHM pilot projects at each level of the SWL system as well as agreeing one major system-wide programme through the ICS Partnership Board
2. **Culture, behaviour and skills** – training, support and development across SWL to adopt a new paradigm in how we use our system resources and to develop the skills required to drive improvement
3. **Sharing and supporting best practice** – from within and without the SWL system
4. **Developing our intelligence function** – creating the right infrastructure to support PHM and meet wider system requirements by developing our management of data, our PHM "platform" (the analytics tool) and our analytical capability and workforce (including the development of appropriate impact measures).

Why does Population Health Management Matter and What is it?

ICS (Integrated Care System) Aims and Context

Triple aim

The Health and Care Bill includes a legal duty for decision-makers across NHS bodies (Foundation Trusts, NHS Trusts, Integrated Care Boards and NHS England) to collectively consider the impact of their decisions on:

- increasing the health and wellbeing of everyone in the population they serve
- the quality of healthcare services for all the population they serve and
- efficient and sustainable use of NHS resources

Four purposes

In addition, in November 2020 NHS England and NHS Improvement (NHSE/I) published "Integrating care: Next steps to building strong and effective Integrated Care Systems (ICSs) across England."[3]

It described the core purposes of an ICS being to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

In South West London, in common with every other ICS, we have variation in the quality of services and significant inequalities in health status, health care and opportunities to live healthy lives. As a system we have struggled to shift resource to support interventions that genuinely impact health inequalities, prevent and manage illness early and that are ultimately more cost-effective.

When practised correctly and implemented fully, PHM should support all four ICS aims, is a fundamental building block for a successful ICS and can help us deliver value-based healthcare.

In addition, the 2022/23 NHS Priorities and Operational Planning Guidance[4] specifically requires that "by April 2023, every system should have in place the technical capability required for PHM, with longitudinal linked data available to enable population segmentation and risk stratification, using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities."

Finally, and most importantly, PHM matters to patients and residents of SWL. It should be used to focus on population segments and residents based on need and to ensure:

- an increased use of interventions that add value, including non-medical interventions
- a reduction in interventions that do not add personal value and may cause harm
- increased equity, particularly in access to healthcare
- systematic processes to continually identify cohorts of people that are underserved by our current care pathways

and can be combined with personalisation measures to ensure a focus on what really concerns those we aim to serve.[5]

Definitions

There is recurrent confusion about population health, public health, data and health inequalities, so it is helpful to set out some standard definitions for the SWL system.

Population Health (an ICS responsibility)
A focus on improving physical and mental health outcomes, promoting wellbeing and reducing health inequalities across an entire population, including a specific focus on the wider determinants of health (such as housing, employment, education).

Population Health Management (a methodology)
A way of working to help frontline teams and system planners understand current health and care needs and predict what residents will need in the future.

[3] https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf
[4] https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf
[5] See Appendix Section 2 Further Definitions for definition of "personalisation" (p54)

In terms of interventions: it involves analysing data (information) to identify population cohorts (or segments) where interventions will add value, intervening, measuring the impact of interventions and incentivising those interventions that add value.

In terms of planning: it involves using the data (information) to allocate resources optimally to population cohorts with the greatest need and to interventions that add most value.

Population Health Management Platform (a tool)

The data-driven infrastructure that provides a window into all the data needed to help understand and manage the health status and needs of a population.

Public Health

"The art and science of preventing disease, prolonging life and promoting health through the organized efforts of society"[6]. Local authorities have, since 1 April 2013, been responsible for improving the health of their residents and for public health services including most sexual health services and services aimed at reducing drug and alcohol misuse. Each local authority in SWL has a Director of Public Health and a Public Health team.

Health Inequalities

The full definition of health inequalities and inequity is found in the appendix.[7] In brief, it is important to state that population health management deals with all members of a population, some of whom will be suffering from health inequalities. Population health management can be one of many valuable methods for addressing health inequalities, which are multi-factorial.

Data and Information

There are two possible definitions of data

1. Data (Computer)

"Information that is produced or stored by a computer." This is what is often meant by "data" in the context of PHM and certainly is what has been presented thus far

[6] Acheson, 1988; WHO

[7] See Appendix Section 2 Further Definitions (p53)

through Population Health Management Platforms. This has historically often been quantitative.

2. Data (Information)
"Facts or information used to calculate, analyse, or plan something." This includes computer data but this broader "information," which should include rich insights from engagement with communities and much qualitative data, is what is required for effective population health management.

We will be continuing to use "data" to refer to computer data and "information" to refer to the broader concept.

Value[8]
"Value-based healthcare (VBHC)" is a comprehensive concept built on four value-pillars: appropriate care to achieve patients' personal goals (*personal value*), achievement of best possible outcomes with available resources (*technical value*), equitable resource distribution across all patient groups (*allocative value*) and contribution of healthcare to social participation and connectedness (*societal value*)

It is important to emphasise that *technical value* means using the resources for all the residents in need in the population not just those who reach services and become patients, for example focusing on all people with hip pain, not just those people who have had a hip replacement. This means that technical value also includes measurement and minimisation of inequity.

See Appendix Section 2 for further definitions (p53 – 55)

Impact (including exemplars)

Collaborating as ICSs and adopting a PHM approach should support systems to take action to reduce health inequalities, to improve quality of care and patient experience and specifically to "tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions

[8] Defining value in 'Value-based healthcare' (europa.eu) – EU Expert Panel on effective ways of investing in health

• supporting those with long-term conditions or mental health issues
• caring for those with multiple needs as populations age
• getting the best from collective resources so people get care as quickly as possible."[9]

There are some good examples from the Wave 3 NHSE/I PHM Development Programme in SWL (some of which are now national exemplars), from elsewhere in the UK and internationally of how this can happen through a PHM approach including:

- **East Merton PCN pilot**: focused on severe mental illness and a dual diagnosis of drug and alcohol dependence

- **Sutton Place pilot**: focused on those with musculoskeletal problems and comorbidities

- **Surrey Heartlands ICS**: developed an effective system-wide intelligence function and analytical community of practice

- **Montefiore health system, USA**: developed system-level intelligence-led integrated health and care with improved managements of those attending emergency departments.[10]

[9] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0886_Interim-guidance-on-the-functions-and-governance-of-the-integrated-care-board-August-2021.pdf
[10] See Appendix Section 3 for full examples (p63-67)

SWL Context – PHM

Baseline

It is important to acknowledge that Public Health teams within Local Authorities have been looking at population segments and using a PHM approach for many years. This is show-cased in the regular Joint Strategic Needs Assessments (JSNAs) that have led to excellent and sometimes highly innovative interventions across many different local authority, health and voluntary sector partners. This continues to be a fundamental pillar of the work required to improve population health.

A key step for the SWL Health and Care system was the enrollment in July 2021 onto the Wave 3 of the NHS England/Improvement (NHSE/I) PHM Development Programme to advance leadership, knowledge and skills in using data and analysis for decision making.

In addition, in October 2021, with new dedicated leadership for PHM, various strands of existing work were pulled together under one umbrella. This included:

- work underway in individual boroughs and PCNs (especially the Croydon place PHM programme and including the Wave 3 pilots)
- the development and use of a new PHM "platform" by the SWL Clinical Networks, transformation programmes and the COVID vaccination team (the "Health Insights" tool, developed by our SWL analysts during COVID)[11]
- an emerging business case for a new PHM platform

Progress to date

- "Health Insights" increasingly made available to SWL Clinical Networks and Transformation Programmes (incl. diagnostics, outpatients and long term conditions) and the product is continuing to be developed and further rolled out
- SWL PHM Steering Group and subsequent Programme Board have been established for strategic oversight of the PHM Programme

[11] See next section for more information

- PHM Stocktake undertaken (including an analytics skills mapping exercise supported by Office for Health Improvement and Disparities (OHID)[12])
- NHSE approved all case studies of the pilots from the Wave 3 PHM Development Programme and published them on the FuturesNHS[13] website
- Sutton Place lessons learnt presented at the PHM Development Programme Place Learning Event National Webinars
- NHS ConfedExpo 2022 presentation on clinical and system leadership of PHM in SWL at the Pop Up University under Collaboration and Partnerships with Optum[14] plus Panel member at the Feature Zone sessions Sustainable Healthcare Zone

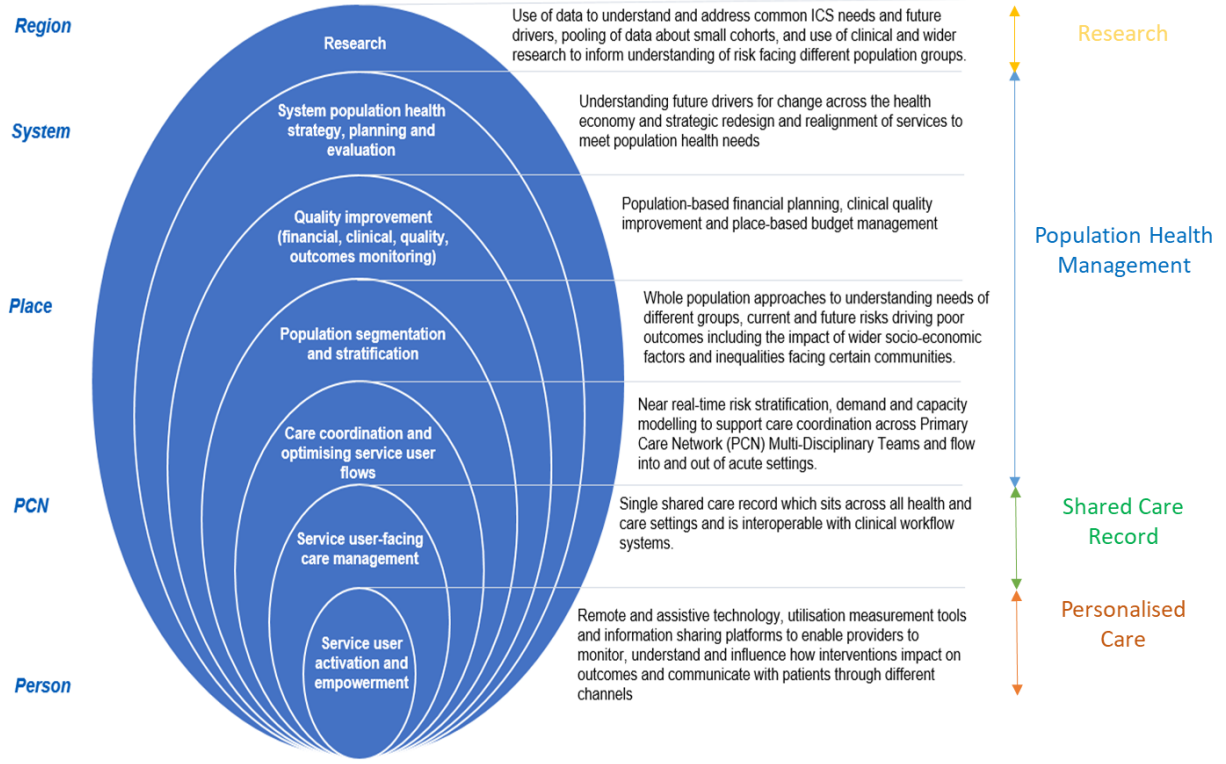
[12] See Appendix Section 5 for more detail on OHID analytics review (p70-71)
[13] FutureNHS Collaboration Platform - FutureNHS Collaboration Platform – self-registration needed
[14] NHS England and NHS Improvement's National Development Delivery Partner for PHM

SWL Context - Interdependencies

Intelligence Function

New national guidance on developing intelligence functions for ICSs[15] sets out the need for improved data; analytics; and the tools used to access and use both the data and analytic insights (e.g. the PHM platform). It sets out the fundamental importance of this function for PHM, as well as for other system responsibilities and activities.[16]

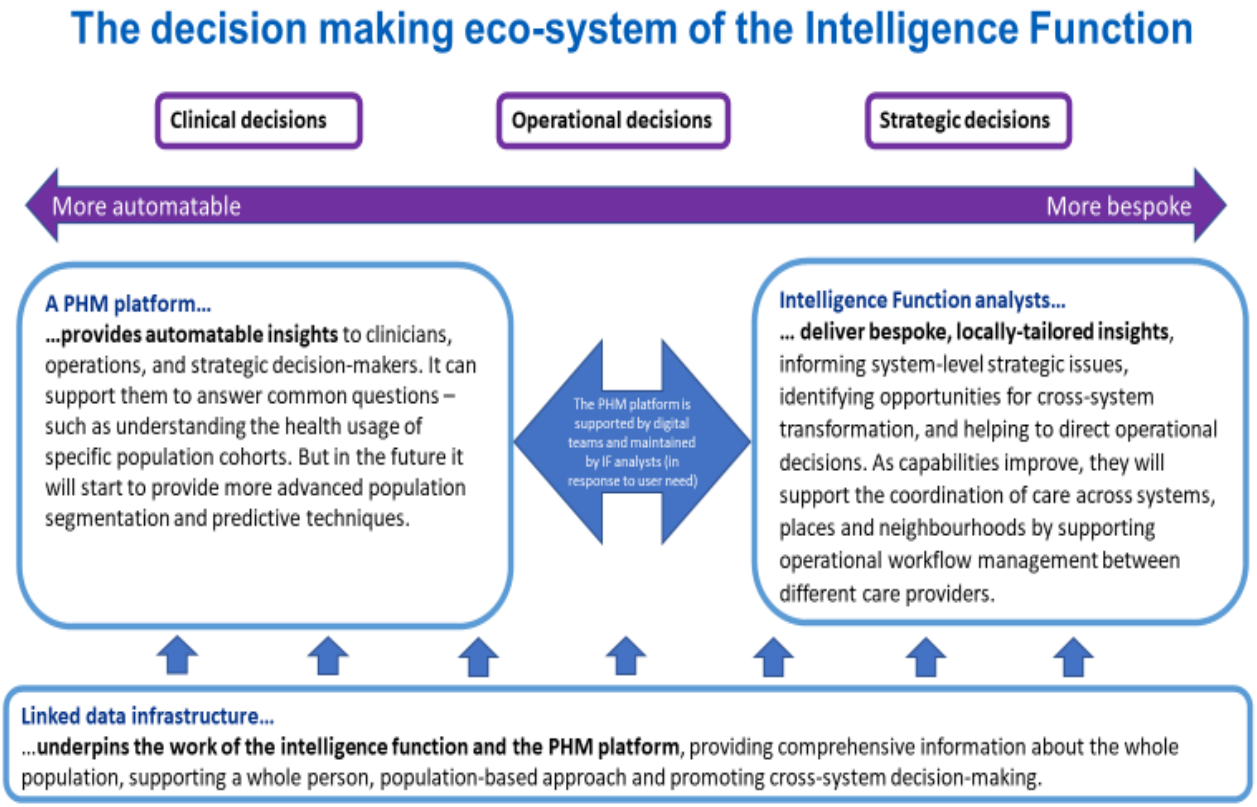
Use of data, analytics and intelligence at different tiers of the system



[15] "Building an ICS Intelligence Function" – draft national guidance for ICSs

[16] "An Intelligence Function is a system-wide, multi-disciplinary collaboration of intelligence professionals, with representation from analytical leaders and key teams across the whole ICS. At its core, it is a way of coordinating a diverse range of analytical skills to support the needs of the system. The purpose of the Intelligence Function is to ensure that ICS decisions are routinely informed by evidence that is tailored to the local context, including a detailed understanding of health inequalities between population groups, and that the system is supported to take a population-based approach to care planning and delivery, including the use of data to shape the personalisation of care.
One key purpose of the Intelligence Function will be to support a PHM approach to care, including by developing a detailed understanding of the local population's health and care needs, such as granular intelligence on inequalities

Key components of a system intelligence function include data, the PHM platform and analysts and it supports a range of decisions, including clinical, operational and strategic decisions:



The recent Goldacre review also references the interdependency of data, analytics and insights leading to action and it is clear that these functions need to be considered as critical components for PHM.[17]

We need to ensure a coordinated approach to managing these elements along with the creation of a Development Plan, and this will be aided by a named executive lead once ICS appointments and portfolio allocations are concluded. According to the guidance, we have an "emerging" intelligence function. Clearly this is a critical function that needs to be operating at a high level for PHM to be effective in SWL.

across different population groups. This will be powered by a person-level, linked data set, which should grow to include information about the wider determinants of health. The Intelligence Function will support place-level leaders to tackle health inequalities in their area by operationally targeting areas where there is greatest need of support, or where there is unwarranted variation in care quality, and by planning new service models in response to unmet need."

[17] See Appendix Section 6 for relevant text from the Goldacre Review: Better, Broader, Safer: Using Health Data for Research and Analysis (p72)

It is worth noting that each Local Authority and many of our NHS providers have been continuing to develop their own intelligence functions and any SWL strategy would need to take this into account and be clear what is being done at place, in providers and at SWL level to ensure synergy and avoid duplication.[18]

1. Data (including Information Governance)[19]

"Raw data does not do great work on its own. This data must be curated, managed, cleaned, reshaped and prepared by people. Then it must be made available in well-designed platforms, which earn public trust through security and transparency, and which facilitate sharing and re-use of prior work."[20]

It would be a timely moment for the SWL ICS to develop a *data strategy* since the London Health Data Strategy is currently being developed. Ensuring good alignment with London and effective support for PHM within our strategy will be key. The first step of a data strategy would be to capture the existing data architecture in SWL and the next step would be to define what is needed for the future. Data will need to be available to serve all the functions set out in the intelligence function diagrams above (e.g. to support a shared care record and research, as well as PHM). It is referenced multiple times in the Fuller primary care stocktake which states very clearly that "integrated neighbourhood teams can only flourish if they have access to good data."[21]

The 2022/23 Planning Guidance sets out the requirement for ICSs to develop plans for system intelligence by June 2022, and specifically plans to put in place the *systems, skills and data safeguards* that will act as the foundation for PHM. It highlights that the safe and effective use of *patient data* is key to this.[22]

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[18] See Appendix Section 9 for a summary of each borough's position (p82-86).
[19] See Appendix Section 2 Further Definitions & London Data Glossary for data definitions (p56-62)
[20] Summary: better, broader, safer - using health data for research and analysis (publishing.service.gov.uk) – the Goldacre Review
[21] See "Data, data, Data" section of Next steps for integrating primary care: Fuller stocktake report.
[22] "Working alongside local authorities and other partners, we will continue to develop our approach to PHM and prevention so that people can play a more proactive role in promoting good health. ICSs will drive the shift to population health, targeting interventions at those groups most at risk, supporting health prevention as well as treatment. ICSs will take a lead role in tackling health inequalities by building on the Core20PLUS5 approach introduced in 2021/22. The safe and effective use of *patient data* is key to this. Systems are asked to develop plans by June 2022 to put in place the *systems, skills and data safeguards* that will act as the foundation for this."

The data *systems* in use in SWL have been provided by North East London Commissioning Support Unit (NEL CSU), some of which has been in-housed, some moved to NEL ICS and some moved to North East England. There are both risks and opportunities in this transition. The in-housed CSU team responsible for business intelligence and analytics have many useful *skills* and have provided the SWL system and the PHM function effectively during COVID. They are currently carrying vacancies and, in common with all other London ICSs, risk exists with this function (see analytics section p.17).

SWL has had a high level of support from the CSU on information governance[23] and *data safeguards*. The environment has been more permissive under the Control of Patient Information[24] (COPI) notice, introduced to allow easier data-sharing in response to the pandemic. Work will be needed to continue to develop this function and ensure it is fit for the future.

2. PHM Platform

The PHM "platform" can best be described as a tool that presents data and insights gleaned by analysts to those who need to understand better the health status and needs of their population. It is clearly highly dependent on the quality, breadth and depth of data that is available as well as the skill of analysts in making sense of the data and presenting it in a meaningful way.

HealtheIntent Pilot

SWL had previously elected to pilot the roll out of a Cerner product, HealtheIntent, with St George's University Hospital. This is a tool which ingests and standardises data, especially from hospital Cerner electronic patient records, stores the data and allows the creation of condition registries and dashboards. It is still a product in development and the roll-out proved much slower than anticipated. It had not been used for PHM within SWL, since this would be dependent on funding to "on-board"

[23] From the Goldacre review: "Information Governance (IG) is often unfairly regarded as an obstructive or bland discipline, but in reality it is a complex multidisciplinary project requiring skills in analytics, IT, ethics and IG. At its best there is a clarity of purpose and an energetic embrace of role and accountability, with IG professionals working with others to leverage maximum benefit from information, enhance patient care and improve services while protecting patients and remaining compliant with the law."

[24] Notice under Regulation 3(4) of the Health Service (Control of Patient Information) Regulations 2002 (COPI).

the data from all other providers in SWL and to develop registries and dashboards with associated human resource, capital and licensing costs.

A business case was being developed by the SWL digital team for this further roll out but was paused to allow a SWL PHM stocktake to take place to establish the priority uses and requirements for a PHM platform, to ensure the platform pilot was properly assessed, and to evaluate the home-grown PHM platform ("Heath Insights") that had been developed in parallel during COVID.

Health Insights

During the COVID pandemic, the need to access holistic data (derived from a Longitudinal Record[25]) about residents was urgent. Working with NEL CSU, the in-housed SWL analytics and business intelligence (BI) team responded to this need by arranging for primary care data to be linked to other health and demographic data and presenting this to clinicians and planners through a dashboard, developed using Microsoft PowerBI. This approach, interface and subsequent series of dashboards became known as "Health Insights". This is the current Platform used for PHM and planning in SWL. It uses de-identified patient data which can be re-identified for appropriate clinicians seeking to make direct interventions with individual patients.

3. Analytics

We have a team of SWL ICS analysts who have been "in-housed" from NEL CSU. In addition, many other system partners in the ICS have their own analysts. Through the National PHM Development Programme and work with OHID[26], we have undertaken a review of analytics capability, capacity and gaps across the SWL system and this has been fed into our SWL PHM stocktake (see subsequent section).

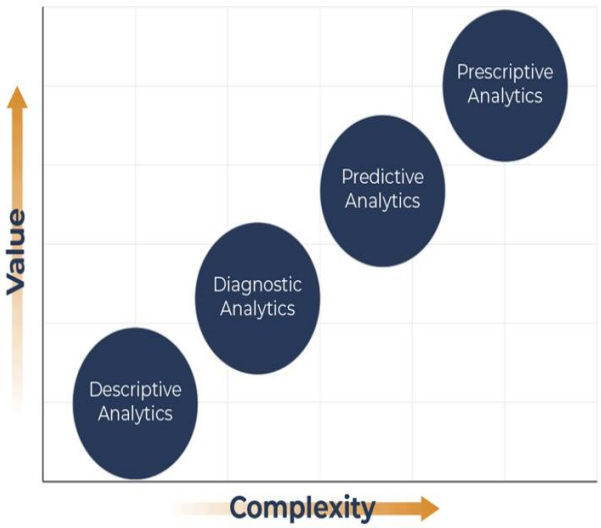
Historically the CSU team has provided predominantly "descriptive analytics," helping the system to track what has happened and use that to assess performance, quality and to guide payments. The ICS will need to expand analytical capability to include explicative, predictive, prescriptive and evaluative analytics. [27]

[25] LHCR – Local Health and Care Record - A shared, normalised, and persisted longitudinal record across primary, acute, mental health, community, and social care, supporting PHM and planning

[26] See Stocktake section (p19-23) and Appendix Section 5 (p70-71) for more detail on OHID analytics review

[27] Building an ICS Intelligence Function – draft national guidance for ICSs

Analytical Capability[28]



- **Descriptive Analytics** tells you what happened in the past
- **Diagnostic Analytics** helps you understand why something happened in the past
- **Predictive Analytics** predicts what is most likely to happen in the future.
- **Prescriptive Analytics** recommends actions you can take to affect those outcomes.

See Appendix Section 6 for further interdependencies, including Core20PLUS5 (p72-79)

[28] Source: Surrey Heartlands Health and Care Partnership

PHM Stocktake

Process and Inputs

In February 2022 we commenced a PHM Stocktake, supported by Optum, across all the sectors of our ICS – Primary Care Networks (PCNs), Local Authority and Borough Partnerships, NHS providers and provider collaboratives, SWL Clinical Commissioning Group (CCG) and ICS functions, St George's University of London and NEL CSU. This aimed to understand existing PHM practice, analytics/change management resource and data/digital infrastructure to form the basis for this SWL PHM Roadmap to advance and further develop our PHM capability. As part of the process, learning from the PHM pilots, the advanced work on PHM in Croydon and the SWL Quality Improvement audits (commissioned by the SWL ICS quality directorate) was considered[29].

The stocktake consisted of

Online survey – wide views on PHM from across the ICS – over 50% response rate

- 170 emails with link to online survey sent
- Current involvement in PHM
- Skills available and skills needed
- Priority use cases
- Ease of use of a PHM Platform

Group interviews – Place based and specialist groups

- 40 people interviewed in 12 one-hour interviews
- Open questions
- Key themes around PHM
- Tease out themes and priorities
- Capture thing that might not get raised in workshops
- Add colour to online responses

System workshops – acknowledge the baseline and plan next steps

- Two Workshops with 25 people at each
- Review of baseline data from survey and interviews
- Add to and contextualise the baseline key themes
- Make the links between baseline, agree priorities, actions and next steps

- Consolidate information into the Roadmap

Final Action Learning Set

- Bringing together all the learning from the Sutton Place and five PCN Pilots as case studies

At the same time SWL ICS analytics teams were invited to participate in the OHID Analytics Skills Mapping Exercise and we supported this work to develop a good understanding of the ICS's current strengths, weaknesses, capacity and capability in analytical skills and what might be needed to enhance our System Intelligence Functions, in order to build on, share and strengthen these together. We are currently waiting for the full analysis to be completed by OHID.[30]

Outputs

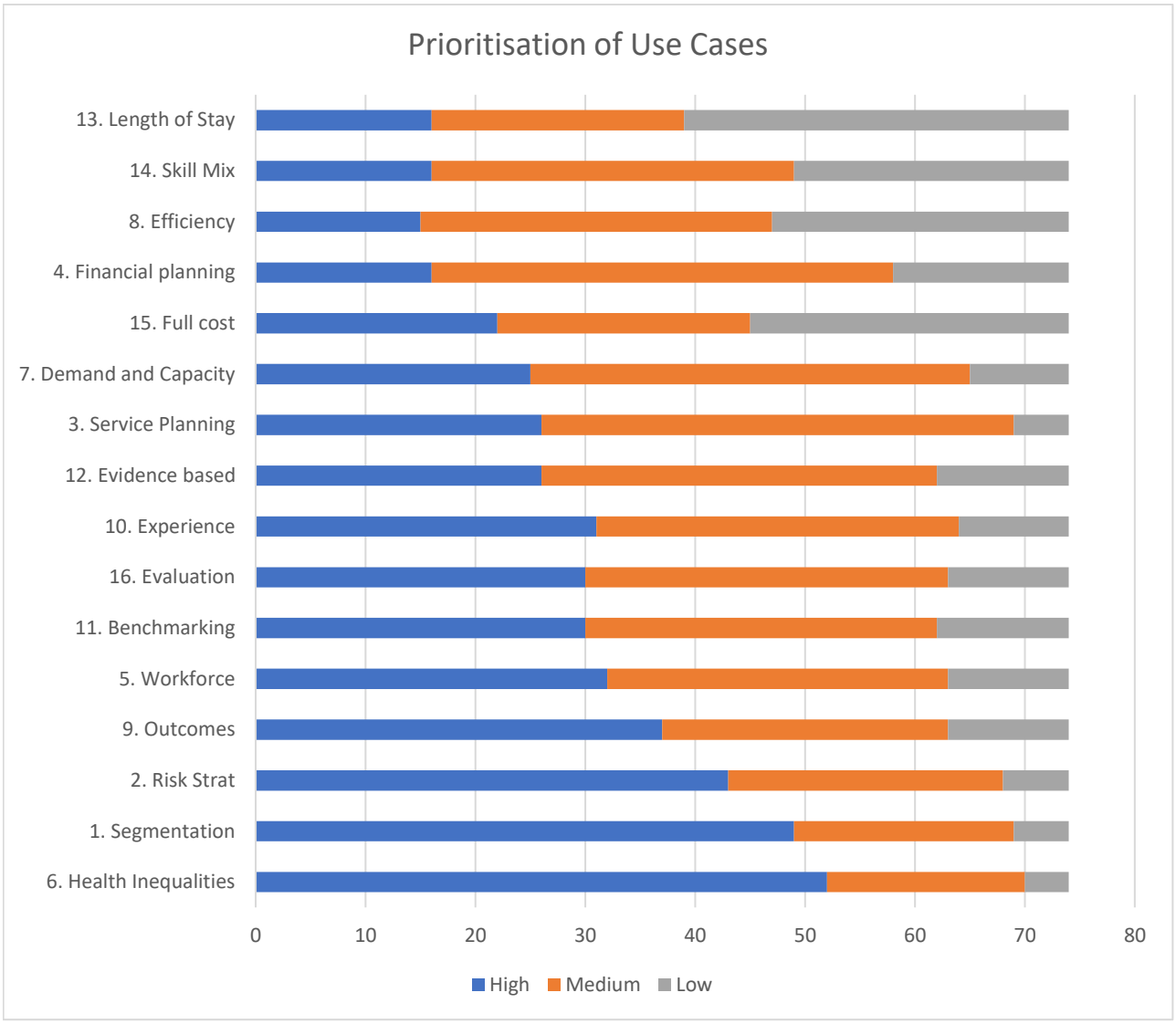
The key themes from the analysis of responses to the online survey identified that the top three uses for PHM in our system were to

1. Plan services and redesign pathways
2. Decide which patients to prioritise
3. Carry out research into local health and care inequalities.

When prioritising/ranking top uses for PHM ("use cases") from a prescribed list, responses indicated

- Health inequalities, population segmentation, risk stratification and outcome-linkage as high priorities
- Service planning, financial planning and demand & capacity as medium priorities
- Length of stay in hospital, full cost determination and efficiency as low priorities.

[29] See Appendix Section 6 for more information on this work from the Quality team (p73-78)
[30] See Appendix Section 5 for more details on the OHID analytics review (p70-71)



In terms of the Platform and the data to support PHM, responses indicated the importance of access to a good range of linked data sets and data sources as well as the data being clear and easily adapted or configured, without support. The types of data to allow as complete a picture as possible of the population cohorts being considered, were ranked and prioritised[31] as part of the Analytics Action Learning Sets.

In discussions it was clear that the purpose of population segmentation was often to deliver anticipatory or more holistic care to individuals so the ability to risk stratify and re-identify individual patients is key.

Exploring these prioritise further using the logic model[32] approach helped create a better understanding of the outputs and short, medium and long term outcomes that could be achieved and would demonstrate that we are making a difference across our system.

This showed that

- data, training on the data and how to use that data in different ways, plus
- co-production in order to reflect patients' real experiences, were important to help better inform decision making, cohort identification and service/pathway changes.

It was felt that short and medium term outcomes should involve

- improved patient experience and supporting the cultural change needed
- helping to build relationships across and between all stakeholders - health, social care, community, voluntary sector and our local communities.

Longer term outcomes should illustrate

- service change and
- a shift from clinical disease-specific care to a focus on prevention being the norm
- measurable objective and subjective outcomes and improvements, focused on health and wellbeing measures including the wider determinants of health, across all age groups in our communities.

The foundation stones for SWL can be summarised as follows:

Data and Analytics Platform

Patient, Public, Team Engagement and Co-Creation

System Relationships and Leadership

Outcomes and value based transformation

Resource mapping of local PHM Skills

The online survey responses enabled some PHM Skills Mapping to take place across our system to help us understand where skills are currently available, any gaps and where training may need to be focused, however the full picture cannot be seen as some responses to the survey were anonymous.

[31] Please see Appendix Section 7 for Data Prioritisation Matrix (p81)

[32] Link to logic model - https://easyretro.io/publicboard/UFNeUShm0PbQkuTLf8XlgYlJId53/b0de2b2a-6164-4dc7-a52d-2c598746e88c

- PCNs and Place
  While clinical leadership and project/programme management skills are indicated as being available when looking across SWL as a whole, when looking solely at individual Places it can be seen that neither skill set is fully available.

- Mental Health Trusts, Acute Trusts and Community Trusts
  While clinical leadership, administration, finance, project/programme management, operational/managerial/service co-ordination and quality improvement skills are indicated as being in existence, the picture is inconsistent across providers. Although the majority of this workforce currently focused on non-PHM work, there may be great potential to incorporate this resource if priorities are aligned between organisations.

PHM Programme Development Plan

These are those elements which fall within the scope of the SWL PHM Programme team.

1. Building a SWL PHM Team

The central PHM team currently comprises three individuals:

- Dr Andrew Murray, the clinical lead and SRO for the PHM development programme (2 days per week until end of June 2022)
- Sam Green, seconded from Sutton Place to be Head of the PHM Programme (full time)
- Mary Coakley, seconded from Merton and Wandsworth to be Project Support Officer (full time).

The principle that the team have adopted is to focus on providing direction and momentum for PHM development, supporting work already underway in boroughs and PCNs and encouraging the adoption of a PHM approach in SWL programmes and Clinical Networks. Key roles have been co-ordination, sharing best practice, developing critical enablers and making connections. This has been augmented by consultancy support from Optum (mainly funded through the National Development Programme but with a small additional investment from the SWL ICS to support the stocktake).

It is proposed that the future PHM team continues to take a devolved approach, ensuring that the system maximizes existing resource rather than seeking significant new resource. This means a lean central team with a focus on supporting work undertaken by system partners. A key principle is that delivering PHM involves a new way of working for existing people, not necessarily new people.

The initial proposal for the make-up of the SWL PHM team for the next 12 months is:

- SWL ICS Clinical Leadership - potentially Senior Clinical Advisor plus Clinical Champion (a developmental role) – 2 days/week in total
- SWL ICS Head of PHM Programme – Full time
- SWL ICS Project Support Officer – Full time

This would generate a small saving on the current resource allocated to the SWL ICS PHM team, as the clinical champion cost would be lower than that for the current clinical SRO.[33]

It would be sensible to demonstrate the ongoing commitment of the ICS to PHM by considering making the non-clinical roles permanent.

In subsequent sections the PHM team resource has been allocated to support different elements of the Development Plan and expressed as number of days/week (5 days per week representing the total capacity of the full team[34])

2. Learning by Doing (including Pilots)

A critical part of the successful development of PHM in SWL so far has been creating the six Pilots across five PCN's and one Place (Sutton) as part of the PHM National Development Programme. They have targeted resource and development at teams who have the enthusiasm and desire to deliver PHM effectively. They have helped us learn as a system what works and what doesn't and what support is required to make PHM successful. In addition with very limited resource (minimal PHM workforce, constrained analytics workforce, limited infrastructure and small OD resource) to support PHM they have allowed that resource to be used effectively and with impact. These Pilots have also raised awareness of PHM in the system and shown what is possible, helping us develop the right cultures, behaviours and appetite for PHM.

In addition, the COVID vaccination programme used PHM methodology and analytics in the work they did and PHM methodology has been adopted by the SWL Outpatients Transformation Programme.

We propose continuing to support all these programmes of work.

The Development Plan proposal is that we continue to incrementally build PHM functionality through further pilots, working where there is energy, enthusiasm and need. SWL has already committed to further Place and PCN pilot work as part of Modules C & D of the ICS Population Health Place Development Programme, funded

[33] See Appendix Section 11 for SWL PHM budget (p89-90)

[34] i.e. 1 day/week of the PHM team would be 1 day from the Head of PHM plus 1 day from the Support Officer plus a few hours of senior clinical input

by NHS England and Improvement and NHSX, being delivered in Croydon, Merton, Kingston and Richmond during 2022. This will be supported by the SWL PHM team.

We would like to ask for expressions of interest and select two SWL Elective Clinical Networks and one SWL Transformation Programme to act as PHM "Pilots" (i.e. they would receive intensive support from the SWL PHM and analytics teams, to test what is possible and establish a model for other Programmes to follow). We would also like to discuss with the two large provider collaboratives and identify one further SWL-scale pilot programme (such as work with patients attending ED).

Finally, it will be the role of the new ICS Partnership Board to agree one at scale programme for the whole system and the SWL PHM team can support that process.

Resource requirements

Dedicated central SWL ICS analytics time is required to support these programmes. This is currently being delivered by the existing SWL ICS analytics team. PHM may require a greater share of the analytics team capacity (see recommendations on analytics team in interdependencies section).

The SWL PHM team will devote 1½ days/week to this element of the plan.

3. Culture, Behaviour and Skills

Changing the paradigm to value-based healthcare and stewardship

Perhaps the biggest challenge is not to get more or better data but rather to make use of the data that we have effectively. This will not only involve giving better access to data but also a change in the way all partners in our ICS think and behave from front-line clinicians to the ICS Board. This is the cultural and behavioural challenge and will involve investment in training and development across the system with all partners.

We will need to move to a way of thinking and behaving where each system partner considers value-based healthcare and has a focus on

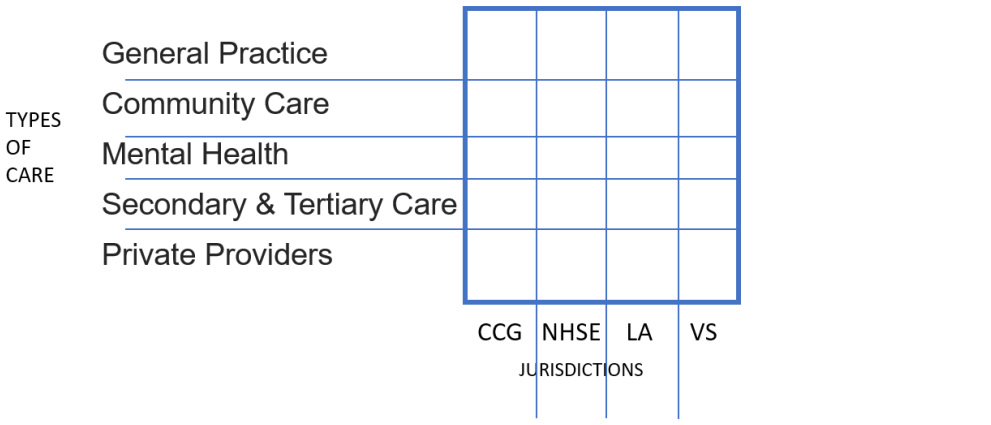
- defining population sub-groups with a common need and allocating resources optimally
- designing the system for each population sub-group

- ensuring each individual makes decisions to optimise personal value[35]
- delivering value for the population and all the individuals in need equitably through networks
- creating the culture of stewardship, with a governance process that promotes collective responsibility
- collective accountability for the outcomes and experience of care for individual residents rather than the delivery of individual care activities or episodes of care

So for example the SWL gynaecology clinical network would need to increase its scope from oversight of the system gynaecology elective waiting list backlog and standardising end-to-end gynaecology pathways, to taking responsibility for the entire population cohort with gynaecological problems (including those who do not present to health services), evaluating the value that procedures add, ensuring that personalisation is built in to support decision-making and taking responsibility for the total system gynaecology budget.

Focussing on people not conditions

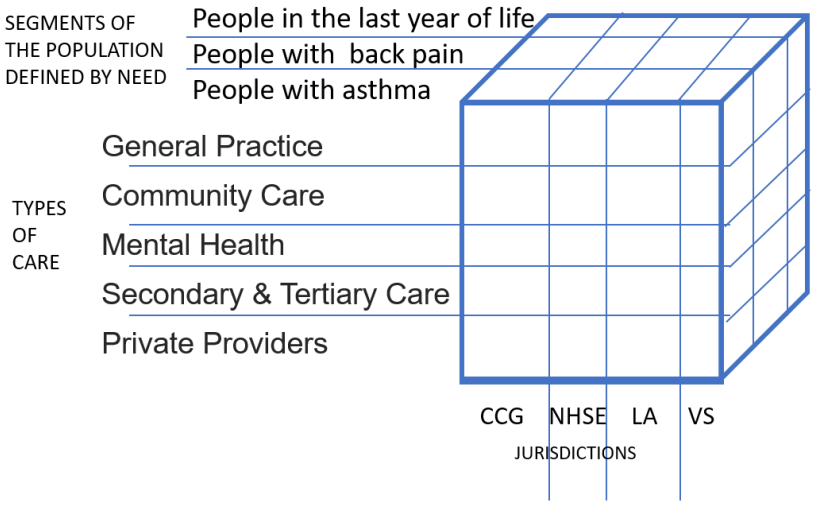
This would allow us to change the system paradigm from "2D" to "3D" healthcare.[36]



[35] See value definition (p9)

[36] Prof Sir J.A. Muir Gray

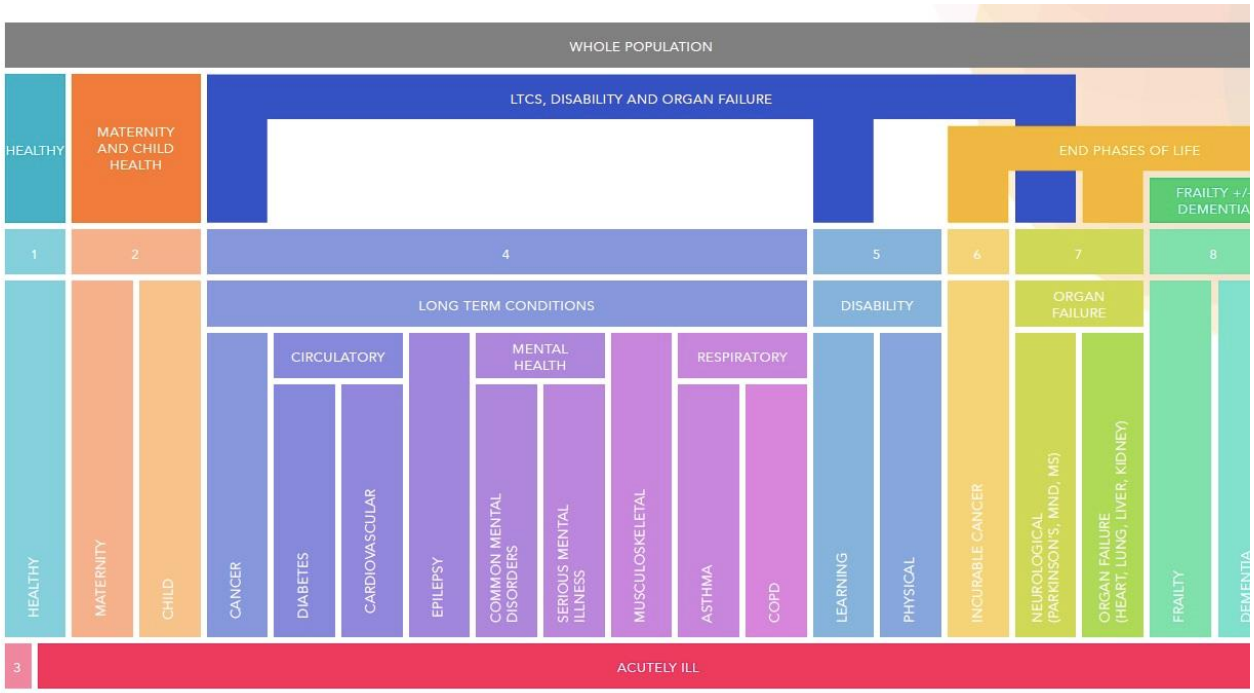
TO 3D HEALTHCARE



Dealing with the whole population segment, not just those presenting to services, and the value added to individuals

The focus on populations provides a third dimension to the way we see, lead and deliver healthcare, moving from the traditional two dimensional model (looking at levels of care and bureaucracies) to a three dimensional model; focusing on segments of the population, allocating resources optimally between them and maximising value within each sub-segment. This is sometimes referred to as Population Healthcare (a slightly higher level description than PHM, since it refers to how the whole health system acts).

In addition, moving to Population Healthcare requires a novel way of describing population segments (a new "taxonomy") beyond using individual conditions and NHSE/I has now adopted the Bridges to Health taxonomy, which (unlike the ICD) includes multi-morbidity:



Focusing on inequity

Population healthcare, should "deliver value…for all individuals in need equitably." This requires that attention is paid specifically to health inequity. All those involved in PHM will need some training and support with identifying health inequity in the population with whom they are intervening. In addition it is proposed that all PHM programmes and projects will need to complete an Inequality Impact Assessment and therefore training and support will be required specifically for this.[37]

Working in partnership with residents

Furthermore, the way we involve and engage with residents and patients' needs to shift gear. If PHM is about creating interventions to meet the needs of our population, then we need to fully understand their personal goals to ensure that those interventions add value. We will need to normalise the "co-creation" (or "co-production") of solutions with those whom they are meant to help. In order to involve those with greatest need, this may require novel approaches.

Extensive engagement and co-creation has already been adopted by many of the SWL PHM pilots and has delivered excellent results. In the national Fuller review of

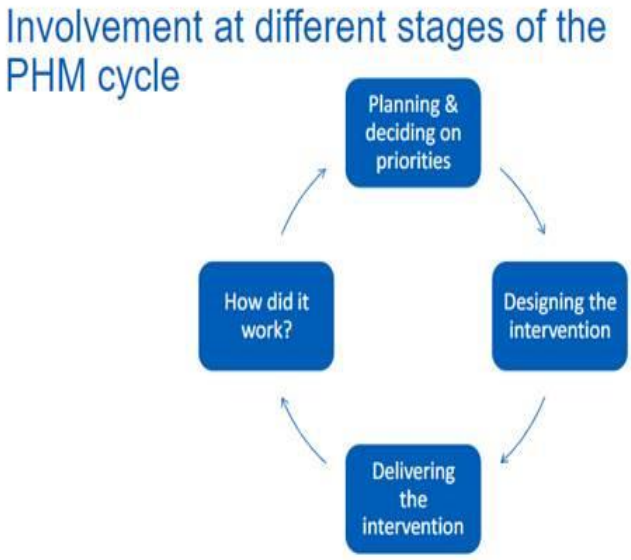
[37] Will be supported by the SWL ICS Quality team

Primary Care[38] it is noted "that the PCNs that were most effective in improving population health and tackling health inequalities, were those that worked in partnership with their people and communities and local authority colleagues. This partnership focuses on genuine co-production and personalisation of care, bringing local people into the workforce so that it reflects the diversity of local communities, and proactively reaching out to marginalised groups breaking down barriers to accessing healthcare."

In addition, it explicitly states that our primary care workforce "needs to be given the time and resources to meaningfully undertake this work. Outreach should not be considered a bolt-on to the day job – it's central to people's roles and should be reflected in protected time and job plans, for both current and upcoming roles."

The highly-regarded SWL communication and engagement team (with leads for each borough) continue to act as a resource for advice on developing engagement approaches in partnership with the community and voluntary sector and are creating an engagement toolkit which we will ensure is available to all those undertaking PHM. We will work with the team to feedback learning from PHM pilots and to adapt and develop the toolkit further.

How we can involve people and communities in PHM:



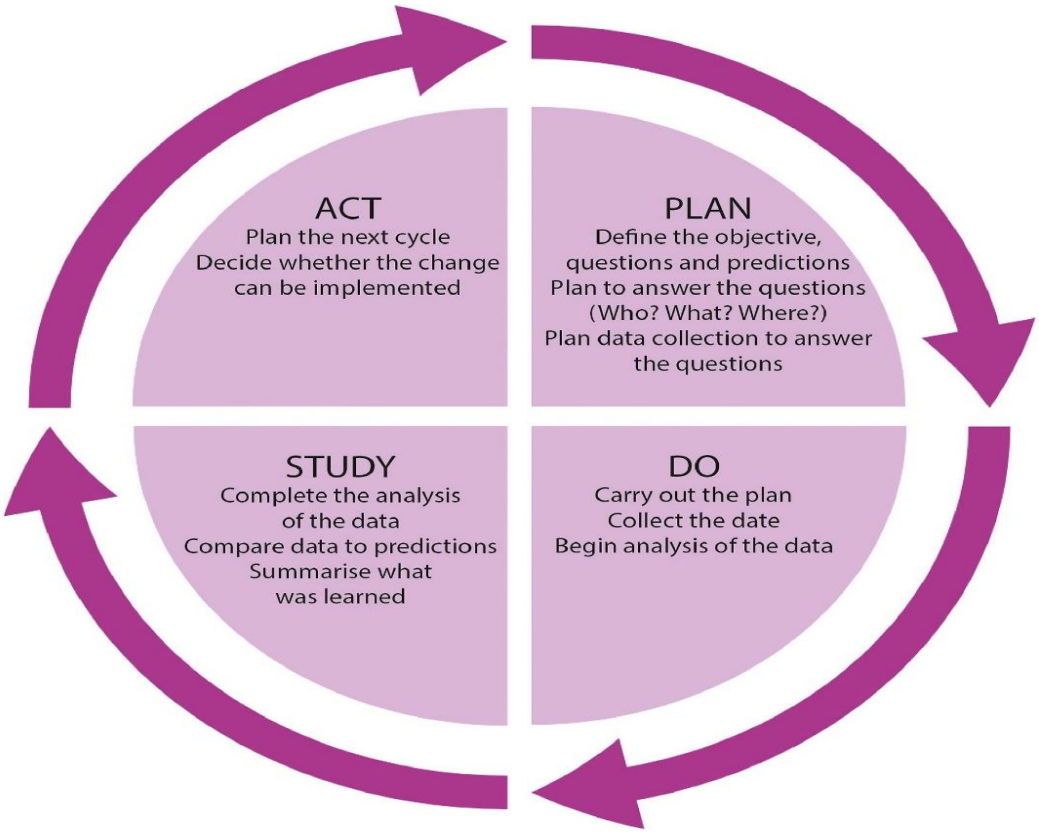
[38] Next steps for integrating primary care: Fuller stocktake report. https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

Using data intelligently

We also need to change the way that all system partners use Analysts (or as has been suggested, “Intelligence Officers”). Increasingly analysts and analytical thinking need to be embedded into non-clinical and clinical teams and Networks, to encourage the effective use of information and to ensure the right questions are asked. This will allow us to better understand the needs of population segments, to ensure that actions are appropriately targeted and that solutions are evidence-based and credible.

Making change happen

The data-driven quality improvement cycles of PHM do not only rely on analytical and engagement skills but also need expertise in all the elements of programme and change management that allow continuous improvement. Teams engaged in PHM may need training and support to develop key skills to support the plan, do , study, act (PDSA) approach:



Training and system development will need to address all these elements of culture, behaviour and skills to ensure success.

Resource requirements[39]

It is critical to note that all our teams need to be given the time to engage with training and development and then to reflect and work very differently. Without this level of commitment and planning as a system, any offers of support and training will be of limited value.

Resource will be needed to support development and training in value-based healthcare, PHM, quality improvement and programme skills. The SWL PHM Programme could source the training material and support the delivery of training but each local system partner will need to be resourced and enabled to participate in training.

Training should be targeted at system and organisational leaders initially (including PCN clinical directors) but ultimately this will need to be directed more broadly at relevant health and care providers. The development programme will need to as a minimum cover:

- Place (including Place Committee, Local Authorities, community providers and PCNs)
- SWL Clinical Networks and Transformation Programmes and Clinical Senate
- SWL ICS Board and Partnership Board.

Once agreed conceptually by the ICS Partnership Board, this element of the Development Plan can be costed by seeking expressions of interest from organisational development partners.

The work could potentially involve three components:

1. Large group conferences/ workshops
2. Training sessions delivered within existing fora/meetings
3. Online resources, including webinars.

An indicative budget of £100k has been allocated to this for 2022/23 in the PHM budget and this could include the development of webinars and other online tools to support self-access to training.

The SWL PHM team will devote 1 day/week to this element of the plan.

[39] See Appendix 11 for PHM budget (p89-90)

4. Sharing and Supporting Best Practice

- Creating a SWL Community of Practice for PHM

We have already brought together a diverse range of PHM experts in the SWL PHM Programme Board[40]. Work is in progress to identify the right resident/ community/voluntary sector voices and they will be included in the Board in future as well as in other groups. We will proceed to set up a formal SWL PHM Network, with webinars, fora and focus groups to allow the regular meeting of PHM practitioners to develop relationships, provide mutual support and sharing of ideas.

- PHM leaders, champions and experts

Each borough now has a named clinical PHM lead. They will be supported by the SWL PHM team and a SWL PHM Clinical Leads forum will be established and each borough should also consider identifying PHM "champions". Moving forward every PCN should have a named PHM lead or champion, but we will start with encouraging those PCNs involved in the new pilots (as part of the Place Development Programme) to identify a lead and will use the pilots as an opportunity to determine appropriate resourcing for this role. We will also have further conversations with the five original PCN pilots to review ongoing resource requirements. The SWL PHM team should also identify and list all PHM "experts" both clinical and non-clinical as a resource that can be called on as needed. The SWL PHM team should ensure that all PHM leads, champions and experts are provided with the right ongoing training and support.

- Creating a PHM library

This will involve creating a virtual place where PHM practitioners can access examples of international, national and regional best practice; share local examples of good practice; access support from other PHM practitioners in SWL.

Resource requirements[41]

The borough clinical leads are already budgeted for in the SWL clinical leadership budget. We have already secured one PHM clinical fellow to support Sutton place with PHM clinical leadership in addition to the ICS-funded clinical lead. This is not shown in the PHM budget as it sits within the SWL clinical leadership budget.

We will apply for more fellowships as they become available.

PCN pilots need to be used to establish how much resource/backfill is required to support PCNs to develop a comprehensive approach to PHM. This will depend on

what is specified in the national PCN Direct Enhance Service (DES) on a year-by-year basis, at present the specification is limited and would not cover all that we expect PCN PHM pilots to deliver.[42]

There will be an initial cost to support training and development for PHM leads and champions.

The PHM library could be hosted on the SWL ICS website or intranet so should not require significant extra cost beyond set-up and maintenance costs. This can be covered by the SWL PHM team.

The SWL PHM team will devote 1 day/week to supporting this element of the plan

5. PHM Platform

- Developing Health Insights

A Health Insights Project Group has been established to ensure continued development of this analytics portal: to improve the quality and quantity of information available; to tailor it to PHM and other needs (the "use cases"); to improve access for relevant system partners; to monitor and resolve information governance (IG) issues; and to ensure training and support for those accessing the portal in order to support self-service functionality. The Development Plan for this has been informed by the SWL PHM Stocktake and is now being supported by the Head of the PHM programme (since it is such a critical enabler for PHM). The Group involves digital, analytics/BI and IG team leaders.

- Obtaining a Platform fit for the future

SWL will need to agree an approach to acquiring an analytics "tool" (or "Platform") fit for the future. We recommend co-ordination on this with other London ICSs aiming to agree a preferred tool to make it easier to share dashboards and prevent duplication of effort (this is unlikely for now to include North Central London, who are focused on developing HealtheIntent). In order to push this forward, it is proposed that SWL start the process now of agreeing the timing and sequencing for

[40] See Appendix Section 1 for Programme Board Members (p51-52)
[41] See Appendix Section 11 for PHM budget (p89-90)

[42] See Appendix Section 10 for PCN DES specification (p87-88)

an options appraisal for the future PHM Platform (which would include continuing with Health Insights as an option).

The output from the stocktake would be used to establish the PHM priority criteria for the appraisal. However, it is important to note that the Health Insights platform is currently being used to support system Quality and Planning functions and so any future solution would need to take into account system uses that are not explicitly PHM priorities. It is perhaps better to consider that the future Platform to support PHM would likely continue to be a broader System Intelligence Platform so it would be wise to

1. Establish ICS data requirements as part of the development of a SWL data strategy (involving a) establishing the current data landscape and then b) defining what is needed for the future) and
2. Establish system uses for the Intelligence Function, prior to undertaking the Platform options appraisal.

This suggested approach can be shared with other ICSs and if they choose to combine to do this jointly then that would be welcome.

Resource requirements

Funding for roll out and maintenance of a new PHM platform (assumed at that stage to be HealtheIntent) is included in the SWL Digital 2022/23 budget submission.[43] It is not proposed to spend this money in 2022/23. There will potentially be some ongoing development and support cost for the existing Health Insights platform but this is already included in the workplan for the SWL ICS analytics team. Recurrent funding has been allocated to this in the PHM budget.

If a full options appraisal is needed, then this will require funding and will depend on whether this is done as an ICS or jointly with other ICSs. There are a number of unknown variables at present, including the possibility that a national product may be made available. This work will largely be undertaken by the SWL digital team but provision is made for consultancy support in the PHM budget.

The SWL PHM team will devote ½ day/week to supporting this element of the plan

[43] See Appendix Section 11 for PHM budget (p89-90)

6. PHM-focussed Analytics

"The NHS analyst workforce is a crucial part of the health service, with vast potential waiting to be tapped in numerous energetic pockets of excellence across the country."[44]

Making better use of the data available has already been noted as a crucial need for both clinical and non-clinical teams. This can be provided by both dedicated analyst support but also by upskilling and training PHM practitioners. The PHM stocktake demonstrated that PHM analytics skills are not evenly matched across our system and this needs to change to match the future ambition for PHM. Analysts from across the ICS have been supported as part of the National PHM Development Programme with Action Learning Sets on linked data models, evaluation techniques and tools.

A recommendation from the Action Learning Sets and Stocktake was that an Analytical Skills (Workforce) Development Plan and linked Training Plan should be developed. This would ensure that capacity and capability in analytics is increased and aligned with need. We are waiting for the outputs from the OHID work on analytics[45] before this can be taken forward and it is a broader piece of work than for the analytics relating to PHM. We therefore have listed this recommendation in the interdependencies section on ICS analytics.

Most national exemplars have embedded analysts in places and in PCNs and we propose adopting this approach in SWL (numbers below are in keeping with these exemplars).[46] Learning from our pilots shows the benefit of embedded analysts being fully connected into the central SWL analytics team and we believe there should continue to be a significant central team with analysts working as part of that team whether they are located in place or provider organisations (similar to the matrix approach taken by the SWL ICS Communication and Engagement Team).

All PHM programmes will need to work with the analysts supporting them to:

- understand the problems affecting their populations
- determine which interventions are likely to be effective
- develop appropriate measures to determine the impact of those interventions.

The learning from this will help inform and broaden the range of measures that we use across the SWL system to understand the impacts of all service changes and improvements and more broadly of service performance and quality.

Resource requirements

It is recommended that each Place is allocated a PHM-focussed analyst (who would be part of the SWL ICS analytics team but located in place) to support them in understanding their data and helping drive cycles of PHM. This would total 6 analysts. In addition, in keeping with other national PHM exemplars, it is recommended that an analyst is allocated across every 3 PCNs that embrace PHM (again part of a SWL team). This would total approximately 13 analysts if fully recruited.

For this year, resource has already been allocated from the central SWL analytics team to support the existing PCN pilots and Sutton place and to support the PCNs and Places involved in the Place Development Programme.

The recurrent funding requirement for future years should reflect the aspiration to have dedicated place and PCN analytical resource but the analytical support for PCNs would likely be phased and rolled out according to which PCNs embrace PHM and would also to some extent depend on what is specified in future iterations of the PCN DES. In addition, the availability of analysts may be the key limitation and (as referenced in the interdependencies section) further work on developing the analytics workforce and a pipeline for analysts is recommended both for SWL and London as a whole.

Resourcing for training and support of non-analysts in analytical techniques is recommended and is included in the PHM budget[47].

The SWL PHM team will devote ½ day/week to supporting this element of the plan

[44] Goldacre review: Better, Broader, Safer: Using Health Data for Research and Analysis
[45] See Appendix Section 5 (p70-71) for more detail
[46] This is in keeping with the Fuller stocktake recommendation of "making available 'back-office' and transformation functions for PCNs, including HR, quality improvement, organisational development, data and analytics and finance."
[47] See Appendix Section 11 (p89-90)

7. Finance

There has been support for the PHM development work from SWL finance experts all along, with some dedicated work on financial incentives as part of the PHM Development Programme.

Further work will be required involving finance experts in developing budgets for any PHM pilots or programmes. A part of this is to ensure all elements of programme delivery are budgeted but more significant is the work that will be required to:

- develop population budgeting, namely budgets for each relevant segment of the population, such as people with respiratory disease or people with musculoskeletal problems
- creation of financial incentives for all system partners to ensure that effective interventions are sustainable

8. SWL PHM Goals

A key area of development for SWL will be to establish clear goals for the development of PHM capability and capacity and for improving health outcomes for each sector of our system. This will be the responsibility of those working in those places and roles.

This should include:

- PCNs
- Places
- SWL system (system functions, networks and transformation programmes, provider collaboratives) – overall system goals to be set by the SWL ICS Partnership Board

SWL Linked Development Needs

These are those elements which have a critical interdependency with the PHM Programme but fall outside the scope of the PHM team. They can be critical enablers and present exciting opportunities but also constitute some of the biggest risks for the successful delivery of PHM in SWL. We recommend that, as the ICS portfolios are developed, greater clarity is needed on the senior executive responsibility for each of these areas of development.

1. Setting SWL system PHM priorities

Each Place already has its own priorities as set out in Local Health and Care Plans. The PHM Programme is designed to support delivery of existing plans and to support each Place to increase their ambition by providing the tools to better understand unmet need and target interventions effectively. The SWL ICS also needs to establish its own shared priorities across the system, where greater scale adds value. This will be done through the Integrated Care Partnership Board.

2. System Intelligence Function

SWL ICS needs to "develop shared cross-system intelligence and analytical functions that use information to improve decision-making at every level, including:

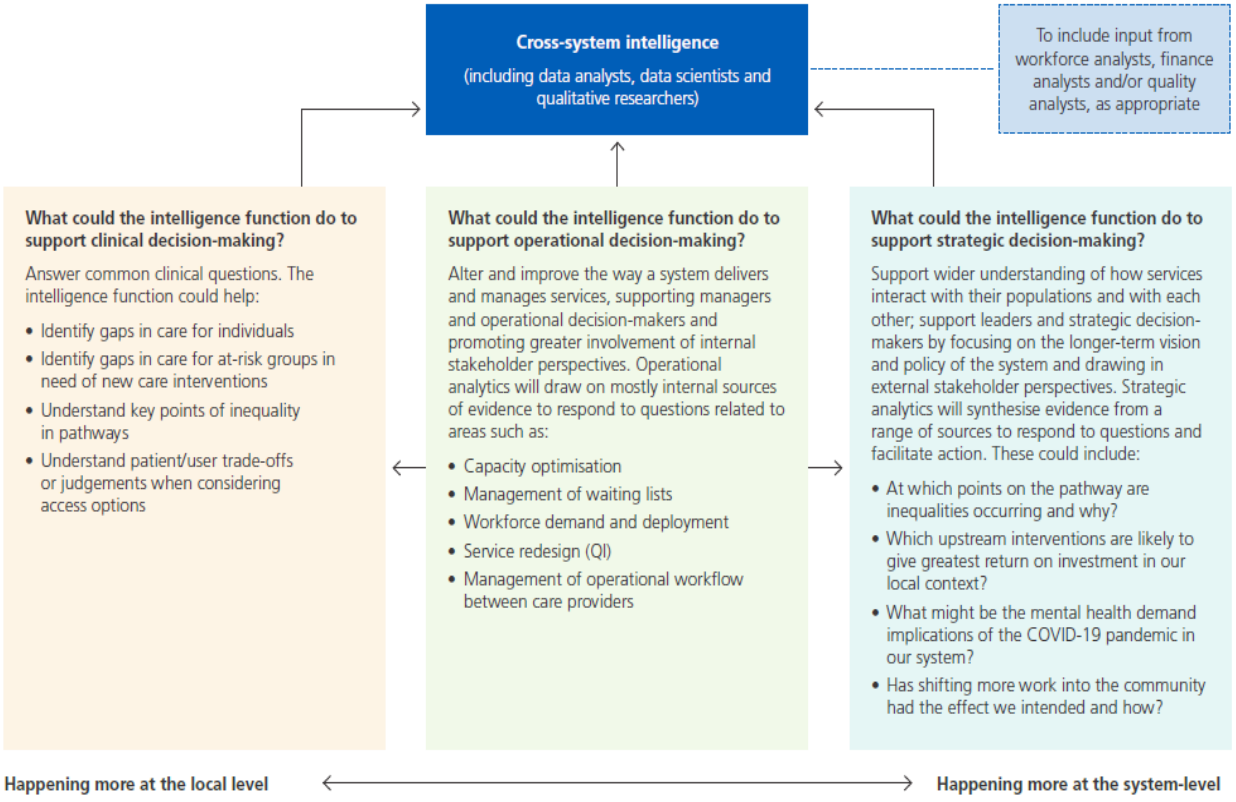
- actionable insight for frontline teams
- near-real time actionable intelligence and robust data (financial, performance, quality, outcomes)
- system-wide workforce, finance, quality and performance planning; and
- the capacity and skills needed for PHM."[48]

As set out in the national draft intelligence function guidance, the aim is that the "Intelligence Function" will draw on analysts and other specialists from all constituent parts of the ICS, including provider organisations and local authorities.[49]

[48] Integrating care: Next steps to building strong and effective integrated care systems across England, first published in November 2020

[49] "While it may have its initial basis within core teams in the Integrated Care Board (ICB), the Intelligence Function will be collaborative and multi-organisational, comprising analysts and other insight specialists from all constituent parts of

It would need to support clinical, operational and strategic decision-making:



In the previous section of the document we have described the capacity and skills required for PHM. The following sections set out some of the actions needed to develop the cross-system intelligence and analytical functions to serve the other purposes listed above.

Data (including Information Governance (IG))

The current data landscape suffers from having developed to serve payment regimes (payment by results) and waiting times tracking – rather than being focused on understanding the needs of the population and the impact of care interventions on

the ICS, including NHS provider organisations, Local Authority care services, public health teams and voluntary sector partners, and serving the strategic goals of the Integrated Care Partnership (ICP). By benefiting from this diverse expertise and by building on existing resources, its work will be founded on a detailed and comprehensive understanding of the local population, enabling the system to hone its allocation of resources, including through an emphasis on preventative care for groups who are most at risk of ill-health. These shared assets of data and insight mean that the Intelligence Function can act as a trusted integrator of the different partners of the ICS."

outcomes and equity. This means that clinicians and planners are presently limited in their ability to plan and deliver the level of consistent, equitable, pro-active integrated care required.

Proactive, integrated and equitable care requires a rounded picture of the current health and wellbeing of the population, and the ability to explore disparities in care for different groups. At present, these views are difficult to achieve because, while there has been good progress in standardising and accessing General Practice (GP) records at scale, progress has been slow in integrating these with secondary care, community, and social care information. The SWL Health and Care record has focused on "the data we have" and has integrated already-structured payment databases with GP records – but this limits the functionality required by clinicians and researchers to improve journeys of care.

We have yet to reach maximum utilisation of our data assets in SWL– many use cases are deliverable based on the existing assets in Primary Care coupled with Secondary Use Services (SUS) data. This is the approach taken by the CSU team supporting SWL and it provides a starting point to build on. For this reason, the SWL Data Strategy would need to start from the data we have and build towards the full future ecosystem in steps. This process can be summarised as:

- Better use of existing and accessible data
- Better access to data
- Better data

Much of the work of the PHM team on data has focused on ensuring data is accessible and encouraging better use of existing data. To meet future requirements, SWL ICS will need to support further work to improve access to data and to ensure data of sufficient quality, breadth and depth (including data curation, management, cleaning, reshaping and preparation). Likewise the IG capability will need developing further and the issue of multiple data controllers should be addressed. In conversation with Local Authority Public Health and analytics leads it is clear that there may be benefit in undertaking some joined up work once across SWL to create clear and streamlined IG processes that would support boroughs in accessing the data that they need. There are IG risks in expanding access to data and this will need

to be carefully overseen by the IG team and consideration given to setting up an Independent Information Access Group.[50]

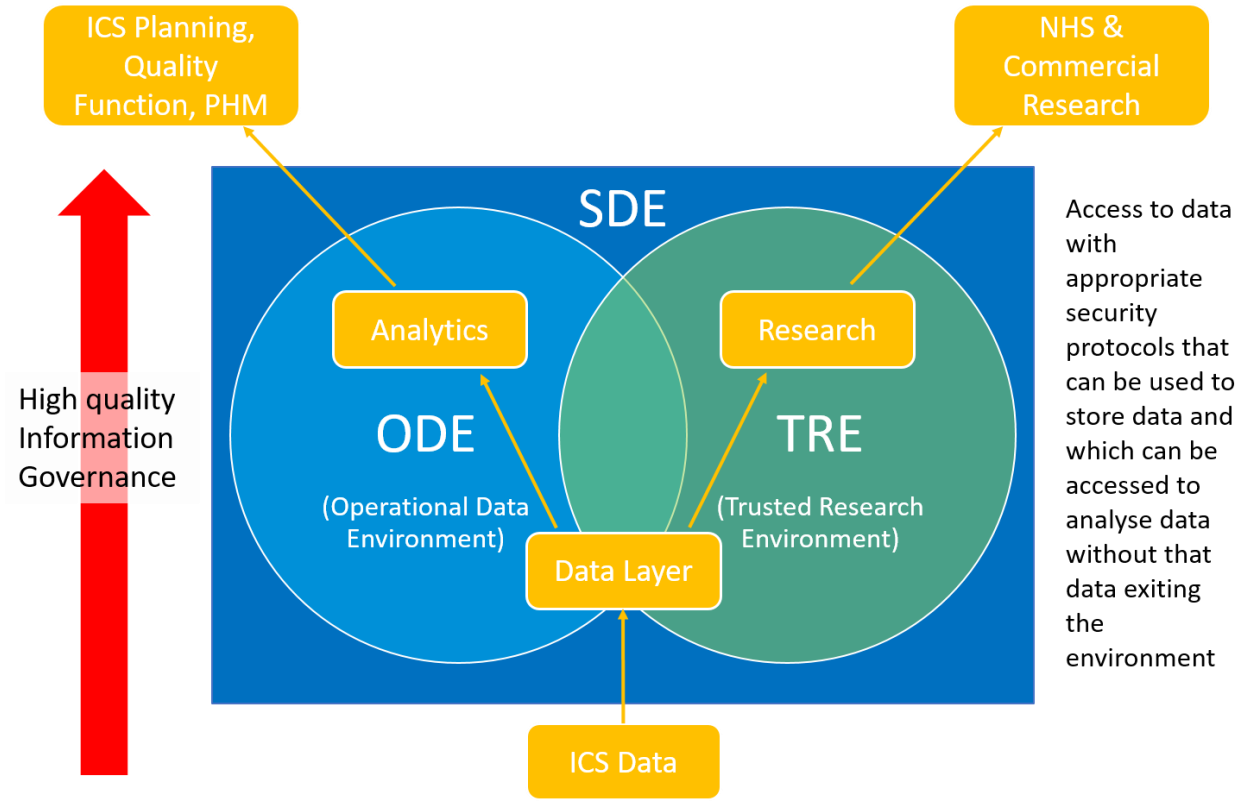
Attention will need to be paid to when patient-identifiable data is needed and for which purposes de-identified data is appropriate. Sometimes data will need to be analysed in a de-identified form to identify patient cohorts and patterns in the data but then to be re-identifiable when passed back to clinicians for interventions involving individual patients.

The OneLondon work and London Health Data Strategy contain many useful recommendations and there may be great benefit in working together on data (and potentially on analytics) across London. It is recommended that SWL support pan-London data workstreams, aiming to benefit from the best practice of NEL CSU experts now hosted by North East London ICS, combined with that of the team based in NEL ICS who have been developing Discovery Data Services.

Ultimately the goal would be to ensure a Secure Data Environment that serves the needs of analysts, system planners and PHM as well as researchers (see following sections on analytics, research and a trusted research environment).

[50] An Independent Information Access Group would provide governance and oversight of requests to access de-personalised SWL ICS health and care data. It would need to ensure that access to data is legal, safe, time-limited, well-monitored, with a clear purpose for public good and that the group providing this oversight is diverse and equal with transparent and well-informed decision-making (in line with the principles that were agreed through London public deliberations on use of data).

A simplistic representation of a Secure Data Environment (SDE):[51]



It is worth noting that the London Borough of Sutton have received £400k as part of the London Data Accelerator Programme, which aims to bring together Children's Services Data across the 33 London Boroughs into a single shared Platform, with sponsorship from the 33 Directors of Children's Care. This work will explore what currently exists in data sharing arrangements, tools and expertise with a view to building a strategy for scaling the linkage of Children's Services and NHS data across London. It will identify the 'use cases', tools and governance required to share and link the data, to streamline access across sectors and enable new preventative interventions. This work is being supported by the SWL ICS analytics team, amongst others, and it will be important to feed the learning from this into any future Data Strategy.

[51] See Appendix Section 6 for detailed explanation of a SDE (p79)

SWL Analytics and BI (Business Intelligence)

The current analytics workforce is stretched thin and is serving many different aims, including:

- Planning
- Performance and Activity Tracking, including elective recovery and diagnostics
- Quality Oversight
- COVID-specific work, such as vaccination data
- Focussed work on Health Inequalities
- PHM
- Support for various Transformation Programmes and Pilots

There are significant vacancies in the SWL ICS analytics/BI team and there are multiple current priorities. There are a large number of requests coming into the team, many of them badged as “PHM” but very few actually originating from PHM programmes. The ask for PHM would be to have a dedicated amount of SWL analytics capacity devoted to PHM to enable the SWL PHM team to manage that ring-fenced resource and ensure effective prioritisation. Analysts are essential for PHM as they help make sense of the data, interrogate the data and build dashboards to allow better access. In the future, analysts should also be used to support the whole quality improvement (QI) cycle that forms a core part of PHM.

A cross-directorate analytics/BI prioritisation group meets regularly to review the requests and demands on the central ICS team and to help manage their workflow. It is recommended that greater structure is provided to this group with work done to determine strategically what percentage of the team’s time should be spend on which system activities and priorities (obviously including the above request for PHM). This could be profiled through the year so that, for example, at key stages of the planning cycle more resource is diverted to support this function and that this is then reduced and allocated elsewhere at other times in the year.

To support this approach it is also suggested that all SWL ICS system partners who are developing pilots, projects and programmes need to scope upfront the analytics support required and to log this with the ICS analytics team.

This describes what can be done now. For the future, work is required to determine the key functions of the ICS, including current functions that need to continue but

also introducing functions to support new ICS requirements, such as the clinical, operational and strategic decision-making referenced in the intelligence function diagram on p.39 e.g. workforce demand and deployment. Once we are clear on the future ICS requirements for an intelligence function, work can be done to plan how the analytics workforce needs to develop to support this.

We are not starting from scratch. Cross-system work has been done in the PHM analytics Action Learning Sets and the analytics/intelligence review undertaken by OHID for the ICS[52]. It is suggested that SWL ICS builds on this to create an Analytical Skills (Workforce) Development Plan and a linked Training Plan. Additionally there may be great benefit in work being undertaken pan-London to develop the analytical workforce (in line with the recommendations contained in the Goldacre review).

3. Research

Population Health Research Institute (PHRI) St George's University of London

A significant ambition of the PHM programme is to carry out high quality research on important population health themes to inform disease prevention locally, and also to contribute to disease prevention both nationally and globally. Research links forged with academics at St George's, University of London will help facilitate this by providing exemplars in specific areas, identified through the PHM programme as being of public health importance to the local population. In particular, we have partnered with researchers within the PHRI at St George's, in order to build links with a focus on research with an increasing societal impact (relevant to the local population), which responds to new and emerging challenges, on which we can work together effectively to address and evidence by demonstrating change using on-going surveillance of the local population, working closely with analysts within the PHM programme. It is envisaged that involvement of St George's will provide the opportunity to share ideas and work alongside academics to stimulate synergies and collaboration.

[52] See Appendix Section 5 for more detail of OHID analytics review (p70-71)

Academic and research staff within PHRI bring both quantitative and qualitative research skills, with special expertise in epidemiology, medical statistics, public health, primary care, health service improvement research and evaluation, behavioural medicine, medical sociology, and anthropology, with experience of using large-scale national data resources in research.[53]

Trusted Research Environment (TRE)

This is a safe way of pulling resident's health and care data into a safe place and ensuring only trusted people can access it in a safe way that is carefully monitored. They cannot remove residents' data from this place.[54]

To support both academic and potentially commercial research, SWL will need to develop a TRE. This forms part of the London Health Data Strategy and it is proposed that SWL does not progress work on its own but rather learns from other London ICSs, such as North West London, who have created Discover-NOW[55], and supports the pan-London work on this.

[53] See Appendix Section 7 for further detail on areas of interest for work with PHRI (Further Interdependencies) (p80)

[54] In technical terms: A technical/digital environment or platform that allows for the safe use of data for research purposes, preventing misuse and leaks through its core design. It follows the principle that the researcher comes to the data rather than the data being released to the researcher.

[55] https://discover-now.co.uk/the-data/ Discover-NOW gives system partners direct access to de-identified data for research, planning and PHM (with the ability to re-identify for direct care) and allows third parties restricted use of the data for research and development. It has developed what Goldacre calls a “service wrapper”, which is the set of rules, regulations, governance and customer service that surrounds a TRE.

4. Summary of Combined Data, Analytics and Research Position and Recommendations

Current Position:

Data Layer – North East London Commissioning Support Unit (NEL CSU) have been providing the "**data layer"** for SWL (data curation, management, linking and storage). With the changes and ending of NEL CSU this function will now be hosted on behalf of all London ICSs by North East London ICS.

Analytics - Our analytics is a combination of the **people** (NEL CSU have had an analytics team focused on SWL who are now being in-housed to the SWL ICS) and the **analytical tool** (Health Insights = dashboards created in Microsoft PowerBI).

These **three** components make up our ICS Intelligence Function.

Our recommendation is that a sensible future solution for the next year or so could be:

Data Layer – provided by the former NEL CSU team who have moved to NEL ICS working together with the Discovery team who are also based in NEL ICS

Analytics – continuing to be provided by our in-housed CSU **team** in SWL (which needs development and support) and there is potential to work together with teams in South East London and the Health Innovation Network (the South London Allied Health Sciences Network) and possibly other ICSs to reduce duplication and share resources. Continuing for now to use **Health Insights** as our PHM platform. Support any wider work on creating an Analytical Skills (Workforce) Development Plan and a linked Training Plan.

In addition, regarding Research – continuing to work with St George's University and the SWL Research leads on developing our research capability and exploring the Discover-NOW product from North West London as a potential TRE as part of the pan-London work.

List of PHM Recommendations

1. Building a SWL PHM Team

a. Clarify clinical leadership for PHM beyond June 2022

2. Learning by Doing

a. Continue to support existing PHM pilots/programmes (Sutton, 5 PCNs, OP)
b. Support new PHM pilots in Croydon, Merton, Kingston & Richmond
c. Select and support two SWL Elective Clinical Networks and one SWL Transformation Programme to act as PHM Pilots
d. Identify and support one further SWL-scale provider PHM pilot programme
e. Support the ICS Partnership Board to agree one SWL-wide whole system PHM programme

3. Culture, behaviour and skills

a. Agree an approach to delivering appropriate system-wide development and training with the ICS Partnership Board (to cover PHM, value-based healthcare, QI, programme skills)

4. Sharing and Supporting Best Practice

a. Create a SWL Community of Practice for PHM
b. Identify and support PHM leaders, champions and experts
c. Create a PHM library

5. PHM Platform

a. Continue to manage the ongoing development of Health Insights
b. Undertake an options appraisal to obtain a PHM Platform fit for the future in co-ordination with other London ICSs

6. PHM-related Analytics

a. Over time, support each Place to obtain a SWL ICS PHM-focussed analyst
b. Over time, ensure that each PCN has access to a SWL ICS PHM-focussed analyst
c. Support further work on developing the analytics workforce and a pipeline for analysts both for SWL and London as a whole (supporting creation of an Analytical Skills (Workforce) Development Plan and a linked Training Plan)
d. Ensure training and support of non-analysts in analytical techniques.

7. Finance

a) Further work will be required involving finance experts in developing budgets for any PHM pilots or programmes, to ensure all elements of programme delivery are budgeted and to:

- Develop population budgeting
- Create financial incentives for all system partners to ensure that effective interventions are sustainable

8. SWL PHM Goals

a) To establish clear goals for the development of PHM capability and capacity and for improving health outcomes for each sector of our system and include:

- PCNs
- Places
- SWL system (system functions, networks and transformation programmes, provider collaboratives) overall system goals to be set by the SWL ICS Partnership Board

Conclusion

South West London has come a long way in the last nine months; from pockets of good practice and a poor external perception of our progress to being recognised as a national exemplar. This has come through an approach that has built on the assets and enthusiasm that already existed, catalysed by the PHM Development Programme and led with energy, purpose and clarity focussed on encouragement, co-ordination, reduced duplication and sharing best practice.

This Development Plan proposes continuing in that vein without a request for significant new financial investment or whole new teams but rather using what we have more effectively and ensuring that all in the system adopt a PHM approach in the work that they do.

The primary goal is that together as a new Integrated Care System we recognise this as a top priority and devote the time to making this successful so that we can

- Reduce unwarranted variation in quality and outcome
- Avoid harm to patients
- Prevent waste, and failure to maximise value
- Effectively tackle health inequalities and inequities
- Prevent disease

These are the challenges facing all health systems but we have the relationships, people and resources in South West London to meet them head on and together to become the best integrated health and care system in the country.

"Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek." - Barack Obama

APPENDIX

1. Contributors

SWL PHM Team:
Dr Andrew Murray, *SRO for PHM, SWL ICS & Chair of PHM Programme Board*
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Quality & Health Inequalities:
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Research:
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Contextual information from:
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PHM Programme Board Members:
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Sam Mason, *Health and Care Programme Manager, South London Partnership*
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Anita Parkin, *Director of Population Health, Central London Community Healthcare NHS Trust*
Prof Andy Rhodes, *Acute Provider Collaborative, Medical Director (until March 2022)*
Simon Robson, *Deputy Director of Adult Social Services and Director of Adult Social Care, London Borough of Croydon*
Dr Laura Rodriquez-Benito, *Clinical Director for Wallington PCN, PHM & Lifestyle Lead for Sutton PCNs*
Dane Satterthwaite, *London Region Head of PHM (Acting) and COVID-19 Vaccine Programme - Inequalities Analytics, NHS England and NHS Improvement*
Amy Scammel, *Director of Strategy, Transformation and Commercial Development South West London and St George's Mental Health NHS Trust*
Susan Sinclair, *Managing Director, Royal Marsden Partners*
Joanna Watson, *Director of Finance, Financial Systems Management, SWL ICS*
Amelia Whittaker, *Director of Contracting, SWL ICS*
Miss Jane Wilson, *Chief Clinical Information Officer (until March 2022)*

2. Further Definitions

Health Inequalities[56]

The avoidable, unfair and systematic

- Differences in the status of people's health (e.g. higher rates of diabetes)
- Differences in the care that people receive (e.g. access to care)
- Differences in the opportunities to lead healthy lives (e.g. wider determinants of health such as housing)

Core actions required are to

- Give every child the best start in life.
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure healthy standards of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill health prevention.

Inequity vs Inequality

The term *health inequality* generically refers to differences in the health of individuals or groups. Any measurable aspect of health that varies across individuals or according to socially relevant groupings can be called a health inequality. Absent from the definition of health inequality is any moral judgment on whether observed differences are fair or just.

In contrast, a *health inequity*, or health disparity, is a specific type of health inequality that denotes an unjust difference in health. By one common definition, when health differences are preventable and unnecessary, allowing them to persist is unjust. In this sense, health inequities are systematic differences in health that could be avoided by reasonable means. In general, social group differences in health, such as those based on race or religion, are considered health inequities because they reflect an unfair distribution of health risks and resources.

The key distinction between the terms *inequality* and *inequity* is that the former is simply a dimensional description employed whenever quantities are unequal, while the latter requires passing a moral judgment that the inequality is wrong.

Personalisation and Personalised Care

Personalised care means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs. This happens within a system that makes the most of the expertise, capacity and potential of people, families and communities in delivering better outcomes and experiences. Personalised care represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision making that enables people to have a voice, to be heard and be connected to each other and their communities.

This approach learns from the experience of social care in embedding personalised care in everyday practice, which has enabled people to take control over the funding for their care. It also builds on pockets of progress made in health.

Critically, personalised care takes a *whole-system* approach, integrating services around the person including health, social care, public health and wider services. It provides an all-age approach from maternity and childhood right through to end of life, encompassing both mental and physical health and recognises the role and voice of carers. It recognises the contribution of communities and the voluntary and community sector to support people and build resilience.

There are six standard components of personalisation:

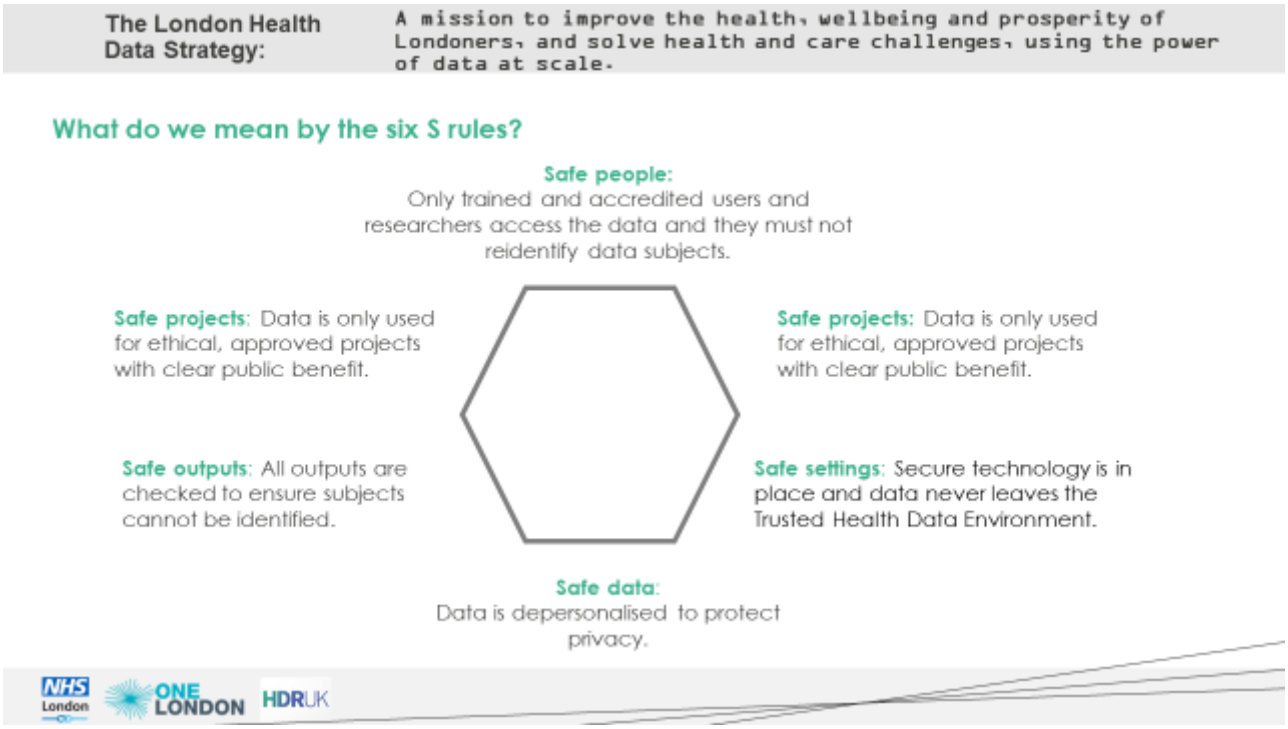
- shared decision making
- personalised care and support planning
- enabling choice
- social prescribing and community-based support
- supported self-management
- personal health budgets and integrated personal budgets

[56] See the 2010 Marmot Review: https://www.parliament.uk/globalassets/documents/fair-society-healthy-lives-full-report.pdf

Data definition

6 safes

6 safes as defined by NHS London/OneLondon team:



London Data Glossary

London Data Glossary – selected entries

Domain	Term	Simple Description	Technical Description proposed in latest pack	Goldacre Review	Intelligence Function Guidance
Shared Care Record	**LHCRE Level 1: London Care Record**	Every health and care professional can see information from other organisations about the patient in front of them			
Getting Data	**LHCRE Level 2: London Data Services**	A way of getting standardised, good data about residents and putting it in one safe place	The common data layer across London – this is still in development, with different data types from different ICSs still being incorporated. At present, the data type with greatest coverage is primary care.		
	Data Services Layer or Shared Data Layer or Common Data Layer	Same as LHCRE Level 2	The technical environment in which data is collected and stored, for a variety of uses in other applications – modern technical design recommends separating this ingestion and storage function from the applications where data will be used		
	Application Layer	All the possible digital applications and tools that make use of the data layer	The technical environment that accesses data from the data layer for the full range of uses – this separation of application and data layers provides increased security and robustness for the system in operations		
	Analytical Layer	A way of safely looking at data in the data layer and analysing it			

	Reproducible Analytical Pipelines (RAP)	Standardising the way data is recorded, shared and analysed to allow researchers and analysts to compare their findings		A set of best practices and training as the minimum standard for academic and NHS data analysis: this will produce high quality, shared, reviewable, re-usable, well-documented code for data curation and analysis; minimise inefficient duplication; avoid unverifiable "black box" analyses; and make each new analysis faster.	
	Data curation	Recording data well and consistently		"Data management" or "data preparation" is the crucial first step of any meaningful data analysis. Data curation is a data management task. Data management is done in code: where there is a desire to share access to curated data, this means sharing access to re-usable data management code with adequate technical documentation, in a library where it is discoverable and managed.	
	Libraries	Agreeing standard ways of recording data		Creating standard catalogues of "approved" variables and datasets, such as a single canonical variable for "patients with diabetes". Create and maintain an NHS Data Curation Library where all data users can	

				assert variables and data management code alongside technical documentation; this must be inclusive, and separate from work around assurance of variables	
Information Governance	**Role-Based Access Control (RBAC)**	A way of ensuring health and care workers only see information relevant to the job they do			
	Shared Care Record Access Control Model (National)	Same as RBAC with 6 possible roles for health and care workers			
Accessing & Using Data	**Secure Data Environment (SDE)**	Describes the combination of a TRE and ODE			
	Trusted Research Environment (TRE)	A safe process to pull resident's health and care data into a safe place and ensuring only trusted people can access it in a safe way that is carefully monitored, for the purposes of research. They cannot remove residents' data from this place	A technical/digital environment or platform that allows for the safe use of data for research purposes, preventing misuse and leaks through its core design. It follows the principle that the researcher comes to the data rather than the data being released to the researcher.	A secure environment that researchers enter in order to work on the data remotely, rather than downloading it onto their own local machine. Users can extract and download the answers from their analyses - such as results tables, or graphs - but individual patients' data always stays within the secure environment. TRE should be conceived of as having three components: a service wrapper; the underlying generic computational and database services; and the bespoke software needed for work with NHS data	

	Operational Data Environment	A safe process to pull resident's health and care data into a safe place and ensuring only trusted people can access it in a safe way that is carefully monitored, for the purposes of planning, monitoring and improving health and care services. They cannot remove residents' data from this place			
	Trusted Health Data Ecosystem	An agreement between health and care organisations to work together in way that safely makes the most of residents' data to improve their health	The Programme has defined this term as the Health Data Environment's technical capabilities and services, plus the broader system in which it sits including all the potential users and providers of data – this is the widest term used		
	Trusted Health Data Environment	The rules and technology that allow health and care organisations to work together in way that safely makes the most of residents' data to improve their health	The Programme has defined this term (abbreviated THDE) as the full 'stack' of the technical environment, including the various data and application layers that exist in the system, plus the services associated with operating the THDE – management, information governance, public engagement, and so on		
	Service Wrapper	The rules and processes to ensure that the TRE (safe-space for data) is definitely safe and used appropriately		The set of rules, regulations, governance and customer service that surrounds a TRE. There will be a range of rules around who can access the data, the skills or certificates they may need; rules around permissioning for projects; processes to evaluate compliance with these rules; forms	

				to collect the data, and administrative processes to manage them; etc. There will be governance for the TRE as a project in itself, and a range of permissions, contracts, relationships and governance arrangements around the patient data that is being ingested. There will be public-facing material to be managed, describing activity in the TRE to a greater or lesser extent. There will also usually be an "output checking service".	
	Data Access Environment	How data is managed, stored and accessed within an organisation		An internal service where staff at an organisation can have some shared resources for secure storage and analysis of data, such as shared databases, or shared provision of computer power	
	Population Health Management platform	A digital portal that allows health care professionals and planners to view data about a population and better understand the needs of segments of that population			A digital tool/platform that performs standard analyses, such as population segmentation and risk stratification, so that care can be targeted and personalised to the greatest effect. As population health analytics develop in power, the focus will grow from condition management to the use of predictive risk factors to aid early detection and the prevention of ill health.

	Intelligence Function	This describes how a health system would get analysts and other teams to work together to use data to improve population health and to monitor and improve health and care services			An Intelligence Function is a system-wide, multi-disciplinary collaboration of intelligence professionals, with representation from analytical leaders and key teams across the whole ICS. At its core, it is a way of coordinating a diverse range of analytical skills to support the needs of the system. The purpose of the Intelligence Function is to ensure that ICS decisions are routinely informed by evidence that is tailored to the local context, including a detailed understanding of health inequalities between population groups, and that the system is supported to take a population-based and approach to care planning and delivery, including the use of data to shape the personalisation of care.
Personal Health Record	**LHCRE Level 3: Personal Health Records**	Every resident can access their own health information through an app			

Documents/Sources	**Purpose**
One London Stocktake	In late 2021, the OneLondon Board requested a 'stock-take' of the programme across London. The rationale for the stocktake was to provide a shared, common understanding of the status of delivery across London.
Towards systems of integrated care and innovation in London: creating trusted health data ecosystems and environments as a basis for health and wealth (London THDE/E - Data Strategy)	How we make the most intelligent and trustworthy use of the data created within the hundreds of thousands of clinical and operation interactions that happen each day. A. Where are we heading to, where have we come from, and where are we now? B. What are our strategic challenges, requirements, and choices? C. Where can we learn from: international comparisons? D. What are our conclusions and next steps?

London Health Data Strategy: Outline Business Case	The vision for the London Health Data Strategy is to materially improve the health and wellbeing of Londoners through better use of data. This is a proposition as to how to deliver the London Health Data Strategy
Goldacre Review: Better, Broader, Safer: Using Health Data for Research and Analysis	This review was tasked with finding ways to deliver better, broader, safer use of NHS data for analysis and research: more specifically, it was asked to identify the strategic or technical blockers to such work, and how they can be practically overcome
NHS Secure Data Environments Capability Specification	Sets out the core required and preferred architectural capabilities for the use of Secure Data Environments (SDEs) by the NHS, or for the use of NHS data, in England
ICS Intelligence Function Guidance: Building an ICS Intelligence Function	This guidance builds on and clarifies the expectations of ICS Intelligence Functions, which have been previewed in other guidance published over the past year, including Integrated Care Systems: Design Framework and most recently in the 2022/23 priorities and operational planning guidance

3. Wave 3 SWL PHM Pilots and Examples from Elsewhere

For 22 weeks as part of the Wave 3 NHSE/I PHM Development Programme multi-disciplinary teams in one Place (Sutton) and five PCNs (Battersea PCN, East Merton PCN, Kingston PCN, North Croydon PCN and Wallington PCN) were supported by the NHSE/I delivery partner, Optum, to focus on a specific selected cohort of their local population through the real time application of advanced analytics and intelligence-led care design. Tailoring health interventions together, aiming to ensure they had better access to health, better engagement, a better experience and better outcomes. In addition, ICS analytics teams were supported by a series of Analytics Action Learning Sets (ALSs) focusing on Insight Tools, creating linked data models and evaluation techniques. The SWL case studies are below and have been approved by NHSE/I and are published on the FuturesNHS website.

Sutton Place

Place population size: 207,075
Cohort size: 2,170
Cohort description: Over 20 years of age, with Osteoarthritis, diagnosis of Hypertension, obesity or depression living in areas of high deprivation in Sutton
Description of intervention/service: To support the individual via a community hub to eat more healthily, be more active, reduce stress and feel more confident in leading a healthy lifestyle and increase their confidence to manage their conditions

Battersea PCN

PCN population size: 55,000
Cohort size:
Cohort description: Patients with evidence-based adverse health indicators, who didn't consult more than twice within the defined year of interest
Description of intervention/service: To gather information from representative individuals, to find out more about their life circumstances, health beliefs, experiences of GP and community services and ideas for improvement

East Merton PCN

PCN population size: 48,000

Cohort size: 557

Cohort description: Over 18 years of age, with Severe Mental Illness (Psychosis, Schizophrenia or Bipolar Affective Disorder) and a Dual Diagnosis of Drug and Alcohol dependence.

Description of intervention/service: health and wellbeing hub in community setting

Kingston PCN

PCN population size: 46,000

Cohort size: 97

Cohort description: The factors that were used to select the cohort were - Prediabetic +/- deprivation +/- depression/anxiety +/- previous declined health promotion interventions.

Description of intervention/service: Social Prescribing team to introduce project and discuss what barriers the patient may have to improving their health (social determinants), followed up by a one to one meeting with a Health and Wellbeing Coach to discuss pre-diabetes, provide initial education and motivation. Personalized pathway then created.

North Croydon PCN

PCN population size: 50,034

Cohort size: 69

Cohort description: People of working age, BAME with a history of Serious Mental Illness and who are obese, in low-middle complexity and non-diabetic were chosen.

Short Term

- Patients understanding the role that they can play in their own health outcomes
- Understanding of what a healthier lifestyle looks like
- Patients motivated to engage with positive lifestyle behaviours, diet/exercise.

Medium Term

- Increased personal responsibility
- Engagement with positive lifestyle behaviours
- People accessing services more appropriately
- Improved well being

Long Term

- Reduced BMI, reduced prevalence of long-term conditions

- Reduction in GP/A&E and acute admissions
- Patients able to care for themselves better by feeling informed, confident and able to achieve their health goals
- Patients feel more connected to their community, involvement with tertiary organisations – improved mental health, improved social situation.

Wallington PCN

PCN population size: 52,140

Cohort size: 338

Cohort description: People with obesity AND depression, chosen because they were identified as the least likely to access and engage with healthcare services

Description of intervention/service: Health coaching intervention to help to change health behaviours (taking up heathy eating and regular physical activity)

Rationale for intervention: To promote population health by proactively identifying patients at increased risk of poor health outcomes. This coaching intervention was chosen because it strives to improve health and wellbeing by increasing patient activation/facilitating positive behaviour change.

Further Exemplars

Dorset

Cohort - frailty population data using segmentation based on long term conditions, hospital admissions, polypharmacy and cost to the system, small group of patients identified.

Intervention - proactive personalized case management.

Outcome - reduced patient frailty score and improved independence, reversing segmental drift.

Surrey Heartlands ICS

Developing a system-wide intelligence function and an analytical community of practice enabling predictive analysis at secondary and primary prevention levels, Artificial Intelligence (AI) and machine learning with impactability and actuarial modelling.

Analytics to support data driven-decision making to guide strategic business decisions that align with identified goals, objectives and initiatives. Enabling outcomes-focused services to be developed aiming to achieve the priorities that people have themselves identified as important, which include wider determinants of health. Developing an ICS wide business intelligence operating model, with data/digital as the enabler and PHM as the lens.

Montefiore, New York, USA[57]

System-level intelligence led integrated health and care, highly centralised case management infrastructure for patient identification, workflow management and monitoring for seamless patient experience.

Cohort – at risk patient criteria agreed = previously identified by housing or social service provider as at risk, home address is a Hospital, Clinic or Shelter, homeless and previously seen by a GP who specialises in homeless care.

Intervention – if presents to ED (Emergency Department), relevant providers notified, Social Worker-facilitated discharge plan, patient discharged to respite housing.

[57] https://www.kingsfund.org.uk/publications/montefiore-health-system-summary

Nuka, Alaska, USA – transformation of primary care delivery model

The NUKA system of care provides health and social services for over 65,000 Native individuals in Alaska, US. Ineffectively utilised and poor quality care was shifted from hospital to patient through primary care partnership and transformation by using their advanced Primary Care Delivery Model, providing same day access either in person or virtually with group visits also available.

Reduced Utilisation

36%

Reduction in ED visits

28%

Reduction in GP visits

Decreased Cost

36%

Improved Quality

Across performance outcome measures

Advanced Primary Care Delivery Model - Integrated Care Teams Staff to GP Ratio

Core GP Team (1 per GP)

- **Registered Nurse Case Manager**
- **Case Manager Administrative Staff**
- **Certified Medical Assistant**

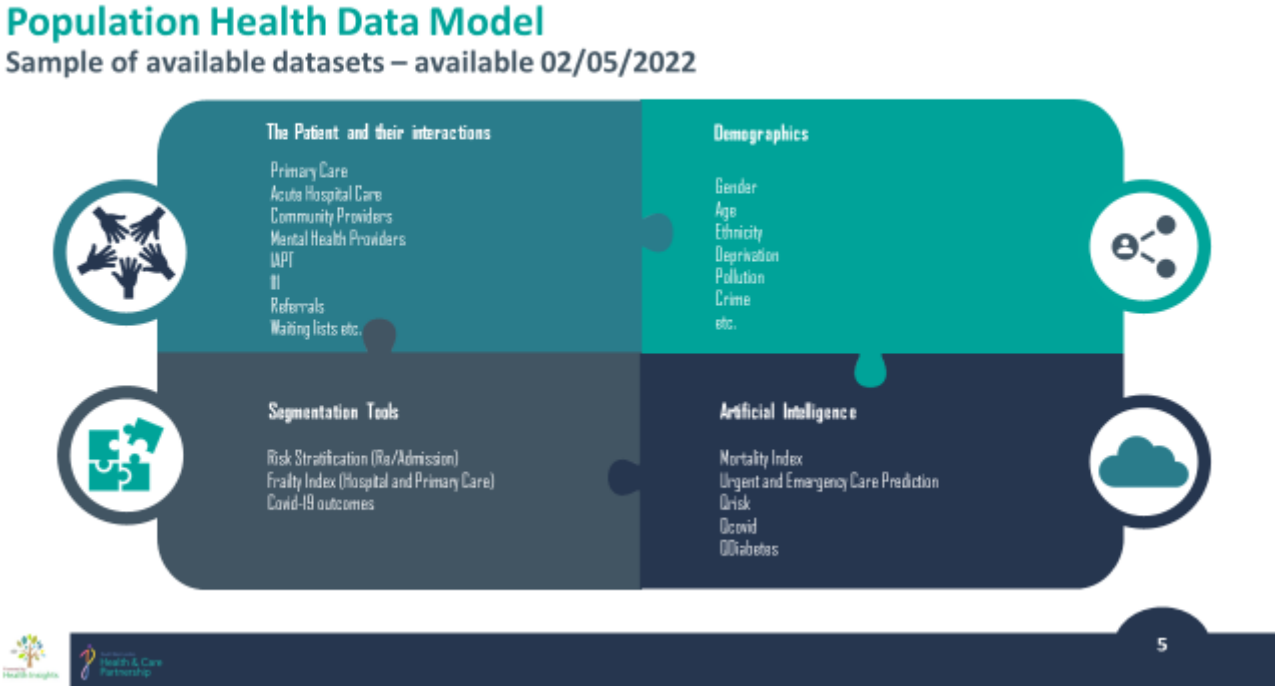
Extended ICT Team (1 per 6 GPs)

- **Behavioural Health Consultant**
- **Registered Dietician**
- **PharmD**
- **Nurse Midwife**
- **Non-Clinical Clinic Manager**

4. Health Insights

Health Insights is the interface built by the NEL CSU analytics/BI team who have been "in-housed" in the SWL ICS. It is built using Microsoft PowerBI and presents a view of data from various sources using interactive dashboards built by the team.

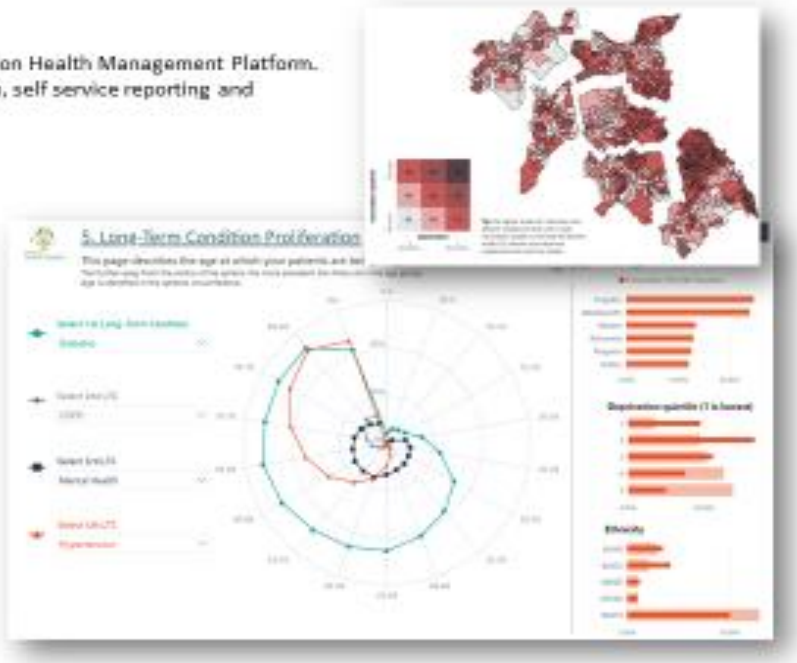
The following slides, give a further overview:



SWL ICS Health Insights Platform

Interactive Population Health Management

Health Insights is South West London's Population Health Management Platform. Acting as a knowledgebase, it hosts all research, self service reporting and documentation.



Health Knowledgebase

A site that contains the wealth of knowledge we have developed under Population Health Management.

Single sign-on, Role based access

Ease of use, web based, scalable, role and level of detail governed by user credentials

Interactive, visually appealing, self service

Simplicity of design, storytelling, intuitive narration

Insightful

Technology and analysts provide the structure, the user decides how deep they want to dive into the story

Depth of analysis

Infrastructure narrates risk algorithms and machine learning outputs, without needing to be an expert

5. Office for Health Improvement and Disparities (OHID) Analytics Skills Mapping Exercise

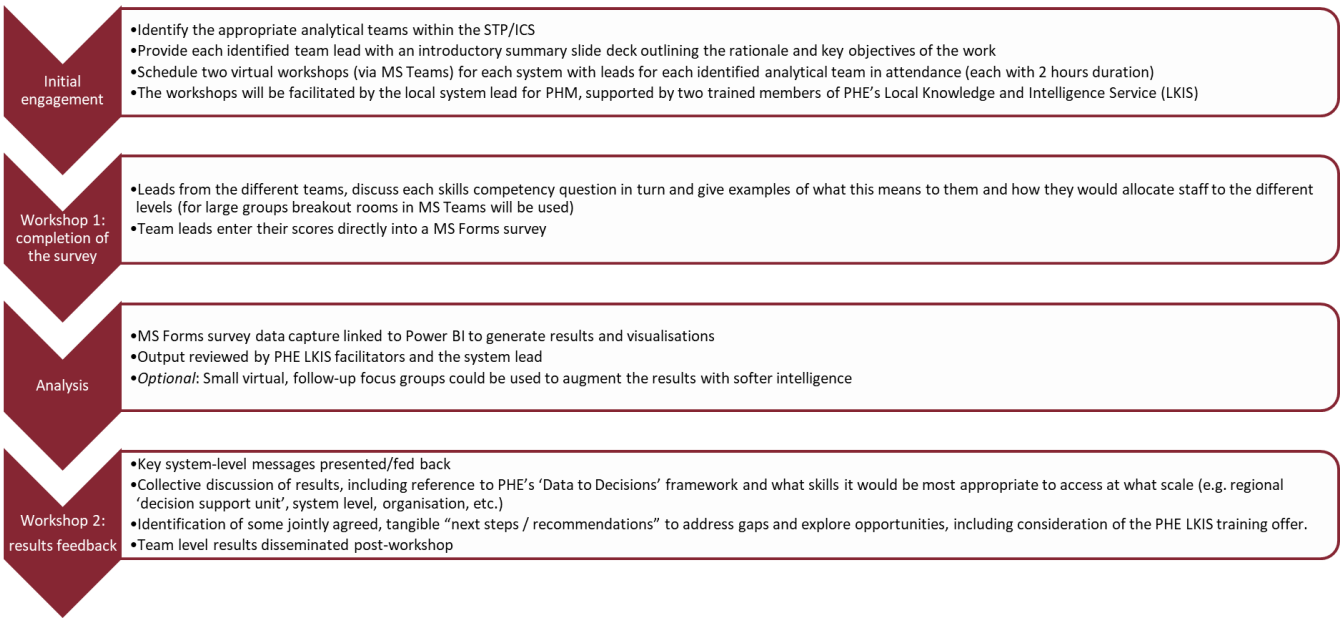
SWL ICS partners (including Directors of Public Health/Local Authorities, SWL Providers, SWL ICS analytics/BI team) were approached by Public Health England (which has now become the Office for Health Improvement and Disparities) since they were undertaking an exercise in each ICS entitled "Team Level Population Health Intelligence Skills Mapping (From data to decisions: *Building blocks for place-based population intelligence systems)*."

The idea was that the skills mapping process would form an important initial step in helping local systems to undertake PHM, by establishing where there are gaps in intelligence skills (both in terms of capability and capacity) and where there might be opportunities for collaboration on analytical work. Once we heard of this exercise, the PHM team helped with the coordination to ensure it complemented the analytics workshops run as part of the National PHM Development Programme and the Stocktake.

The aims of the skills mapping process were stated as:

- to map, at a high level, existing skills and capacity in population health intelligence across local partners in an ICS or STP footprint
- to identify particular strengths of teams across the patch
- to begin to set out potential opportunities available through collaboration
- to start to understand current gaps in the system which can inform:
  - Training needs
  - Arm's length body (e.g. PHE/NHSE) support offers
  - Priorities for other external support

The process is:



Those involved in the process include SWL CCG/ICS/CSU analytics/BI team, SWL NHS Acute and community providers, Primary Care, Local Authority analysts and Public Health teams and PHRI (St Georges, University of London).

We are still waiting for the feedback of results and a report.

6. SWL Context – Further Interdependencies

Intelligence Function

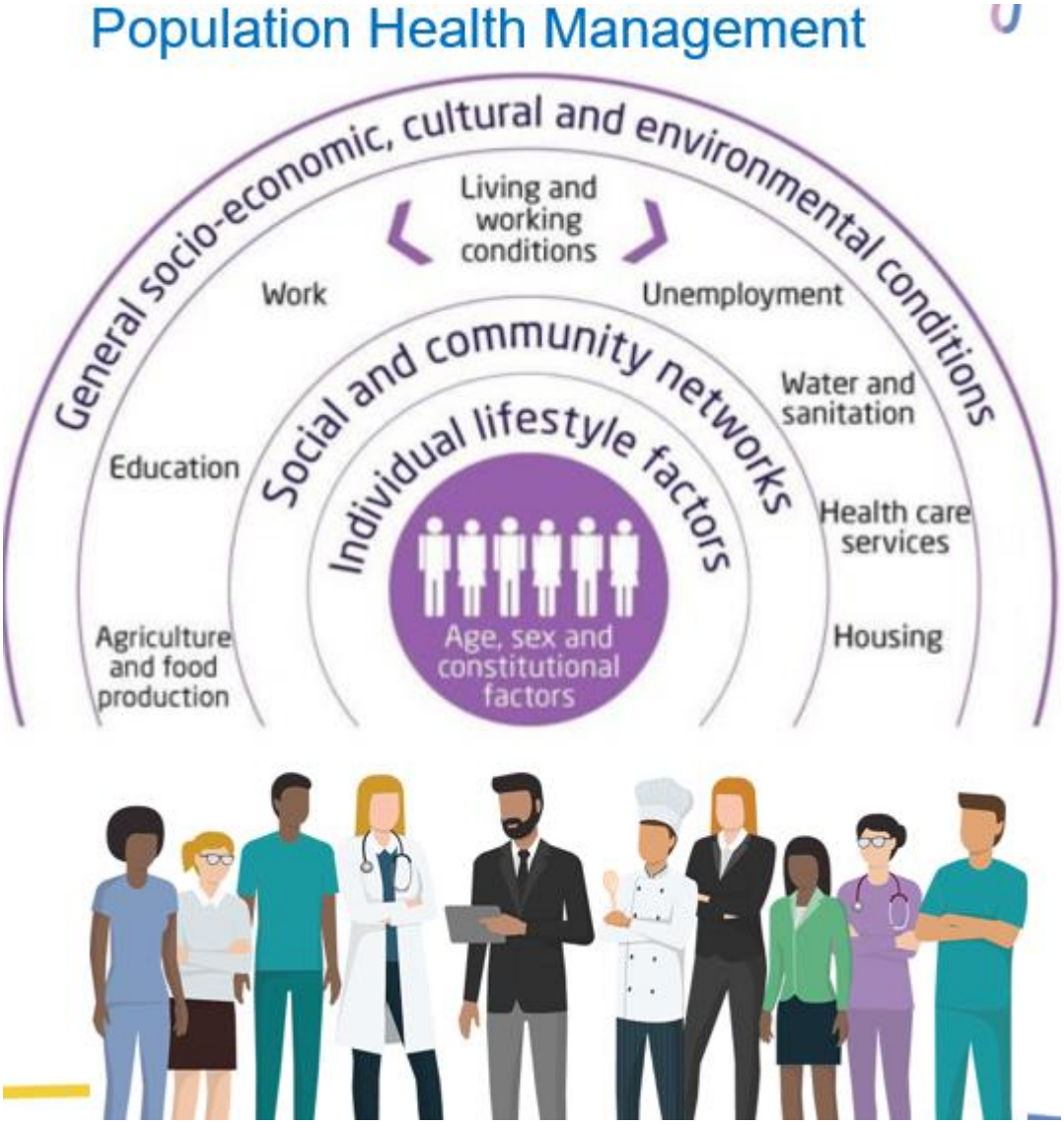
Goldacre Review: Better, Broader, Safer: Using Health Data for Research and Analysis – selected quotes

"Data can be used to compare service activity and clinical outcomes between organisations; to identify opportunities for improving the quality, safety, and cost effectiveness of services; to locate excellence, and share best practice; to model and forecast waiting lists; to predict the best locations and sizes for new services; to evaluate service recovery after the COVID-19 pandemic; to measure the impact of new interventions or new service delivery models; and to ensure value from clinical contracts. These kinds of analyses deliver direct improvements in patient care by identifying problems early and improving services for all.

As is clear throughout this review, data alone does not produce these insights on its own. Raw data must be managed, curated, processed, analysed, presented, and interpreted before it can generate action. This requires a wide range of features to be in place across the system: individuals with strong analytic skills; good training and oversight; data that is accessible; modern data analysis tools; and data that is high quality wherever possible, with any shortcomings documented informatively and accessibly. It also requires senior managers with the skills to recognise good analytics, understand the reports they receive, and pose informed answerable questions to their analytic staff."

Quality Improvement[58]

Population Health Management as enabler to improve quality



Planning and delivering quality at Place and system level will have a greater focus on PHM. Traditionally, we use service level data and intelligence to improve outcomes, services and experiences of care. As we develop the system's capability, we plan to use PHM insights which include data on the wider social-economic determinants of health (*i.e. education, housing, employment)* which will provide the system leaders with richer information about the health and wellbeing of individuals, families, and communities to define quality improvement programmes and pathways and support inequity of care.

[58] This section provided by SWL ICS Quality Directorate

This will also support us in delivering areas of mutual interest across health and social care (e.g., safeguarding and safety) and to improving quality through a system approach remaining focused on patient outcomes, developing a Quality Management Systems (QMS) framework as a learning system, as well as a culture of continuous learning system and SWL Peer Support and Assurance.

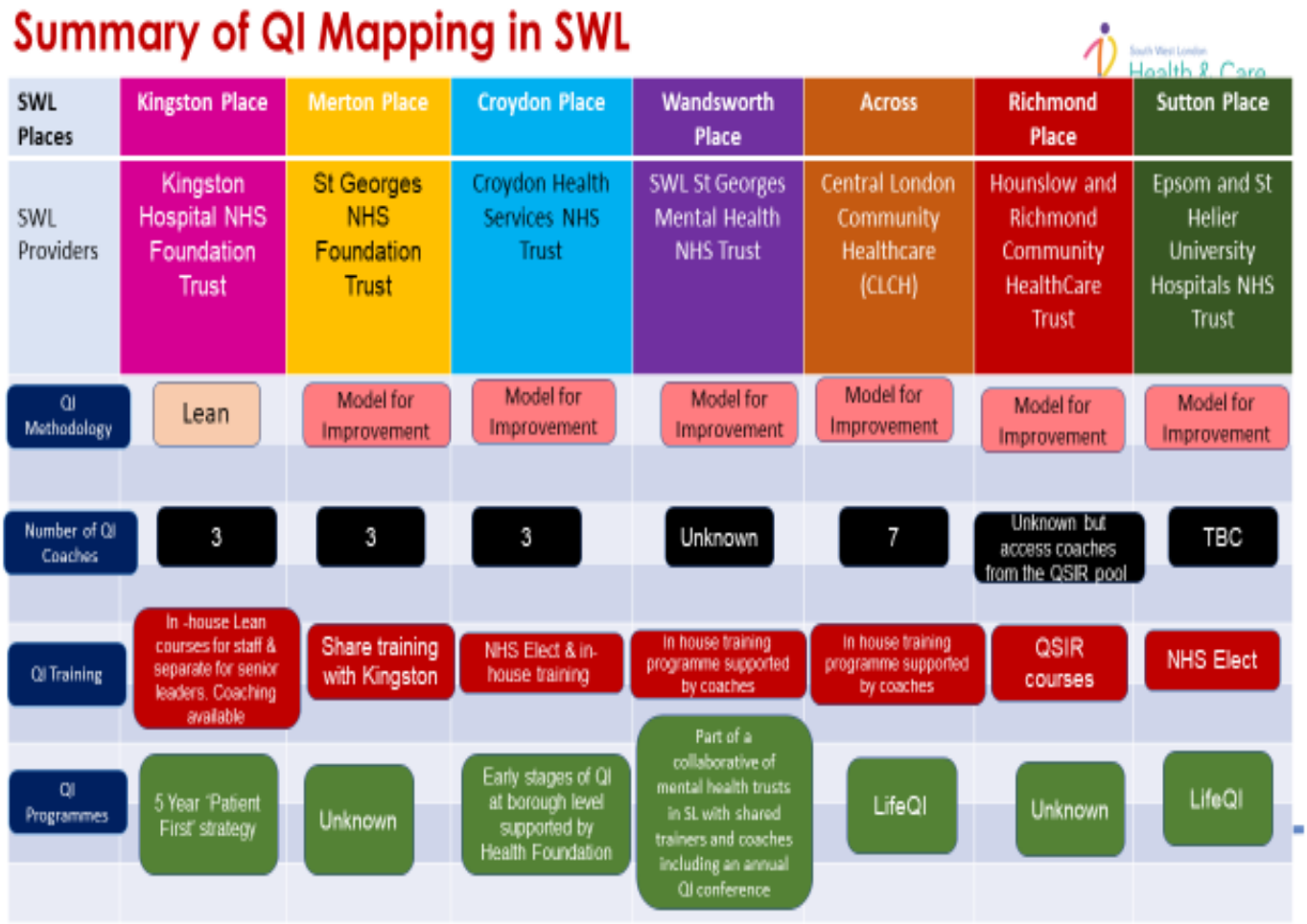
Quality Improvement Audits

The SWL ICS Quality directorate commissioned two audits on Quality Improvement at system level. One was undertaken by the NHSE/I QI team and the other by PPL consultants in March 2021.

- Methodologies across all Trusts and providers were mapped
- Themes and recommendations similar on both audits

Findings and recommendations:

- **As is-** QMS is primarily **focused on clinical quality**
- **Proposed:** There is appetite from system stakeholders to ***'go big'*** with QI
- SWL ICS to draft roadmap for development and delivery of QI at system level



Next steps that were suggested:

- NHSE/I QI team to lead and facilitate a 90 min ***'making data count'*** workshop to the SWL ICS Senior Management Team
- Repeat for Provider CEOs / CNOs, Quality Execs
- Map QI capability in Primary Care (General Practice to be specific)
- Complete market research and develop options appraisals

Health Inequalities

ICSs are taking a lead role in tackling health inequalities and building on the Core20PLUS5 approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level.

Consultation on this with our ICS partners has enabled agreement on the health inequalities work to progress across four tracks:

1. The five urgent (must-dos) actions for systems through the 2022/23 operating guidance
2. Core20PLUS5 Improvement Programme
3. Local medium to long term priorities (linked to Place Health and Care Plans) to be implemented in 2022/23
4. Resourcing and funding to deliver and tackle inequalities

The five urgent actions

Maintain focus on preventing ill-health and tackling health inequalities by redoubling efforts on the five priority areas for tackling health inequalities set out in guidance in March 2021.

Restore NHS services inclusively - focusing on decline in access amongst some groups during the COVID 1st wave which highlighted pre-existing disparities in access.
Mitigate against digital exclusion - be inclusive of those who are unable to access remote services and make adaptations for access.

Ensure datasets are complete and timely - continue to improve the collection and recording of ethnicity data across primary care, Outpatients, A&E, Mental Health, Community and Specialist Services.

Accelerate Prevention - ongoing management of long term conditions, annual checks for people with Learning Disabilities and Serious Mental Illness, implement CoC for at least 35% of BAME women.

Strengthen leadership & accountability - systems and providers should have a named Executive Board level lead for tackling Health Inequalities and should access training from Region.

Core20PLUS5 Improvement Programme

The Core20PLUS5 approach is designed to support Integrated Care Systems to drive targeted action in health inequalities improvement. The target population is the most deprived 20% of the population as identified by the index of Multiple Deprivation PLUS our local ICS chosen population groups experiencing poorer than average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored health care approach. The National 5 Clinical Priorities are early cancer diagnosis, Serious Mental Health Illness, Maternity, Chronic Respiratory Disease, Hypertension case finding.

In SWL the Core20 population has been identified using PHM as a tool as a population of 340,000, further detailed analysis has taken place to understand their specific health care needs, barriers, locations, ethnicities and other wider demographics. The SWL PLUS population group is focused on improving outcomes for Black and ethnic minority populations specifically in Croydon. The National 5 Clinical Priorities has been expanded to also include diabetes and work has taken place to implement and achieve outcomes thorough the development of plans and targets.

The Core20PLUS Connectors Programme is a funded initiative to support focused action across Integrated Care Systems to impact on the goals of Core20PLUS5 by developing and supporting community-based roles, acting as a voice to focus on barriers and enablers to reduce health inequalities and connect people with decision makers, SWL has recently secured funding as part Wave 1 of this Programme.

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Targeting our Population to improve health outcomes

In SWL, we want far reaching benefits for our local communities, specifically those with poorer outcomes *(i.e. those who may not feature in our Core20 as they may not be known to health or care services)* whether it's better access, experience, and outcomes for health, or creating employment opportunities, to raising aspirations and local skills. As part of our medium to long term priorities aligned to Health and Care Place plans, our focus areas include:

- **Race and health**: Implementing recommendations from the NHS Observatory Report for ethnic minority communities, homeless and rough sleeping communities, gypsies and traveller communities, asylum seekers, refugees, and other protected characterized communities
- **Equality, Diversity and Inclusion for our Staff**: We will develop our quality, diversity, and inclusion strategy for our staff
- **Anchor Institutions & Strengthening Communities Programme**: Economic development and environmental sustainability at the core of tacking socio-economic health inequalities
- **Develop and build capacity and capability in our VSCE organisations** to enable proactive co-production with our communities and people with lived experiences

Priorities for Children and Young People (CYP) and how we are linking to the Strengthening Communities Programme and Local Authorities

A core commitment and priority for the SWL CYP Board is to tackle inequalities of access, experience and outcomes for our local children and young people. Some key priorities we are looking to deliver in 2022/23 include:

- Undertake a mapping analysis for our neurodevelopment/ASD CYP population, with an aim to implement innovative pilots to support better and timelier diagnostics and support for service user and their families.
- Aligning to the Anchor Institution programme, our plan is working with LA partners to establish opportunities for our care leavers to have employment opportunities in the NHS. Kingston and STG Hospital are supporting these initiatives.
- Tackling inequity in Special Educational Needs and Disability (SEND), Complex Care and Transitions is a priority across SWL - each borough is working on their written statement of action.

Secure Data Environments

A Secure Data Environment is the term for a platform that provides users access to data with appropriate security protocols that
1) can be used to store data (the 'data layer') or
2) which can be accessed to analyse data without that data exiting the environment (the 'analytical layer').

This includes Trusted Research Environments (TREs) which are utilised for research activities, and Operational Data Environments (ODEs) which are utilised by NHS analysts, and at times broader government analysts, for operational insights and planning purposes. Regardless of function, SDEs are usually not singular units, and will be made up of components including:

- Infrastructure & hosting: the computing power, network usage, and storage that is leveraged.
- Platforms & applications: analytical and data management tools; utilisation of/ communication with external platforms e.g. GitHub.
- Data & data exchange: data storage in lakes and warehouses, as well as data streams from EHRs and person generated sources (e.g. wearables).

These components may be delivered by multiple providers, some of whom might supply more than one aspect of the SDE e.g. a vendor may provide both cloud hosting and an analytical platform.

SDEs should utilise common software (particularly at a system level) and platforms/tools (with understanding that specialist capability may at times be required), with no 'workarounds' leveraged or deployment of inappropriate software patterns. They should be built upon open principles and standards, for software interoperability, data and document formats.

There should also be transparency of SDEs security and design approach, with this information included in the data controller/ deploying organisation's Data Protection Impact Assessment and made publicly available for data subjects, without posing a risk to their integrity.

7. Research

See SWL Linked Development Needs section of the plan which describes both the context and the recommended approach.

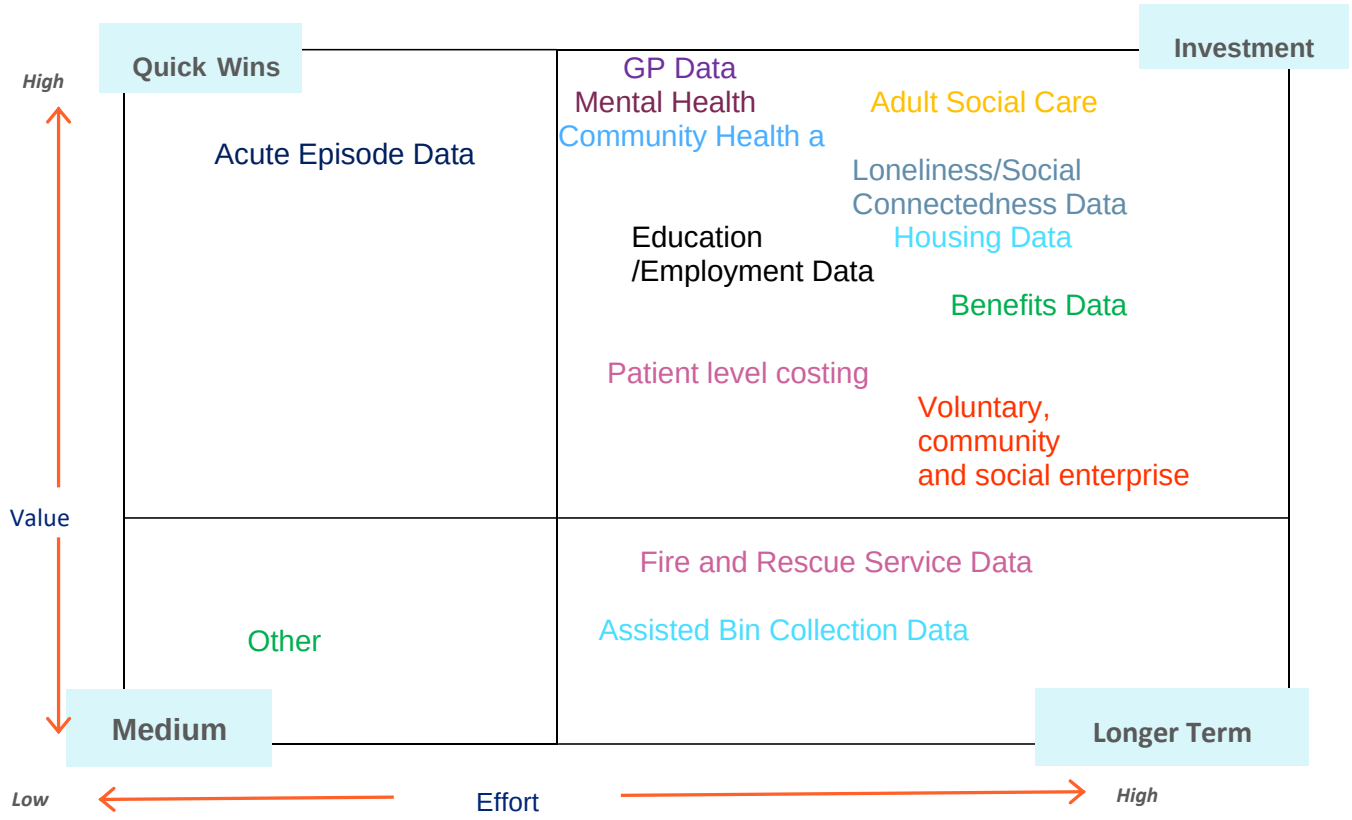
Population Health Research Institute (PHRI) St George's University of London

Following on from this section, a particular area of interest for St George's University PHRI is the prevention of cardiovascular disease and type 2 diabetes, which is closely linked with NIHR Applied Research Collaboration South London, a collaboration between NHS Foundation Trusts, Academic networks, and Universities in South London (including both St George's University Hospitals NHS Foundation Trust and St George's, University of London), which has the strongly aligned vision of improving lives and the quality of health and social care in South London through applied research.

Other specialist areas include the epidemiology and prevention of asthma and food allergies, chronic conditions over the life course (including child health and ageing; the latter is particularly relevant with increased life expectancy and associated co-morbidities), as well as health and health care research (including primary care and mental health), and examining key determinants of disease, including physical activity, diet and nutrition, smoking, environment, inequalities in health, especially social and ethnic inequalities (which is particularly relevant given the ethnic diversity of the South West London population). A further understanding of the role of these determinants within the local population, will provide opportunities and inform strategies for upstream prevention.

8. PHM Stocktake Outputs

Data Prioritisation Matrix – output from Analytics Action Learning Set exercise ranking and prioritising types of data currently available helping to identify the types of data to focus on in the medium/long term and identification of quick wins.

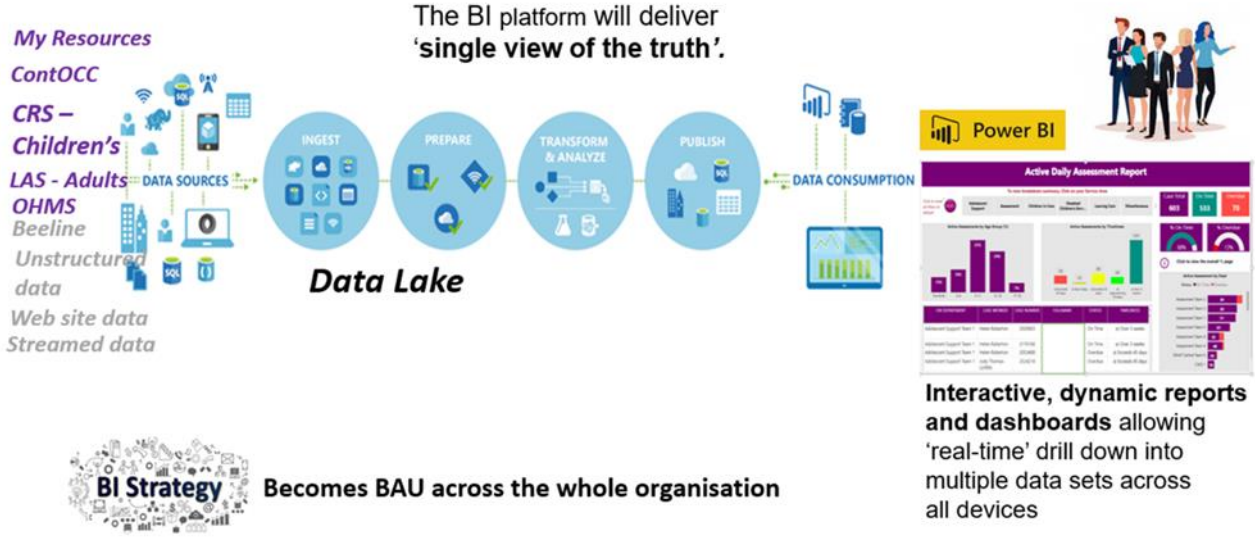


9. Place

Each of our boroughs is different and has developed their own approach to building their analytical capability, which has largely relied on non-health data. All our Local Authorities either use Microsoft PowerBI or a Google platform. The following information is from an initial workshop and identifies SWL Boroughs' priorities and potential uses for PHM and data, and how they say they need to develop including what they might need from the SWL ICS.

Croydon

Business Intelligence Platform



Kingston

Public Health Insight and Data

- Ensuring that data is used to identify our priorities and underpin provision of services
- Needs Assessments (including the 'Joint Strategic Needs Assessment', 'Pharmaceutical Needs Assessment', data for strategic plans including Kingston Health & Care Plan and others)
- Currently creating a dashboard of core metrics for regular review which will help identify areas where deeper dives are required
- Kingston Data Site, signposting to key data releases (with a particular emphasis on utilising upcoming Census data) and supporting staff to use available tools e.g. Fingertips, SWL SharePoint

- Building on the use of data and relationships built with key services and partners during the pandemic
- PHM: Roadmap to integrating health and social care data, seeing the route of a 'resident' (vs a council or NHS service user), use to refine and enhance local service design and communications.

Merton

- Small Public Health Intelligence Team (two permanent full time, two COVID interims), other teams dealing with relevant data e.g. adult social care, children's social care data
- SWL past work to explore integrated health and social care record – needs to be revisited for Merton and consider linkages with PHM
- Use of PowerBI now developing including for service and population data
- Analyst Network, Merton data hub and use of GIS across the council
- Insights to intervention project developing internal data linkage and eventually plans to develop external linkage
- Currently benchmarking our data maturity across the council – learning from internal and external interviews
- Wide range of data assets – examples include housing (e.g. stock condition) and benefits
- Links to other stakeholders who hold additional datasets (e.g. housing providers)
- Priorities – improving JSNA process, increasing data automation and linkage including PowerBI, embedding PHM skills, cross council data for strategy delivery and monitoring

Sutton

Public Health has a priority to collaborate with Sutton Place and Primary Care on small but scalable projects that can support them to see the potential of using their data more strategically to prioritise resources at those most at risk.

As part of this work we have:

- Worked with the CSU to look at health data for the PCN and explored the possibility of access to this data for our Public Health Analyst
- Currently work is focused exclusively around EMIS so that clinicians have actionable insights
- Other work involving linked data is more difficult as held by other teams
- The next phase will follow a similar approach but with more sophisticated data searches
- Using data to make links to social prescribing, National Diabetes Prevention Programme, Weight management referrals
- Linked in with Wave 3 PHM Development programme in Sutton Place.

In house:
- Public Health has made the case for LIFT software bringing together a range of welfare and housing datasets to identify a number of poverty indicators - including people at risk of homelessness or eligible for benefits including free school meals.
- Our Health Visiting and School Nursing teams are moving to EMIS to come in line with primary care and community services, which will help with PHM approaches
- A programme of work led by Hitachi.

Substantial work and investment in summary care records in Sutton Place would provide lots of learning that could be applied to PHM approaches. Some of the further support for Sutton include the following

- Helping to provide better/wider access to Health Insights, including access to the backend data for at least one of our Public Health Analysts.
- Helping to unblock barriers we come across from parts of the system not working together enough to deliver for our residents.
- Helping to create/maintain a forum for sharing best practices, innovative ideas and impactful projects.

Richmond and Wandsworth

(Insight and Analytics Team Richmond and Wandsworth Councils)

Journey to the Data & Analytics Strategy

Moving away from data as an afterthought to support decisions, and towards using data from the outset to:

- inform service planning and delivery
- base decisions on the strongest analysis
- use data-driven technology to transform the way we work

Consequences of not using our data well: inefficiencies, not reaching the right people with the right services, decision based on incomplete information.

Colleagues telling us their issues – data quality, inconsistent data collection and storage, more skills needed.

Impact of Covid and lessons learnt.

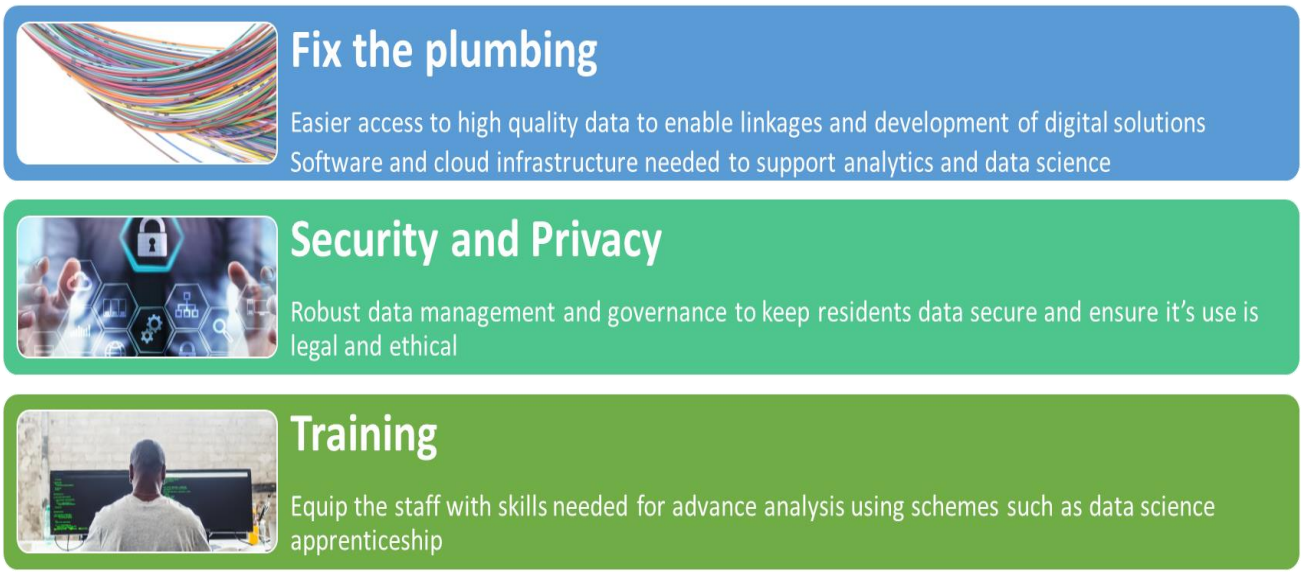
Key features

- Focus on deliverable actions
- 2 years of work to build momentum for change to ensure Strategy and Action Plan stick
- Building strong foundations
- Consistent growth across the organisation
- Not written by analysts
- Owned by all – data is everyone's business

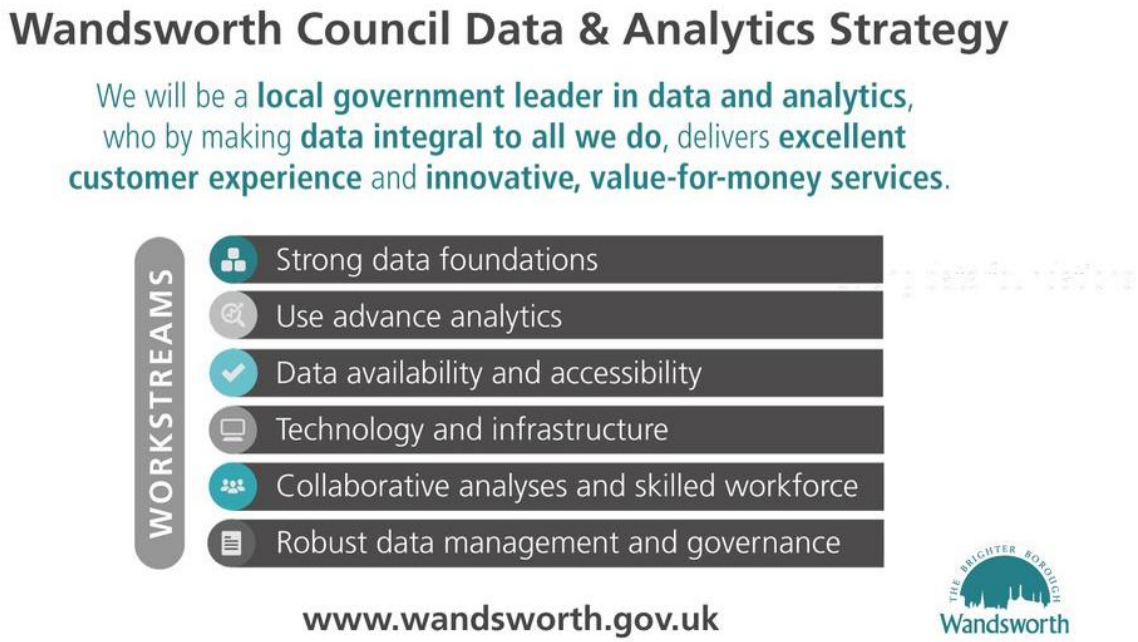
Strong support from political leaders and senior managers

Comprehensive consultation process to ensure the views of staff across the organisation were reflected in the strategy

Richmond



Wandsworth



- Similar action plan to be delivered across both boroughs

10. PCN Directed Enhanced Service Specification for PHM

5.4. Data, analytics and monitoring

5.4.1. A PCN must share non-clinical data between its members in certain circumstances. The data to be shared is the data required to: a. support understanding and analysis of the population's needs; b. support service delivery in line with local commissioner objectives; and c. support compliance with the requirements of this Network Contract DES specification.

5.4.2. A PCN must determine appropriate timeframes for sharing of this data.

5.4.3. Where the functionality is available, a PCN should ensure that clinical data sharing for service delivery uses read/write access, so that relevant workforce from any practice can refer, order tests and prescribe electronically, and maintain a contemporaneous record for every patient.

5.4.4. A PCN must:

a. benchmark and identify opportunities for improvement;

b. identify variation in access, service delivery or gaps in population groups with highest needs; and

c. review capacity and demand management across the PCN, including sharing appointment data for the PCN to action (this could be achieved through using the GP workload tool or other similar tools), and the PCN must monitor, share and aggregate relevant data across the Core Network Practices to enable it to carry out these requirements.

5.4.5. A commissioner and the wider system may support PCNs in the analysis of data.

8.7. Tackling Neighbourhood Health Inequalities

8.7.1. From 1 October 2021, a PCN must:

a. identify and include all patients with a learning disability on the learning disability register, and make all reasonable efforts to deliver an annual learning disability health check and health action plan for at least 75% of these patients who are aged over 14;

b. identify and include all patients with a severe mental illness on the severe mental illness register, and make all reasonable efforts to deliver comprehensive physical health checks for at least 60% of these patients;

c. record the ethnicity of all patients registered with the PCN (or record that the patient has chosen not to provide their ethnicity); and

d. appoint a lead for tackling health inequalities within the PCN.

8.7.2. By 31 December 2021, a PCN and commissioner must jointly:
a. utilise available data on health inequalities to identify a population within the PCN experiencing inequality in health provision and/or outcomes, working in partnership with their ICS, including local medical or pharmaceutical committees, and local authority commissioners.
b. hold discussions with local system partner organisations who have existing relationships with the selected population to agree an approach to engagement.
c. begin engagement with the selected population to understand the gaps in, and barriers to their care; and
d. define an approach for identifying and addressing the unmet needs of this population.
8.7.3. By 28 February 2022, a PCN must finalise its plan to tackle the unmet needs of the selected population, which should include:
a. locally defined measures agreed with local commissioners in line with, and co-ordinated between, wider system strategies to tackle drivers of inequalities;
b. delivery of relevant interventions or referrals to services that provide these interventions for the selected population; and
c. ongoing engagement with the selected population.
8.7.4. By 1 March 2022, the PCN must proceed to deliver the plan referred to in section 8.7.3

11. SWL PHM Budget

The budget proposal below is an indicative 2022/23 budget. The second table is the indicative budget for future years. The budgets will need to be properly scrutinised and approved through the ICS system governance before they can be confirmed.

DRAFT SWL ICS Population Health Management Budget 2022/23							
		Initial Proposal From Digital Investment Plan				Updated Proposal May 2023	Difference
Recommendation	Description	Agreed funding	Digital budget submission capital 22/23	Digital budget submission revenue 22/23	Digital budget submission recurrent revenue (incl 22/23)	Development plan proposed spend 22/23	Cost/saving for 22/23
		£000's	£000's	£000's	£000's	**£000's**	£000's
PHM Team	Clinical leads	18				**79**	61
	Head of PHM (Band 8c)	102				**102**	0
	PHM Support (Band 6)	55				**55**	0
Culture & Behaviour	PHM system development & training					**100**	100
Sharing & Supporting Best Practice	Training for PCNs, leads & champions					**25**	25
Set up	Set-up & maintenance of PHM library and website					**10**	10
PHM Platform	Supplier costs (8 data connections, Cerner licenses)		543		842	**0**	-1,386
	Implementation & transformation			252		**0**	-252
	Resource to maintain				142	**0**	-142
	Options appraisal consultancy support					**50**	50
PHM Analytics	19 Analysts (band 8a)				1,246	**146**	-1,100
	Analytics training and development of tool					**50**	50
TOTAL		**175**	**543**	**252**	**2,230**	**617**	**-2,583**

DRAFT SWL ICS Population Health Management Budget Future Years				
Recommendation	**Description**	**Digital budget submission recurrent revenue (incl 22/23)**	**Development plan proposed recurrent spend**	**Comment**
		£000's	**£000's**	
PHM Team	**Clinical leads**		**79**	This would need to be included in future years' budgets
	Head of PHM		**102**	Currently secondment so would need to be included in future years' budgets
	PHM Support		**55**	Currently secondment so would need to be included in future years' budgets
Culture & Behaviour	**PHM system development & training**		**25**	
Sharing & Supporting Best Practice	**Training for PCNs, leads & champions**		**25**	
Set up	**Set-up & maintenance of PHM library and website**		**2**	
PHM Platform	**Supplier costs (8 data connections, Cerner licenses)**	**842**	**TBC**	This depends on an options appraisal
	Implementation & transformation		**TBC**	
	Resource to maintain	**142**	**TBC**	
	Options appraisal consultancy support		**0**	
PHM Analytics	**19 Analysts (band 8a)**	**1,246**	**1,246**	Recurrent costs would gradually increase to this level over subsequent years as PCNs come on board and analysts are recruited
	Analytics training		**25**	
Non-pay			**3**	
TOTAL		**2,230**	**1,562**	To note most of this cost is analytics

NHS
South West London

Population Health Management Roadmap

Implementation Plan 2022

PHM Implementation Plan 2022

NHS South West London

Recommendation	Description / Activities	Owner	Programme status and update	Timeline	RAG
1) Build a PHM Team	Clarify senior clinical leadership for PHM from June 2022	John Byrne/ Andrew Murray	Awaiting decision from John Byrne (incoming CMO)	June - July 2022	
	Agree PHM Team, currently: - Dr Andrew Murray (Clinical lead and SRO for PHM development programme (Two days pw until end of June 2022) - Sam Green, seconded from Sutton Place, Head of the PHM Programme (full time) - Mary Coakley, seconded from Merton and Wandsworth, Project Support Officer (full time)	John Byrne/ Andrew Murray	Need to confirm proposal with incoming CMO - initial proposal for SWL PHM team for the next 12 months is • SWL ICS Clinical Leadership - potentially Senior Clinical Advisor PLUS Clinical Champion (developmental role) two days/week • SWL ICS Head of PHM Programme – Full time • SWL ICS Project Support Officer – Full time	June - July 2022	

PHM Implementation Plan 2022

NHS South West London

Recommendation	Description / Activities	Owner	Programme status and update	Timeline	RAG
2) Learning By Doing - 1.5 days per week	**Continue to support** existing PHM pilots in Sutton and the 5 PCNs plus Outpatients Transformation Programme	Sam Green	Continue to share and learn plus identify PHM Champions from these pilots	Ongoing	
	Support new PHM pilots as part of Module C/D - Croydon, Merton, Kingston & Richmond	Sam Green	Need to co-ordinate with consortium providing external support	June 2022 onwards	
	Select and support further PHM Pilots Two SWL Elective Clinical Networks One SWL Transformation Programme	Andrew Murray/Sam Green	Gather Expressions of Interest from Clinical Networks/ Transformation Programmes for decision September 2022	July - August 2022	
	Identify and support one further SWL-scale provider PHM pilot programme	Sam Green	To be discussed with the two provider collaboratives	July - August 2022	
	Support the ICS Partnership Board to agree one SWL-wide whole system PHM programme	Andrew Murray	Request to add to agenda for future ICS Partnership Board	September 2022	
	Resource requirement Establish/ringfence dedicated central SWL ICS Analytics time to support pilots	Sam Green	Discussion ongoing with Amelia Whittaker	June - July 2022	

PHM Implementation Plan 2022

NHS South West London

Recommendation	Description / Activities	Owner	Programme status and update	Timeline	RAG
3) Culture, behaviour and skills - 1 day per week	**Move to value-based healthcare and a focus on people not conditions** - focus on creating a culture of stewardship (governance process that promotes collective responsibility and accountability for outcomes and experience of care)	Andrew Murray	Further discussions required to include as part of system Organisational Development Plans. Item for discussion at a future ICP.	September 2022	
	Focusing on inequity - training and support to identify health inequity and to complete Inequality Impact Assessments	Gloria Rowland/ Sam Green	Further discussion with Quality Team	July 2022	
	Working in partnership with residents to involve and engage	Sam Green	Work with Comms and Engagement Team to support promotion of new Engagement Toolkit (due)	September 2022	
	Resource requirement Support development and training in value-based healthcare, PHM, quality improvement and programme skills to make change happen	Sam Green/Mary Coakley	PHM team could help source if required	September 2022	

PHM Implementation Plan 2022

NHS South West London

Recommendation	Description / Activities	Owner	Programme status and update	Timeline	RAG
4) Sharing and Supporting Best Practice - 1 day per week	Create a SWL Community of Practice for PHM - Set up PHM Network for PHM Practitioners - Identify and support PHM leaders, champions and experts	Sam Green/ Mary Coakley	Identify PHM Practitioners and PCN/Borough Leads/Champions. Set up a database. Establish Practitioners Network and Leads/Champions Forum. Plan webinar/focus group topics, promote and engage Review ongoing resources/training requirements	July - August 2022	
	Create a PHM library	Sam Green/ Mary Coakley	Collate best practice examples – local/national/international/Toolkits Explore and create virtual space for content and share to all	July - August 2022	
	Resource requirement Borough clinical leads, PHM Clinical Fellow, resource/backfill needs	Sam Green/ Mary Coakley	Clinical leads and PHM Fellow (from September 2022) are budgeted for. PCN pilots and review of DES, to help identify future resource needs. Costs to be identified.	September 2022	

PHM Implementation Plan 2022

NHS South West London

Recommendation	Description / Activities	Owner	Programme status and update	Timeline	RAG
5) PHM Platform - ½ day per week	Ongoing development of Health Insights to maximise usage, training and support for system users in accessing and using data	Sam Green/Mary Coakley	Ongoing work as part of established Health Insights Project Group. PHM stocktake outputs fed in. Highlight reporting to Digital Board (PHM Programme Board for information) established.	Ongoing	
	Potential options appraisal, to include National Platform Product (noting platform also used for quality and planning). As part of this broader ICS data requirements and uses to be established.	Sam Green Andrew Murray	Link in with Digital Team Co-ordination with other London ICSs and ongoing discussion with SWL ICS COO	Ongoing Ongoing	
	<u>Resource requirements</u> SWL Digital budget submission 22/23 not proposed to be spent in year. Health Insights development/support costs in workplan for SWL ICS analytics team (recurrent funding allocated to the PHM budget). Full options appraisal would require funding	Andrew Murray	Current activity is within budget For consideration	Likely from September 2022	

PHM Implementation Plan 2022

NHS South West London

Recommendation	Description / Activities	Owner	Programme status and update	Timeline	RAG
6) PHM focused analytics - ½ a day per week	Support each Place to obtain a SWL ICS PHM focused analyst	Sam Green	Discussions ongoing - 6 Place based analysts required (part of SWL ICS analytics team). Module C in place. Availability risk/issue	September 2022	
	Ensure every 3 PCNs have access to a SWL ICS PHM focused analyst	Sam Green	7 analysts required (part of SWL ICS analytics team) phasing consideration linked to DES - availability risk/issue	Decision on next steps by October 2022	
	Support development of analytics workforce and pipeline. Support creation of Analytical Skills (Workforce) Development Plan (with linked training plan)	Sam Green Amelia Whittaker	Analytics Action Learning Set held from April to June 2022 Output from OHID mapping required	Completed Due	
	Training and support available for non-analysts on analytical techniques	Sam Green	Linked to Health Insights project	September 2022	
	Resource requirements Recurrent spend required for additional 13 analysts Resource for training non-analysts included in budget (linked Learn by doing and Sharing/supporting Best Practice)	Andrew Murray	Resource not yet agreed	September ongoing 2022	

PHM Implementation Plan 2022

NHS South West London

Recommendation	Description / Activities	Owner	Programme status and update	Timeline	RAG
7) Finance	Further work required to develop population budgeting and creation of financial incentives for all system partners to ensure effective interventions are sustainable	Andrew Murray	Further discussions with SWL Finance Team	September 2022	
8) SWL PHM Goals	For development of PHM capability and capacity – including PCNs, Place, SWL system	Andrew Murray	Capture goals as set at each level	September 2022	

9) Linked development needs	- Setting SWL system priorities
	- System Intelligence Function
	  - Data (including IG)
	  - SWL Analytics and BI
	- Research
	  - Trusted Research Environment
		Andrew Murray	Future discussion with ICP
			
			Ongoing discussion with ICS COO and Digital Team
				September 2022	

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board	
Date	Friday, 01 July 2022

Document Title	Health Inequalities Programme: CORE20PLUS5 Update		
Lead Director (Name and Role)	Dr Gloria Rowland, Chief Nursing and AHP Officer & Executive Director for Patient Outcomes		
Author(s) (Name and Role)	Dr Gloria Rowland, Chief Nursing and AHP Officer & Executive Director Patient Outcomes, SWL ICB June Okochi, Deputy Director of Quality Improvement, SWL ICB		
Agenda Item No.	8	**Attachment No.**	08

Purpose (Tick as Required)	Approve	Discuss	Note
		✓	✓

Executive Summary

The aim of the CORE20PLUS5 report is to update the Board on the development and delivery of the health inequalities agenda at system level and to provide assurance that, in line with the NHS Operating Plan guidance for ICS, we continue to focus on preventing ill-health and tackling health inequalities by redoubling efforts on the five priority areas set out in guidance in March 2021 and delivering on the CORE20PLUS5 approach.

The report outlines the agreed priorities by the Health Inequalities Board for the system to narrow the inequalities gap and improve equity of access, experience and outcomes.

The King's Fund **describes health inequalities as 'avoidable, unfair and systematic differences in health between different groups of people'** and can be analysed looking across 4 main categories: socio-economic, geography, specific characteristics, and socially excluded groups (2021).

Our ambition in SWL is to continue to provide high quality care, tackle inequalities and improve outcomes in access, experience and care for population regardless of who they are and where they live. We will plan, deliver, and evaluate our programmes of work within the context of the newly formed Integrated Care System (ICS), aligned to wider national and regional equity and equality policies and plans.

Purpose:

To provide assurance to the Integrated Care Board (ICB) that the right steps have been taken to understand our CORE20PLUS5 population, enabled by population health management data, and that plans have been put in place for oversight and delivery. To provide assurance that SWL is working towards the delivery of the national requirements for ICS to deliver the five priorities of the NHS Operating plan 2022/23 to reduce inequalities.

Recommendation:

- The Board is asked to note the full report and system areas of focus to tackle reduction of inequalities.

- The Board is asked to note the risks and challenges to delivery and be assured that there are mitigations to managing system risks through the existing health inequalities governance arrangements.

Key Issues for the Board to be aware of:

- **Finances and resources:** Funding and resourcing is required to deliver community targeted interventions that will narrow the inequalities gap for our population specifically where we have more deprived boroughs and communities in SWL. Without preventative interventions, those impacted including the sickest communities within our population stand the risk of poorer outcomes and therefore costing the SWL health and care economy more in the next 3-5 years.

- **Data coding** remains a challenge nationally and for SWL: We know there are challenges to recording and coding data accurately such as ethnicity, sexual orientation, physical disabilities, autism, loneliness and isolation etc. In line with the NHS Operating guidance, Systems are asked to continue to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning.

- **Long term conditions:** Currently, 794,284 out of 1,785,675 (44%) individual assessments have not been made. In terms of patient numbers, around 168,841 out of 213,502 (79%) individual patients have not had all assessments made in relation to SMI, COPD, Diabetes and Hypertension. These assessments were paused as a result of COVID-19. However, SWL has not yet recovered back to pre-COVID levels and this remains a risk for our CORE20 patients and those who are yet to be diagnosed.

- **Commitment and pace**: Tacking health inequalities should be everyone's priority and not just a function to be delivered by those who lead work programmes within the system. We need all providers of health and care services across the system to be committed to this agenda and working in collaboration to improve outcomes for our communities.

Conflicts of Interest:

N/A

Mitigations for Conflicts of Interest:
N/A

Corporate Objectives This document will impact on the following Board Objectives:	The CORE20 approach aligns to the ICS/ICB objectives and will meet these objectives: • Improve outcomes in population health and healthcare. • Tackle inequalities in outcomes, experience and access • Enhance productivity and value for money; and • Help the NHS support broader social and economic development.

Risks This document links to the following Board risks:	• Equality risks are included in the SWL ICB Corporate risk register and escalated to the Board Assurance Framework where appropriate
Mitigations Actions taken to reduce any risks identified:	Mitigations are detailed in the quality risk register

Financial/Resource Implications	• National funding has been allocated to ICSs to tackle health inequalities for their population. The CORE20 approach provides a needs-based approach to allocation of funding based on communities with the poorest health and care outcomes.

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	An EIA is necessary to evaluate the impact of inequality to ensure we provide equitable and high-quality care to all our population regardless of their characteristics, who they are and what part of SWL they live in. We are in the process of developing a robust EIA which will focus on these key areas: • Improving outcomes all SWL residents with specific focus on our CORE20 population (i.e the 340,000 people live in our top 20% most deprived communities. • The impact assessment will consider how we build racially equitable cultures where all ethnicities have equal opportunities to thrive in their careers as highlighted in recent national policies that health and care workforce continue to experience structural and institutionalised racism specifically black and ethnic minority groups.

	• We will evaluate wider system inequality metrics including the mandated CORE20 metrics and the impact it has on reducing health inequalities.
What are the implications of the EIA and what, if any are the mitigations	Some key mitigations of the points raised above are: The assessment will consider our patients and residents who fall within the nine protected characteristics and will be aligned to the quality impact assessments. In line with the CORE20PLUS5 approach, we are recruiting community connectors to adapt the Asset Based Community Development model in the most deprived communities of SWL to build capacity and deliver targeted based interventions for those with the poorest outcomes. In line with the NHS Observatory Race and Health Report which highlights that structural and institutional racism continues to be prevalent in the NHS, our ambition is to become anti-racist ICS system. The Messenger Report 2022 also acknowledges that although good practice is by no means rare, there is widespread evidence of considerable inequity in experience and opportunity for those with protected characteristics, of which we should call out race and disability as the most starkly disadvantaged. We will do this through the development of an anti-racist framework. This framework will take into account our commitment to ensure our health and care workforce are supported, developed and valued as employees regardless of their backgrounds, ethnicities and where they live. The SWL Health Inequalities Board will play a key role in developing the priorities to tackle health inequalities and holds the system to account for delivery.

Patient and Public Engagement and Communication	We are working with communities and residents, patients and public including specific impacted communities linking with our Voluntary Care Sector organisations and the

	Connectors programme to ensure we are listening to the voices of our population and using this insight to improve equity of outcomes.

Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
	SWL CCG Health Inequalities Board	Monday, 23 May 2022	Noted and assured
	SWL Health Inequities Delivery Group	Thursday, 05 May 2022	Noted and assured
		Click here to enter a date.	
Supporting Documents			

NHS South West London
Integrated Care Board

South West London Integrated Care Board
1st July 2022

Tackling Health Inequalities: CORE20PLUS5

1. Introduction/ Overview

The aim of this report is to update the Board on the development and delivery of the health inequalities agenda at system level and to provide assurance that in line with the NHS Operating Plan guidance for ICS, that we continue to focus on preventing ill-health and tackling health inequalities by redoubling efforts on the five priority areas set out in guidance in March 2021 and delivering on the CORE20PLUS5 approach.

2. Purpose of the Integrated Care Board and Integrated Care System

The ICB has four core purposes. These are to:

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

3. South West London's Strategic Priorities to tackle Health Inequalities

Over the last 12 months, South West London (SWL) has established governance and oversight arrangements to tackle health inequalities in SWL. A key deliverable was the establishment of the Equality Diversity and Inclusion (EDI)/Health Inequalities Board in December 2021. The Board has been working to steer the strategic direction of the health inequalities programme as well as agree the long-term priorities to tackle inequalities. The **key priorities** include:

- ❑ Development and delivery of our **ICS Equity Strategy** aligning to **Health and Care Plans and the Mayor of London's strategy embedded by the CORE20PLUS approach.**
- ❑ **Strengthen and enable the role of our communities** and the VCSE to improve trust in services through proactive co-production of people with lived experience including increased Board presence to inform decision making.
- ❑ **Developing our Anchor Institutions structures** and programmes of work at both Place and system to tackle and reduce socio-economic inequalities.
- ❑ **Improve rates of our Black and ethnic minority staff in senior leadership** positions both clinical and non-clinical working with our HR/Workforce across the system
- ❑ **Delivery of antiracism framework** and action plan- aligned to NHS Observatory Race and Health report and the Messenger Report 2022.
- ❑ **Improve data coding** to ensure we are accurately monitoring the impact of programmes on our population.

At Place, Provider Collaboratives and Primary Care Network (PCN) levels, local systems continue to tackle to health inequalities enabled by all six Place based Health and Care Plans and the **Primary Care Inequalities Direct Enhanced Services – *Tackling Neighbourhood Health Inequalities*.**

4. National and Local Policy Context

The King's Fund **describes health inequalities as 'avoidable, unfair and systematic differences in health between different groups of** people' and can be analysed looking across 4 main categories: socio-economic, geography, specific characteristics, and socially excluded groups (2021).

Our ambition in SWL is to continue to provide high quality care, tackle inequalities and improve outcomes in access, experience and care for population regardless of who they are and where they live. We will plan, deliver, and evaluate our programmes of work within the context of the newly formed ICS, aligned to wider national and regional equity and equality policies and plans.

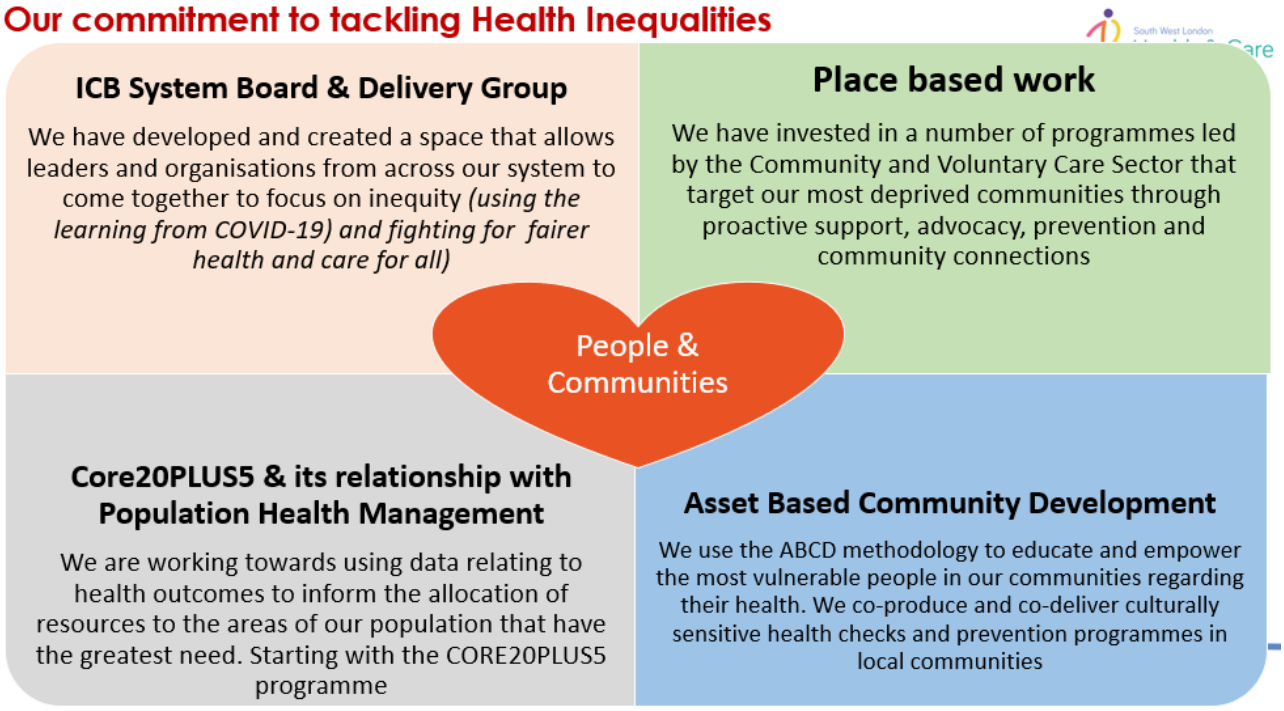
At a national level the NHS Long Term Plan, published in January 2019, focuses on one of the NHS's priorities for ***care quality and outcomes improvement*** for the decade ahead.

The Mayor's Health Inequalities Strategy **London Health Inequalities Strategy 2018-28** sets out his plans to tackle unfair differences in health to make London a healthier, fairer city

Our delivery at system level to reduce structural inequalities will be enabled by the emerging Health and Care Disparities White Paper 2022.

One of the core priorities of 2022-23 priorities and operational planning guidance is to tackle and reduce health inequalities and ICS are expected to deliver on five priority areas whilst maintaining the CORE20PLUS5 approach. The five areas include:

The five priority areas set out in March 2021 guidance are:
Priority 1: Restoring NHS services inclusively, breaking down performance reports by patient ethnicity and indices of multiple deprivation (IMD) quintile
Priority 2: Mitigating against digital exclusion, identifying who is accessing different modes of consultation by collecting data on patient age, ethnicity, disability status, condition, IMD quintile
Priority 3: Ensure datasets are complete and timely improving data collection on ethnicity across primary care, outpatients, A&E, mental health, community services, specialised commissioning
Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
Strengthening leadership and accountability, which is the bedrock underpinning he four priorities above.



5. CORE20PLUS5

The national policy: An approach to reducing health inequalities states that ICSs will take a lead role in tackling health inequalities, building on the **Core20PLUS5** approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level.

Core20PLUS5 is an NHS England and NHS Improvement (NHSESI) approach developed by the Health Inequalities Improvement Team to support NHS Integrated Care Systems (ICSs) to reduce health inequalities.

5.1. Core20

Core20 are the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

5.2. PLUS

- Integrated Care System (ICS)-determined population groups experiencing poorer than average health access, experience and/or outcomes, but not captured in the 'Core20' alone. This should be based on ICS population health data.
- Inclusion health groups include: ethnic minority communities, coastal communities, people with multi-morbidities, protected characteristic groups, people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller

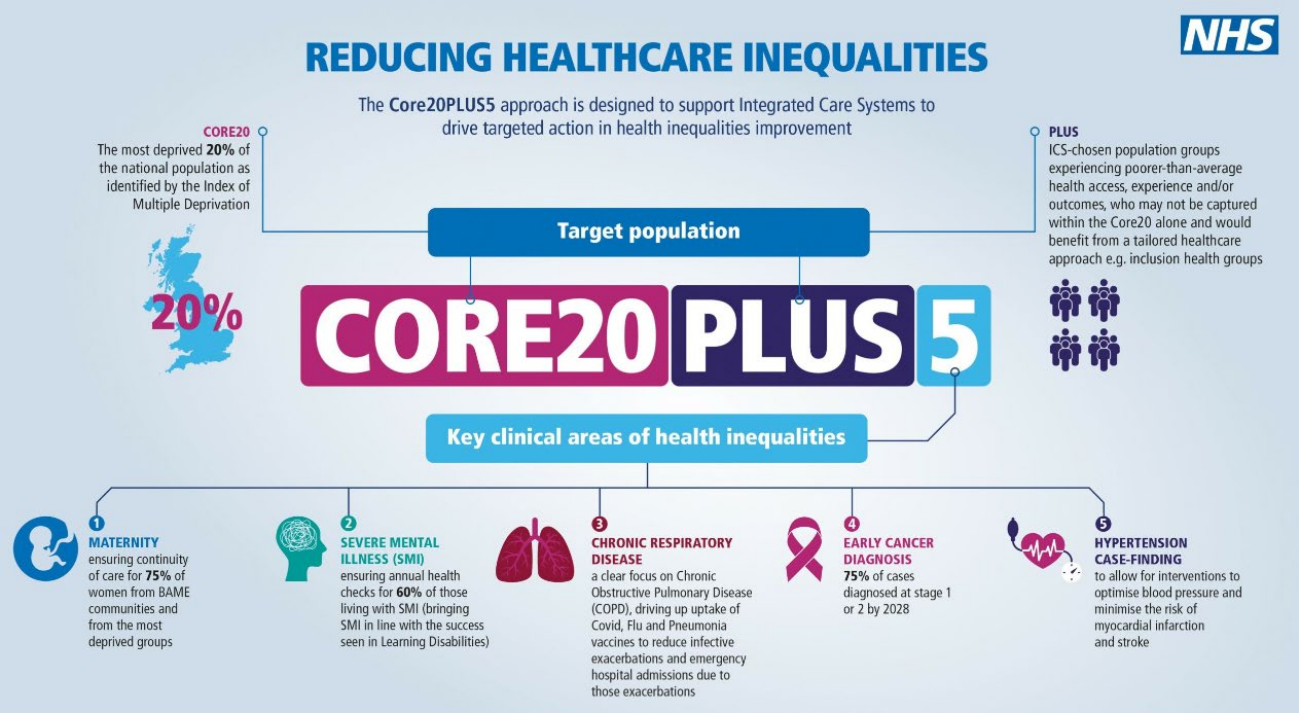
communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

5.3. The '5'

The final part sets out five clinical areas of focus. Governance for these five focus areas sits with national programmes; national and regional teams coordinate local systems to achieve national aims.

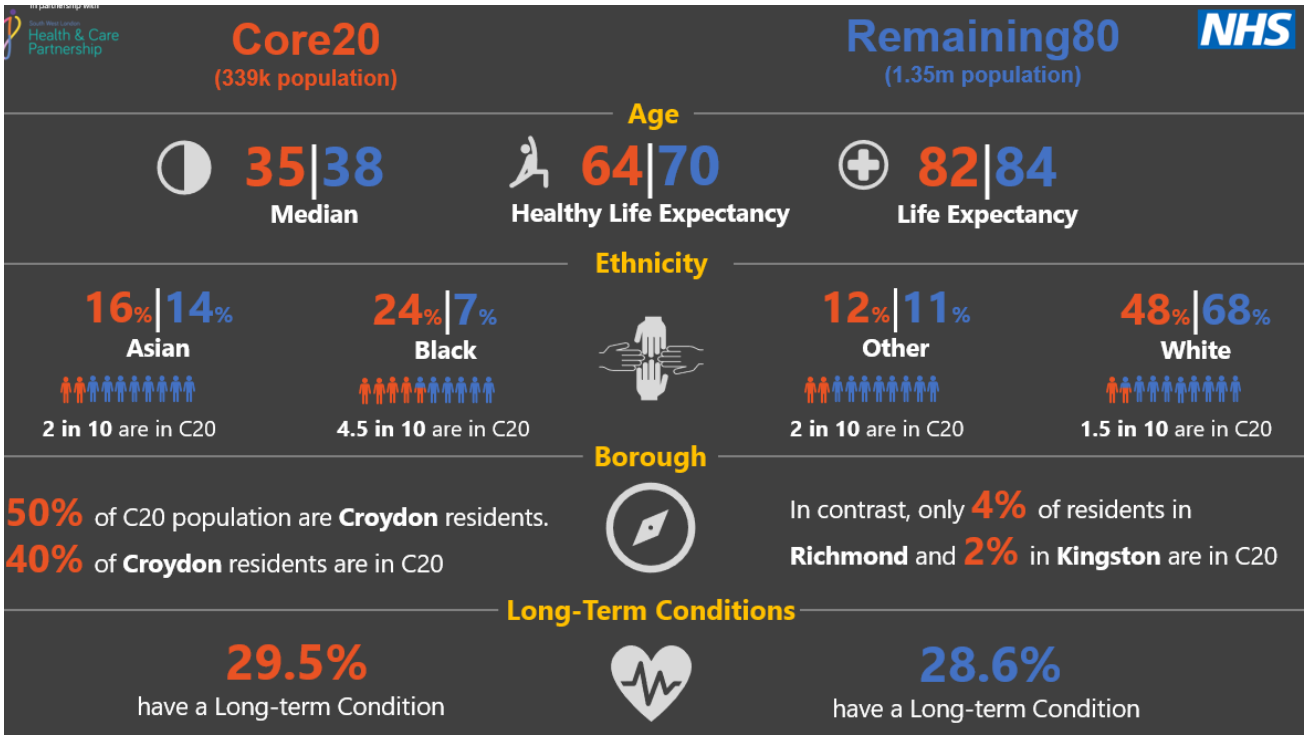
1. **Maternity:** ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.
2. **Severe mental illness (SMI):** ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).
3. **Chronic respiratory disease**: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
4. **Early cancer diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028.
5. **Hypertension case-finding**: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

Core20PLUS5 offers ICSs a focused approach to enable prioritisation of energies and resources as they address health inequalities in the period 2021-2024. NHSEI presents the Core20PLUS5 approach as the NHS contribution to a wider system effort by Local Authorities, communities and the Voluntary, Community and Social Enterprise (VCSE) sector to tackling healthcare inequalities – and aims to complement and enhance existing work in this area.



5.4. Key messages of South West London's CORE20PLUS5

South West London ICS has successfully undertaken a system wide and place-based analysis of our CORE20 PLUS5 and the data has been summarised into the infographic below.

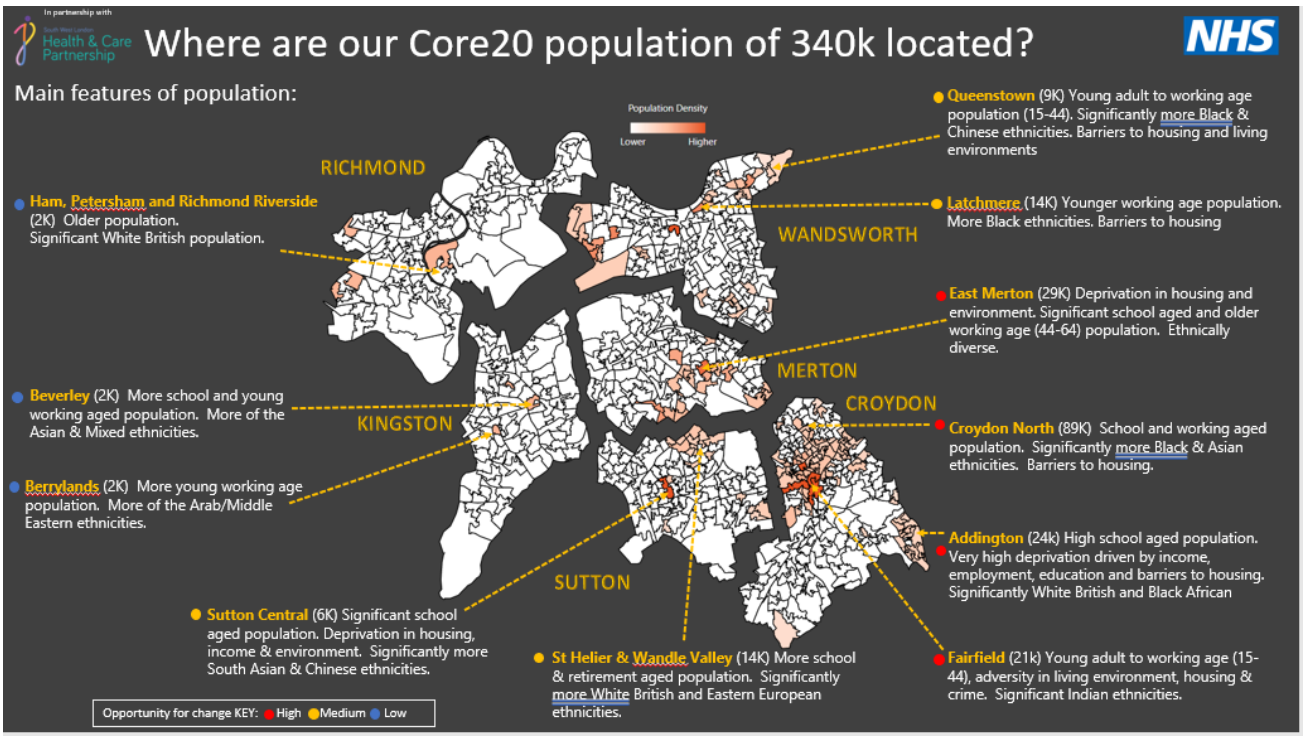


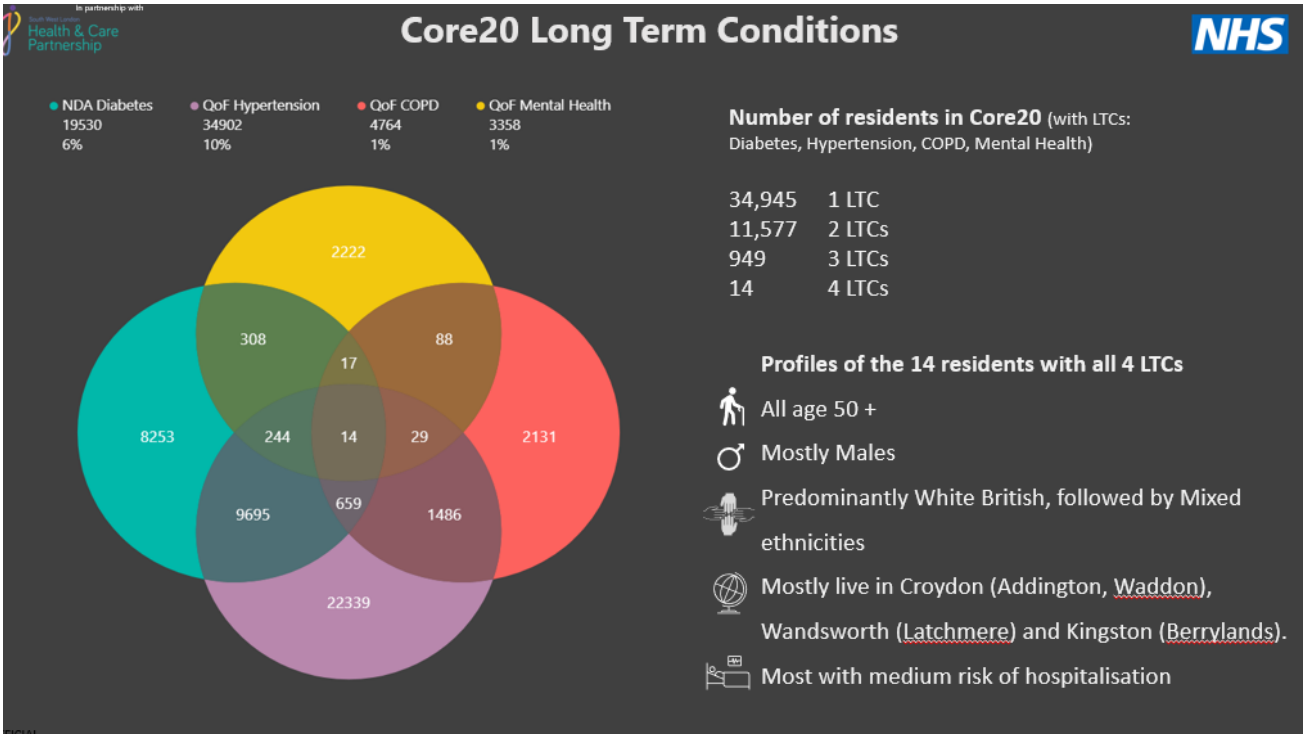
5.5. SWL's CORE20 population

- ❑ 20% of our most deprived population equates to 340,000 people
- ❑ Majority are between 15–44-year-olds
- ❑ Are CORE20 are proportionally white. However, the black population are disproportionally affected when compared to the SWL population
- ❑ 50% of our CORE20 live in Croydon in contrast to Richmond with only 2%
- ❑ Nearly 30% of our CORE20 population live with a long-term condition

5.6. SWL's 'PLUS'

Our '*PLUS*' are disproportionately black. They are young and mostly live in Croydon. Data analysis proves that being black is not the main driver in inequality, it is instead deprivation.





5.7. CORE20 Long Term Conditions

- ❑ 34,945 people within our CORE20 live with one long term condition.

- ❑ 11,577 people within the CORE20 live with two long term conditions.
- ❑ 949 people within our CORE20 live with three long term conditions
- ❑ 14 people within our CORE20 live with four long term conditions.
- ❑ The profile of the 14 people include: predominantly White British and mixed ethnicities.
- ❑ They mostly live in Croydon, Wandsworth and Kingston.
- ❑ They are mostly males and all aged 50 and over.

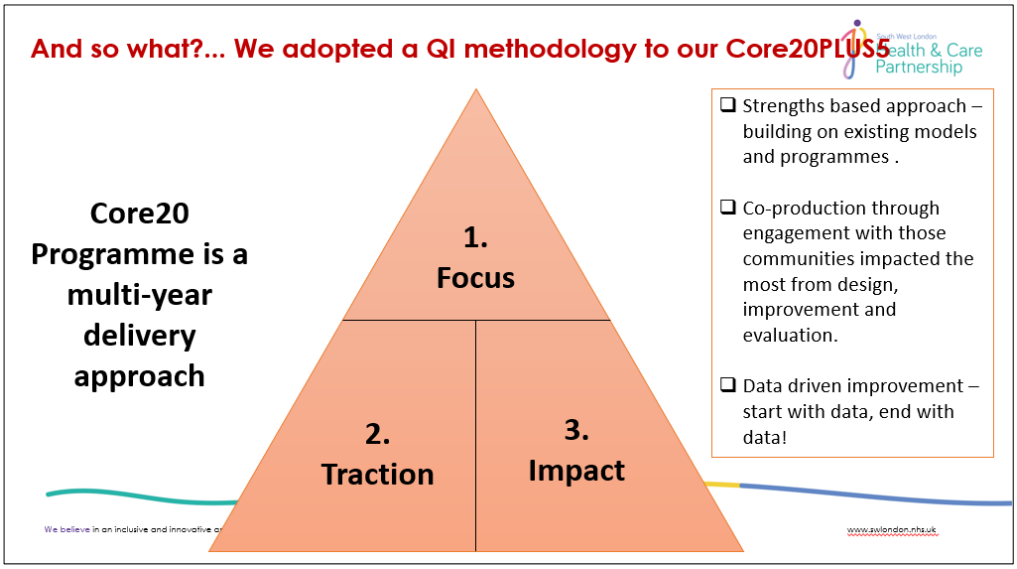
5.8. 5 +1

1. Serious Mental Health Illness (SWL's data showing high levels of depression) – **4,422 patients who live with a SMI are in our CORE20**
2. Maternity – An average CORE20 mother's age is 38 and two times likely to be smoking.
3. Chronic Respiratory Disease including COPD – **5,894 patients who live with COPD and 28,975 patients who live with asthma are in our CORE20**
4. Hypertension – **33,141 patients who live with hypertension are in our CORE20**
5. **Cancer** - Cancer patients in the Core20 cohort are likely to have longer waits under the 18-week threshold.

- ❑ **+1 : - Diabetes** remains a significant challenge for the population of SWL**. 18,578 patients who live with diabetes are in our CORE20.**

6. Delivery and Progress Update

We have successfully analysed our population health using the CORE20 approach and work has commenced to begin to focus, on our most impacted communities, ensure traction through taking action and measure impact as we go along. We recognise this is a multi-year programme and impact of reducing health inequalities is evidenced to be a long-term journey. However, through adapting a quality improvement approach to this programme, we will measure impact in the short, medium and long term. The diagram below adapted from NHSE/I summarises our approach to improving quality for the CORE20 programme.



6.1. Actions we have taken to develop and implement the CORE20PLUS5 Approach in SWL:

- ❑ We have taken steps to invest PHM input into our Core20 population to help us identify who they are **(see narrative above)**
- ❑ We have socialised the programme and data widely across the system, ICS, Place, Provider level, PCNs and our Voluntary and Social Care Enterprise (VSCE)
- ❑ We have applied to the CORE20 Connectors bid and have been successful for three-year funding to recruit connectors in our communities.
- ❑ Connectors Key Performance Indicators (KPIs) have been agreed and reporting framework developed for outcomes monitoring.
- ❑ We have identified our sickest most deprived Core20 population and Place based leads are working with GPs who care for our Core20 population to ensure the right support is wrapped around them.
- ❑ We are developing our outcomes framework at system level to ensure we are measuring outcomes that matter to our communities, triangulating them to quantitative metrics.

6.2. CORE20 Community Connectors

SWL was selected in February 2022 as one out of 11 ICS' in England to form part of the NHSE/I Wave 1 Core20PLUS Connectors Programme. The programme is one of a number of funded initiatives that support focused action across Integrated Care Systems to reduce inequalities and improve experiences of care and outcomes for those who suffer most.

A range of our SWL Voluntary Care Sector partners are leading the programme and recruiting the connectors.

CORE20 Connectors Delivery model - Our SWL integrated model reflects the priorities set by the NHS Long-Term Plan and the CORE20+ strategy and consists of 4 pillars:

1. Prevention
2. Detection
3. Supported Self-Management
4. Optimised Management and Care

The model is underpinned by 5 steps including: Insights Gathering; Relationship Building; Capacity Building; Co-produced interventions and impact and outcomes measuring. The delivery model is based on the asset-based community development (ABCD) methodology

Connectors have been successfully recruited in four out of our six boroughs and they are focused on targeting the communities who need support the most. Areas connectors are focused on include:

- Cardiovascular conditions such as hypertension and diabetes
- Homeless and rough sleeping communities
- Ethnic minority groups

6.3. Evaluation and impact

As part of our evaluation framework, we have established an outcome subgroup working with Public Health partners to measure outcomes and impact of our programmes. Core system metrics have been agreed and will be presented to the SWL Health Inequalities Board by September.

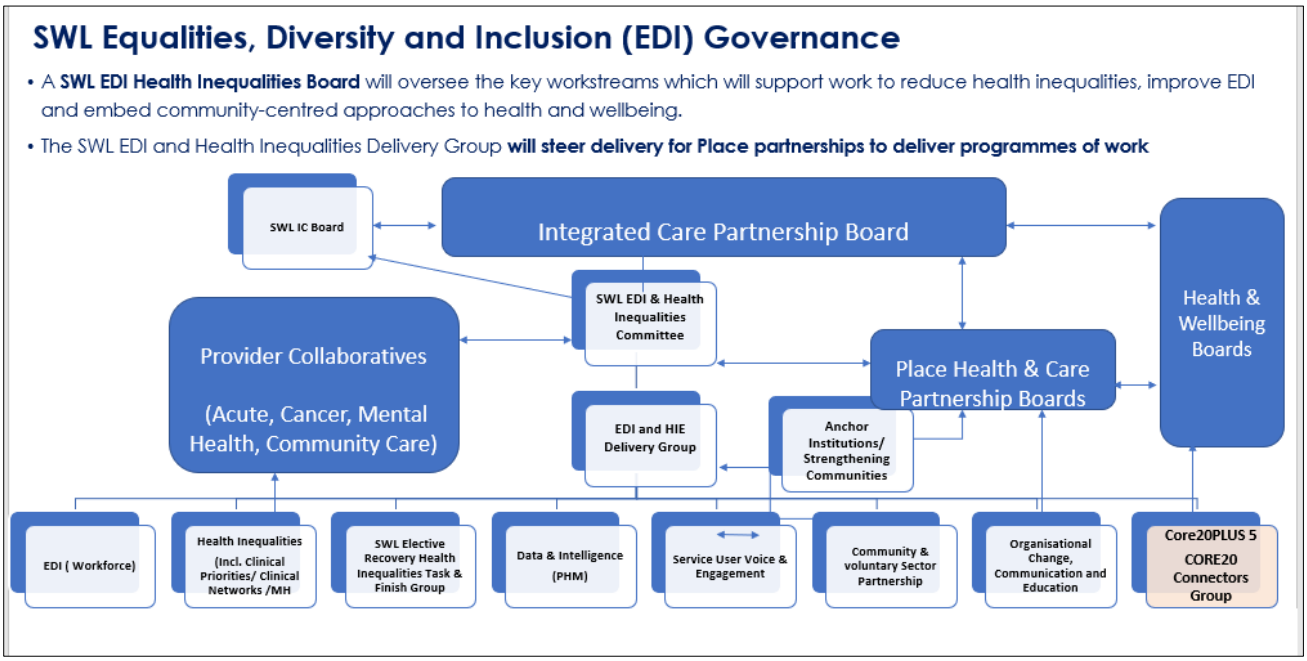
As a Core20 Connectors early adopter site, we will be evaluating and sharing outcomes pf the programme and impact not just locally but also nationally in order for other ICS sites to learn where there has been best practice.

7. Governance: Addressing inequality is a priority for SWL

- The SWL system has formally established its Health Inequalities/Equality Diversity and Inclusion (HIE/EDI) Delivery Group and the HIE/EDI Board. The HIE/EDI board will become a sub-committee of the ICP Board (from July 2022). Terms of references for both committees have been drafted. The Board will take strategic decisions and actions to address structural inequalities in SWL and will be tasked with identifying bold systemic actions for the people of SWL. The monthly delivery group meetings will report to the Board, steer for direction and recommendations and be responsible for designing, development, delivery, and evaluation of Health Inequalities programmes in SWL.
- All six Place health and care plans have been currently refreshed and a core priority for each Place is tackling health inequalities at borough level
- SWL has a named executive lead and SRO for the Health Inequalities programme and the Chair of the ICB chairs the HIE/EDI Board.
- SWL is engaged with the London and national HIE delivery groups.

7.1. The role of Place in delivering Health inequalities and CORE20

In line with national policy and the ICS and Thriving Places technical guidance, Place based partnerships are responsible for the delivery of their Health and Care Plans and a core part of the plan is their role in tackling health inequalities for their local communities in line with population health management insights. SWL Health and Care Plans have all been refreshed with priorities to tackle health inequalities and deliver the CORE20 approach aligned to their plans. The diagram below outlines the responsibilities of Place based partnerships.



8. Key Challenges and risks to delivery

- **Finances and resources:** Funding and resourcing is required to deliver community targeted interventions that will narrow the inequalities gap for our population specifically where we have more deprived boroughs and communities in SWL. Without preventative interventions, those impacted including the sickest communities within our population stand the risk of poorer outcomes and therefore costing the SWL health and care economy more in the next 3-5 years.

- **Data coding** remains a challenge nationally and for SWL: We know there are challenges to recording and coding data accurately such as ethnicity, sexual orientation, physical disabilities, autism, loneliness and isolation etc. In line with the NHS Operating guidance, Systems are asked to continue to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning.

- **Long term conditions:** Currently, 794,284 out of 1,785,675 (44%) individual assessments have not been made. In terms of patient numbers, around 168,841 out of 213,502 (79%) individual patients have not had all assessments made in relation to SMI, COPD, Diabetes and Hypertension. These assessments were paused as a result of COVID-19. However, SWL has not recovered back to pre-COVID levels and this remains a risk for our CORE20 patients and those who are yet to be diagnosed.

- **Commitment and pace**: Tacking health inequalities should be everyone's priority and not just a function to be delivered by those who lead work programmes within the system. We need all providers of health and care services across the system to be committed to this agenda and working in collaboration to improve outcomes for our communities.

9. Next steps for delivery

- Develop our Health Equity strategy as we transition into an ICS from July 2022.

- Develop and adapt a need-based resource allocation matrix framework for SWL to enable a fair distribution of investment to communities who are most impacted.

- Expand the connectors model in SWL and increase community capability and co-production e.g. SWL is developing maternity connectors in addition to the programme to tackle inequalities in women from Black and ethnic minority backgrounds and vulnerable women using the CORE20 approach.

- Build on the measurement framework for CORE20 metrics and use baselines to overlay population health story e.g identifying inequalities in cervical cancer screening for young people.

- Develop CORE20 insights in alignment with the nine protected characteristics and 'Vital 5'

- Work towards recovery of Long Term Conditions (LTCs) metrics- increase in detection and assessments.

- Use insights from our engagement framework to support those in the CORE20 communities through the role of connectors, champions and community builders.

- Continue working with our Local authorities to identify communities not registered under GP data but could be within our CORE20 population e.g gypsy /traveller, homeless communities.

- Improve our data coding and develop a Health Inequities system wide dashboard to monitor medium to long term impact.

Action for the Board

- The Board is asked to note the full report and system areas of focus to tackle reduction of inequalities.

- The Board is asked to note the risks and challenges to delivery and be assured that there are mitigations to managing system risks through the existing health inequalities governance arrangements.

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board			
Date	Friday, 01 July 2022		
Document Title	South West London ICB Performance Report (May 2022)		
Lead Director (Name and Role)	Jonathan Bates, Chief Operating Officer		
Author(s) (Name and Role)	Suzanne Bates, Director of Performance Oversight Leo Whittaker, Deputy Director of Performance Oversight		
Agenda Item No.	9	**Attachment No.**	09 (a)

Purpose (Tick as Required)	Approve	Discuss	✓	Note	✓

Background:

The South West London (SWL) ICB performance report presents published and unpublished data assessing delivery against the NHS Constitutional standards and locally agreed on metrics.

These metrics relate to acute, mental health, community and primary care services, and other significant borough/Place level indicators.

Data is sourced through official national publications via NHSE, NHS Digital, and local providers. Some data is validated data published one month or more in arrears.

However, much of the data is un-validated but may be incomplete or subject to change post-validation. Therefore, the data presented in this report may differ from data in other reports for the same indicator (dependent on when the data was collected).

Purpose:

The SWL performance report provides Board Members with a high-level update on performance against NHS Constitutional Standards and locally agreed metrics. It aims to identify issues that may require additional focus and providing high level commentary on actions undertaken to improve both quality and performance outcomes.

Recommendation:

The Board are asked to note the contents of this report.

Key Issues for the Board to be aware of:

Update on performance:

- **Planned Care:** good progress in response to recovery from the COVID pandemic continues - in March outpatient First activity was at 97.5% against a plan of 102% against business as usual (BAU) achievement, with follow ups at 99.0% against a

plan of 102%. Diagnostics was 113.3% of BAU in March 2022 above the 96% H2 trajectory, which is the trajectory set for the second half of 21/22. Ordinary electives with 2,310 inpatient stays equated to 92.2% BAU in April 2022. The London region are meeting London ICSs monthly from June to discuss waiting list assurance and the sharing of best practice.

- **52 Week Waits:** 1,207 patients were waiting over 52 weeks for treatment in April 2022, against a plan of 1,119. In the longer waiting cohorts, 77 patients were reported waiting over 78 weeks at the end of April 2022, the majority in St. George's University Hospitals NHS Foundation Trust in General Surgery and Cardiology.

- **Cancer:** Performance against the 2-week wait standard was below the national standard of 93% (81.0% in March 2022). On the 62 Day cancer standard, SWL was the highest performing sector in London, with 79.4% in March 2022 against the 85% standard, up 5.0% on February 2022.

- **A&E 4 Hour Waits:** At an ICS level, 76.1% of patients were seen within 4 hours in April 2022, a decrease on the 78.0% in March 2022. In April 2022 attendances decreased to 56.1K from 57.5K in March 2022. The percentage of 111 calls answered in 60 seconds was 20.9% in April 2022. The new 111 service went live on 31st May 2022 and went directly into the long bank holiday weekend. Nonetheless, we have seen an improvement in the total number of calls answered for SWL. The service includes an expanded Clinical Assessment Service which is working well, as is the Out of Hours service. The mobilisation process will continue until September 2022 to improve and embed the service including further recruitment and technical enhancements

- **Physical care 12 Hour A&E Breaches:** 941 patients waited over 12 hours from decision to admit to admission in April 2022, up from the 665 reported in March 2022. Ambulance handover delays were also a significant factor in April 2022.

- **Mental Health 12 Hour A&E Breaches:** In April 2022, 117 over 12-hour mental health breaches were reported, a 39% increase from the 84 reported in March 2022

- **Learning Disability Health checks:** Based on the final NHSE data SWL achieved the target of 75% target for Annual Health Checks in 21/22.

- **Mental health Improving Access to Psychological Therapies** – data for March 2022 shows 3,430 clients entered treatment, indicating that performance levels remain below the monthly target of 3,996 clients. Whilst 21/22 targets have not been met, when compared to 20/21, there has been a 16% increase (5,395 clients) in clients entering treatment.

- **Severe Mental Illness Health checks**: Final submitted data for Q4 21/22 showed performance at 39% with 6,295 people with SMI having received an

annual health check. This is an improvement on Q3 position of 32.8% (5,363 people).

Conflicts of Interest: No specific conflicts of interest are raised in respect of this paper.

Mitigations for Conflicts of Interest: N/A

Corporate Objectives This document will impact on the following Board Objectives:	Meeting performance and recovery objectives across the SWL ICS.

Risks This document links to the following Board risks:	Poor performance against constitutional standards is a risk to the delivery of timely patient care, especially in the current climate of recovery following the COVID pandemic.	
Mitigations Actions taken to reduce any risks identified:	Action plans are in place within each recovery workstream to mitigate poor performance and enable a return to compliance with the constitutional standards, which will support overall patient care improvement.	

Financial/Resource Implications	Compliance with constitutional standards, particularly following the pandemic will have financial and resource implications

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	N/A	
What are the implications of the EIA and what, if any are the mitigations	Work has begun to identify the inequality issues associated with elective waiting lists	

Patient and Public Engagement and Communication	N/A

Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
	Recovery & Transition Board	Wednesday, 08 June 2022	Current performance and actions noted.
		Click here to enter a date.	
		Click here to enter a date.	

Supporting Documents	Attached ICB Performance Report – May 2022	

NHS
South West London

South West London ICB Performance Report

Month 2 Data (May) 2022

South West London ICB Performance Report

Commentary on contents and data

NHS South West London

- The South West London (SWL) performance report presents the latest published and unpublished data assessing delivery against the NHS Constitutional standards and locally agreed on metrics. These metrics relate to acute, mental health, community and primary care services, and other significant borough/Place level indicators.
- Data is sourced through official national publications via NHSEI, NHS Digital, and local providers. Some data is validated data published one month or more in arrears. However, much of the data is unvalidated (and more timely) but may be incomplete or subject to change post-validation. Therefore, the data presented in this report may differ from data in other reports for the same indicator (dependent on when the data was collected).
- The report contains current operating plan trajectories.

South West London ICB Performance Report

Key Findings

- **Planned Care:** comparatively good progress continues - in March outpatient First activity was at 97.5% against a plan of 102% BAU achievement, with follow ups at 99.0% against a plan of 102%. Diagnostics was 113.3% of BAU in March 2022 above the 96% trajectory. Ordinary electives with 2,310 inpatient stays equated to 92.2% BAU in April.
- **52 Week Waits:** 1,207 patients were waiting over 52 weeks for treatment in April, against a plan of 1,119, an increase on the 1,122 pathways reported in March. In the longer waiting cohorts, 77 patients were reported waiting over 78 weeks at the end of April 2022, the majority in St George's Hospital in General Surgery and Cardiology, the number continues to be relatively static predominantly due to ongoing challenges with IPC, site pressures and bank holidays. Two patients are waiting above 104 weeks, both have dates booked for treatment.
- **Cancer:** Performance against the 2-week wait standard was below the national standard (81.0% in March 2022). On the 62 Day standard, SWL was the highest performing sector in London, with 79.4% in March against the 85% standard, up 5.0% on February. SWL performance on the 2WW Breast symptomatic pathway was 58.4% in March, up on 51.2% in February.
- **A&E 4 Hour Waits:** At an ICS level, 76.1% of patients were seen within 4 hours in April, a decrease on the 78.0% in March and the 78.4% reported in February. In April attendances decreased to 56.1K from 57.5K in March. The percentage of 111 calls answered in 60 seconds was low at 20.9% in April but a new service provider was commissioned from 31st May and a significant improvement in performance is expected.
- **Physical care 12 Hour A&E Breaches:** 941 patients waited over 12 hours from decision to admit to admission in April, up from the 665 reported in March. Ambulance handover delays were also a significant factor in April. Regional escalation calls occur across London plus discussions via the A&E Delivery Boards. Local systems maximise all opportunities and work closely with London Ambulance Service to minimise waits and improve this situation for all patients.
- **Mental Health 12 Hour A&E Breaches:** In April 2022, 117 over 12-hour mental health breaches were reported, a 39% increase from the 84 reported in March 2022 and 1 below the year to date high in February 2022. Mental health provider bed availability continues to impact performance.
- **Learning Disability Health checks:** Based on the final NHSE data SWL achieved the target of 75% target for Annual Health Checks in 21/22. Local data still indicates that we have not yet caught up on activity which was delayed during Omicron.
- **Mental health - Improving Access to Psychological Therapies:** Provisional data for March 2022 shows 3,430 clients entered treatment, indicating that performance levels remain below the monthly target of 3,996 clients. Whilst 21/22 targets have not been met, when compared to 20/21, there has been a 16% increase (5,395 clients) in clients entering treatment.
- **Severe Mental Illness Health checks:** Final submitted data for Q4 21/22 showed performance at 39% with 6,295 people with SMI having received an annual health check. This is an improvement on Q3 position of 32.8% (5,363 people). A new dedicated SMI health checks programme is being established for 22/23 to build on the good work in 21/22 and continue working to achieve the 60% standard.

South West London ICB Performance Report

Performance Horizon scanning

NHS South West London

UEC and Integrated Care

- **Ambulance handover delays** have improved from the immensely challenged position in late winter but are still far from where we need to be in terms of delivery to patients**. There are high numbers of patients waiting over 12 hours** from the 'decision to admit' to admission and high numbers of **super-stranded patients** which is driving capacity and flow issues across the system.
- Whilst intensive work continues on a day-to-day basis across the system, there is agreement amongst the CEO leadership community of **the need for a UEC system reset** through the summer months. A workshop is planned for 8th July to share learning and consider what more can be done in both the medium and longer term.
- **The new 111 service has gone live** on 31st May 2022 just prior to the long Jubilee Bank Holiday weekend. Since the launch we have seen an improvement in the total number of calls answered for SWL. The service includes an expanded Clinical Assessment Service which is working well, as is the Out of Hours service. The mobilisation process will continue until September to improve and embed the service including further recruitment and technical enhancements.

Cancer

- 2 Week Wait **breast pathway access remains a significant challenge**, with performance on the breast pathway being 58.4% in March (154 breaches out of 370 pathways). The challenges remain at St. George's and Royal Marsden. Although RM Partners and the ICS are working to develop a solution, this remains a key risk to the sustained delivery of Faster Diagnostic Standard, 31 and 62-day targets in Q1 22/23.

Planned Care

- As new Infection Prevention Control (IPC) guidance is implemented, there are encouraging signs of progress on achieving higher levels of business as usual activity. However, given demand trends, **there are signs of increasing challenge in treating long waiter patients** with overall numbers of 52 week waiters growing in recent months. Whilst this area will receive intensive attention, the focus on **outpatient transformation** at scale is also an important priority. The London region are also meeting London ICSs monthly from June to discuss waiting list assurance and the sharing of best practice.

Mental Health

- **Improving Access to Psychological Therapies performance remains challenged** despite the actions being taken. The ICS is actively working to improve the position in Q1. **There are also significant growing pressures on Mental Health services more generally** as referral and activity levels increase to year to date highs.

Primary care

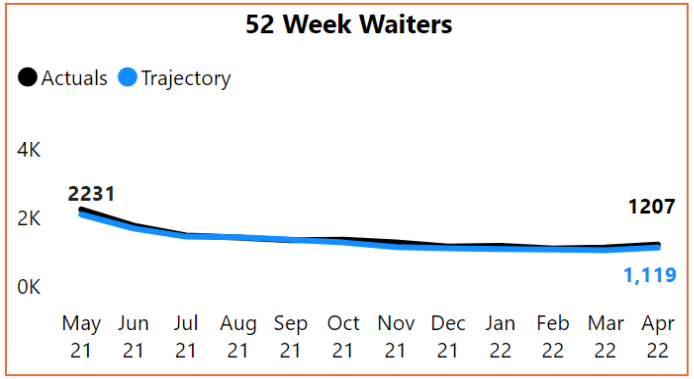
- There has been **some improvement in the delivery of Severe Mental Illness (SMI) health checks** to 40% delivery, however, the standard was not achieved in Q4 2021/22. A new dedicated SMI health checks programme is being established for 22/23 to build on the good work in 21/22 and continue working to achieve the 60% standard.

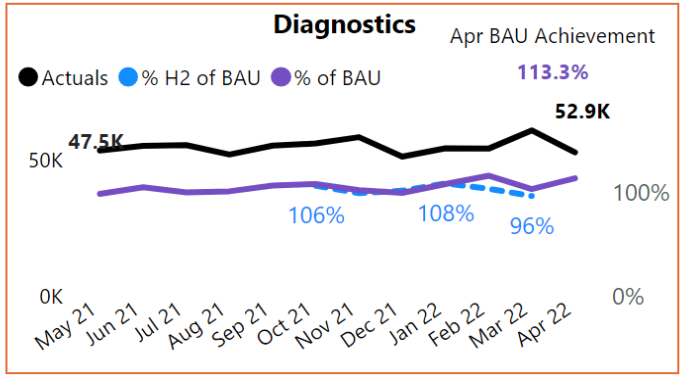
South West London ICB Performance Report

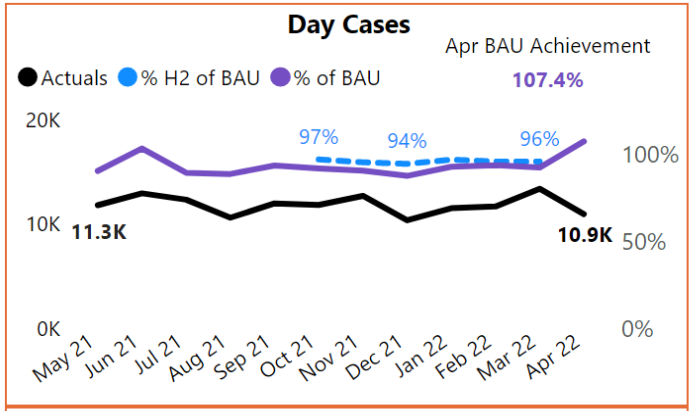
Planned Care

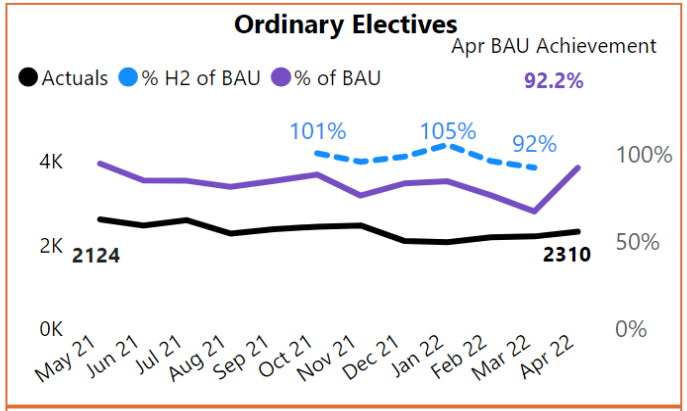
BAU Achievement is comparing activity in the recent month against the corresponding month of 2019/2020.
SRO: Jacqueline Totterdell

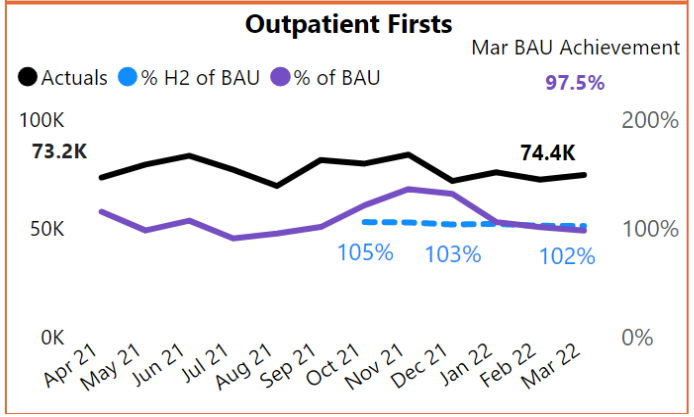
NHS South West London

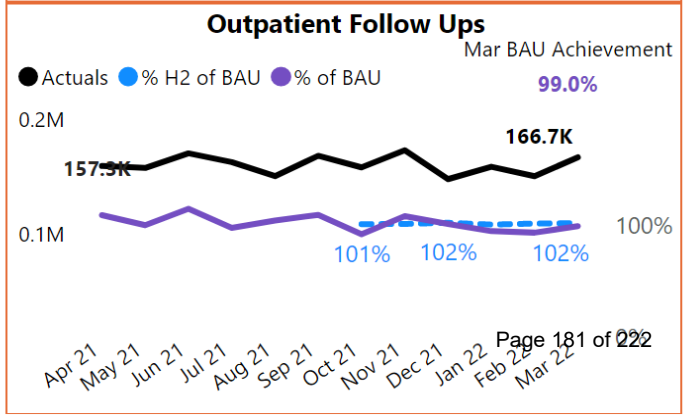












Long Waiters – April 2022
1,207 patients were waiting over 52 weeks for treatment in April (against a plan of 1,119), up from 1,122 patients in March. This growth is driven by Epsom and St Helier Trust and St George's(SGH). SWL mutual aid operational and clinical leads continue to work collaboratively to reduce 78+ and 52+ week waiters with clinical reviews of all patients who are waiting over 52 weeks being undertaken in general surgery and Ear Nose and Throat to support expansion of mutual aid criteria. In addition, the provision of staffed Saturday lists at Croydon Hospital is being offered to SGH surgeons. There were 77 patients waiting over 78 weeks at the time of reporting, with the majority at SGH within general surgery and cardiology. 2 patients were waiting for 104+ weeks and have both now been treated.

Diagnostics – April 2022
Overall, diagnostics was 113.3% of BAU (19/20) in April 2022. Recent weekly data (week ending 8th May) continues to show over performance against plan, Imaging being at 118%, Endoscopy 102% and Echocardiology at 115%. Previously, productivity across Endoscopy services has been challenged due to infection, prevention control (IPC) measures. However, as these policies have recently been relaxed, productivity has improved across all Trusts. SWL continues to have backlog (6+ week waiters) challenges for Echocardiology, mainly at Croydon and Kingston. Future demand management strategy is being explored via the Cardiology Network.

Elective Day Case and Ordinary Electives – March 2022
There were 10,933-day case procedures in the month, equating to 107.4% of BAU. For ordinary electives, 2,310 inpatient stays equated to 92.2% BAU. A clinically led theatre productivity bi-weekly system group has been established to share good practice, reduce variation and identify productivity opportunities.

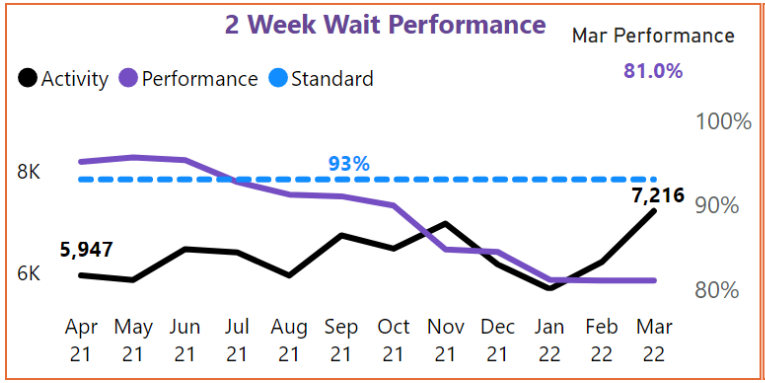
Outpatient First and Follow-Up Attendances – March 2022
First appointments totalled 74,369, equating to 97.5% of BAU and below the 102.0% (H2) plan. For follow-ups, this was 166,705, equating to 99.0% BAU, also below the 102.0% (H2) plan. The programme continues to work to strengthen plans to deliver an increase in advice & guidance and a reduction in follow up appointments, whilst also detailing the risks associated with the 25% required reduction when referrals remain above BAU.

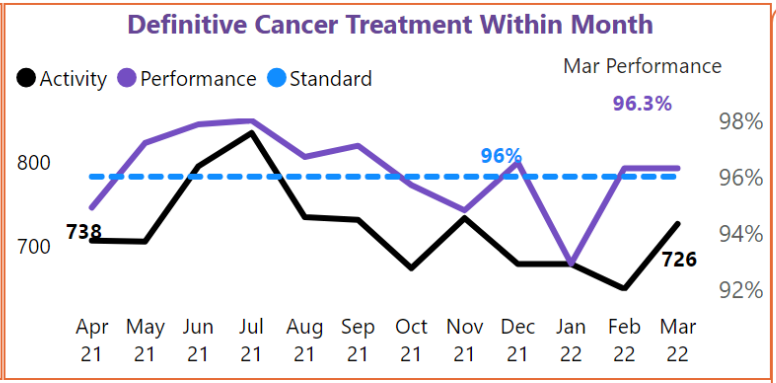
South West London ICB Performance Report

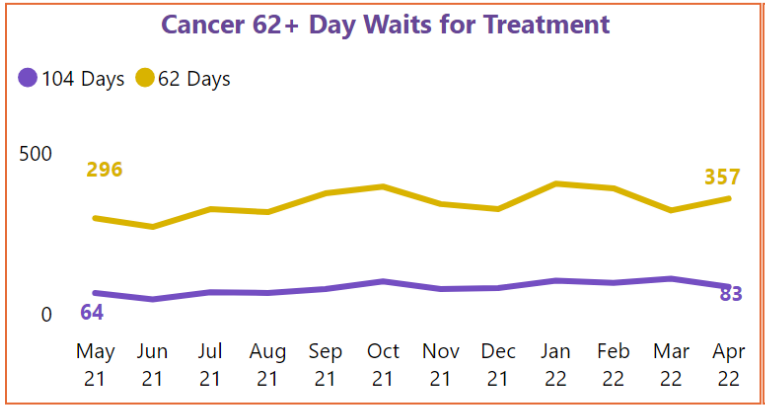
Cancer and Specialised Care

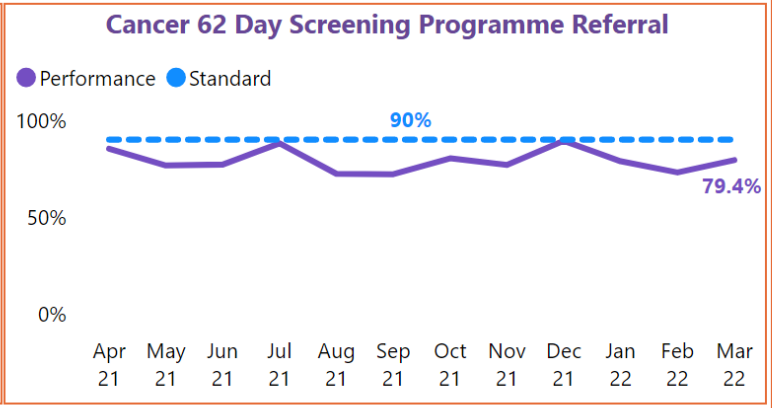
SROs: Jonathan Bates and Susan Sinclair

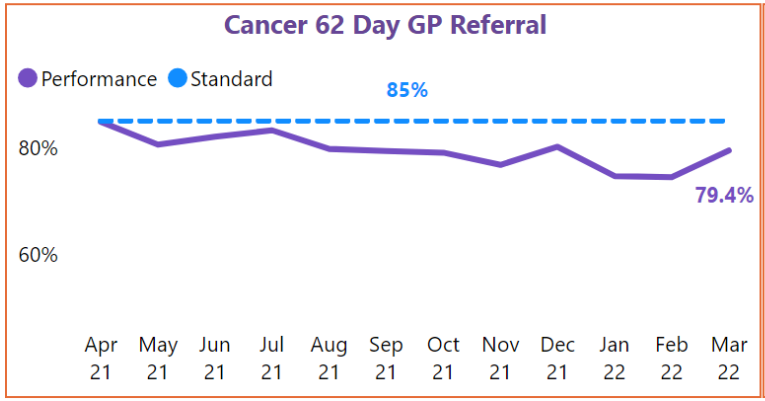
South West London

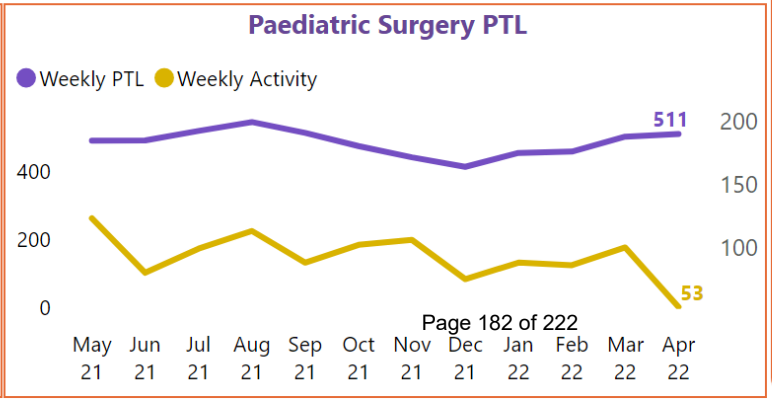












2 Week Wait (2WW) Performance (all SWL Providers)
SWL ICS delivered the third-highest performance in London in March 2022 with an outcome of 81.0%. SGH continued implementing their 2WW Recovery Plan, the Trust did not meet the 2WW standard (75.2% in March), however continued to report a compliant Faster Diagnosis Standard (FDS) position of 78.1%. RMH reported 2WW performance at 42.8%, driven by sustained increases in Breast and Sarcoma referrals however, RMH achieved 77% for FDS in March. Kingston reported 2WW March performance at 82%, driven by a 23% increase in referrals. Royal Marsden Partners (RMP) have developed a recovery plan in collaboration with the ICS, to address short and medium-term performance. The SWL Breast Task and Finish Group continues to support Trusts to implement pathway efficiencies and share best practice.

Definitive cancer treatment within the month
SWL Performance was 96.3% in March 2022, compliant against the 96% standard.

Patients Waiting Over 62 Days for Cancer Treatment
The number of patients waiting over 62 days at the end of April 2022 was 357, against the 2022/2023 Operating Plan trajectory of 438. Providers continue to ensure the prioritisation of key diagnostics and surgical treatment capacity.

Cancer 62 Day Screening Referral to Treatment Performance (Screening)
Breast, Bowel and Cervical Screening programmes continue to operate as business as usual. SWL has launched a public awareness campaign to encourage new eligible patients to participate in their Bowel Screening invitation, as the roll out of year 2 age extension to 58 year olds has now started. SWL Bowel Screening Service has successfully bid for £633k of funding towards initiatives, including Health Promotion uptake and coverage, education and training (National Breast Education Centre).

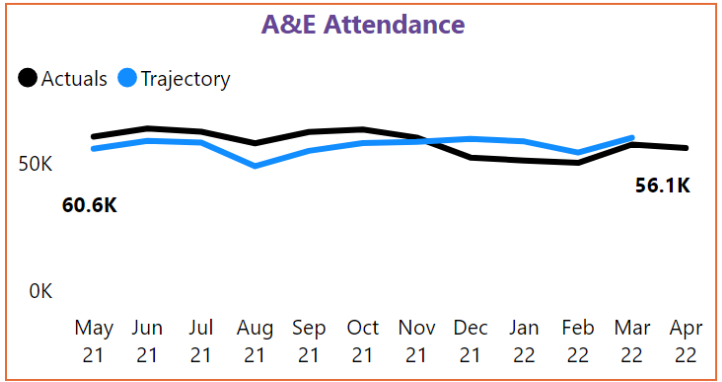
Cancer 62 Day Referral to Treatment Performance (GP Referrals)
SWL providers were the highest performing in London, with a performance outcome of 79.4% in March 2022.

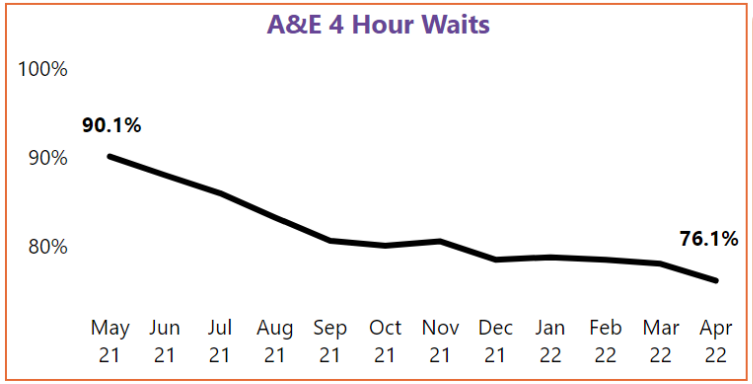
South West London ICB Performance Report

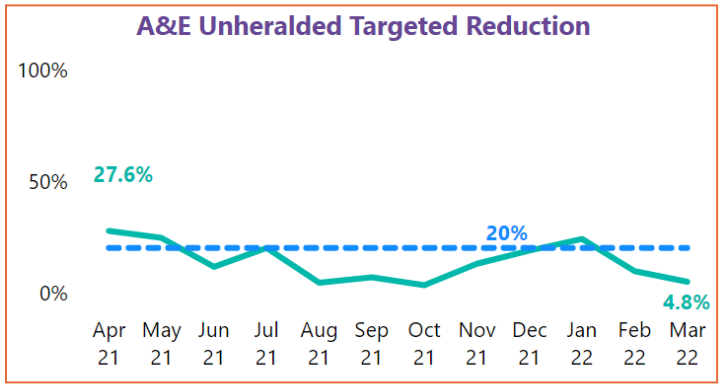
Urgent and Emergency Care

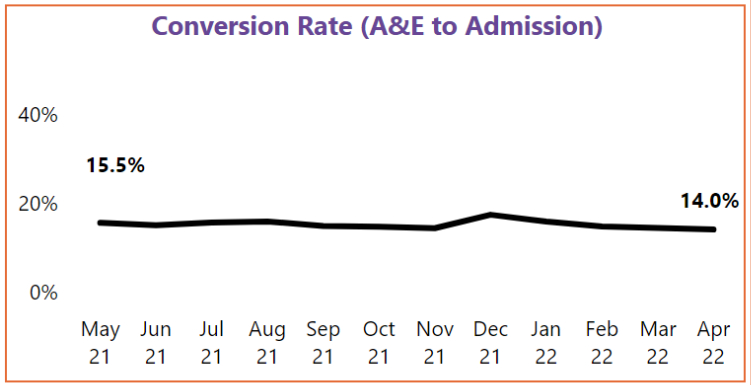
SROs: Jonathan Bates and Matthew Kershaw

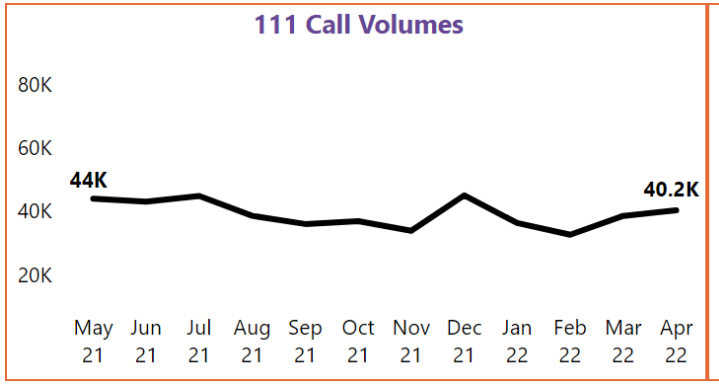
South West London

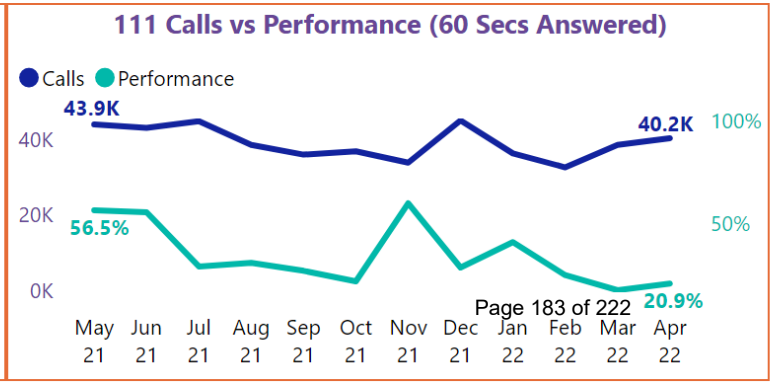












There has been significant preparatory work ahead of the bank holiday weekends, with particular focus on ambulance handover and response and keeping up the momentum on discharge, especially those patients on Pathway 0, where there is the largest opportunity for reducing delays. All local systems took additional actions over these weekends including: increased senior decision making at the front door and to expedite discharge, MADE and other events to give greater focus on flow and discharge, increased capacity including SDEC (same day emergency care), departure lounges and therapy provision. Changes to infection, prevention and control (IPC) and mixed ward guidance was also enacted.

A&E Attendances (for SWL ICS residents) There were 56,055 attendances, a reduction on 57,451 reported in March 2022.

A&E 4 Hour Waiting Times The target was not met by SWL Providers in April2022 and performance has remained at a similar level in recent months. It should be noted that preparations for the two bank holiday weekends improved ambulance handover and response times, as well as performance against the 4-hour target. The most significant cause of delay across all EDs continues to be the pressure on the non-elective admitted pathway, with increased 12-hour breaches – 941 reported in April. Extended waits directly affected ambulance handover times, with over 75% of patients waiting longer than the 15-minute standard and rising numbers of 30 and 60-minute breaches. Local systems are maximising all opportunities for improvement, working closely with LAS to minimise waits for all patients, balancing risk, using measures such as cohorting and boarding, allowing crews to be released for patients waiting in the community.

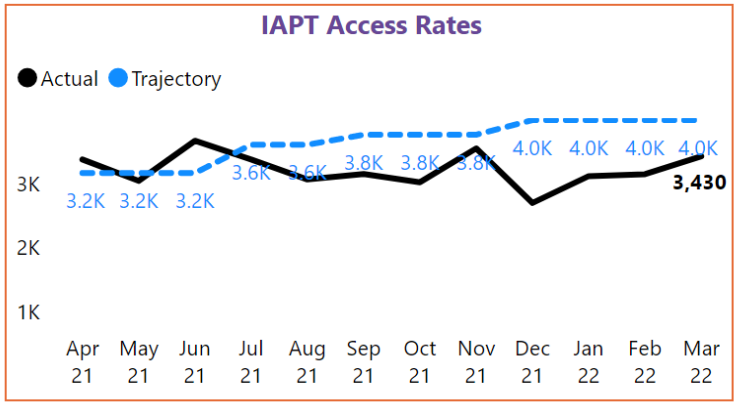
111 There was a small increase in calls in April 2022 and calls answered within 60 seconds remain low. Extra quality assurances have been sought to ensure this is a safe service and Vocare confirmed that there has been no increase in incidents, complaints or SI's in the last quarter. LAS are now taking 25% of calls to provide additional resilience. The Vocare contract ended on 31 May 2022 and new arrangements are coming into place led by Practice Plus Group (PPG).

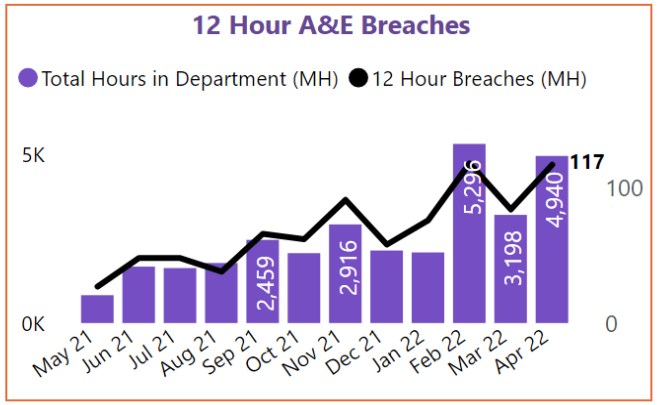
South West London ICB Performance Report

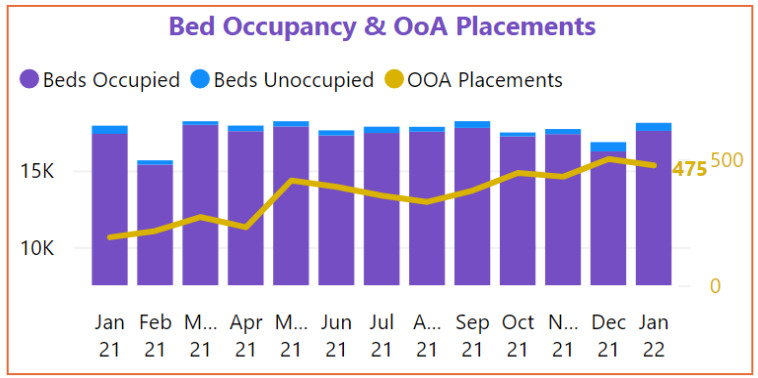
Mental Health

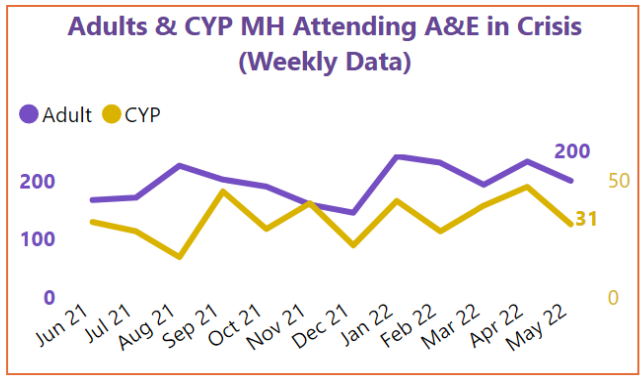
SROs: Vanessa Ford and Tonia Michaelides

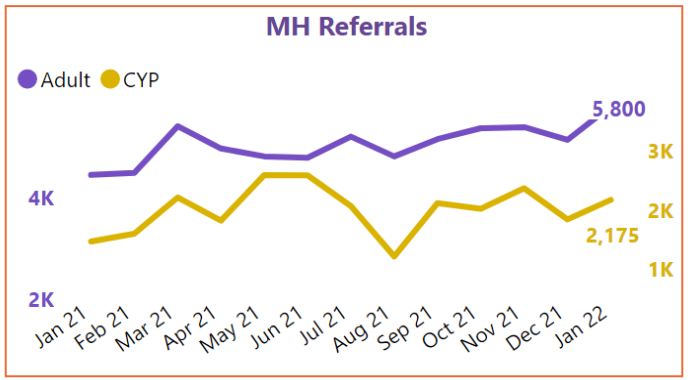
NHS South West London

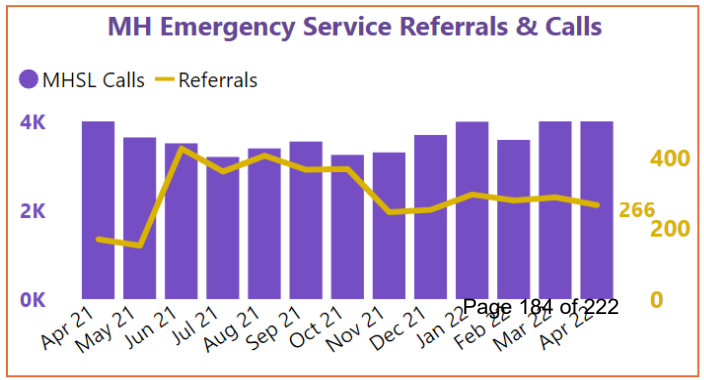












IAPT Access Rates
March 2022 data shows 3,430 clients entered treatment, indicating that performance levels remain below the monthly target of 3,996 clients. The provisional year-end position shows a shortfall of circa 4,700 clients. Whilst 21/22 targets have not been met, when compared to 20/21, there has been a 16% increase (5,395 clients) in clients entering treatment.

12 Hour A&E Mental Health Breaches
In April 2022, 117 over 12-hour mental health breaches were reported, a 39% increase from the 84 reported in March and one below the year to date high in February. Mental health provider bed availability continues to impact performance.

Bed Occupancy and Out of Area Placements (January 2022 is the most up to date data)
There were 475 out of area placements reported in January 2022 for SWL, a 5% reduction from 500 in December 2022. Demand and Mental health provider bed availability impacts performance.

Adults & Children & Young People Mental Health attending A&E in Crisis
The number of adult attendances in April 2022 was 200. The CYP numbers decreased to 31 in March 2022, compared to 39 in the previous month, continuing variability in attendance trend since September 2021.

Mental Health Referrals (Latest data January 2022)
The latest figures show a 13.0% increase in adult referrals to 5,800 in January 2022, a year to date high. The CYP referrals increased by 17.9% in January 2022.

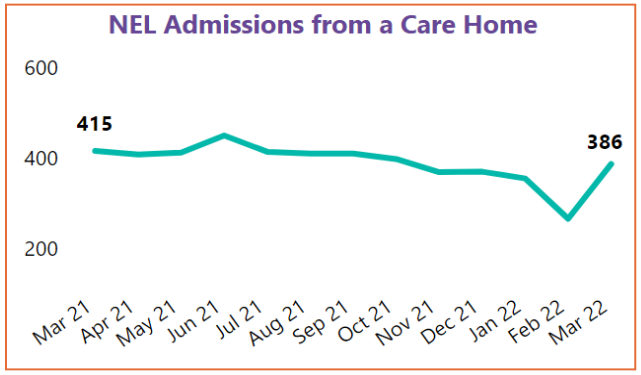
Mental Health Emergency Service Referrals, Coral Crisis Assessment Hub
The number of Mental Health Service Line (MHSL) calls were the same in April 2022, compared to March 2022 and continue to be inline with the activity 12 months ago. The referrals to the Coral Crisis Hub decreased by 7.6% in April 2022 compared to March 2022.

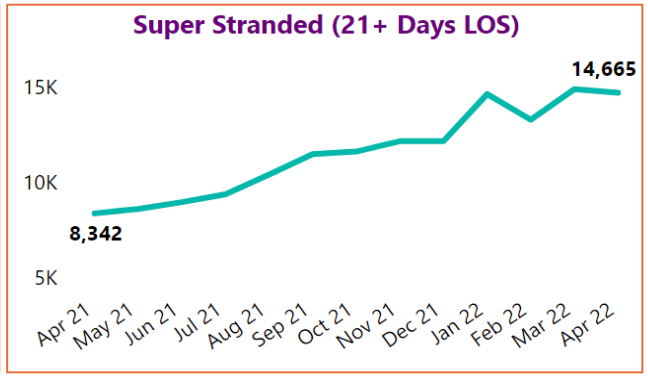
South West London ICB Performance Report

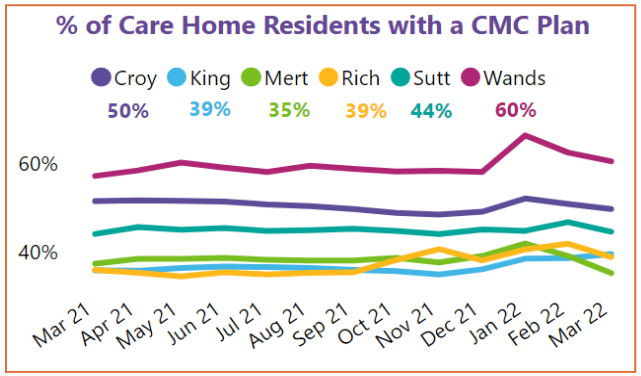
Integrated Care

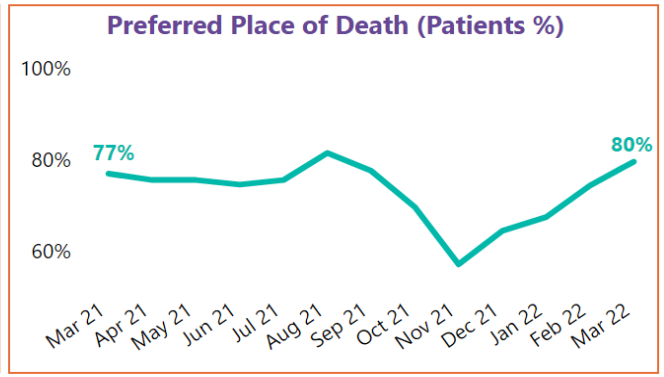
SROs: Tonia Michaelides and Ian Thomas

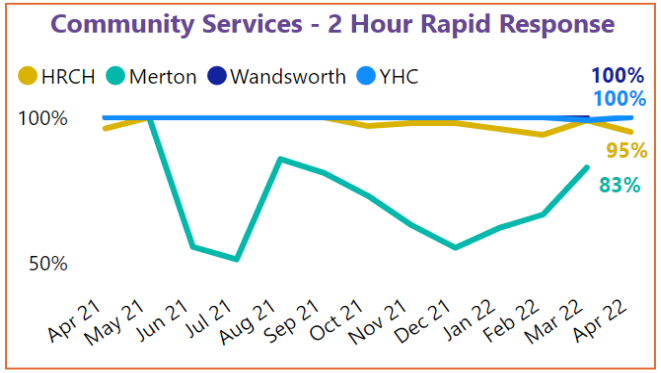
NHS South West London

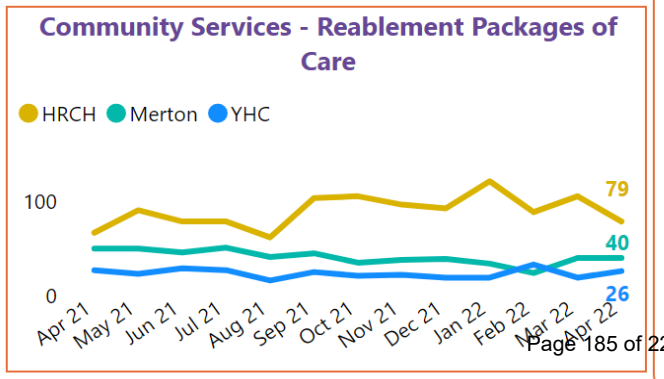












Non-Elective (NEL) Admissions from a Care Home
Following a downward trend from June 21 to January 22 there was a slight increase in March. Work continues to establish whether the February dip was due to fewer working days or a data quality issue. All Enhanced Health in Care Homes (EHCH) workstreams contribute towards this indicator. Community Services have been working with the Care Homes through the Support Teams and broader services to support residents to stay in their Care Homes where possible. Care Homes have been informed about the new Urgent Care Plans. An ambitious programme of digital transformation initiatives for Care Homes is set to continue through 2022/23.

Super Stranded (Over 21 Days Length of Stay)
Super stranded patients accounted for over 14,665 bed days in April '22. The following schemes are planned to ensure timely discharge for all patients, and they are on the optimum pathway:

- Improving flow through hospital for discharges
- Optimising the provision of community health services
- Improving ICS wide discharge processes with Local Authority / Social Care

% of Care Home Residents with a Co-ordinate My Care (CMC) Plan
The contract for the service provided by Coordinate My Care (CMC) ended on 31 March 2022. People using CMC can continue to do so until it is replaced by the new London wide system, called Urgent Care Plan, in June.

Preferred Place of Death (Patients%)
There has been an increase in the preferred place of death recording from 74.3% in February to 79.5% in March 2022. Data will not be available between April and September 2022 due to changeover of Urgent Care Plan system providers, but continuity of the underlying solution means that there has been no gap in patient care or change in clinical activities.

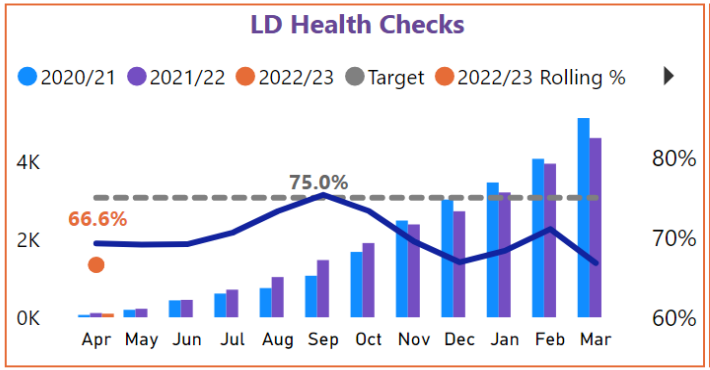
Virtual Wards
All local systems have been fully briefed and agreed allocation of funds. The full business case was approved by the Programme Board on 19 May 2022 followed by wider governance approvals. Clinical engagement and Standard Operating Procedure (SOP) development is underway across SWL. The combined capacity of the virtual wards across SWL is currently 126.

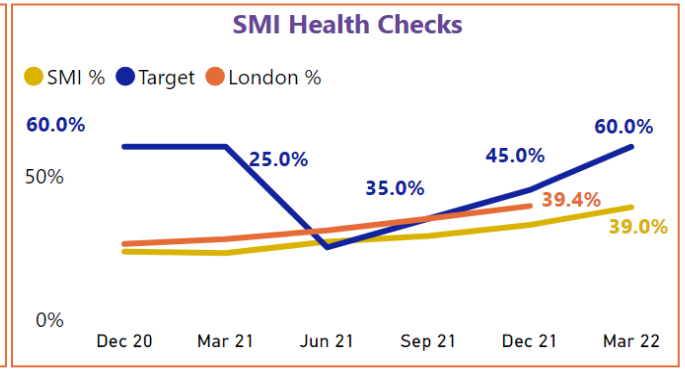
South West London ICB Performance Report

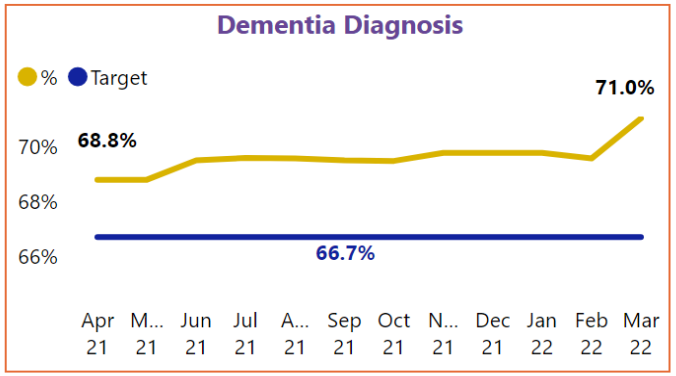
Primary Care

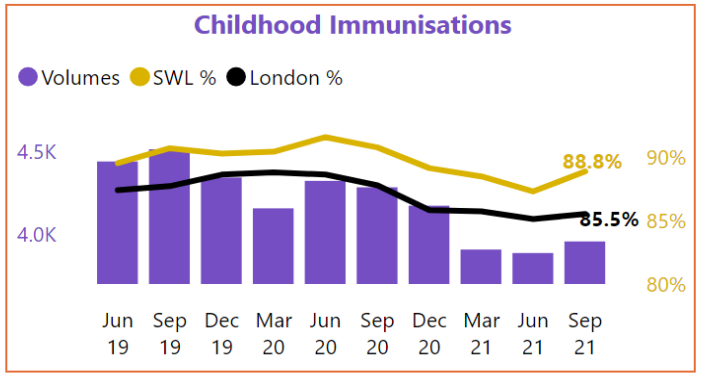
SROs: Mark Creelman and Nicola Jones

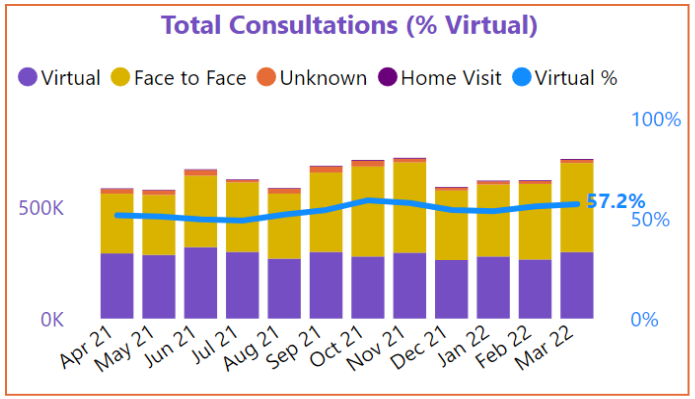
South West London

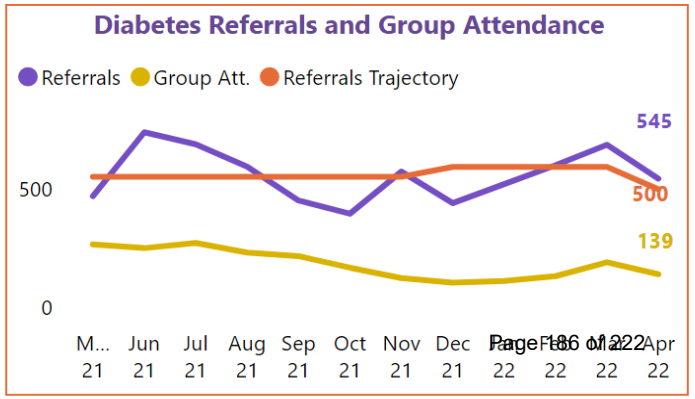












Learning Disability Health Checks
Based on the final NHSE data, SWL achieved the target of 75% target for Annual Health Checks in 21/22. Work continues with practices to ensure that the rolling twelve month run rate returns to pre-Omicron levels.

Severe Mental Illness Health Checks
Final submitted data for Q4 21/22 shows performance at 39% with 6,295 people with SMI having received an annual health check. This is an improvement on Q3 position of 32.8% (5,363 people). A new dedicated SMI health checks programme is being established for 22/23 to build on the progress made in 21/22.

Dementia Diagnosis
SWL ICS continue to maintain good performance levels which exceed the national benchmark threshold of ensuring that over 66.7% of patients with dementia are diagnosed. Current performance also met the 70% milestone ambition with performance at 70.5%.

Childhood Immunisations
Current nationally published data is up to September 2021. At present, the Local Immunisation Coordinators are continuing to undergo practice visits to identify call/recall processes, challenges and areas of improvement.

Total Consultations
In May 2022 the Recovery Board received a deep dive report into Primary Care. Total appointments in recent months compared to comparator months in previous years show a significant increase in appointments. Additionally, the percentage of Face-to Face appointments over the past 6 months has increased from circa 45% to 56%.

Diabetes Referrals and Group Attendance
Referrals were down compared with March, due to Easter, but still exceeded the target for the Month.

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board	
Date	Friday, 01 July 2022

Document Title	SWL Quality Report		
Lead Director (Name and Role)	Dr Gloria Rowland, Chief Nursing and AHP Officer & Executive Director for Patient Outcomes		
Author(s) (Name and Role)	Dr Gloria Rowland, Chief Nursing and AHP Officer & Executive Director Patient Outcomes, SWL ICB June Okochi, Deputy Director of Quality Improvement, SWL ICB		
Agenda Item No.	9	**Attachment No.**	09 (b)

Purpose (Tick as Required)	Approve	Discuss	✓	Note	✓

Executive Summary

The quality report provides key exceptions for SWL's health and care services and highlights the mitigations in place to address them.

The second part of the report is to provide assurance to the SWL Integrated Care Board (ICB) that a CCG quality closure report has been completed and presented to both the System Quality Council and the CCG Quality and Performance Committee Closure meeting in June 2022. In addition, SWL has taken adequate steps to ensure statutory, operational and policy quality functions have transitioned into the ICB and that due diligence has been formally completed and signed off.

The report further outlines next steps for continued development of quality oversight for our newly established health and care system.

Purpose:

To provide:

- A summary of quality issues within South West London,
- Assurance to the ICB that the right steps have been taken to develop a robust quality framework for oversight and delivery.
- Assurance that all statutory quality requirements have transferred from the CCG to the ICS.

Recommendation:

The Board is asked to:

- Note the full report and the quality issues it identifies in South West London.
- Note the risks and challenges to delivery and be assured that there are mitigations to managing system risks through the current quality governance arrangements.

• Note the development of quality within the ICB and the transition of quality from the CCG to the ICS.
Key Issues for the Board to be aware of: • That adequate resourcing and funding is required to deliver quality priorities and national requirements for systems. As part of the ICB resources review we will consider quality requirements alongside all other priorities to ensure that resources set are adequate to cover specific and overall ICB requirements. • There are six requirements from the National Quality Board for ICS to deliver by July, SWL has met five (please refer to report) The pending requirement to develop quality metrics through a system dashboard has not been met due to business intelligence capacity. There are discussions ongoing to mitigate this challenge. • All quality risks are detailed in the risk register and managed by the Quality directorate and mitigations are developed and shared with system partners.

Conflicts of Interest: N/A
Mitigations for Conflicts of Interest: N/A

Corporate Objectives This document will impact on the following Board Objectives:	Our system quality approach aligns to the ICS/ICB objectives and will meet these objectives: • Improve outcomes in population health and healthcare. • Tackle inequalities in outcomes, experience and access

Risks This document links to the following Board risks:	• Quality risks are included in the SWL ICB Corporate risk register and escalated to the Board Assurance Framework where appropriate • Key areas impacting performance of quality for the Board to note include: Continuing Health Care, Klebsiella infections across Trusts and assessments of SWL's Children Looked After.
Mitigations Actions taken to reduce any risks identified:	As detailed in the quality risk register

Financial/Resource Implications	To deliver quality requirements for the ICS, there will be financial and resource implications for the following areas: • New regulatory requirements from the CQC to inspect ICSs, Places and Local authorities from April 2023 will require additional resource given this will be a new requirement to resource system readiness. • Continuing Healthcare is a statutory function which is over-spending due to backlog of assessments. A key mitigation is to bring in additional resource to support SWL working with Local Authorities to clear backlogs. • Development of quality dashboard in line national mandate requires funding from the quality budget • The ambition for SWL to become a Quality Improvement system in order to drive safer care requires resourcing. As part of the ICB resources review we will consider quality requirements alongside all other priorities to ensure that resources set are adequate to cover specific and overall ICB requirements.

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	An EIA is necessary to evaluate the impact of quality and inequality to ensure we provide equitable and high-quality care to all our population regardless of their characteristics, who they are and what part of SWL they live in. We are in the process of developing a robust EIA which will focus on these key areas: • Improving outcomes for all SWL residents with specific focus on our CORE20 population (i.e the 340,000 people live in our top 20% most deprived communities. • The impact assessment will consider how we build racially equitable cultures where all ethnicities have equal opportunities to thrive in their careers as highlighted in recent national policies that health and care workforce continue to experience structural and institutionalised racism specifically black and ethnic minority groups. • We will evaluate wider system quality metrics and the impact it has on reducing health inequalities.

What are the implications of the EIA and what, if any are the mitigations	Some key mitigations of the points raised above are: The assessment will consider our patients and residents who fall within the nine protected characteristics and will be aligned to the quality impact assessments. In line with the CORE20PLUS5 approach, we are recruiting community connectors to adapt the Asset Based Community Development model in the most deprived communities of SWL to build capacity and deliver targeted based interventions for those with the poorest outcomes. In line with the NHS Observatory Race and Health Report which highlights that structural and institutional racism continues to be prevalent in the NHS, our ambition is to become anti-racist ICS system. The Messenger Report 2022 also acknowledges that although good practice is by no means rare, there is widespread evidence of considerable inequity in experience and opportunity for those with protected characteristics, of which we should call out race and disability as the most starkly disadvantaged. We will do this through the development of an anti-racist framework. This framework will take into account our commitment to ensure our health and care workforce are supported, developed and valued as employees regardless of their backgrounds, ethnicities and where they live. The SWL Health Inequalities Board will play a key role in developing the priorities to tackle health inequalities and holds the system to account for delivery.

Patient and Public Engagement and Communication	We are working with Safety and Quality Patient Partners, patients and public including specific impacted communities linking with our Voluntary Care Sector organisations to ensure we are listening to the voices of our population and using this insight to improve quality.

Previous Committees/	Committee/Group Name:	Date Discussed:	Outcome:

Groups Enter any Committees/ Groups at which this document has been previously considered:	SWL CCG Quality and Performance Oversight Committee	Thursday, 09 June 2022	Noted and assured
	SWL System Quality Council	Friday, 17 June 2022	Noted and assured
		Click here to enter a date.	
Supporting Documents			

South West London Integrated Care Board
1st July 2022

South West London System Quality Report

1. Introduction/ Overview

The aim of this report is to provide quality exceptions for SWL's health and care services and highlights the mitigations in place to address them.

The second part of the report is to provide assurance to the SWL Integrated Care Board (ICB) that a CCG quality closure report has been completed and presented to both the System Quality Council and the CCG Quality and Performance Committee Closure meeting in June 2022. In addition, SWL has taken adequate steps to ensure statutory, operational and policy quality functions have transitioned into the ICB and that due diligence has been formally completed and signed off.

The report further outlines next steps for continued development of quality oversight for our newly established health and care system.

PART ONE: SWL QUALITY OVERVIEW

1. System Quality Exceptions Report

This section provides exceptions based on the quality-of-service delivery, key metrics affecting performance of quality in SWL and this cuts across patient safety, patient experience and clinical effectiveness. This section further summarises and highlights recent CQC exceptions for providers in SWL.

a. Never Events

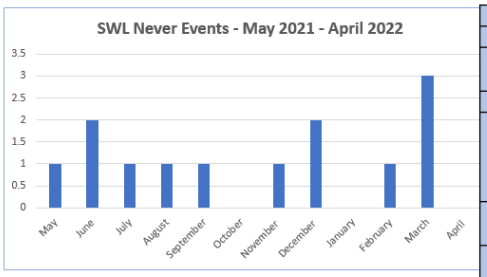
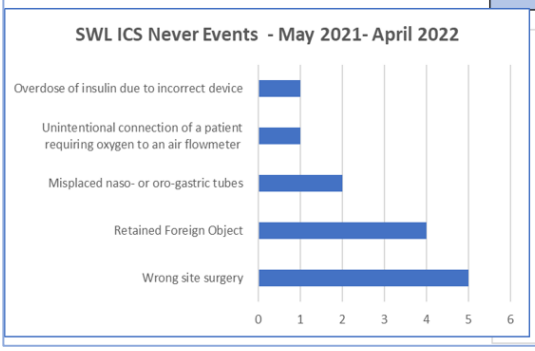
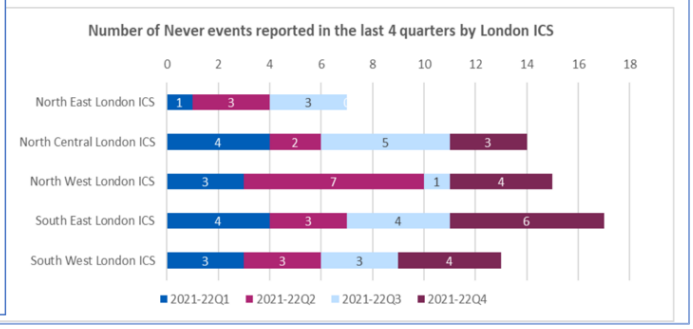


Table 2. Never Events in the last 12 months May 21 – April 22

Provider	Descriptors	Total
CHS	• Retained foreign object x1 • Wrong site surgery x1	2
ESH	• Misplaced naso- or oro-gastric tubes x1	1
Kingston	• Wrong site surgery x2 (1 now deescalated) • Unintentional connection of a patient requiring oxygen to an air flowmeter x1 • Retained foreign object x1	4
Royal Marsden	• Retained foreign object x1	1
SGH	• Retained foreign object x1 • Overdose of insulin due incorrect device x1 • Wrong site surgery x2 • Misplaced naso- or oro-gastric tubes x1	5





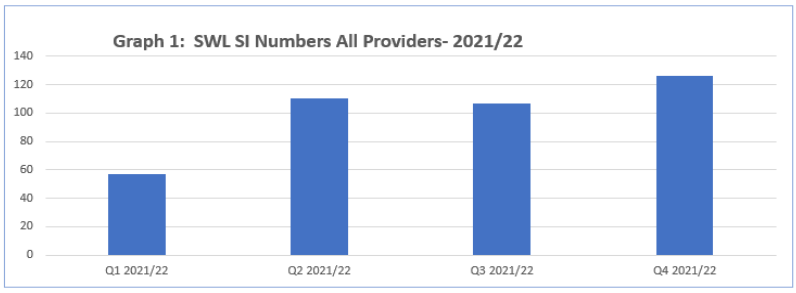
There are three Never events (NEs) reported between March and April 2022 by (2) St George's Hospital (SGH) and (1) Royal Marsden Hospital (RMH) as a result of Wrong Site Surgery, Misplaced naso- or oro-gastric tubes and retained foreign objects. Wrong site surgery remains the top theme in the last 12 months, this is also similar across London. Overall, SWL ICS has the second lowest number of NEs compared to other London ICS's as seen in the graph above.

Immediate actions have been taken by the Trusts. As we transition to the ICB, we will:

- Strengthen cross-system learning as part of our Quality Management System and QI approach.
- We will undertake regular, planned deep dive across the system to focus on thematic analysis and share learning with quality leads through existing governance arrangements e,g SWL System Quality Council.
- Further analysis will be carried with specific focus on *barrier analysis* including next steps for implementation.

b. Serious Incidents (SI)

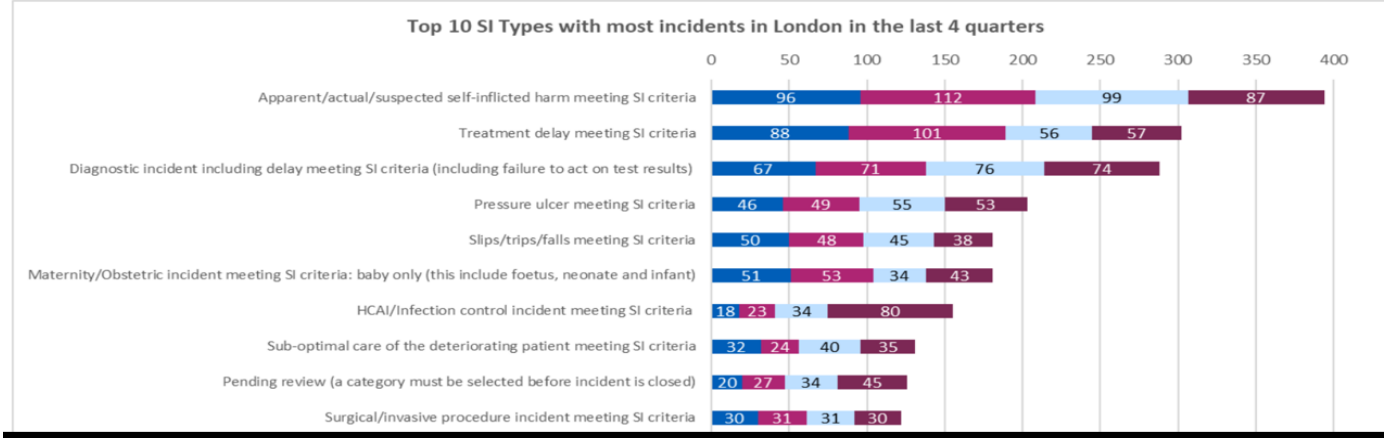
63 SIs have been declared by SWL providers between March and April 2022. Apparent, actual and suspected self-harm is recorded as the highest causes of SIs. There have been 15 related to self-harm, 14 relating to health care acquired infections (HCAIs) and 12 relating to diagnostic incidents including delays in meeting the SI criteria or *failure to act* on test results.



Summary

Top 5 themes for 21/22 are

- Apparent/actual/suspected self-inflicted harm;
- Diagnostic incident including delay
- HCAI/Infection control incident,
- Treatment Delays
- Surgical/invasive procedure incidents
- 3 out of the 5 top themes for SWL are consistent with London data



Actions identified from all independent investigations will be implemented by system partners involved in the SIs and there has been a particular focus on learning actions identified from those investigation reports. A deep dive reviewing five-year data on diagnostic delays has commenced and thematic analysis and learning will be shared across all SWL providers.

c. Infection and Prevention Control (IPC)

All SWL Trusts are impacted by Klebsiella spp infections. As seen in the dataset below, similar rates are recorded across all London ICSs so this is not a unique position to our IPC performance.

SWL is also experiencing high rates of Pseudomonas aeruginosa specifically impacted in both Kingston and St George's hospitals.

Actions SWL is taking:

- All Trusts are carrying out surveillance and, measuring harmful outcomes and recording learning points for HCAI, Klebsiella and Pseudomonas aeruginosa.
- Trust Boards are responsible for the performance of their infection control rates. However, SWL is working to pull together a system wide plan to support Trusts to reduce infection control rates.

Infection and Prevention Control

Table 1 sets out the threshold levels for each trust and the year total of healthcare associated infections (HCAI) 1st April 2021- 31st March 2022 This include HOHA and COHA cases

- All trusts flag red for *Klebsiella* spp. With Kingston and SGH also flagging red for *P aeruginosa*.
- SWLCCG is now flags red for *P aeruginosa* and *klebsiella* against the thresholds set by NHSE/I. Half of these are healthcare associated in comparison to *E.coli* which just 32% are healthcare associated.

Table 2 shows that SWLCCG are performing comparably to other London ICS

- Some of the key priorities/workstreams include
- Weekly surveillance of community and provider prevalence and accurate reporting of IPC events (including to NHSE and PHE and SWL Covid Room
- Care home support arrangements (variety of seminar/ teaching and training/ information cascade)
- SWL level IPC group to review the support and action plans across SWL to establish common root causes of HCAI's in particular GNBSI's

Table 2 : London CCGs Table shows data for period 1.4.21 – 31.3.22 (all cases) shows cases over thresholds, red where threshold breeched

ICS	C-difficile	MRSA	MSSA No threshold set	E-coli	Pseud A	Klebsiella spp.
SWL	249/261	15	213	733/830	115/107	249/231
SEL	282/247	18	298	1008/1,044	181/161	378/358
NEL	223/209	37	322	1,101/1,178	147/150	455/374
NCL	287/267	18	235	810/960	126/98	302/284
NWL	343/423	29	267	1,251/1,387	179/165	454/357

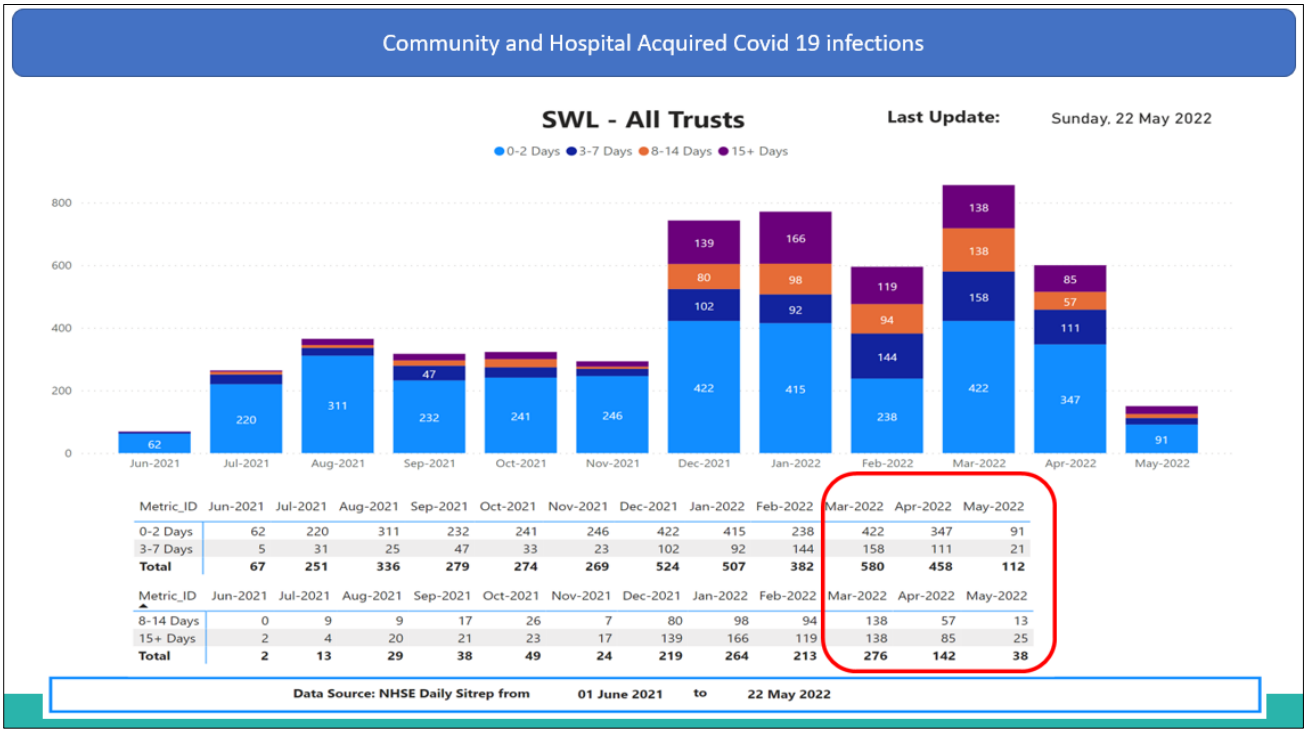
Table 1 Apr 21- March 22	C. difficile case threshold for 2021/22	E. coli case threshold for 2021/22	P. aeruginosa case threshold for 2021/22	Klebsiella spp. case threshold for 2021/22
CROYDON HEALTH SERVICES NHS TRUST	Threshold 23 Year total 19	Threshold 59 Year total 53	Threshold 16 Year total 7	Threshold 16 Year total 27
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	Threshold 51 Year total 50	Threshold 61 Year total 61	Threshold 12 Year total 4	Threshold 24 Year total 32
KINGSTON HOSPITAL NHS FOUNDATION TRUST	Threshold 29 Year total 35	Threshold 43 Year total 39	Threshold 6 Year total 12	Threshold 16 Year total 16
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Threshold 52 Year total 43	Threshold 111 Year total 87	Threshold 21 Year total 26	Threshold 49 Year total 53

It is important that there is a focus across local health economies on reducing infection levels. The following table therefore show threshold levels for C. difficile and for Gram-negative bloodstream infections at clinical commissioning group (CCG) level.

In contrast to the thresholds for trusts which only include healthcare-associated cases (HOHA & COCA) , the CCG thresholds encompass infections identified whether they are community or healthcare associated..

NHS SOUTH WEST LONDON CCG	Threshold 261 Year total 223	Threshold 830 Year total 668	Threshold 107 Year total 103	Threshold 231 Year total 228

d. COVID- 19 infections



Metric_ID	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022
0-2 Days	62	220	311	232	241	246	422	415	238	422	347	91
3-7 Days	5	31	25	47	33	23	102	92	144	158	111	21
Total	**67**	**251**	**336**	**279**	**274**	**269**	**524**	**507**	**382**	**580**	**458**	**112**

Metric_ID	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022
8-14 Days	0	9	9	17	26	7	80	98	94	138	57	13
15+ Days	2	4	20	21	23	17	139	166	119	138	85	25
Total	**2**	**13**	**29**	**38**	**49**	**24**	**219**	**264**	**213**	**276**	**142**	**38**

Data Source: NHSE Daily Sitrep from 01 June 2021 to 22 May 2022

- NHSE and England have recommended to ministers that COVID Alert Level should move from Level 4 to Level 3.
- Business Continuity and Emergency Preparedness response remains in place and will remain under review.
- Testing in community increasing, positive cases up in SW London by 70% in SW London from previous week.
  - 60yrs group 'to watch' (make up 25% of community cases)
- Hospital admissions increasing slowly over the period of June 2022 but mainly asymptomatic, no increase in covid patients requiring intensive care yet.
- Trusts are working towards national guidance for next steps and returning to pre covid non-pharmaceutical precautions such as social distancing, cleaning and mask wearing in non-high risk areas.

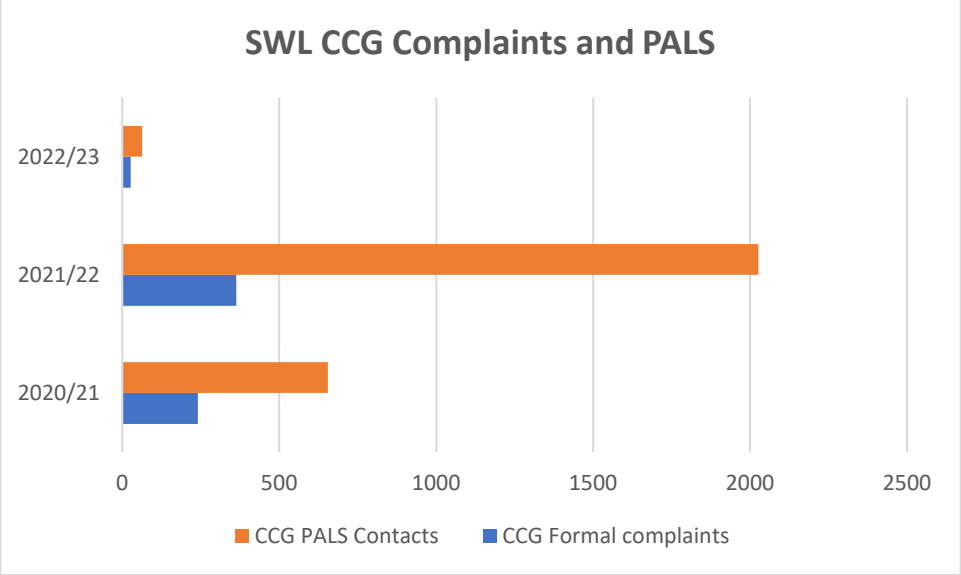
PHE Positive Tests Activity per 100k Population (Rolling 7 Day Period)

Borough	30th May to 5th June	6th to 12th June	>=100	>=250	>=5 (seven day shift)	Week to Week Movement
Croydon	55.82	92.01			Warning	↑ 65.0%
Kingston	65.50	110.70	High Alert		Warning	↑ 69.0%
Merton	76.23	102.22	High Alert		Warning	↑ 34.0%
Richmond	61.38	113.34	High Alert		Warning	↑ 85.0%
Sutton	55.18	129.61	High Alert		Warning	↑ 135.0%
Wandsworth	55.18	90.45			Warning	↑ 64.0%
SWL	60.28	102.43	High Alert		Warning	↑ 70.0%
London	0.00	0.00				

>=60 Trigger
>=20 Warning
>=100 High Alert
>=5 (seven-day shift) warning

Note: Rates here will not reconcile to NHSe figures due to a difference in reporting periods and population numbers used

e. Patient Experience



- There was a higher rate of CCG related complaints during the pandemic years compared to pre-pandemic. Top themes were predominantly focused on the pandemic, the COVID vaccination programme and Continuing Health Care.
- SWL's Quality Complaints Review Panel has been established and will take place every quarter starting April 2022.
- Implementation of a new data recording system for complaints, to support intelligent reporting is underway.
- Roll out of revised complaints framework on how we learn and improve performance of closed complaints from within timescales from 67% to 80%

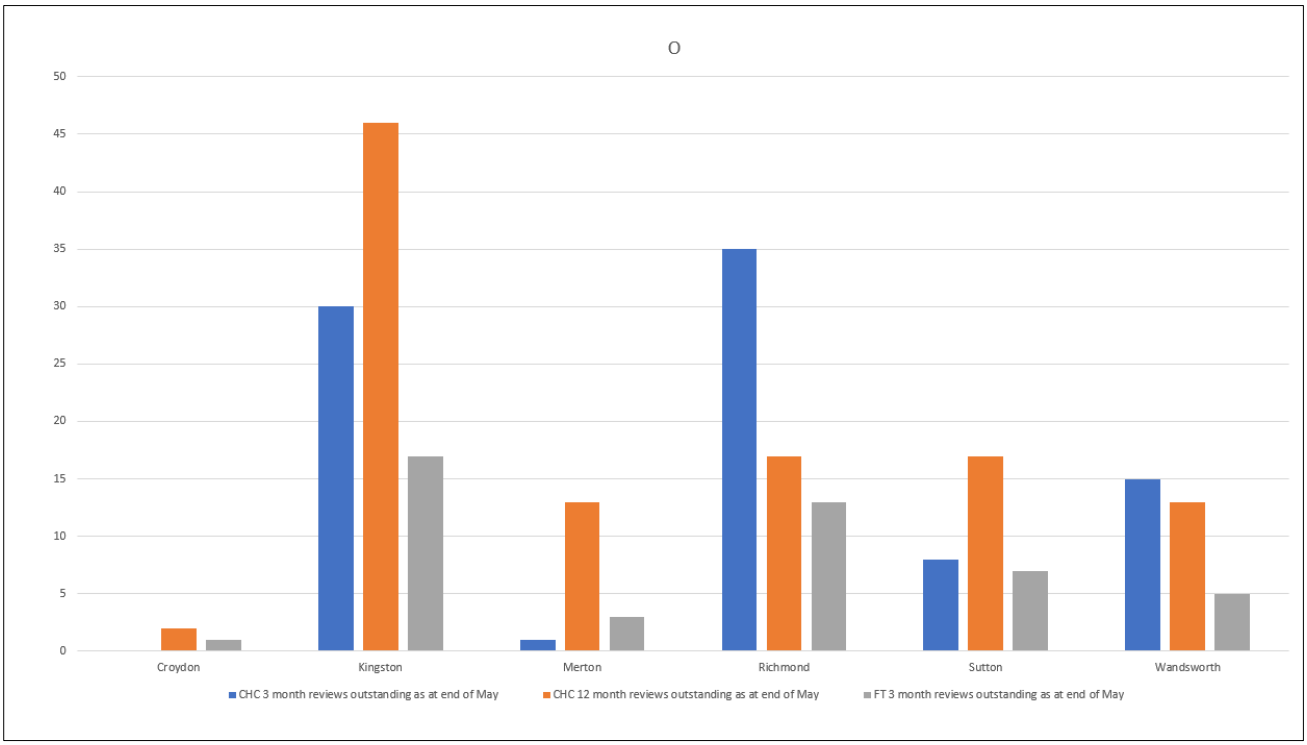
f. SWL Looked After Children (LAC)

There are varying degrees of compliance challenges for LAC for Initial Health Assessments (IHA) and Review Health Assessments (RHA). System challenges are consistent around timeliness of assessments in all six boroughs of SWL. The main cause of this issue includes notification and completion of IHA's and RHAs. A system wide scoping and mapping exercise has been completed. Outcome of the LAC scoping exercise will be a focused piece of work on improving outcomes for children and a renewed focus on learning including transforming SWL's community paediatric workforce.

SWL LAC Population Data & Demographic Snap Shot – Up to 30.05.2022

Croydon	Kingston	Merton	Richmond	Sutton	Wandsworth
Looked after Children Population on					
542	140	125	131	230	269
New Referrals					
32	0	12	6	11	39
Initial health Assessment compliance					
43%	n/a	33%	75%	42%	83%
Review Health Assessment compliance					
73%	67%	100%	Not currently available	97%	96%

g. Continuing Health Care (CHC)



There remain high numbers of outstanding reviews across SWL for all key indicators. 89 x 3-month reviews, 106 x 12-month reviews and 46 x FT 3-month reviews Some of the risks due to the outstanding reviews include:

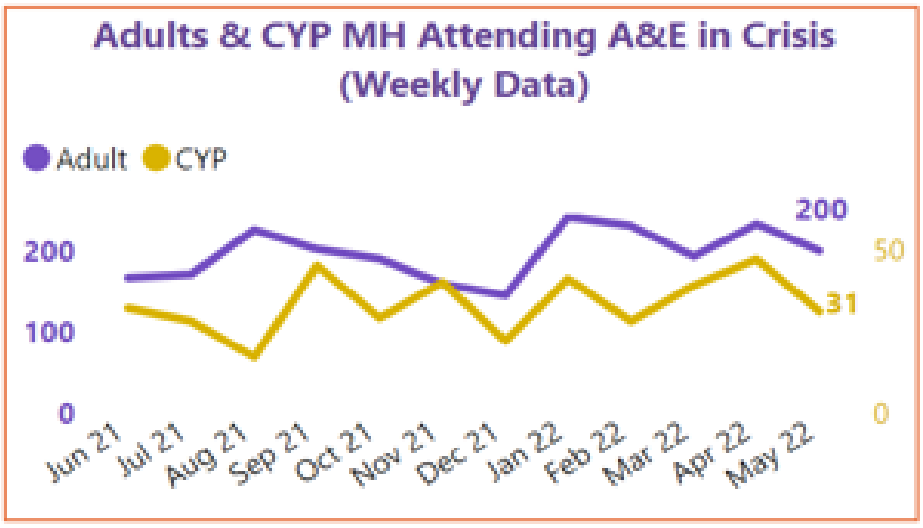
- That patients/clients are not receiving the care they need.
- That the costs of providing care exceed our budget for doing so.
- Impact of Hospital Discharge Programme (which ended on 31 March 2022) will continue to change the nature of the CHC service.
- Timely reviews of cases are the key control for both quality and finance
- Staff capacity, recruitment and retention are impacting on our ability to improve performance – danger of an 'arms race' with other CCGs

Mitigations include:

- Improvement process has commenced. Some of the key risks noted are timely reviews, staff capacity, recruitment, retention and management of services commissioned outside of ICB. Actions to address these are in place.
- Senior Responsible Officer for CHC has commissioned external support to review overall delivery model for service and to provide recommendations regarding implementation and resourcing.
- Review will also include 'deep dive' into quality-of-service provision
- Putting together an escalation team to work on the outstanding backlogs

h. Mental Health Provider Collaboratives

- Children and Adolescent Mental Health Services (CAMHS) in Emergency Department remains an issue for SWL and similar challenges are being experienced across ICSs in the country due to increased demand post pandemic.
- Adult mental health services are generally facing increased demand.
- Significant increased pressures for mental health in adult acute and urgent care.
- CQC and NHSE/I have acknowledged that this is a national issue with Children and Young People's Mental Health services and commended SWL's approach to resolving the issues.



Mitigations

- Mental Health providers have developed a detailed action plan on improving patient experience, overseen by a revamped Improving Patient Outcomes Group.
- Services have worked well across urgent care and inpatient services to accommodate demand and provide beds and safe alternatives to hospital admission.
- Additional private beds have been secured for 6 months as of April 2022
- SWL St George's Mental Health Trust have launched quality strategy including 3-year suicide prevention strategy and continue to use Quality Improvement (QI) as an enabler to improve patient and workforce experience.
- SWL ICS Chief Nurse has escalated system challenges to regional Joint Strategic Oversight Group (JSOG) and Mental Health Transformation Board is aware and aligned.

1.1. Other Quality and Safety Performance Exceptions

Exceptions for the period of May 2022	Mitigations
Regulation 28: Prevention of future deaths • Coroner issued a regulation 28 to St Georges on the 9th of May 2022 regarding Cardiac Surgery following review of a case from 2013.	• Trust is required to provide a response by the 4th of July • Response will follow with action plan
Serious Incidents • 63 SIs declared by SWL providers in March and April 2022. • Self-harm remains the highest number (15); HCAI (14) and Diagnostic delay (12)	• Actions identified from the independent investigation will be implemented by the system partners involved with learning actions. Learning points identified from investigation reports. Deep dive on data analysis on diagnostic delays has commenced with a review of five years data.
Mental Health Homicides • Staff homicide by patient in a community hospital • Independent Investigation report Pre-publication meeting held mid-May 2022. Awaiting publication date.	• Actions identified from the independent investigation will be implemented by the system partners involved with learning actions. Learning points identified from investigation reports.

i. Care Quality Commission Exceptions Updates

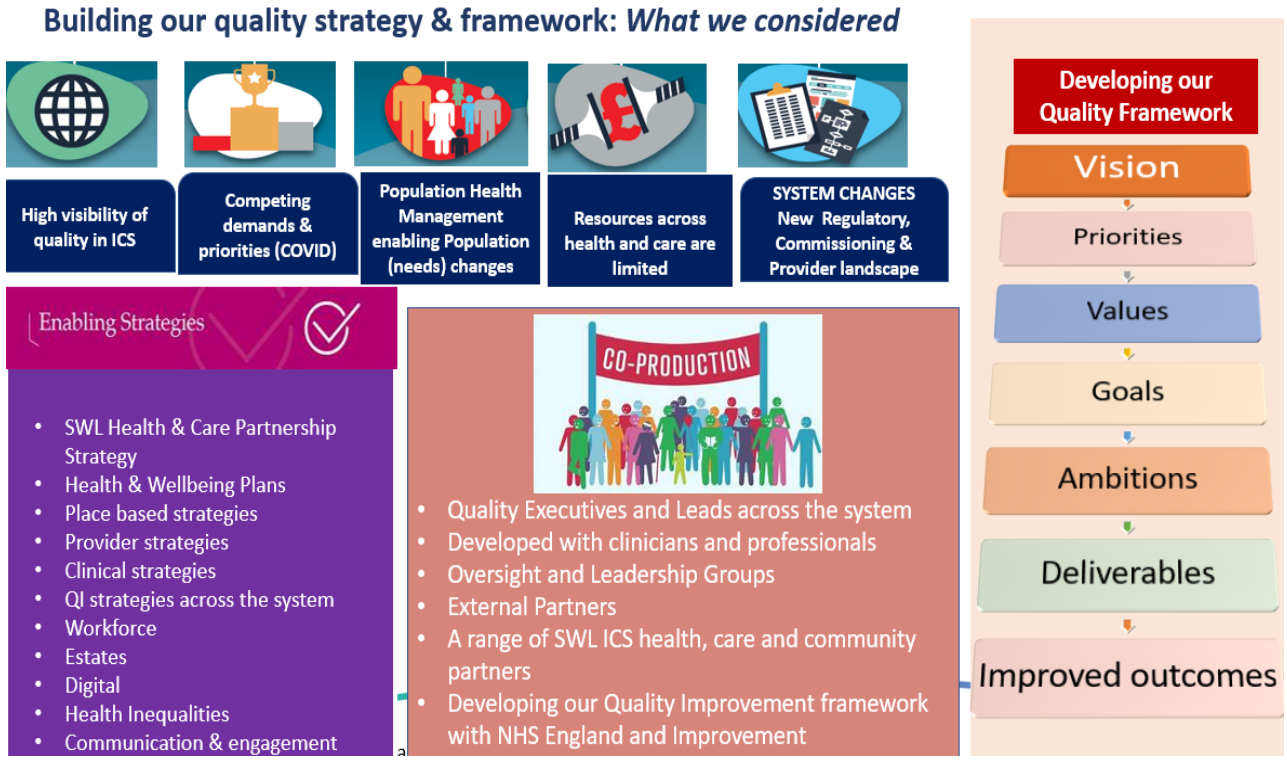
Status	Outcome
Acute Providers: St George's had a recent CQC inspection on the 26.04.2022 on their interventional radiology services.	• Trust advised that initial feedback was positive. Awaiting final report outcome.
Primary Care	• Groves Health New Malden has been appointed as a caretaker for 3 months. Most staff are TUPE'ing to Groves

Closure of Village Surgery (Kingston) - Clinical concerns raised by CQC are mostly about lack of monitoring of high-risk drugs and long-term conditions. • PMS contract was terminated by mutual agreement with the partners as of midnight 19.05.2022. • CQC registration cancelled with effect from midnight 19.05.2022	Health and the service remains open for patients as usual, but under new management.
There are two General Practices with inadequate ratings: • Croydon: South Norwood Hill Medical Centre • Wandsworth: Trinity Medical Centre	• Primary Care and Place Quality leads continue to work with practices to provide support on their CQC action plans
Care Homes There has been two recent Care homes closures: Rosedene Active Prospect (Sutton) and Fiddlers Green (Kingston)	• The CQC working with care homes and the Local Authorities on adequate transition arrangements for residents
Non-NHS Providers Mediscan re- inspection outcome in May 2022	• Rating has improved from Inadequate to Requires improvement
Specialist commissioning **Wandsworth Prison**: Since December 2020 there have been six self-inflicted deaths of inmates at Wandsworth Prison. CQC gave Warning Notice following six self-inflicted deaths. Some of the issues included: that all open referrals have not ensured that prisoners are reviewed, assessed and treated promptly; governance systems were ineffective which meant that 37 patients had not received the assessment and/or care needed.	• CQC working in collaboration with NHSE/ region's Health and Justice team linking in SWL Quality on remedial actions. • Mitigation discussed on agenda as part of the regional quality meetings at the Joint Strategic Oversight Group (JSOG)

PART TWO: DEVELOPING QUALITY FOR THE ICB

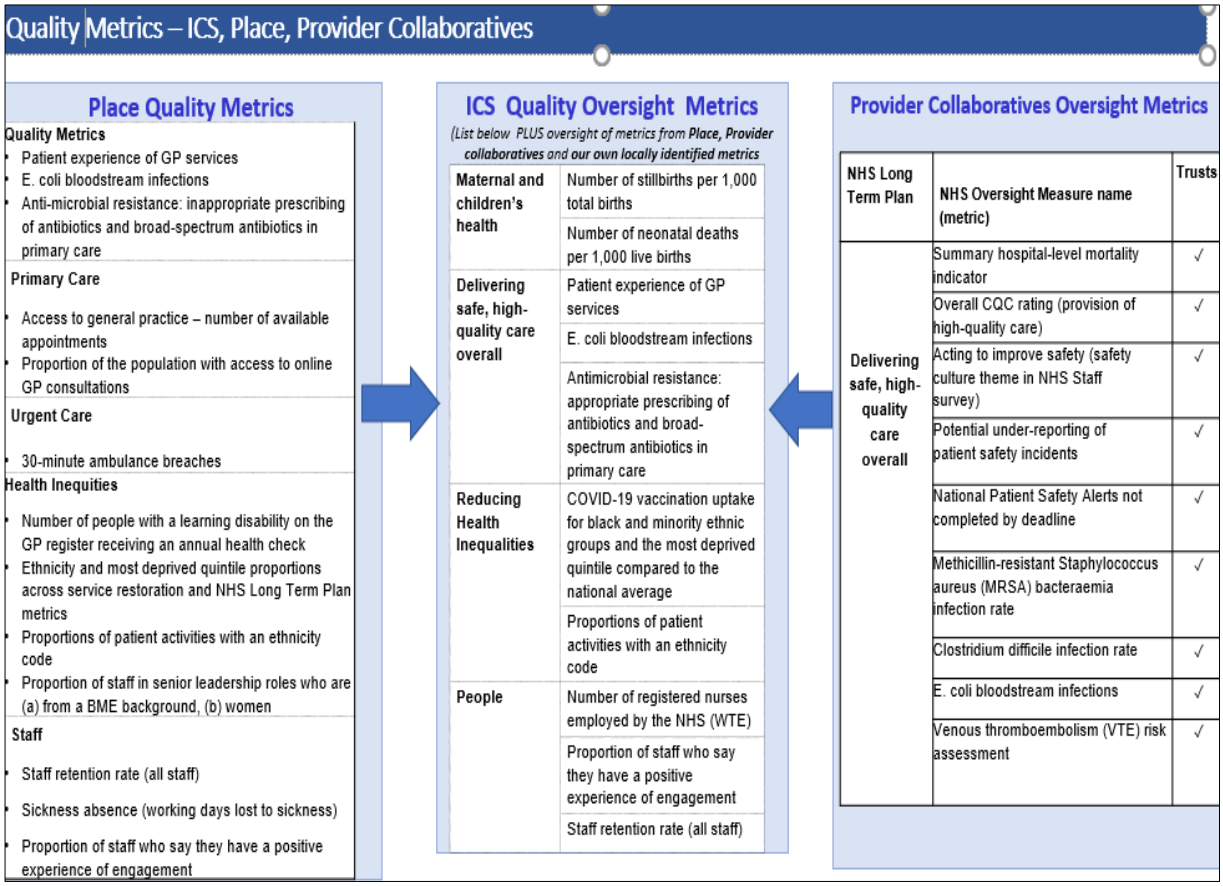
2. Developing the SWL ICS Quality Strategy

Our developing quality strategy and approach will detail how the ICB and the wider ICS partnership will achieve improved outcomes for our local population using quantitative and qualitative metrics that will improve quality of care across services. We have developed a roadmap on how the ICB will develop a system wide quality improvement approach using the Quality Management System for care delivery. We will use our existing governance framework to ensure clarity of responsibilities, delivery and accountability. Consultation is currently ongoing. The ICB Board will sign off the final draft for publication in September 2022.



3. South West London (SWL) Quality metrics

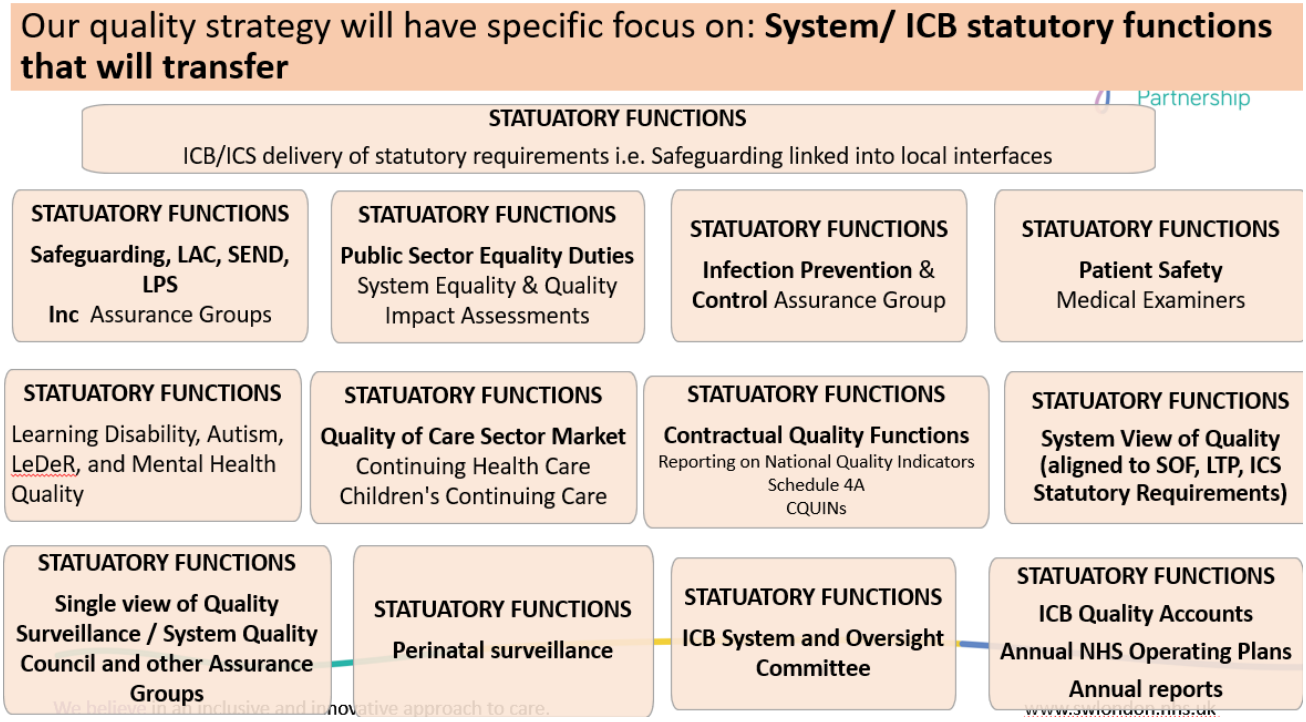
SWL has completed mapping on quality metrics and agreed what will be measured across the ICS for oversight, at Place for delivery and across Provide collaboratives. We have considered the NHS Oversight metrics with the aim to integrated quality and performance metrics, triangulating with finance and workforce where appropriate. We have also mapped the listed national Quality Toolkit metrics which will be measured at provider and Place level as well as local SWL metrics aimed at Quality improvement. Baselining has been completed from all providers and the next step is to develop the system dashboard for reporting. Below are some of the metrics we will measure across ICS, Place and provider collaboratives.



4. CCG Transition of quality functions to ICB

The Quality directorate has worked closely with system partners to develop an effective transition of statutory, operational and policy quality functions that would transfer, through a rigorous due diligence process. We have assessed ourselves against the national requirements and completed evidence gathering for all 50 transferrable functions working closely with the Corporate Due Diligence planning team, external auditors, and NHSE/I regional colleagues.

a. **Statutory requirements that must transfer include**:



The six principles below are quality requirements for ICS outlined by the National Quality Board NHSE/I to be delivered as we transit into an ICS. We have successfully completed four out of the six areas and work is progressing to deliver on the two outstanding areas.

2. Strategic/Policy Quality Functions - National Quality Board Requirements for ICS/ICB

Blue	Mature and signed off
Green	Completed and requiring formal sign off
Anber	In development
Red	Not started

Quality Principles- System Priorities & Responsibilities	Timeline	RAG May 2022	Position statement
1- A designated executive clinical lead for quality, including safety, in the ICS and clinical and care professional leaderships embedded at all levels of the system.	July 2022		GR appointed and signed off
2- Population focused vision: Clear vision and credible strategy to deliver quality improvement across the ICS, which draws together quality planning, quality control, quality improvement and assurance functions to deliver care that is high-quality, personalised and equitable	July 2022		In development- First draft by beginning of July Ongoing consultation with system leaders
3- Co-production with people using services, public and staff- A defined governance and escalation process in place for quality oversight – covering all NHS and local authorities (included devolved direct commissioning functions)	July 2022		Completed – planned to take to PPI groups and Healthwatch Groups Communication and Engagement Assurance Group will dovetail into quality groups
4- Clear and transparent decision making- An agreed way to measure quality, including safety, using key quality indicators triangulated with intelligence and professional insight, which is reported publicly and transparently at Board-level to inform decision-making and effective management of quality risks.	July 2022		Quality dashboard yet to be developed due to BI Capacity
5- Timely and transparent information sharing- A defined way to engage and share intelligence on quality, including **safety -at least quarterly and delivered through a system Quality Group**	July 2022		SWL's System Quality Council established and running
6. Subsidiary- A defined approach for the transfer and retention of legacy organisation information on quality in accordance with the Caldicott Principles.	July 2022		Completed as part of Quality Due diligence – handover planned for June from QPOC to Qual * Oversight Committee for sign off

b. SWL's System's Readiness to Operate

As part of our transition to become ready to operate as an ICS, quality delivery has been reviewed by NHSE in line with the six requirements and principles set by the ICS and based on their assessment, we are a system assessed as Ready to Operate based on delivery.

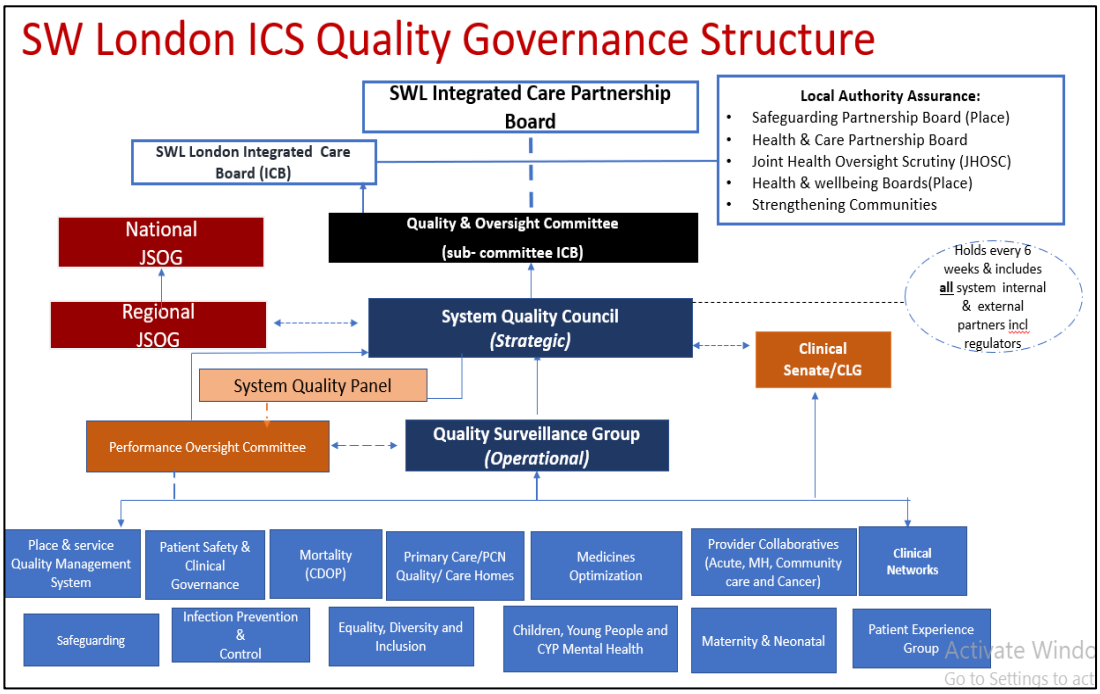
Quality and Safety Systems Q4 2021-Readiness to Operate	SWL RAG	Comments	NHSE/IRAG
SWL rated Green in line with the CCG/ICS's self-assessment (***On target, no concerns)***		SWL was invited by the London region **to share best practice** with other ICSs on the development of quality oversight.	

c. System Governance, Oversight, Quality Risk and Escalation

SWL ICB will set the direction and governance framework for which our local systems will be expected to plan, improve, and provide assurance on quality in collaboration with our regional NHSE/I colleagues and other regulators.

Our governance at system level includes:

- The ICB Quality & Oversight Committee, a subcommittee of the ICB Board (**ICB / system assurance, quality risk management and oversight).**
- The ICS System Quality Council (knows as the System Quality Group mandated for all ICSs) includes regional NHSE/I representation **(Peer assurance, quality improvement, escalation and system quality risk management**
- The ICS Quality Surveillance Group (**Planning, triangulation, data and intelligence, peer support, learning & improvement, sharing best practice, quality risk management).**



Our ICB's quality escalation framework aligns with the recently published national quality escalation framework. This takes into account escalation process through the SWL System Quality Council with regional representation or through the regional / national Joint System Oversight Group (JSOG) with representation from the ICB/ICS's Chief Nurse.

5. Next Steps for Quality Development

Over the last 12 months, a significant amount of work has been undertaken to develop the system's quality oversight and operating framework including our approach to improve quality in SWL. The following areas highlight our next steps to develop and improve quality for SWL

- Development of ICS Quality strategy, metrics and outcomes with focus on QMS and Peer assurance.
- Develop system maturity and readiness for CQC inspections for ICS, Place and LA from April 2023.
- Continue to co-design and consult with health and care leaders re ongoing development of quality arrangements and functions.
- Improve patient experience and strengthen our system co-production framework with patients, residents and users of services in order to improve patient experience. We will do this through the SWL Patient Experience Panel.
- Development and establishment of quality functions with care (map joint commissioned services and establish / agree joint governance arrangements.
- Carry out system baselining, delivery and reporting of CQUINs 2022/23.

- Ongoing development of SWL's Integrated oversight with Performance, Quality, Workforce and Finance through our ICB Quality & Oversight Committee.
- Development of PHM framework for quality to enable reduction in variation and tacking the inequalities agenda in alignment with our QMS programme and CORE20 PLUS 5 framework.
- Transformation and quality improvement of safeguarding and CHC with a view to improve areas of poor performance.
- Development of workforce strategy to improve professional leadership, capability and capacity on nursing, midwifery and AHPs as workforce has a significant implication on quality.

6. Recommendation

The Board is asked to:

- Note the full report and the quality issues it identifies in South West London.
- Note the risks and challenges to delivery and be assured that there are mitigations to managing system risks through the current quality governance arrangements.
- Note the development of quality within the ICB and the transition of quality from the CCG to the ICS.

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board	
Date	Friday, 01 July 2022

Document Title	South West London ICB Finance Report month 2		
Lead Director (Name and Role)	Helen Jameson CFO		
Author(s) (Name and Role)	Neil McDowell/Joanne Watson – Deputy CFO		
Agenda Item No.	9	**Attachment No.**	09 (c)

Purpose (Tick as Required)	Approve	Discuss	Note
			✓

Executive Summary

The ICB budget has been set as part of the overall system plan. The attached report shows the SWL Integrated Care Board financial position, the SWL System Position and the SWL System Plan. . The overall position for South West London as a system at month two shows a small year-to-date small deficit of £0.8m.

The report identifies that there are significant risks attached to the delivery of the financial plan across SWL.

Purpose:

This report is brought to the Board to update the ICB on the SWL financial position and plan and highlights the risks to achieving the plan.

Recommendation:

The Board is asked to note:

- The overall system financial position at month 2 is £0.8m adverse to plan and the plan to month 12 of an overall breakeven position.
- The profiling of the plan means that the majority of savings are expected to be delivered from month 4
- ICB is holding the allocations for the system for winter capacity, innovation and inequalities funds
- The significant risks to delivering the plan overall and the savings target.

Key Issues for the Board to be aware of:

- The SWL system plan for 2022/23 submitted to regulators on 20 June is a full year breakeven position.
- All organisations are planning breakeven, apart from The Royal Marsden (£3.0m surplus) and South West London ICB (£3.0m deficit).
- Delivery of this plan will require significant savings, delivery which equates to c.7% of system cost base, and much of the savings are profiled in the latter half of the year.
- The current SWL system position is small deficit against plan at month 2.

Conflicts of Interest: N/A

Mitigations for Conflicts of Interest:

Corporate Objectives This document will impact on the following Board Objectives:	Achieving Financial Balance

Risks This document links to the following Board risks:	There are significant risks to delivering a break-even financial plan.
Mitigations Actions taken to reduce any risks identified:	• Trusts continue to develop Cost Improvement Plans • A South West London Planning and Sustainability task Group is in place looking at further system wide schemes • Finance and Planning Committee will scrutinise the ICB's financial performance • Trust and ICB Chief Executive scrutiny and leadership is focussed on financial delivery

Financial/Resource Implications	Within the report

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	N/A
What are the implications of the EIA and what if any are the mitigations	N/A

Patient and Public Engagement and Communication	N/A

Previous Committees/	Committee/Group Name:	Date Discussed:	Outcome:

Groups Enter any Committees/ Groups at which this document has been previously considered:	SWL CCG Finance Committee (Partial report)	Tuesday, 21 June 2022	Finance Committee has seen the place financial position not the overall ICB position at M2. The committee has seen the overall system 2022/23 plan report. The Committee noted the reports
	Finance and Activity Committee	Click here to enter a date.	The committee has developed the financial plan
		Click here to enter a date.	

Supporting Documents	SWL ICB Finance Report Month 2

NHS
South West London

SWL System Finance Report

July 2022

Introduction

NHS
South West London

When describing the financial narrative we can define the ICB budget in 2 ways:

1. ICB internal budget
2. SWL system budget

- The ICB is made up of 6 individual place budgets which are comprised of community services, continuing healthcare and local primary care services such as local commissioned services and prescribing. The ICB core budget is largely made up from the primary care delegated function which is for the provision of primary medical services through GP practices.
- The SWL System comprises all of the SWL Providers (6 in total) as well as the ICB as set out above
- When added together the total SWL system budget is £4.7bn which is broadly split £3.3m for SWL Providers, £0.6m for out of SWL Providers, £0.6m with the SWL Places and £0.25m with delegated primary care.

The finance paper presented is a high level view for the first meeting of ICB, covering:

1. The ICB internal budget at month 2
2. The SWL system budget at month 2
3. The SWL system plan

As we move forward the Board will receive more detail.

NHS
South West London

The ICB internal budget at month 2

SWL Integrated Care Board (ICB) Position

2022/23 Month 2

South West London

- The overall SWL plan to month 12 is an overspend of £3m.
- The SWL ICB only position, at month 2 is £6.1m overspent.
- All six SWL places are reporting on plan at month 2 although savings are planned from month 4 which will bring the overall ICB plan down to £3m overspent
- Risks to not hitting the savings target are mainly around the significant challenge to bring the overspend-down for continuing healthcare and limiting growth in prescribing. Medicine Optimisation teams in each borough are focussed on prescribing. There is an Oversight Group that has a detailed action plan in place to deal with the efficiency ask for CHC. This involves, but not limited to, dealing with backlogs of assessments, reviews carried out in a timely manner, protocols in place for recharging back to Local Authorities now that the hospital discharge programme funding has ended.
- Other financial risks relate to delegated primary care which are being worked through to mitigate. At this stage we are able to mitigate them.
- Within the ICB position we have funding set aside for:
  - Health inequalities (£4.3m)
  - SWL Innovation Fund (£4.9m)
  - Winter capacity (£8.8m)
  - Excess inflation for place contracts (£8.8m)
- The mental health investment standard and running cost targets have been met within the plan.

Area	Year to Date Budget (M2)	Year to Date Expenditure (M2)	Variance to M2
	£m	£m	£m
Acute	252.5 m	252.5 m	0.0 m
Community	33.2 m	33.1 m	0.1 m
Continuing Care	27.1 m	33.0 m	-6.0 m
Mental Health	51.8 m	51.8 m	0.0 m
Primary Care	83.7 m	83.9 m	-0.2 m
Other Programme Services	12.7 m	12.6 m	0.0 m
Running Costs	4.9 m	4.9 m	0.0 m
Total	**465.9 m**	**471.9 m**	**-6.1 m**

NHS
South West London

The SWL system budget at month 2

SWL System Position

2022/23 Month 2 Year to Date

NHS South West London

- The overall SWL system position is to breakeven by the end of the year; the year to date plan at the end at month 2 is profiled to be £34.8m deficit for which we are £0.8m adverse to this position.
- The £0.8 adverse variance at Royal Marsden driven by income below plan. The system are working to resolve this.
- The savings profile of the system results in a run-rate reduction in the latter half of the year due to increased delivery of efficiencies.

MONTH 2	Surplus/(deficit) for the purposes of system achievement			Total Annual Income/ Allocation
£m	YTD Plan	YTD Actual	YTD Variance	
Croydon Hospital	-3.2	-3.2	0.0	407
Epsom and St.Helier Hospital	-8.0	-8.0	0.0	583
Kingston Hospital	-4.4	-4.3	0.0	359
St. Georges Hospital	-11.8	-11.8	-0.0	1,029
Hounslow & Richmond Community Healthcare	-0.0	-0.0	-0.0	119
South West London & St. Georges Mental Health	-1.3	-1.3	0.0	252
The Royal Marsden Hospital	-0.1	-0.9	-0.8	576
Trusts Total	**-28.8**	**-29.6**	**-0.8**	
South West London Integrated Care Board (ICB)	-6.0	-6.0	0.0	2,916
South West London System	**-34.8**	**-35.6**	**-0.8**	

Note: at M2 organisations were not required to do a forecast outturn as plans were not finalised. M3 report will include a forecast outturn.

NHS
South West London

The SWL system plan

SWL System Plan

2022/23

NHS South West London

Revenue

- The SWL system plan for 2022/23 submitted to regulators on 20 June is a full year breakeven position.
- All organisations are planning breakeven, apart from The Royal Marsden (£3.0m surplus) and South West London ICB (£3.0m deficit).
- Delivery of this plan will require significant savings, delivery which equates to c.7% of system cost base.
- In the context of very high savings plans, rising inflation costs and the continued impact of Covid, there are significant risks to the delivery of the plan, particularly in terms of in-year balance.

Capital

- SWL has balanced its 3 year capital plan to 2022/23-2024/25 capital allocations
- The plan includes key strategic schemes in addition to business as usual expenditure and top up funding for critical infrastructure.
- The plan has been approved by SWL ICS's Capital Committee.

Revenue

2022/23 plan financial performance	£m
Croydon Hospital	0.0
Epsom and St.Helier Hospital	0.0
Kingston Hospital	0.0
St. George's Hospital	0.0
Hounslow & Richmond Community Healthcare	0.0
South West London & St. Georges Mental Health	0.0
The Royal Marsden Hospital	3.0
Trust Sub Total	**3.0**
South West London Integrated Care Board (ICB)	-3.0
South West London System Total	**0.0**

Risks

NHS
South West London

The table highlights key risks.

The most significant risk is the under delivery of efficiency plans.

SWL ICS have been working to mitigate these risks as much as possible through the planning round.

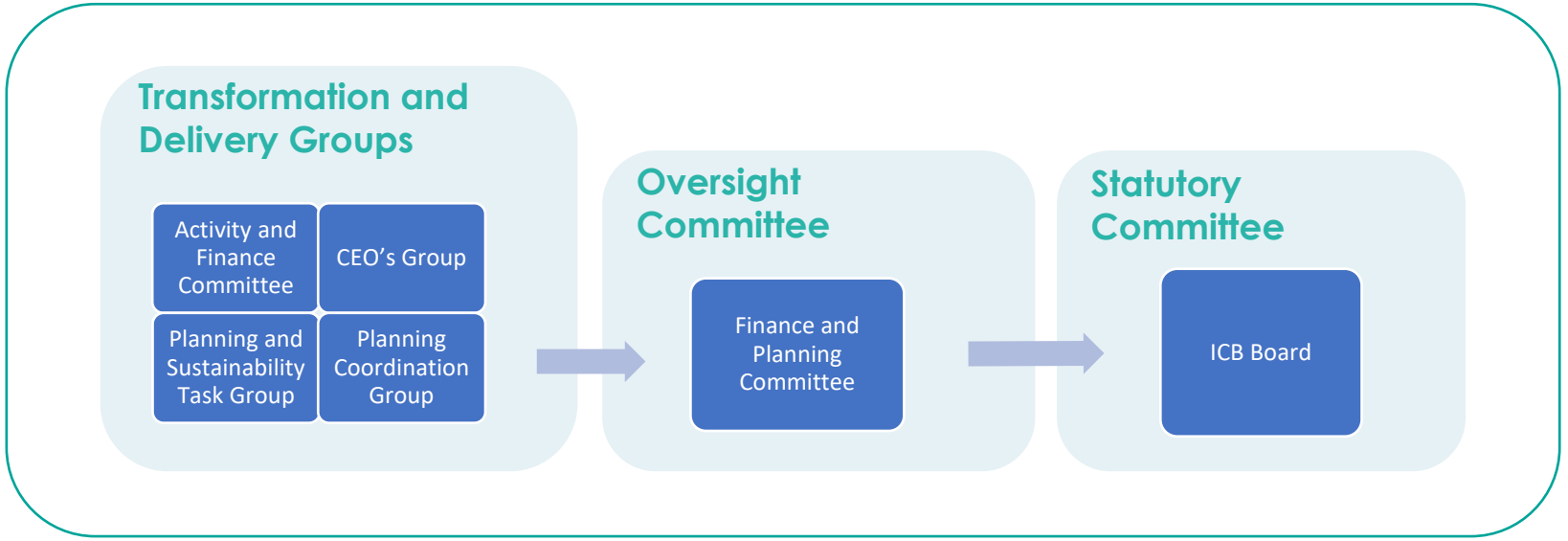
Any remaining risks will need to be closely monitored throughout the year.

£m's	Risk	Mitigation
142 (3.4% of ICS Income)	Delivery of ambitious savings target over 7% of cost base The efficiency savings include: 29% categorised as opportunities and 23% as yet unidentified These two categories total £142m	31% fully developed plans, 18% plans in progress with the Planning and Sustainability Task Group taking forward actions to deliver further opportunities. There is a collaborative approach to the savings target with a newly formed whole SWL PMO which will help organisations identify and deliver savings. Further work is required in all organisations, with StG, ESTH and Kingston facing the biggest challenges to identify and de-risk plans.
13	Continuation of high levels of covid beyond Q1 Q1 covid costs were	Scrutinising IPC guidance to ensure minimum levels of additional costs.
15	Further clarity on ERF rules and resolution of outstanding technical issues. Underperformance against current rules	Work closely with NHSE to understand future changes to ERF rules and specific technical challenges and their impact on the financial position.
15	Unfunded inflationary pressures.	Some unknown and unmitigated risk here. Organisations are working to negotiate contracts and use other suppliers where possible. Additional national allocations will mitigate some but not all risk.
11	RMH national block funding	Continue to work closely with national team at NHSE to resolve this specific issue
13	Out of system contracting.	ISC have ensured adherence to contracting guidance and will work with London and national team where other ICSs do not pass on ERF and inflationary funding.
	Activity deliverability	Any changes to service delivery must be agreed through the correct oversight and governance, allowing for full and frank discussions and clarity of outcomes before decisions are made.
	Potential impact of workforce moral on ability make productivity changes at pace	Clear, transparent and inclusive communication with staff. As part of the SWLICB development a new People Board will be established, one of the workstreams will be belonging and inclusion.
	Balancing delivery of activity targets with workforce management	The SWL People Board will work to gain improved recruitment and retention.
	Communications to staff and stakeholders and loss of support	SWL will work closely to manage a consistent and structured message to staff and stakeholder
	Balance of delivering financial plans against impact on patients and health inequalities	The SWL quality and oversight committee will ensure that the quality of services are consistent and improving. A health inequalities fund will health inequalities in SWL to ensure SWL are improving as planned
	In solidifying financial plans and making further potential financial improvement there is a risk to service delivery and some unpalatable choices may have to be made	Any changes to service delivery must be agreed through the correct oversight and governance, allowing for full and frank discussions and clarity of outcomes before decisions are made.
	Cash shortfall in providers where stretch targets have been agreed	Frequent cash monitoring as part of the SWL ICB oversight role will be needed, alongside tight cash management and cash controls at each SWL organisation
	IFRS16 cost pressures. Page 219 of 222 revenue not included within in the plan	Detailed work to accurately assess revenue and capital IFRS cost pressure

Process, Governance and Oversight

How will the Plan be Delivered and Monitored:

- **A SWL PMO/system Intelligence Hub** is currently being scoped. **This will work across the whole system including all the SWL providers.**
- The PMO/system Intelligence Hub will have oversight of **triangulation of quality, finance, activity and workforce** and will help with future planning rounds as well as delivery of our current plan.
- In addition the new **SWL ICB Finance and Planning Committee** will provide assurance to the ICB Board on delivery against the system control total and wider planning targets, and to assure that plans lead to run-rate sustainability at both the institutional and system level.
- A new task and finish group has been set up; **The Planning and Sustainability Task Group.** This group is chaired by a trust CEO and members are a cross section from all system partners and includes clinical and operational representation**.** The group will meeting weekly with the aim, in the short term, to agree the actions that need to be taken forward that will move us to a breakeven recurrent run-rate and outline the longer term action we need to take individually and collectively to get to a sustainable recurrent position.
- ALL CEO's in SWL meet weekly, the financial position is a standing item on that agenda and the group is supported by the SWL Finance and Activity Committee.
- The **SWL Finance and Activity Committee, made up of Directors of Finance from all NHS provider organisations and and the SWL ICB,** will continue to meet twice weekly, this allows for quick decision making and shared understanding of finance priorities across the system. Up to date accurate financial information can therefore be circulated at other groups for discussion such as the CEO's group.



Next Steps

NHS South West London

The system faces significant financial challenge and there remains work to complete potential mitigations.

Key areas of focus:

- Reduction in monthly recurrent run rate
- Grip and review of workforce costs
- Improvement in productivity
- De-risking of savings plans
- Identifying further savings to cover unidentified efficiencies in plan
- Development of additional mitigations and additional system actions; identification and clear understanding of areas of expenditure that can be reduced but will have a service impact
- Implementation of a monthly monitoring and oversight process focused on delivery of run rate trajectories across the system, through the new ICB finance and planning governance.
- Further work on exit run rates across 24 months to ensure work on developing savings plans for next year is in train early to support delivery in 2023/24
- Robust oversight across the ICS and into NHS London to ensure support is available and appropriate where and when required.
- Close monitoring of cash position, including work with London and national team if cash issues arise
- Ensuring that there is robust grip and control embedded in organisations; the national grip and control tool is currently being completed by all organisations alongside the HFMA financial sustainability assessment.

Action of the ICB:

NHS
South West London

The Board is asked to note:

- The overall system position at month 2 is £0.8m adverse to plan and the plan to month 12 of an overall breakeven position.
- The profiling of the plan means that the majority of savings are expected to be delivered from month 4
- ICB is holding the allocations for the system for winter capacity, innovation and inequalities funds
- The significant risks to delivering the plan overall and the savings target.