Meeting Pack

South West London Integrated Care Board

17 October 2022
10:00 – 13:00pm

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

NHS South West London Integrated Care Board

Monday 17 October 2022
10:00am – 1:00pm
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.

	Time	Agenda Item	Sponsor	Enc
1	10:00	**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	01
3	10.05	**Minutes, Action Log and Matters arising** Minutes and action arising from the ICB held on 1 July 2022	Chair	02
4	10:10	**Decisions made in other meetings**	Chair	03
5	10.15	**Chief Executive Officer's report**	CEO	04
		Items for Decision		
6	10:25	**Delegation of Specialised Commissioning** **Pre-delegation Assessment Framework** (For approval)	Lucie Waters	05
7	10.45	**Virtual Wards Business Case** (For approval)	Martin Ellis	06

8	10:55	**Board Assurance Framework** (For approval)	Ben Luscombe	07
Items for Information				
9	11:00	**ICP update**	Cllr. Ruth Dombey	08
10	11:10	**Winter Preparedness**	Matthew Kershaw & Jonathan Bates	09
11	11:25	**Comfort break**		
12	11:35	**ICB reports** a. SWL ICS Quality & Oversight 1. Quality 2. Performance b. Finance Report	 Dr Gloria Rowland Jonathan Bates Helen Jameson	 10 11
13	12.20	**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.	Chair	
14	12:40	**Any Other Business**	All	
15		**Items for information only** **Committee reports** a. Audit & Risk Committee b. Finance & Planning Committee c. Quality & Oversight Committee		12

NHS SOUTH WEST LONDON INTEGRATED CARE SYSTEM - REGISTER OF DECLARED INTERESTS - August 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
Mercy Jeyasingham	**Non Executive Member** ICB Board Member Chair of the Quality Oversight Committee Member of the Remuneration and Nominations Committee Chair of the People and Communities Engagement Assurance 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
Martin Spencer	**Non Executive Member** ICB Board Member Chair of the Audit & Risk Committee		1. NHS Counter Fraud Authority 2. Ofsted 3, Achieving for Children 4. Civil Service Commissioner 5. Education Skills and Funding Agency	1 2 3 4 5				1 Non Executive Director and Chair of the Remuneration Committee 2 Non Executive Director and Chair of the Audit Committee 3.Non Executive Director and Chair of the Audit and Risk Committee 4. Civil Service Commissioner 5. Chair	1. 09/18 2. 07/19 3. 11/20 4. 10/21 5. 10/18	1. 09/24 2. 07/23 3. 11/23 4. 10/26 5. 10/24	Recuse from all discussions
Sarah Blow	**ICB Chief Executive** ICB Board Member ICP 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 ICP 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 ICP Board Member Member of the Quality Oversight Committee Member 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** ICB Boad Member ICP Board Member Member of the Quality Oversight Committee Member of the Finance and Planning Committee	N	Nil Return								
Helen Jameson	**Chief Finance Officer** ICB Board Member ICP Board Member Attendee of the Finance and Planning Committee Attendee of the Audit and Risk Committee	N	Nil Return								
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 and a CEO member of the south London Mental Health and Community Partnership (SLP) 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 and a CEO member of the south London Mental Health and Community Partnership (SLP) 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 Member of ICP Board Richmond Place Memeber	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

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
Dr Nicola Jones	**Partner Member Primary Medical Services** ICB Board Member ICP Board Member	Y	1. Managing Partner Brocklebank Practice, St Paul's Cottage Surgery (both PMS) and The Haider Practice (GMS) 2. Joint Clinical Director, Brocklebank PCN 3. Brocklebank PCN is part of Battersea Healthcare (BHCIC) 4. Convenor, Wandsworth Borough Committee 5. Primary Care Representative, Wandsworth 6. Co-Chair Cardiology Network, SWL ICS 7. Clinical Director Primary Care, SWL ICS	1 3 4 5	2 6			1. Practices hold PMS/GMS contracts. Dr Nicola Jones holds no director post and has no specific responsibilities within BHCIC other than those of other member GPs.	1. 1996 2. 2020 3. 2018 4. 2022 5. 2022 6. 2022 7. 2022	1-7 Present	Adherence to COI policy
Ruth Dombey	**Partner Member Local Authorities** ICB Board Member Joint Chair of the ICP	N	Nil return								
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** ICB Board Member ICP Board Member	N	Nil Return								
Ian Thomas	**Participant Member Local Authorities** ICB Participant ICP Member	Y	to follow								
James Blythe	**Place Member Sutton** ICB Board Member	Y	1.Managing Director , Epsom and St.Helier University Hospitals Trust 2.Spouse is a consultant doctor at Surrey & Sussex Healthcare NHS Trust		1		2		1.02/22 2. 01/22	Present	Recuse from discussions relating to relevant speciality and provider
Mark Creelman	**Place Member Wandsworth** ICB Board Member		to follow								
Jonathan Bates	**Chief Operating Officer** Participant of the of the ICB Board Member of the of the Quality Oversight Committee Member 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 Attendee Quality Oversight Committee	N	Nil Return								
Martin Ellis	**Chief Digital Information Officer** Attendee of the of the ICB Board	N	Nil Return								

MINUTES
South West London Integrated Care Board
Friday 1st July 2022
10am to 1pm
The Chaucer Centre, Canterbury Road, Morden, SM4 6PX

Chair: Millie Banerjee, SWL ICS Chair

Members:	**Designation & Organisation**
Millie Banerjee (MB)	Chair, SWL ICB
Dick Sorabji (DS)	Non-Executive Member, SWL ICB
Mercy Jeyasingham (MJ)	Non-Executive Member, SWL ICB
Dame Cally Palmer (CP)	Partner Member, Specialised Services (Chief Executive Officer, The Royal Marsden NHS Foundation Trust)
Jacqueline Totterdell (JT)	Partner Member, Acute Services (Group Chief Executive Officer St George's, Epsom and St Helier University Hospitals and Health Group)
Vanessa Ford (VF)	Partner Member, Mental Health Services (Chief Executive Officer, South West London & St. Georges Mental Health Trust)
Dr Nicola Jones (NJ)	Partner Member, Primary Medical Services, Wandsworth GP
Dr Annette Pautz (AP)	Place Member, Kingston. Kingston GP
Dagmar Zeuner	Place Member, Merton, Director of Public Health, London Borough of Merton
Ian Dodds (ID)	Place Member, Richmond. Director of Children Services Royal Borough of Kingston upon Thames & London Borough of Richmond upon Thames
James Blythe (JB)	Place Member, Sutton. Managing Director Epsom & St Helier NHS Trust
Mark Creelman (MC)	Place Member, Wandsworth. Executive Locality Lead, Merton and Wandsworth
Sarah Blow (SB)	Chief Executive Officer, SWL ICB
Karen Broughton (KB)	Deputy CEO/Director of People & Transformation, SWL ICB
Helen Jameson (HJ)	Chief Finance Officer, SWL ICB (in post from 18.7.22)
Dr Gloria Rowland (GR)	Chief Nursing and Allied Health Professional/Director for Patient Outcomes, SWL ICB
Attendees	
Jonathan Bates (JB)	Chief Operating Officer, SWL ICB
Charlotte Gawne (CG)	Executive Director for Communications, Engagement and Strategic Stakeholder Relations, SWL ICB
Observers	
Simon Shimmer (SS)	SWL Voluntary Sector Representative.
Liz Meerabeau (LM)	SWL HealthWatch Representative
In attendance	
Ben Luscombe (BL)	Chief of Staff, SWL ICB
Yvonne Hylton (YH)	Corporate Governance Officer, SWL ICB (Minute Taker)

DRAFT

Sam Green (SG)	SWL Population Health Programme Manager, SWL ICB (Item 7)
Dr Sayanthan Ganesaratnam	Primary Care Lead, Merton GP (Item 7)
Apologies	
Ruth Bailey (RB)	Non-Executive Member, SWL ICB.
John Byrne (JB)	Executive Medical Director, SWL ICB.
Jo Farrar (JF)	Partner Member, Community Services (Chief Executive Officer Kingston Hospital Foundation NHS Foundation Trust).
Ruth Dombey (RD)	Partner Member, Local Authorities (London Borough of Sutton).
Matthew Kershaw (MK)	Place Member, Croydon. Chief Executive Officer Croydon Healthcare Services.
Ian Thomas (IT)	Participant, Local Authorities (The Royal Borough of Kingston and London Borough of Richmond).

No.	AGENDA ITEM	Action by
1	**Welcome and Apologies**	
	The Chair welcomed everyone to the inaugural Board meeting of the SWL Integrated Care Board (ICB). Apologies received are noted above, and with no further apologies the meeting was quorate.	
2	**Declarations of Interest**	
	A declaration of interest register was included in the meeting pack. There were no further declarations relating to items on the agenda.	
3	**Chairs welcomed and introduced the NHS SWL Integrated Care Board (ICB)**	
	The Chair welcomed new Board members, executives, staff and members of the public to the first ICB Board meeting and provided a verbal update, outlining the role and responsibilities of the ICB, within the context of delivering the four statutory objectives: 1. Improve outcomes in population health and healthcare 2. Tackle inequalities in outcomes, experience, and access 3. Enhance productivity and value for money and 4. Help the NHS support broader social and economic development Members were also reminded of the role of the of the unitary board in the decision making process. It was noted that the Integrated Care Partnership (ICP) which brings together a wide range of partners from health, local authorities, providers, voluntary sector, including Healthwatch and patient groups is meeting for the first time on 13 July and will start to review and develop the priorities further, driven by the needs of the local population.	
4	**Chief Executive Officer report**	
	In addition to her written report SB noted the following points:	

	• SB thanked colleagues and partners for their support and work as part of the transition in establishing the ICB and ICP. • The importance of the Messenger Review report was highlighted. It is important that the wider NHS and South West London (SWL) provide high quality leadership. • The robust system-wide response, alongside local authorities across SWL to support Ukrainians arriving in SWL was also acknowledged. The Board **noted** the report.	
5	**SWL Governance & procedures process**	
	KB provided an overview of the report and supporting documentation in establishing the ICB. It was noted that since the paper was written, further appointments to the Board have been made as follows: - Mark Creelman, Place representative for Wandsworth; - James Blythe, Place representative for Sutton; - Ruth Dombey, Local Authority Partner Member; and - Ian Thomas, Local Authority Participant. SB added that on the 30 June 2022, the ICB establishment letter and documents associated with the ICB and the associated transfer of people and properties from other organisations were received from NHS England. The Board was asked to: - Note the ICBs Constitution and Standing Orders and approve the remaining documents and policies - Note the membership of the Board and approve the additional appointments - Approve the Committee Structure and Terms of Reference - Note the due diligence and Readiness to Operate process that has been undertaken to abolish the CCG and create the ICB The ICB Board **noted** and **approved** the recommendation.	
6	**The next steps for Primary Care Integration: The Fuller stocktake**	
	MC provided an overview of the Fuller report which sets out a new vision for primary care centred around three essential offers: streamlining access to care; providing more proactive, personalised care; and prevention to keep people healthy. The report identified 15 shared actions, with progress against the key actions highlighted. The Primary Care Transformation Group will review the ICS recommendations from the stocktake review, together with the current SWL primary care transformation plan. It was noted that an ICS Primary Care	

	Transformation Delivery Plan will be brought to a future meeting of the ICB for approval. A number of comments from the Board highlighted the innovative, multi-disciplinary, collaborative approach undertaken across Primary and Secondary Care. The workforce, digital and estate challenges within Primary Care were also noted, along with building on the established community engagement links within each Place. It was also noted that a SWL Digital Investment Plan to support the IT infrastructure, will be brought to the Board for approval. During discussion, the Board acknowledged that, whilst good progress had been made in SWL, further work is required. Success will depend upon the integration between Primary and Secondary Care, building on the learning from the pandemic to make the best use of the resources in the delivery of care, and achieving the right balance to realise the benefits of working at scale. **Action: BM-01** A SWL Digital Investment Plan to support the IT infrastructure, will be brought to a future Board meeting for approval. **Action: BM-02** A Primary Care Transformation Delivery Plan / strategy for SWL, that reflects the Fuller review, will be developed and brought to a future Board meeting for approval. The Board **noted** the report.	 **JBy** **MC**
7	**Improving Care through Population Health Management**	
	The Chair welcomed Sam Green (SGr) and Dr Sayanthan Ganesaratnam (SGa) to the meeting. SGr updated the Board on the progress and plans for Population Health Management (PHM) in SWL, outlining the implementation plan risks, with key interdependencies to improve capacity and capability of PHM. In addition, SGa provided an example of a PHM pilot in East Merton which worked with people with a severe mental illness, and a dual diagnosis of drug and alcohol dependence. A number of comments from the Board commended the approach which presented opportunities to leverage. In response to a question from JT on how the programme is linking with the universities and research sites across SWL, SB said that it is acknowledged that we need to take a more strategic approach to research in SWL and Dr John Byrne, ICB Executive Medical Director, will take a leadership role for the system on this work linking with the medical schools, university and research sites across SWL. SGr added that Professor Chris Owen, Professor of Epidemiology in the Population Health Research at St George's University is a member of PHM Programme Board together with	

	representatives from South West London & St. George's Mental Health Trust and South London & Maudsley Mental Health Trust. CP asked about supra-PCNs, providing the example of Montefiore Medical Centre, and SGr said that expressions of interest for PHM pilots at scale will be sought from SWL Clinical Networks and transformation programmes. SGa commented on the different options for PCNs to work at scale and gave the example in Merton where a pan-PCN partnership was used to deliver a very successful vaccination programme, with partners from the voluntary and community sectors. The Board **approved** the PHM Roadmap and Implementation Plan for SWL.	
8	**Reducing Health Inequalities (Core 20+5)**	
	GR provided context around the aim of the Core20+5 approach to reduce health inequalities and presented the report to provide assurance to the Board on the steps taken to understand our Core20+5 population, enabled by Population Health Management (PHM) data, and the plans in place for oversight and delivery. The Board noted the importance of triangulating the data, collaboration, and that funding and resourcing will be crucial to ensure that the interventions put in place to reduce inequalities for communities are sustainable. ID asked about inclusion of Children and Young People and was assured by GR that SWL's collaborative approach included the development of a Children and Young People's Board in SWL. **Action: BM-03** Update to be provided on the development of the Children and Young People's Board in SWL. In relation to the use of data and the terminology used, MB said that it is important that we are open and sensitive about how data and terminology are used. The importance of achieving the appropriate balance between local place and at-scale approaches to ensure value for money and efficient use of resources was also noted. The Board **noted** the report and system areas of focus to tackle reduction of inequalities.	**GR**
9	**Committee Updates and Reports**	
	Performance Report (May 2022) JBa presented the report which provided the Board with a high-level summary update on performance against NHS Constitutional Standards and locally agreed metrics. In response to a number of questions from the Board, JBa commented that information will be provided at place level and agreed with the breadth of the	

	challenge impacted by the pandemic on the discharge elements of the patient pathway. **Action: BM-04** Ensure performance related information is provided at place, to support discussion at a local level. The Board **noted** the performance report <u>Quality Report</u> GR presented the report to provide a summary of quality issues within SWL and assurance to the Board that the right steps have been taken to develop a robust quality framework for oversight and delivery, and all statutory quality requirements have transferred from the CCG to the ICS. In response to a number of questions from the Board, GR commented on the importance of learning from Never Events and the impact on patients, adding that a patient safety forum and quality improvement approaches have been established. The Board **noted** the quality report <u>Finance Report (Month 2)</u> SB welcomed HJ to the Board as the new Chief Finance Officer who takes up post from 18 July 2022. SB provided a verbal update noting the complex nature of finance within an ICS, with a requirement for balance across the system. It was noted that a balanced plan for 2022/23 has been submitted to regulators, with a breakeven position. Delivery of the plan will require savings of 7% which is significantly higher than we have had to deliver before. It was noted that robust processes and oversight arrangements are in place across the system including the Finance and Planning Committee which will report to the Board. The Board noted that the ICB has protected funds for innovations to enable transformation of services to improve outcomes for patients, and an inequalities fund. JT noted that delivery of a 7% savings target is a significant challenge and it was important for the Board to understand the risk for the system both of achieving the target and the risk if the target is not achieved. The Board **noted** the Finance Update	 **JBa**
10	**Questions from Observers and Members of the Public**	
	The Chair invited questions from observers and members of the public which the Board members responded to during the meeting. In response to a question from LM, MC acknowledged the importance of engaging with patients regarding the challenge of digital access.	

GR responded to a question from LM on the potential impact of the cost of living crisis on Core20+5 and explained that work is ongoing at place level to assess the impact particularly with regard to children living in poverty.

JBa suggested that LM sends the article referred to in the question relating to dementia services and welcomed the opportunity to discuss thereafter.

MC acknowledged comments from SS regarding the importance of frontline voluntary sector organisations, and the co-location of service delivery.

Responses to written questions received prior to the meeting were taken:

MC responded to a question received regarding the development of the Health and Wellbeing Hub at the Wilson Hospital. It was noted that further discussions are taking place with the mental health trust around the services that can be delivered from the site, and with the local authority around the consideration of alternative sites. It was reiterated that the Wilson is the NHS preferred site, and a period of stakeholder engagement will follow the conclusion of the discussions.

In response to a question received regarding the provision of British Sign Language interpretation, CG responded to state that going forward, video recordings of meetings held in public will be signed.

NJ responded to a question received regarding the representation of wider Primary Care services by GPs at the ICB, and pharmacy commissioning. It was noted that the national deadline for the delegation of pharmacy and primary care services, other than General Practice, is April 2023. In addition, the national guidance regarding the establishment of ICBs has also been that, in the first instance the Primary Medical Services (PMS) Partner Member should be a GP. The concerns raised within the question were acknowledged and further advised that the role of the PMS member is to bring knowledge and experience of the sector to the Board, not to represent individual areas.

The Chair provided assurance in response to a question received regarding the diverse commercial experience of Non-Executive Members (NEMs) of the Board, acknowledging that Board members have to possess comprehensive skills, and the biographies of the ICB NEMs reflect the skills and experience required.

Questions from members of the public attending the meeting were invited.

In response to a question regarding the importance of frontline voluntary sector organisations, CG responded that a voluntary sector alliance for SWL is being created, and at place level, voluntary sector leads will be equal partners on committees to help co-produce and design services together.

SB responded to a question relating to working with local authorities, by acknowledging that Integrated Care Systems and place committees provide an opportunity to work more closely together.

	The Chair reiterated the Board's commitment to equality and diversity in response to a question on the diversity of the Board and racism within the NHS, and GR further added that an anti-racist framework is being developed.	
11	**Any Other Business and date of the next meeting**	
	There was no further business for discussion. The date of the next ICB is Wednesday 21 September 2022 at 10am to 1pm.	

ACTION LOG

Date	Minute Ref	Action	Responsible Officer	Target Completion Date	Update	Status	Committee	Type
01.07.22	1	A SWL Digital Investment Plan to support the IT infrastructure, will be brought to a future Board meeting for approval.	John Byrne	16.11.22	Closed - this will now align to the production of the SWL ICB Strategy	Closed	ICB Pt1	Action
01.07.22	2	A Primary Care Strategy for SWL will be developed and brought to a future Board meeting for approval.	Mark Creelman	15.03.23	Closed - Primary Care Strategy is on the ICB agenda for March 2023	Closed	ICB Pt1	Action
01.07.22	3	Update to be provided on the development of the Children and Young People's Board in SWL.	Gloria Rowland	17.10.22	In progress	Open	ICB Pt1	Action
01.07.22	4	Ensure performance related information is provided at place, to support discussion at a local level. JBa to confirm this is happening	Jonathan Bates	17.10.22	Closed - complete	Closed	ICB Pt1	Action

NHS South West London Integrated Care Board			
Date	Monday, 17 October 2022		

Document Title	Decisions made in other meetings		
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.	04	**Attachment No.**	03

Purpose (Tick as Required)	Approve	Discuss	Note ✓

Executive Summary

The SWL ICB Board held a Part 2 meeting on 21 September 2022. Part 2 meetings are used to allow the Board to meet in private to discuss items that may be business or commercially sensitive and matters that are confidential in nature. The following items were reviewed and discussed.

SWL Urgent & Emergency Care Winter Preparedness

The Board approved the allocations of NHS England (NHSE) Winter Funds against the proposed schemes across SWL for Urgent & Emergency Care. An update on winter plans will be provided at the ICB Board meeting.

Croydon Urgent Care Alliance (CUCA)

The Board approved a request for a tender waiver to extend the current Urgent Care service model in Croydon, for a period of 12 months which would provide support over the winter and allow preparation for next winter aligned to the national directive for Urgent & Emergency Care.

IT Contract

The Board approved the award of a contract to Egton (the supplier of EMIS Web) to ensure continuity of service across SWL GP practices.

ICT Transition Managed Service

Two contract extensions for ICT Transition support have been agreed by the ICB CEO and Chair of the Finance and Planning Committee following discussion at the ICB Board.

Delegation of Pharmacy, Optometry and Dental services Pharmacy, Optometry and Dental services are being considered for delegation to ICB's in April 2023. As part of the process, a pre-delegation assessment framework (PDAF) needs to be submitted to both the regional and national NHS teams. At the recent Board seminar, it was agreed that the Sarah Blow (Chief Executive Officer) and Mark Creelman (SRO Primary Care) would complete and submit the PDAF in line with other London ICBs, with a future paper setting out the delegation process and decision for the Board to consider. **Recommendation:** The Board is asked to note the key points and decisions made in the 21 September 2022 Part 2 meeting.
Key Issues for the Board to be aware of: As noted above.
Conflicts of Interest: Where appropriate, Board members declared conflicts of interest with both the approval of the allocations of NHSE Winter Funds across SWL for UEC and the award of the CUCA contract.
Mitigations for Conflicts of Interest: The SWL CoI register is updated with all current declarations. Members of the Board were not part of the decision-making process where direct Conflicts of Interest were present.

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	Contract awards have been through the appropriate ICB governance processes, including Finance and Planning Committee.

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.	
Supporting Documents	None		

NHS South West London Integrated Care Board	
Date	Monday, 17 October 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.	05
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. **Quality and Safety of Mental Health Learning Disability and Autism Inpatient Services**

A recent BBC Panorama programme showed appalling abuse of patients while in the care of an NHS Mental Health Trust. Claire Murdoch, NHS England's National Director for Mental Health, wrote to the CEOs of all Mental Health, Learning Disability and Autism Providers at the end of September 2022 setting out a number of actions that she expected all such providers to undertake to review the safeguarding of care and identify any immediate issues requiring action. South West London's two Mental Health Providers (South West London and St Georges Mental Health NHS Trust and South London and Maudsley NHS Foundation Trust) are both in the process of conducting these reviews. The results of these reviews will be discussed at the South West London

Quality and Oversight Committee and reported back to a future meeting of the Integrated Care Board. A copy of Claire Murdoch's letter is attached (Annex A) to this paper for information.

2. The Secretary of State for Health and Social Care's priorities for the health and care sector

In September the new Secretary of State (SoS) for Health and Social Care set out her priorities for the Health and Care sectors. These priorities set out an 'ABCD' for the Health sector:

- **Ambulances**:

  The Government aims to have shorter response times for Category 1 and Category 2 incidents, enabled by quicker handover of patients.

  - Ensuring patients are directed to the most appropriate setting for their needs;
  - Expanding the use of remote monitoring at home;
  - Increasing the number of call handlers;
  - Establishing a new ambulance auxiliary service;
  - Creating more capacity in hospitals.

- **Backlogs**:

  To address the waiting list for planned care, the Government will:

  - Expand capacity, including via the creation of surgical hubs;
  - Accelerate the hospital building programme;
  - Change elements of the NHS pension scheme to help retain doctors, nurses and other senior NHS staff;
  - Enhance the availability of mental health support;
  - Establish community diagnostic centres.

- **Care**:

  - The Government will launch:
    - A £500 million Adult Social Care Discharge Fund to support discharge from hospital into the community and bolster the social care workforce;
    - The next phase of their national recruitment campaign to encourage more people to join social care.

- **Doctors**: The Government recognises that primary care is the gateway to the NHS. It will therefore:

  - Make it easier to get through to practices;

- Increase the number of appointments for patients by over one million;
- Launch a new community pharmacy offer, reducing reliance on GPs.

- **Dentists:**

- Those dentists who can provide more NHS care will be able do so,
- Integrated Care Boards will be held to account for the provision of dentistry in their areas;
- A priority will be to enhance retention of dental care professionals providing NHS treatment.

If you would like to read the SoS's priorities in full, the report can be accessed here www.gov.uk/government/publications/our-plan-for-patients/our-plan-for-patients.

3. SWL ICS Chair arrangements

Millie Banerjee stepped down as the SWL ICB Chair in September 2022. NHS England will shortly be starting the process to appoint a new Chair. I will update the Board with further updates on this process as appropriate.

4. London Health and Care Partnership

The London Health and Care Partnership Leaders' Group met on Tuesday the 11th of October 2022. The meeting brought together London's communities, organisations and partnerships and discussed the opportunities to share and work through jointly some of the key lessons of our integration journey to-date. The meeting also discussed the next steps in improving support to people living, working and receiving care in London.

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	Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services Letter

Mental Health, Learning
Disability and Autism
provider CEOs

National Mental Health Director
Mental Health Team

Wellington House
133-155 Waterloo Road
London
SE1 8UG

By e-mail

claire.murdoch@nhs.net

30 September 2022

Dear Colleagues,

Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services

Like me, you will have been appalled at the BBC Panorama programme which showed patients being abused while in the care of an NHS Trust. It is both heart-breaking and shameful and I know that patient groups, professionals and partners will want to leave no stone unturned to ensure that we collectively do all in our power to identify, eradicate and prevent this kind of abuse from happening.

In the immediate aftermath of the programme we need to proceed on the basis that this could be happening elsewhere. We are urgently considering what more we can do nationally, with regulators, with our inpatient quality programme about to be launched and with issues such as workforce supply. However, abuse is grown and prevented locally by registered staff taking accountability for theirs and other's actions, by teams who regularly review the quality of care they provide, by local leaders who support, challenge and role model, by senior clinicians and managers, who train colleagues and have an open door and by boards who have line of sight to data, complaints, other intelligence, who walk the patch and who create a safe environment for people to speak up about poor care.

Most fundamentally organisations who place the voice of people and families at the heart of their governance, service design and delivery and who have the mindset of "this could happen here" are those most likely to identify and prevent toxic and closed cultures. I know you and your teams will all be reflecting on what you saw and asking yourselves what more you can do to ensure these behaviours and actions are not present in your own services. With this in mind, I am asking you and your teams to urgently undertake the following:

1. Your boards to review the safeguarding of care in your organisation and identify any immediate issues requiring action now; including but not limited to:
    a. freedom to speak up arrangements,
    b. advocacy provision,

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c. complaints,
d. CETRs and ICETRs,
e. other feedback on services.

We all have a responsibility to our patients and their families to ensure they receive the best possible care, treated with dignity and compassion in safe surroundings. It is vital boards ask:

- could this happen here?
- how would we know?
- how robust is the assessment of services and the culture of services?
- are we visible enough and do we hear enough from patients, their families and all staff on a ward e.g. the porter, cleaner, HCAs?

2. In the programme, patients told those around them of the unsafe and abusive care they were subjected to. In your own organisations you must ask how you are not only hearing the patient voice, but how you are acting on it? When people and families tell us things are not right as leaders, we must take action. You should therefore consider independent peer-led support to people being cared for in your most restrictive settings and peer-led feedback mechanisms.

3. We also saw the role inappropriate use of restrictive interventions played in the unsafe treatment of patients, including Long Term Segregation and Seclusion. You will want to double down on the efforts in your organisation to tackle and reduce the use of restrictive interventions. You should review why people in your services are in Seclusion and Long Term Segregation, how long for, what is the plan to support them out of these restrictive settings?

4. We want to ensure that the inpatient quality programme we are about to launch tackles the root causes of unsafe poor-quality care, looking at the best evidence for preventing and uncovering abuse. The work will capture your views about what support, education and information, will best help you prevent and fight abusive and poor care. To this end we are fast tracking the roll-out of the programme and will want to shape it with you, your clinical experts, people with lived experience and partners. Therefore, your feedback to the national team through Liz Durrant (L.Durrant1@nhs.net) our recently appointed head of programme, will be appreciated.

Clearly, there is positive work already in train across many parts of the country, but we must act now to ramp up that action to prevent the formation or perpetuation of toxic and closed cultures, and tackle unacceptable practices; the mindset that ‘it could happen here’ must be front and centre of each organisation's response to what we collectively witnessed. We must prioritise listening to the people we serve and their families and taking effective action when they tell us something isn’t right. The NHS has repeatedly made clear that it expects providers to deliver a safe and high standard of care, and where this is not happening, we will work with partners to take the strongest action possible.

Yours sincerely,

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Claire Murdoch
National Director, Mental Health

CC Regional Directors
Regional Chief Nurses
Regional Chief Medical Officers
ICB CEOs

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NHS South West London Integrated Care Board	
Date	Monday, 17 October 2022

Document Title	Pre-Delegation Assessment Framework (PDAF) for 2023 Delegations – Specialised Services		
Lead Director (Name and Role)	Jonathan Bates, Chief Operating Officer		
Author(s) (Name and Role)	Lucie Waters, Programme Director, South London ICBs		
Agenda Item No.	06	**Attachment No.**	05

Purpose (Tick as Required)	Approve	X	Discuss		Note	

Executive Summary

Since the Health and Social Care Act of 2012, around 150 specialised services (with a low number of cases and/or very high treatment costs) have been managed by NHS England and Improvement, through a central commissioning process. National policy is that the first set of 65 of these 150 specialised services should be delegated to ICBs from April 2023.

Delegation of specialised services to SWL ICB will enable the ICB to join up end-to-end pathways, reduce barriers for patients and focus on whole system reduction in health inequalities and improvement in health outcomes.

As outlined in a previous presentation, delegation of specialised services will increase the SWL ICB budget by around £485M, with the majority of spend at St George's Healthcare NHS Foundation Trust and The Royal Marsden NHS Foundation Trust.

The paper attached is the draft response on behalf of SWL ICB to the Pre-Delegation Assessment Framework (PDAF), the assessment process for ICBs taking on the delegation of specialised services for April 2023.

Purpose:

The Board is asked to review the submission of this draft PDAF response to the NHSE London regional team, with the aim of supporting submission to the NHSE London regional team.

Recommendation:

The Board is asked to approve the content of the PDAF for submission to NHSE London region.

Key Issues for the Board to be aware of:
• The two south London ICBs have been working in partnership on the approach to delegation of specialised services for nearly two years. The PDAF reflects this history of collaborative work across providers and commissioners over this time. • Where possible, and reflecting the joint work across south London, there is one response on behalf SEL and SWL ICBs. There are a couple of sections which are specific to each ICB (and, for SWL, included here). • This PDAF is a draft document, with feedback from NHSE London region expected by the end of October, and a final version to be submitted in early November. • A final decision on ICB readiness to take on delegation of specialised services will be taken at the NHSE board on the 2nd February 2023.

Conflicts of Interest:
N/A

Mitigations for Conflicts of Interest:
N/A

Corporate Objectives This document will impact on the following Board Objectives:	The delegation of specialised services will allow SWL ICS to integrate care for patients across the entire care pathway focussing resources to support prevention, early diagnosis and better, well-connected management of ill health.

Risks This document links to the following Board risks:	The draft PDAF highlights a number of risks as set out in the attached paper. Some risks reflect existing BAF risks, such as securing financial balance, as the specialised budgets inherently increases risk in this space. Other risks are new, such as the availability of staff with the specialist expertise to manage these services and contracts.
Mitigations Actions taken to reduce any risks identified:	The draft PDAF sets out actions taken by SWL ICS in partnership with colleagues from SEL ICS and NHSE to reduce and mitigate these risks. There is regional and national recognition that South London is relatively well prepared to take on these additional responsibilities given the close working over the last two years.

Financial/Resource Implications	There is a workforce section in the draft PDAF which outlines the proposal for the current NHS England and

	Improvement regional commissioning team to operate as a central 'hub' to share expertise with the five London ICBs. It is very likely that SWL will want to complement this central hub with additional capacity in key areas (notably finance and quality) as further information about the operation of the central hub becomes available.

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	No EIA has been completed. However, the shift of focus from national commissioning to local ICB is intended to increase the opportunity to identify and address health inequalities (e.g. in access to specialised services) being experienced by local populations.
What are the implications of the EIA and what, if any are the mitigations	N/A

Patient and Public Engagement and Communication	There is a section in the PDAF on patient and public engagement, outlining the work currently taking place to ensure that people with a specialised condition or requiring very complex care are engaged in the planning, delivery and experience of that care.

Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
	Board Seminar	Wednesday, 21 September 2022	
		Click here to enter a date.	
		Click here to enter a date.	

Supporting Documents	Delegation Assessment Framework (PDAF) for 2023 Delegations – Specialised Services

Classification: Official

Publication reference:

DRAFT Pre-Delegation Assessment Framework for 2023 Delegations: Specialised Services

11 August 2022

System readiness assessment for specialised commissioning

The questions below are aligned to the domains and criteria set out within the pre-delegation assessment framework for specialised services (see **Annex 1**) and should be completed and signed by each ICB, and the relevant NHS England Regional Director of Commissioning. The responses should then be verified and signed-off by the relevant NHS England Regional Director, along with an overall assessment of whether the ICB is ready for delegation. The completed assessment proforma should then be sent to the national mailbox for the programme - fcmp.england@nhs.net - by **Friday 4 November 2022.** The outcome of this assessment will determine which delegation model (as set out in the '*Roadmap for integrating specialised services with Integrated Care Systems*') ICBs will adopt from April 23.

As delegation agreements will be signed with each ICB, this regionally-led assessment will need to be completed by/for all ICBs individually. It will need to be informed by an assessment of the readiness of the multi-ICB footprint/s of which that ICB is part, through which they will likely commission some or all of the services that are appropriate for delegation. When considering the multi-ICB perspective, we recommend ICBs work with the other systems in the arrangement/s to draft a collective response.

As part of this assessment process, regional colleagues will be responsible for reviewing any evidence or further documentation supplied by ICBs, ahead of providing summarised responses below. No additional attachments should be provided as part of the final submission to the national mailbox.

The pre-delegation assessment framework for specialised services, and associated assessment process, has been designed to assure NHS England as the 'sending' organisation, that the 'receiving' organisations have the capacity and capability to carry out the delegated responsibilities safely and effectively and in line with its statutory duties. There is recognition that ICBs will want to

carry out their own, concurrent internal governance exercises and we will release a Safe Delegation Checklist to support ICBs in this process in the coming months.

Completing the assessment

- Responses should be inputted into the template below. Please ensure they reflect on the management of the in-scope services at both an individual ICB level, and where relevant, within the context of planned multi-ICB arrangements. When considering the multi-ICB perspective, we recommend ICBs work with the other systems in the arrangement/s to draft a collective response.

- Examples of supporting evidence – which aim to support systems with 'what good looks like' for each question – can be found in the response column in grey italics. These should be deleted prior to submission.

- This assessment of system readiness is to take on the full set of services that have been identified by the Service Portfolio Analysis as suitable and ready for greater ICS leadership from April 2023. There will not be an option to select a sub-set of services from this list. Responses should therefore focus on broader approaches to managing the set of in-scope services rather than a service-by-service assessment, though may draw in examples relating to specific services where appropriate.

- Regions should work with ICBs – including reviewing relevant evidence – to support the responses to the questions. Regions are then asked to provide an assessment of the ICB's readiness for delegation against each domain based on these responses.

- At the end of the assessment, considering the responses across all of the domain areas, the Regional Director will be asked to determine whether the ICB is:

Ready for delegation	The ICB is ready to move to statutory delegated commissioning arrangements (including as part of any multi-ICB arrangements) from April 2023.
Ready for delegation with further support	Where ICBs within a wider, multi-ICB footprint may not be ready on their own - but could be with the support of either NHS England or neighbouring ICBs, from April 23.
Further support required via joint commissioning arrangements with NHS England	The ICB is not yet ready to take on delegated responsibility, therefore a joint commissioning arrangement, via a statutory joint committee, will be established between the (multi-)ICBs and NHS England from April 2023.

- A series of FAQs are available on NHS Futures **[DN:** Link to be added] to support this exercise. If you require any further support, please contact your Regional Director of Specialised Commissioning and Health and Justice in the first instance. If any further clarification is required following this, please contact fcmp.england@nhs.net.

Name of ICB	(SEL ICB) (SWL ICB)

Domain 1: Health and Care Geography	
Question	**Response** *Please ensure this reflects on both the individual ICB and where relevant, any multi-ICB arrangements*
1. What is the geographical footprint(s) proposed and is it appropriate to manage the in-	A detailed review of specialised services activity and financial data relating to South London providers has been undertaken. This identified that many specialised services delivered in South London are provided for a wide population base covering the London and South East Regions – the pan regional flows allow for

scope services (as per the Service Portfolio Analysis). ***(400 words max)***	minimum populations to be met in accordance with national guidance for a range of specialised services. We are currently working to link the NCDR Data with our local work on population health, a piece of work that will be informed by a data collection into key specialised service lines with known finance, quality, performance or capacity issues. Governance structures have been established to reflect the populations covered and patient flows - with SEL and SWL ICBs working together as the South London Specialised Board, engaging Kent, Surrey Heartlands and Sussex ICBs in a south Thames collaboration and working with ICSs and the London regional team in the London Partnership Board. Along with other London and Surrey Heartlands ICBs, the south London specialised board has assessed services suitable for management on a single and multi-ICS basis. SWL ICB has established a local Specialised Board (incorporating Surrey Heartlands) for management of single ICS services/those with limited patient flows and SEL has incorporated specialised services planning for single ICS services into local governance. Links are being made into SEL and SWL APCs to ensure that opportunities for local quality and productivity improvement are maximised for single ICS services, including local networks (e.g. ACC, NICU). The south London Specialised Board is the key forum for multi-ICS service decision making, with joint accountability agreed between NHSE London and the south London board for multi-ICB specialised clinical networks, with joint sign off of 22/23 workplans achieved. Discussions are in train with South East Region for a workshop in December comprising Chief Executive representation from south London, Kent, Surrey Heartlands and Sussex to develop the relationships and governance for across the south Thames footprint, recognising the importance of patient flows across the five ICSs for cardiac, paediatrics and neuro-surgery in particular.
2. Are there plans in place to mitigate against any issues that arise because of significant patient flows in and out of the footprint(s) for the	The approach for mitigating against issues relating to services with significant flows is in early identification of these services, identification of key stakeholders, development of ICS relationships and proactive discussions with ICSs regarding how to best manage to meet population needs – supported by multi ICS governance arrangements.

| in-scope services - including working with neighbouring geographies to manage them? ***(400 words max)*** | This may involve repatriation of services that can be better delivered closer to home – as identified by clinical leaders. ICS can collaborate to ensure that services are delivered as close to home as possible in a planned way that avoids destabilising existing providers. The process to agree significant service changes would be supported by the national service change SOP.

Identification: Several pieces of analysis have been completed to identify potential issues, this includes:
• a detailed review of activity and income to flag services with significant patient flows (e.g. cardiac, paediatrics, neurosciences) and improvement opportunities (e.g. sickle cell).
• provider and network report of service, financial, clinical and quality, data, performance and operational and workforce issues across all specialised services due to be delegated, and
• four clinical pilots with developed cases for change.

The expectation is that maturing population health management strategies across ICSs will identify health inequalities opportunities and issues. These data sources will be triangulated to identify priority areas for joint working with neighbouring geographies.

Relationships: S London director lead is a member of the South East Region Delegation Reference Group. S London governance arrangements have been shared, with enthusiasm from KSS ICS representatives to participate in South Thames multi ICB governance. The South London Specialised Board will write to KSS representatives to join a December seminar session at the CEO Strategic Oversight Group meeting.

Proactive collaboration: priority areas have been identified by clinical networks and clinical pilots with joint work already being delivered; for example – South West London and Surrey Heartlands Neurology pilot, and South Thames Cardiac network collaboration. Tertiary based clinicians are proactively identifying where there are opportunities to deliver care closer to home and collaborating with DGH counterparts to develop proposals. There are 47 clinical networks hosted in S London providers, covering varying clinical specialties and geographies – these offer significant architecture and clinical expertise to support this model.

Governance: This will be supported by a multi-ICS South London Specialised Board, with representation from Kent, Surrey and Sussex for discussions relating to services with high out-of-area flows. This |

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<table>
<tr><td></td><td>Specialised Board will connect with structures within SEL ICS and SWL ICS, where work needing to be taken forward on individual ICS footprints will be managed.

Mitigations for issues relating to significant income relating to out-of-area patient flows is detailed under Domain 4: Finance. South London Providers already contract with all 42 ICSs nationally, and out-of-area patient flows for specialised services are anticipated to be treated in the same manner.</td></tr>
<tr><td colspan="2">For completion by regional colleagues: With consideration of the responses above, please indicate the ICB’s readiness for delegation - including as part of any multi-ICB arrangements - against the ‘Health and Care Geography’ domain:

☐ Ready ☐ Further work required

If further work is required, please summarise this, including any actions, plans or support needed (along with timescales) to move to ‘ready’ status by April 23.</td></tr>
<tr><td colspan="2">Domain 2: Transformation</td></tr>
<tr><td>Question</td><td>Response

Please ensure this reflects on both the individual ICB and where relevant, any multi-ICB arrangements</td></tr>
<tr><td>1. Describe how you are going to plan for integrating delegated specialised services into wider pathways. This should include any plans and proposals to address specialised services health inequalities. (400 words max)</td><td>In 2020, three clinical priorities (Cardiac, Renal, Neurology) were selected to develop pilots focussed on delivering a population health benefit that tests the opportunities and learnings associated with specialised services integration. In 2021 a fourth pilot (HIV) was identified, and since April 2022, these pilots have begun delivering several projects focussed on integration, health inequalities and early intervention. This approach has been effective at combining integration and transformation and now acts as a framework for delivery through clinical networks.

To identify the following years’ opportunities, a dedicated informatics support has been appointed to develop intelligence to support a comprehensive assessment of further opportunity for transformation and improvement. This will enable further clinical priorities to be identified and agreed by specialist providers and ICBs via the Specialised Board. So far, several pieces of analysis have been completed to identify potential</td></tr>
</table>

	opportunities. They include a detailed review of activity and income to flag services with significant patient flows and improvement potential, providers and network completed report of service, financial, clinical and quality, data, performance and operational and workforce issues across all specialised services due to be delegated, and four clinical pilots with developed cases for change. These data sources will be triangulated to identify priority areas for integration. An Atlas of Variation covering deep-dives of all priority areas is being developed and chapters covering the four pilot areas have been completed. Networks are being supported to undertake deep dives on further clinical areas using a framework developed by the programme – a plan for inherited cardiac conditions (ICC) is currently in development and recommendations will be targeted to opportunities for ICS integration and addressing inequalities. The pilots and analysis have been developed with close working with the NHSE London specialised public health team. ICBs are currently developing 2 and 5 year plans, which will consider the full end to end pathway, including the very complex end of the pathway and themes featuring in the five year plan will have an impact on specialised services overall.
2. Describe how you intend to approach service transformation, service prioritisation and service sustainability across the in-scope services. This should include ensuring these align to national policy and service standards, as well as ensuring linkages with clinical networks. ***(400 rds max)***	Transformation will be delivered through a combination of clinical network and finance, systems and analytics forums working in a matrix way. **Prioritisation:** A Transformation forum will bring together clinical leaders across settings of care to identify and address high priority/greatest impact workstreams to deliver the ICS triple aim. The group will support the data-driven approach to specialised services integration by ensuring that there is optimal integration of ICS PHM approaches, London specialised commissioning public health input and clinical network data management. They will work alongside the System Analytics and Finance Working Group to use a variety of benchmarking inputs. They will take referrals from ICS quality and performance committees for issue resolution, and they will understand key performance and quality challenges within and across SEL and SWL services, considering options for resolution and how to take forward.

	Identification of financial efficiencies: System and Analytics and Finance Working Group has been established. They will act as the engine room of South London Specialised Services; understanding historic activity/trends and identifying opportunities for system improvement. They will use a variety of inputs (clinical networks, benchmarking, GIRFT etc.) to ensure South London services are cost effective. They will do this in conjunction with the transformation forum, QIPP efficiencies will be identified via the ICS CFO system efficiencies forums, which have been extended to include specialised services. **Articulation and assessment of benefits:** A benefits realisation framework centred around the delivery of the triple aim has been created. Benefits are considered in four domains: health outcomes, healthcare utilisation, system benefits, and societal benefits. A benefits calculator that translates non-monetizable benefits into currency was also created to assess non-cash releasing benefits as part of business cases. **Reflection in planning / contracting:** Service improvement initiatives are reflected in planning and funding intention per the attached process. **Networks and Regional and National Programmes:** The Specialised Board has co-signed network work plans for multi-ICS Cardiac, Renal, Paediatrics and Neurosurgery clinical networks in 22/23. Clinical networks are a key delivery vehicle for transformation, including national programmes. To mitigate the disparate network operating models and services not covered by Networks, the S London Office of Specialised Services acts as a liaison with London Specialised Services and Medical Directorate teams to ensure South London responds to regional and national transformation programmes.
(401 How do you intend to involve people and communities (including those with lived experience) in the commissioning of the in-scope specialised services from April	ICBs have developed people and communities engagement strategies. SEL SWL Existing engagement mechanisms can be flexed to cover specialised services, including:

| 2023, including meeting legal duties around involvement? ***(400 words max)*** | • Online engagement platforms - enabling involvement of local people and communities in conversations and decision making in relation to health and care services.
• Citizens' panels
• Community outreach and engagement through trusted leaders and organisations – prioritising communities who experience the greatest health inequalities
• Involvement of people with lived experience in governance and decision making processes and wider engagement with people who have lived experience.

The team supports clinical networks and programmes to work with people with lived experience – e.g. patient reference group for the neuroscience network (SWL) and lived experience groups for people with diabetes and MSK in SEL. They are well placed to support the engagement structures and processes in place as referenced in the London Partnership Board Paper on Patient and Public Involvement.

There is senior leadership for engagement with executive directors reporting directly into CEOs. ICBs are establishing engagement assurance committees in to provide ICB assurance that best practice, statutory guidance and the duty to involve have been met. ICBs have established professional networks for engagement practitioners to share insight and good practice and work collaboratively on programmes of work, including a London ICB engagement lead network – which could coordinate work commissioned on a multi-ICB footprint.

ICBs have worked collaboratively to develop toolkits and resources, such as 'guides' and 'top tips' for working with specific communities, to support the wider workforce in their approach to planning, delivering and evaluating engagement – as published by SEL https://www.selondonics.org/get-involved/engagement-toolkit/

ICBs have a strong history of effectively engaging with disadvantaged communities and people with relevant lived experience. For example, SWL conducted extensive, best practice engagement around potentially bringing together specialist inpatient kidney care from two sites into a single new £80m unit at SGH. Report can be found here.

SEL had a programme of outreach as part of the vaccination work reaching into disadvantaged communities and commissioned targeted community outreach as part of the engagement strategy development process. They work with people with lived experience in work programmes such as the MSK and diabetes |

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	programmes where they established groups of people with lived experience with representation into the governance and decision making bodies of these programmes. Furthermore, targeted engagement is conducted by ODNs, who all have an emphasis on PPI and co-design and have a range of opportunities for community participation.
For completion by regional colleagues: With consideration of the responses above, please indicate the ICB's readiness for delegation - including as part of any multi-ICB arrangements - against the 'Transformation' domain: ☐ Ready ☐ Further work required *If further work is required, please summarise this, including any actions, plans or support needed (along with timescales) to move to 'ready' status by April 2023.*	
Domain 3: Governance and Leadership	
Question	**Response** *Please ensure this reflects on both the individual ICB and where relevant, any multi-ICB arrangements*
1. Describe the governance arrangements you will put in place for the oversight and management of delegated specialised services. This should include the arrangements for specialised services in regard to Board and Committee structures and Executive and senior management leadership. ***(400 words max)***	This response outlines governance arrangements for single ICS delegated services. For arrangements relating to multi-ICS delegated services, please see question 4. It should be noted that in South London, ICBs are electing to designate a greater number of services as 'multi-ICB' for planning and/or management via multi ICB forums, which may be on a South London, Kent, Surrey and Sussex basis or on a subset of that group (e.g. South West London and Surrey Heartlands) . **London Partnership Board** – brings together all ICS and London Regional team in a formal decision making forum and Joint Committee during the first year of delegation for 2023/24 for particular services. **South East / South West London ICS** – leads on single ICS services The ICBs are proposing to discharge their formal responsibilities around the delegated services through existing infrastructure that has been set up for the ICB. This will ensure that the spectrum of services can be

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	considered in its totality and that priorities for change can be evaluated and considered collectively. The key purpose for delegation is to break down silos between specialised and core services, which this enables. This will also ensure a proportional approach to the newly delegated services and effective prioritisation of areas for focus. The remit of all executive and senior management leadership will include specialised services, and this is supported by dedicated leads for specialised services housed within the 'South London Office of Specialised Services' – detail is provided under question 4.
2. Describe the clinical and quality governance, capability and leadership that will be in place to oversee delegated specialised services. ***(400 words max)***	The ICB Chief Nurse (quality lead) and Chief Medical Officer are members of the ICB's **Clinical Advisory Groups (CAGs)**, where identified clinical issues are escalated. There are dedicated specialised clinical leads for each specialist provider on the South London Executive Management Board. In addition, specialty level clinical leadership is provided via the clinical networks. The **ICB Quality Oversight Committee** will be widened to include specialised quality issues raised by Providers. Providers currently exception report key pathway and service quality issues into the **ICS System Quality Council/Group** (NQB System Quality Group). ICB representatives participate in **Clinical Quality Review Group/Meetings,** which NHSE have in place for providers for which they are the lead commissioner, which are established meetings at a defined frequency depending upon risk and level of activity. As part of ICB development, this model will be reviewed to align with the model across contracted ICS providers, with the anticipation that ICB representatives will be embedded in **internal quality governance structures of providers**, enabling a transparent approach, and ensuring early identification of quality issues and timely support from ICS partners. These processes review similar themes, sometimes wider than those of the CQRG/CQRM model, manage clinical and quality issues, patient and staff experience, workforce and capacity issues that impact on quality, infection control issues, safeguarding, CQC action plans and KPI achievement. ICB representatives in the internal committee structures strengthens links and relationships to the ICB and provide assurance of effective internal governance. Existing **policies for patient safety, incident reporting and safeguarding** will apply to delegated services and will follow established processes within the ICBs. Safeguarding leads already work with specialised providers and are part of safeguarding partnership structures and engagement. Providers already report

	serious incidents to the ICB and the host ICB is responsible for overseeing these, sharing with associate commissioner (patient originating ICB) for input. Medicines matters will be raised with the **IMOC (Integrated Medicines Optimisation Committee)** with links to Finance and Strategy Development, the IFR process and CAG for pathways, with further operational/clinical groups feeding from the IMOC. Prior to finalising the quality structure to support delegated specialised services we require information on; resource transferred to support capacity for taking on delegated functions, and the assurance framework adopted by NHSE to oversee ICB management. In addition, ICBs are currently reviewing and developing new safeguarding structures. In addition, further support is provided through the **South London Specialised Services governance** – see Q4.
3. Describe the mechanisms you will put in place which enable risks to be identified and monitored, and allow for the management of mitigations and potential impacts for delegated specialised services. ***(400 words max)***	Risks related to the delegation and integration of specialised services will be managed in accordance with the current ICB risk policy and management processes. Risk processes for the ICB are detailed in the *ICB Risk Management Framework 2022/23.* This framework sets out organisational risk processes, roles and responsibilities, and details the governance arrangements in place to manage risk. Risks related to the delegation of specialised services will be incorporated into the ICB risk register and Board Assurance Framework depending on the nature of the risk identified; with more operational risks included in the former and strategic level risks to the achievement of the ICB's corporate objectives, the latter. The ICB's governance arrangements ensure that the ICB Board is kept informed of significant risks facing the organisation and associated mitigation plans. These include corporate, strategic, operational, clinical, financial, information and reputational risks. The ICB in south east London operates with a Planning & Finance Committee, which is tasked specifically with the detailed monthly review of BAF and other significant risks. In addition to ICB arrangements, further support is provided through the South London Programme. The System Analytics and Finance Group will create, maintain and escalate risks to London, ICS and/or Trust boards as appropriate; identify and manage mitigations. The Specialised Executive Board will ensure that there is rigorous risk identification and mitigation processes for the delegation and integration of specialised services.

4. Describe the governance arrangements you will put in place for the establishment and oversight of any joint/multi-ICB commissioning arrangements and the powers and responsibilities delegated to joint/multi commissioning arrangements. ***(400 words max)***	**South London Strategic CEO Strategic Oversight Group** – focusses on multi-ICS services. There is a CEO lead forum, meeting quarterly, with two meetings dedicated to sign-off and assurance, and further meetings including representatives from key ICS with significant patient flows – Kent and Medway, Surrey Heartlands and Sussex. The purpose of this group is to develop a shared vision and ambition for development and delivery of specialised services to the south London and south Thames populations. This group is supported by a **South London Specialised Executive Management Board**, which meets fortnightly and is responsible for managing the process of specialised integration. They will develop ambitious transformation proposals to improve outcomes, reduce inequalities and reduce costs across the south London system. In addition, they will oversee Networks, approve budgets, manage risks and agree the communications and engagement approach. Terms of Reference for both groups is attached. This will be supported by a **South London Office of Specialised Services (SLOSS),** which will maintain a small central team of staff supporting the integration of specialised services into ICS and post-delegation and will lead on the development of multi-ICS commissioning across the relevant geographical footprint. This model will provide necessary accountability to NHSE/London through delegation and beyond. Details are provided on the attached operating model. Clinical and quality governance and capability – the **Transformation and System Analytics and Finance Groups** have responsibilities for identifying issues and are structured to support ICB capability. A key function of the Transformation forum will be to understand key performance and quality challenges within and across SEL and SWL services, considering options for resolution and how to take forward. In addition, the Transformation forum will take referrals from ICS quality and performance committees for issues they are able to aid in resolving. **SWL and Surrey Heartlands have agreed a Specialised Services Board** which will interface with South London and Surrey Heartlands Governance – see attached Terms of Reference. Decision making processes will follow existing governance processes as defined within the Standing Financial Instructions. Conflicts of interest will be managed via existing ICB conflicts of interest policies and

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	the related national policies (such as the Nolan Principles). Management of COIs in regards to multi-ICB decisions will depend on the guidance received by NHSE, but we are also working with London ICS colleagues on a Collaborative Commissioning Agreement that will apply to Specialised Commissioning and will set out responsibilities for managing COIs when working collaboratively.
For completion by regional colleagues: With consideration of the responses above, please indicate the ICB's readiness for delegation - including as part of any multi-ICB arrangements – against the 'Governance and Leadership' domain: ☐ Ready ☐ Further work required *If further work is required, please summarise this, including any actions, plans or support needed (along with timescales) to move to 'ready' status by April 2023.*	
Domain 4: Finance	
Question	**Response** *Please ensure this reflects on both the individual ICB and where relevant, any multi-ICB arrangements*
1. Describe how specialised commissioning will be embedded within the financial governance and accountability framework of the ICB/s, including multi-ICB working where applicable? ***(400 words max)***	ICBs are fully established with schemes of delegation in place that detail accountability for the budget. Delegation arrangements are not yet confirmed but are likely to be – a population-based allocation for specialised services on the ICB ledger and an indicative budget for high-cost drugs (with this spend being on the NHSE ledger). There is no proposal for risk sharing between ICBs for 23/24. The ICBs are undertaking a programme of preparatory work to ensure its readiness for specialised commissioning delegation from 1st April 2023, including: • Working across ICBs and all South London providers with governance in place including: ○ **South London Specialised Services System Analytics and Finance Group** – focusing on the understanding of specialised commissioning data, the attribution of historic data to ICB populations, and financial risk management.

	○ **South London Specialised Services Executive Management Board** and **South London Specialised Services CEO Strategic Oversight Group** – to oversee governance and pre-delegation assurance ○ **London Partnership Board** – overall co-ordination across London systems, including the consideration of multi-ICB commissioning arrangements. • Support by specialised services leads across South London, including key co-ordination and leadership by a Programme Director working on behalf of both ICBs. • Working alongside existing specialised commissioning teams to ensure understanding and facilitate agreement of 2022/23 contract agreements with providers in the ICB area. • Close working across ICBs finance, commissioning and Business Intelligence teams in the analysis and understanding of ongoing data, information, and attribution exercises with the aim of maximising learning, best practice and capacity. Specialised Commissioning will be fully embedded within the ICBs planning functions including: • Oversight by the ICB Planning & Finance Committee alongside oversight of the ICB's existing planning and budgetary responsibilities • Identification of lead executive responsibility and accountability for newly delegated specialised commissioning budgets and responsibilities. • Integration of specialised commissioning into the ICBs existing management structures and responsibilities, including the incorporation of staff from NHSE where applicable. • Incorporation of specialised commissioning into the ICB's reporting arrangements. • The development of collaborative multi-ICB working for those services appropriately commissioned on a multi-ICB basis. This will build on existing Associate commissioner arrangements. Close working with NHSE specialised commissioning teams will continue to be required as we continue the delegation journey, with more commissioning responsibilities being delegated over time, the requirement for alignment of commissioning processes and intelligence across High Specialised Services and newly

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	delegated services and the necessity to review data attribution and risk management as new arrangements are embedded.
2. How do you intend to approach the management of transactional specialised commissioning, in particular contracting and cashflow? Please give consideration as to how this will relate to existing processes and agreements. ***(400 words max)***	While not yet confirmed, the strong expectation is that there will be a single agreed national approach for the contracting of delegated specialised services for 23/24. The south London ICBs will be the 'host' for a collaborative contract with the trusts within SEL and SWL, with other ICBs in the country as associates to the contract, and NHSE regions having the potential to also be associates to the same contract on behalf of ICBs not yet ready for delegation, for delayed services and for retained services. ICBs will be given the allocation for their populations for 23/24 alongside the main allocation. Using the **Collaborative Commissioning Agreement (CCA)** the host will identify values for the contracts for 23/24 alongside all other services. The CCA will be the starting point for a common approach across all 42 ICBs to the identification of an agreed value for specialised services. Activity levels will be agreed via the **Indicative Activity Plans** within contracts along with the standard contracting schedules of **SDIPs, DQIPs and CQUINs** etc (all based on national guidance). Cashflow will be managed along the same standard contractual terms, with trusts being paid 1/12 agreed values, subject to further national guidance. It is very likely that High Cost Drugs funding will be retained by NHSEI for 23/24 and ICBs will note the indicative budget and financial flows of pass-through payments to local trusts. ICBs (and predecessor CCGs) have a long history in the successful operation and financial management of contractual arrangements and associated cashflow. The intention would be to integrate newly delegated specialised commissioning arrangements into existing arrangements.
3. How will you approach and manage commissioning-led changes to specialised service	Commissioning led changes will be managed according to the **Commissioning Change Management SOP** within the **Delegation Agreement**. This draws out the distinction between changes within an ICB (to be managed using ICB process and procedures) and those that are across ICBs, either within a single region or across regional boundaries.

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flows in your ICB/s? ***(400 words max)***	Most specialised services, while delegated to individual ICBs, will be managed in a variety of **multi-ICB partnerships** including **formal Joint Committees**. The decision making for service change between ICBs within a region will be through the formal multi-ICB partnership arrangements and these delegation arrangements will be designed to ensure the correct governance is in place. To ensure that service changes proposed are compliant with national service specifications and impact across ICBs is understood and agreed, a Business Case will be required for all service change proposals over the designated threshold(s) of £500k per service in a single year. Some specialised services, through the clinical networks of care, cross regional boundaries and will require ICBs to form multi-ICB partnerships between and across regions. The decision making for service change across regions will be through the formal multi-ICB partnership arrangements and these delegation arrangements will be designed to ensure the correct governance is in place. To ensure that service changes proposed are compliant with national service specifications and impact across ICBs and regions is understood and agreed, the same Business Case will be required for all service change proposals over the designated threshold(s) of £500k per service per year. If there is a dispute between ICBs within a multi-ICB commissioning arrangement that goes across regional boundaries, then the NHSE/I regional teams will come together to arbitrate and/or make a final decision on the scale and process of service change All statutory duties related to service change (e.g. engagement with patients and the public) will be undertaken by the ICB proposing service change, in partnership with any other ICB whose services or population are affected.
4. What historical evidence can you provide to demonstrate there has been a track record of good financial management within the footprint/s? This should include a background of partnership working	South West London organisations have a strong track record of financial delivery which has been enhanced by longstanding partnership working, which has been enhanced over the period since the Covid pandemic but also in evidence before it. In 2022/23, as a system South West London have agreed a balanced financial plan; this would mean that SWL had met its year 1 convergence target alongside containing spend and working towards reducing its underlying deficit. For 2023/24 onwards this means continuing to contain spend

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between organisations and plans to improve financial performance where appropriate, including over a multi-year timeframe ***(400 words max)***	in line with system income, meeting additional convergence targets and continuing to reduce the system's underlying deficit. Covid has demonstrated the benefits of collaborative system working including our joint work across health and care, 'Place' based partnerships driving delivery and population health management approaches that target inequalities such as elective recovery, vaccinations, and mutual aid across providers. We have shown maturity in our approach to funding and allocations with both capital and revenue requirements being assessed and prioritised at a system level. The ICB is fully committed to driving financial and service recovery and our governance supports this, including: • A new system Planning & Finance Committee to oversee the development and delivery of agreed savings plans, with peer review to ensure credibility and stretch across all parts of the system. • Our strategic plans will drive our investment strategy and we have continued to develop whole system planning and agreement of collective strategic priorities and outcomes. • A Delegation model with a principle of subsidiarity with planned full delegation, inclusive of associated funding, to our Local Care Partnerships and Collaboratives. With autonomy comes a clear delivery expectation with partners empowered to work collaboratively across organisational boundaries to secure optimal productivity and efficiency and value from our end-to-end care integrated pathways. As a system our ambition and commitment is: • To secure a financially balanced ICS that has eliminated its recurrent underlying deficit and established a sustainable forward financial position that enables us to respond to the needs of our population effectively • To live within the resources allocated to us at system level each and every year- that will result in significant improvements to our underlying position

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	All system partners recognise and are committed to working together to meet this objective.
For completion by regional colleagues: With consideration of the responses above, please indicate the ICB's readiness for delegation - including as part of any multi-ICB arrangements -against the 'Finance' domain: ☐ Ready ☐ Further work required *If further work is required, please summarise this, including any actions, plans or support needed (along with timescales) to move to 'ready' status by April 2023.*	
Domain 5: Workforce Capacity and Capability	
Question	**Response** *Please ensure this reflects on both the individual ICB and where relevant, any multi-ICB arrangements*
1. What is the staffing model you are proposing for the deployment of NHS England staff to support the delivery of functions delegated to ICBs? ***(400 words max)***	London region has a small specialised team, which is not practicable to redeploy across the five ICS. Therefore the ICB understands that there will not be a transfer of specialised commissioning to ICBs. The proposed London functions are as follows: **Quality** – London is proposing to retain a team able to be accessed by ICB quality teams for multi ICB support. They will retain oversight through attendance of System Quality Group (SQG) meetings in HiJ, Mental Health and other directly commissioned services. They will be available to support ICSs with escalation processes for risk management of quality concerns – e.g. Sickle Cell and work with ICSs where a quality concern affects multiple ICSs. **Programme of Care** – London is proposing to retain a central team of programme of care managers who will act as a knowledge resource and support the ICBs to carry out their functions. They will remain responsible for commissioning networks, will deliver the programme of work to develop services requiring further work pre-delegation, provide assurance on service specification compliance and support London's strategic overview.

	Contracting – London is proposing to establish a hub of 6-7 NHSE contracting staff to support each ICB in their commissioning of specialised services as associate schedules within an ICB led contract. The hub will support liaison with other region's specialised commissioning hubs, support the programme of care leads on services requiring development before they are ready for delegation, and work closely with ICB planning and finance teams to support the planning of multi-ICB services. **BI** – to be confirmed by London region. **Pharmacy** – London is proposing to retain a HCD team within the Medical Directorate, and that ICSs develop their teams through a lead pharmacist per ICS. The London team will act as a resource to the region, manage circulars and coordinate advice. **Medical** – London will retain a team to lead on clinical strategy, service specification assurance, arbitrate on service arguments, act as a regional link with national policy and a regional lead for HSS. **Finance** – London will retain a team to audit specialised services spend and assure/assess ICB budgets. **HiJustice** – will continue as a regional function until agreement on delegation level. **Mental Health** – will continue as a regional function until Acute Provider Collaboratives are delegated to ICBs in 2024. **HSS** – commissioning/contracting will be done by POC London team but nationally overseen/organised.
2. How confident are you that the proposed staffing model will provide sufficient capacity, skills and knowledge to enable ICBs to carry out the delegated functions? ***(400 words max)***	The redeployment of NHS England staff would dilute an already depleted team and thus will not provide sufficient capacity, skills and knowledge to enable ICBs to carry out the delegated functions. South London ICBs are therefore building internal capacity in finance, quality, contracting and performance where they anticipate delegation will move responsibility to them. This will be incorporated into the role and remit of those responsible for these functions in core/CCG services. The internal ICB capacity will be supported by a dedicated South London joint team – the South London Office of Specialised Services. The role and function of this team is described under Domain 3: Governance and Leadership, Question 4. The team structure will

	include a Director for Specialised Services, Deputy Director, Informatics Programme Manager, and a small team of project, communications and business management support. The Workforce model will need to reflect and work within whatever government guidance is released with respect to management costs. ICBs need clarity on if they will be allowed to increase their running costs in view of the additional functions and capacity required to take on delegated responsibilities, or if these running costs will be reported against NHSE and managed as recharge (per POD delegation). Further clarity is also required on if the NHSE staffing reductions apply to specialised.
For completion by regional colleagues: With consideration of the responses above, please indicate the ICB's readiness for delegation - including as part of any multi-ICB arrangements against the 'Workforce Capacity and Capability' domain: ☐ Ready ☐ Further work required *If further work is required, please summarise this, including any actions, plans or support needed (along with timescales) to move to 'ready' status by April 2023.*	
Domain 6: Data, Reporting and Analytics Infrastructure	
Question	**Response** *Please ensure this reflects on both the individual ICB and where relevant, any multi-ICB arrangements*
1. Describe your approach to integrating specialised services into (existing) population health management analytics. This should provide assurances of the intended data and analytical framework, and CSU support that	SWL will be ingesting the SUS based specialised work into our Population Health infrastructure, Health Insights. This will allow us to profile past, current, planned and future impact on specialised care. Longer term plan will be to also ingest the SLAM based patient level files into Health Insights. By doing so, we will be able to profile our specialised activity spend by deprivation, disability, ethnicity, regionality, travel times(accessibility), digital divide, covid impact and waiting times amongst other datasets from Health Insights. The pressing concern is that the upcoming reduction of funding in specialised services is most likely to affect our most ill, which demographically, tends to also be our most deprived and vulnerable. The analysis will be scalable, going down to patient level and across to look at other illnesses.

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is required for the delegation of specialised services. ***(400 words max)***	If we can understand the scale of the problem, it will allow us to understand which services need redesign to cope with the ever increasing population living with a long term illness. All available service lines will be covered where the data is available, with the order of priority being: 1. SUS admitted 2. SUS non admitted 3. SLAM based drugs, devices etc. depending on delegation status Additional reviews will look into the accessibility of specialised services. Accessing hospital care is the end stage, we also need to review if patients being diagnosed with illness are likely to equitably navigate their way through the health system to treatment. This will provide a deeper understand of whether patients are hesitant, or unable to access care, or if the system is weighted against them accessing care. The question being whether or not we are inadvertently treating the willing and easy to access.
2. How are the ICB/s planning to use data to support transformation and service redesign for delegated specialised services? ***(400 words max)***	Whole-pathway data analysis will be at the heart of transformation and service redesign for delegated specialised services across South London. Over the past 18 months, comprehensive data packs have already been put together for a variety of specialised services, detailing the demographic overview of the population to be served, current burden of disease, activity levels, outcome results, staffing levels, and costs of delivering the service. These packs provide an overview of the entire service (through primary, secondary and tertiary care) to give clinicians and managers a common understanding of the challenges each service faces, and where unwarranted variation exists. This has enabled pilot projects to be put in place to address some areas within specialised services where potential for improvement has been identified. Identifying and addressing inequalities in access, experience and outcomes for specialised services has been a key part of the service transformation work undertaken, and will continue to be so. Disaggregated data is used not only to understand the key clinical drivers of disease (including the CORE20PLUS5 priorities), but also to recognise where inequalities in accessing specific specialised services exist. For each service analysed, level of access and outcomes has been mapped by age, gender, geographical location, deprivation

	category and ethnic group. This has highlighted very specific areas where further work is required to improve access to services, and pilot projects have been launched to address these inequalities (for example working with a charity to hold community engagement events in areas where access levels are low, and providing mobile clinics to bring services to areas more easily accessible to patients). Over time further specialised services will be mapped and analysed, and each pack will be drawn together to form an Atlas of Variation for South London.
3. Describe your plan to ensure there will be appropriate access to data and reporting infrastructure across the system in relation to the delegated services. This should include the requirements as set out in the NHS Standard Contract and Information Schedule. ***(400 words max)***	SWL ICB has robust set of processes, frameworks for data management and reporting infrastructure, most of these requirements are aligned with NHS Standard contract Schedule 6A which ensures SWL ICB commissioned service providers submit their agreed services data as per the agreed timetables nationally and locally. SWL ICB has SLA in place with NECS DSCRO Data management services and ISL in the delivery of 1. Nationally specified and nationally available commissioning datasets via NHS Digital - The national data sets are made available in agreed timescales to the ICB via SQL Datawarehouse, which are maintained and provisioned by ISL. The list of these datasets are available at Commissioning datasets - NHS Digital. 2. Nationally Specified and Locally Administered Data – these are specified and agreed through national governance framework but collected locally and processed by DSCRO. 3. London specified and locally administered data – these data services are specified through London governance framework but collected and processed via DSCRO For 23/24 SWL ICB will amend the NHS Standard contract Schedule 6A to include delegated specialised services for the identified providers. SWL ICB will work with NECS and ISL in ensuring the current infrastructure is scaled up for the flow of specialised data through the current SLA. This would enable us to use existing infrastructure in the flow of specialised service data, avoid duplication, cut costs and able to extend the existing best practices such as data quality improvements, data analysis frameworks, IAP framework, performance management for delegated specialised services.

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	SWL ICB has been working with the SWL acute providers in provision of new data flows and to support commissioning intentions. ICB has setup monthly Information Data Quality Reporting (IDQR) meetings to manage data quality issues, provision of new data flows and local reporting. ICB has robust data quality checks in place via Activity Reporting and Coding Checks (ARCC) which are generated monthly and shared with SWL acute providers. We aim to bring specialised services into ARCC by April 2023. ICB has setup Activity workstream meetings across SWL to help monitor and mitigate any deviations from operating plan, these meetings are held every week and includes existing specialised service providers. DPIA is being carried out to assess the impact of the additional dataflows on the current infrastructure and reporting to support delegated specialised services.
For completion by regional colleagues: With consideration of the responses above, please indicate the ICB's readiness for delegation - including as part of any multi-ICB arrangements – against the 'Data, Reporting and Analytics Infrastructure' domain: ☐ Ready ☐ Further work required *If further work is required, please summarise this, including any actions, plans or support needed (along with timescales) to move to 'ready' status by April 2023.*	

Signatories
This document should be signed by the ICB and the relevant NHS England Regional Director of Commissioning. It should also be verified and signed by the relevant NHS England Regional Director.

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For completion by the ICB Chief Executive (and, where different, the duly authorised signatory of the delegation agreement as defined by the ICB Scheme of Reservation and Delegation):

I confirm that the information provided is accurate and complete. Where applicable, supporting evidence has been provided to the regional team. This submission indicates our willingness to proceed with delegation arrangements as per the model determined by this assessment.

NHS [Insert name] Integrated Care Board

[Insert name]

[Insert title]

Signature: [insert scanned image of handwritten signature]

Date: [Click or tap to enter a date.]

[Insert name]

[Insert title]

Signature: [insert scanned image of handwritten signature]

Date: [Click or tap to enter a date.]

For completion by the NHS England Regional Director of Commissioning:

I confirm that the information provided is accurate and complete. Where applicable, supporting evidence has been provided by the ICB and reviewed by the regional team.

[Insert name]

[Insert title]

Signature: [insert scanned image of handwritten signature]

Print Name:

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Date: [Click or tap to enter a date.]
For completion by the relevant NHS England Regional Director: Based on the information provided, I am satisfied that the ICB is ready to take on delegated commissioning responsibility for the in-scope services (in line with Annex A of the Roadmap), including as part of any multi-ICB arrangements, from April 2023. Please check box as appropriate. ☐ Ready for delegation ☐ Ready for delegation with support ☐ Further support required via joint commissioning arrangements with NHS England Please provide any further comments below. If ‘Ready for delegation with support’ or ‘Further support required via joint commissioning arrangements with NHS England’ have been selected, please summarise the rationale behind this decision, including any actions, plans or support needed (along with timescales) to move to ‘Ready for delegation’ status. [Insert name] [Insert title] Signature: [insert scanned image of handwritten signature] Date: [Click or tap to enter a date.]

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Annex 1: Pre-Delegation Assessment Framework: Specialised Services

Introduction and context

In May 2022, NHS England set out the next steps for the delegation of NHS England direct commissioning functions in April 2023, including the roadmap for integrating specialised services with Integrated Care Systems.

The pre-delegation assessment framework (PDAF) has been developed to support ICBs prepare for delegation arrangements from April 2023; and will underpin the assessment of system readiness. It is aligned to the framework developed for the delegation of primary care Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services commissioning functions, but has been tailored specifically for specialised services commissioning.

It is structured around six domains, each of which has its own underpinning criteria, designed to support systems on building wider system capacity and capability. It is therefore not intended to be used on a service-by-service basis.

The criteria set out the areas that ICBs should have considered, undertaken or have in place by April 2023 in order to be 'ready' to take on greater responsibility. These criteria should be used to support ICBs – both on an individual basis and as part of multi-ICB footprints - as they develop, plan, and prepare for the new arrangements.

ICBs are being asked to complete and submit the assessment proforma above with the support of their NHS England regional team, which will be used to inform the system readiness assessment in November. These submissions will be reviewed by a National Moderation Panel in December 2022, which will provide a recommendation to the NHS England Board in February 2023, before any final decisions around delegation are made for 23/24.

Principles of the Pre-Delegation Assessment Framework

Domain	Principle
Health and care geography	There is a meaningful geographical footprint which takes into account key patient flows, with clear plans in place to manage and mitigate against any risks.
Transformation	There is a clear understanding of how receiving each new responsibility will benefit population health outcomes, deliver improved care quality, reduce healthcare inequalities, improve preventative capacity, and increase efficient use of resources.

	There is a shared understanding across all ICS partners on the benefits of delegation.
Governance and leadership	Governance enables safe, high quality delivery.
	Clinical leadership combines the specialist expertise to lead and scrutinise individual functions, and the collaborative working necessary to identify, enable, and oversee clinical improvements.
Finance	Major financial risk factors and issues are clearly understood and mitigated, and there is a track record of delivering a balanced budget.
Workforce capacity and capability	There is an understanding of the workforce and capability and capacity requirements, with any major risks understood and processed for mitigation.
Data, analytics and reporting infrastructure	There is a clear understanding of the level of digital maturity required, with any gaps identified and prioritised for improvement.

Domains and criteria

1. Health and care geography	
Domain description	**Criteria**
The ICB/s has a health and care geography with a population footprint(s) large enough to sustainably commission the services in question with the appropriate supporting infrastructure in place. Any impact on other populations should be considered, including appropriate safeguards for users of local services from outside the relevant geography.	• A specific, sustainable health and care geography has been identified and has the appropriate supporting infrastructure in place. The partnership reflects the (multi-)ICBs and other relevant planning footprints (e.g. cancer alliances, clinical networks, provider collaboratives) within this geography - including where this spans multiple regions and/or ICBs. • The (multi-)ICB footprint(s) is appropriate for the services in scope of delegation and has been informed by the Service Portfolio Analysis and patient flows. Significant patient flows in and out of the footprint(s) have been identified, and the ICB/s has plans in place to work with neighbouring footprints to manage these.

	• Ongoing engagement with neighbouring footprints and NHS England is planned to ensure that other areas of the country do not receive a detrimental service because of the commissioning arrangements being proposed. • The impact of any commissioning changes on the sustainability of providers has been considered and there are plans to mitigate against any risks.

2. Transformation	
Domain description	**Criteria**
The ICB/s is developing clear, feasible plans to improve population health outcomes where these are compatible with the use of the delegated functions. These plans will be underpinned by realistic and sustainable financial assumptions and reflect patient priorities and engagement.	• The ICB/s is developing plans which demonstrate how it could use the functions to improve population health, deliver improved care quality, reduce health inequalities (including by tackling unwarranted variation and in line with the Core20PLUS5 approach), improve preventative capability, co-produce services with patients, and increase efficient use of resources. • The ICB/s has demonstrated an understanding of how the functions could be integrated into wider pathways, including interfaces with provider collaboratives, for patient benefit. It will also demonstrate how this transformation aligns with national policy where appropriate. • The ICB/s has an understanding of the complexity and diversity of the specialised services they will be taking on, including in relation to scale and quality. They are also aware of the appropriate routes and methods for accessing clinical advice, leadership, and support around these services, e.g. via Clinical Reference Groups. • The ICB/s has plans for how clinical networks and provider collaborations will lead service continuity planning and transformation, to ensure optimal service provision for patients. • The ICB/s have arrangements in place for involving people and communities in the commissioning of

	specialised services, including meeting legal duties around involvement. • The ICB/s is aware of the NHS England legal duties they must comply with when exercising the functions.

3. Governance and leadership	
Domain description	**Criteria**
The ICB/s will have a clear governance structure in place. This must involve the expertise necessary to scrutinise Specialised Services, and to oversee integrated planning and service development. Executive and clinical leadership should be robust and embedded in the delivery of Specialised Commissioning functions. Engagement mechanisms should enable people who use services to influence commissioning decisions.	• The ICB/s will have clear quality assurance and risk management systems and supporting policies in place with accountability clearly defined and transparent, standardised processes for management. • The ICB/s will have sufficient relevant board expertise and experience embedded in their leadership to ensure that all commissioning, quality, risk, safety, finance and performance functions can be undertaken. Standardised processes will be evident. This will include early identification and management of risk with timely mitigation put in place. • The ICB/s will have governance structures that enable oversight of patient safety including identification and management of serious incidents and never events, compliance with the duty of candour and relevant safeguarding processes in place. • The ICB/s will have demonstrable capacity to utilise data and metrics relating to quality governance, healthcare inequalities and quality assurance and improvement for the in-scope services. • The ICB/s will have cross-functional governance and accountability structures which can direct and manage integrated pathways, and which align with other stakeholders to support integration and co-commissioning. This will include cross boundary working and integration.

4. Finance

Domain description	Criteria

The ICB/s will have developed a distinct plan for identifying critical financial risk factors and issues. The (multi-)ICBs financial plans enable the wider improvement objectives.	• The ICB/s will have developed a financial risk management strategy which identifies and mitigates all critical risks associated with the function.
	• The ICB/s will have scrutinised key delegation-related decisions for their degree of financial risk throughout its governance and accountability structures and can demonstrate ongoing financial sustainability of those services.
	• The ICB/s will have earmarked and agreed an appropriate level of funding to enable the transformation and improvement benefits identified in the relevant planning processes.
	• The ICB/s can demonstrate transactional readiness with regards to standard operating procedures from a finance perspective, such as reporting, managing cash flows and raising invoices, and the level of workforce required to transact these – and demonstrate clear financial governance procedures.
	• The ICB/s will have developed a strategy in relation to severe financial management issues, which identifies and mitigates against critical issues associated with the function. This will also set out escalation processes.
	• The ICB/s will have plans for:
	  ○ managing the cross-border impact of other local systems' decisions, including identifying potential risks and financial uncertainties;
	  ○ ensuring other systems are notified and aware of the ICB's decisions where there will be cross border impacts; and
	  ○ managing the impact of any NHSE decisions around retained services as well as ensuring NHSE are notified where the ICB's own decisions may impact on retained services
	• The ICB/s is committed to reducing unwarranted variation and is set up to act upon it where necessary or appropriate.

	• The ICB/s has a track record of good financial management, including the delivery of balanced budgets.

5. Workforce capacity and capability	
Domain description	**Criteria**
The ICB/s will assess the capability development and capacity needed to deliver the function, and to ensure a smooth transition for staff (in alignment with the applicable regional workforce model).The workforce model enables and supports the four aims for ICSs. Evidence of consideration of the wider needs of staff – for example, OD and cultural integration – will be necessary.	• The ICB/s has assessed its current workforce capabilities through a People Impact Assessment (or similar) and is confident that there is adequate capacity needed to deliver the function, with joint OD planning with NHSE where relevant to enable new ways of working and capability development. • The ICB has assessed the impact of the interim and future operating model for complaints as part of their People Impact Assessment (or similar). • The ICB/s have an understanding of the current external support in place and have agreed sustainable plans for the immediate future and outlined future transformation opportunities. • The ICB/s have a robust and agreed workforce plan in place with joint OD planning with NHSE where relevant and any appropriate management of change process clearly identified where necessary. • The ICB/s have considered, and identified to what extent, capacity in existing job roles within ICB structures (including corporate roles) may need to be amended to reflect the responsibilities relating to the delegation, and integration of the planning, of specialised services.

6. Data, analytics and reporting infrastructure	
Domain description	**Criteria**

The ICB/s has a robust data sharing and reporting infrastructure across organisations to ensure data access and visibility along the clinical pathway. Data infrastructure must be cognisant of the need to maintain a single version of truth, so not duplicating systems and processes in existence elsewhere. In the case of Specialised Commissioning services, utilising analytical subject matter expertise held centrally (within NHS England) to aid interpretation and support local analysis.	• The ICB/s will have a robust approach to Information Management, utilising the NHS Contract to stipulate reporting requirement (e.g. detailed Information schedule), enforcing data requirements with contractual sanctions where appropriate and active user of Data Quality Improvement Plans to drive data quality improvement in a managed manner. • The ICB/s will contribute to the development and maintenance of a single version of truth within the system recognised by all stakeholders. • The ICB/s will adopt of population health management analytics / tools and statistical techniques to aid identification of service delivery models requiring transformation. • The ICB/s will have considered how data can be used to support service transformation and redesign. • The ICB/s has a Data Privacy Impact Assessment document in place articulating the data flows and their uses supporting the commissioning of delegated services.

NHS South West London Integrated Care Board			
Date	Monday, 17 October 2022		

Document Title	SWL virtual ward and remote monitoring hub business case		
Lead Director (Name and Role)	Tonia Michaelides, Director of Health and Care in the Community		
Author(s) (Name and Role)	Busayo Akinyemi, Programme Director - Integrated Care		
Agenda Item No.	07	Attachment No.	06

Purpose (Tick as Required)	Approve	x	Discuss		Note	

Executive Summary

Virtual wards are a safe and efficient alternative to NHS bedded care enabled by technology. Virtual support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home or place of residence. Virtual wards form part of the SWL transformation plans to address winter pressures and improving acute hospital flow by providing multidisciplinary care for patients at home.

By March 2023 we are planning to have established 220 virtual ward beds across SWL and 428 by March 2024.

The Virtual Ward model in SWL has two parts – local virtual wards and a SWL central remote monitoring hub (CRMH). The CRMH will work in partnership with and act as a key component of each local virtual ward system (of which there are 4: Croydon, Sutton, Merton & Wandsworth, Kingston & Richmond).

Each local virtual ward will agree how to work with local partners to deliver and develop the local care model. The remote monitoring hub team will also agree 8 key clinical pathways with the local virtual wards. A lead provider in each local system will be clinically, operationally, and corporately responsible for their virtual ward model. Every patient discharged into a virtual ward will have an agreed shared care plan with a named local system responsible clinician and a named CRMH responsible clinician.

A SWL Framework for Governance, Service Delivery and Quality Improvement is outlined within this proposal to ensure all partners including the CRMH deliver high quality local virtual ward models that continue to evolve, learn, and improve.

Our modelling indicates that local virtual wards enabled by a centralised CRMH could potentially save a maximum equivalent of 31 acute hospital beds in the first year with the potential to increase to a maximum 111 beds in the second year. Financial modelling has identified up to of £21.6 million worth of efficiencies over two years could be realised if the maximum predicted bed days saved are achieved.

Purpose:

This paper is presented to the Board to update members on the progress to date in the roll out of virtual wards across SWL.

Recommendation:

The Board is asked to note the contents of the paper and approve the application of the national transformation funds identified to support the development of virtual wards.

Conflicts of Interest:

N/A

Mitigations for Conflicts of Interest:
N/A

Corporate Objectives This document will impact on the following Board Objectives:	• Improving health outcomes and reducing inequalities of care access • High quality care • Supporting our staff • Sustainable finances

Risks This document links to the following Board risks:	• Risk of increased cost on device management – under discussion
Mitigations Actions taken to reduce any risks identified:	• In negotiation with third party provider on a more realistic model. • Place have been informed that any additional costs will be shared across the programme • 25% of budget released to enable recruitment and the remainder will be adjusted based on outcome of negotiations

Financial/Resource Implications	The virtual wards model is intended to reduce bed occupancy and length of stay, improving patient outcomes and flow. New clinical resources will be required to support his initiative, but these costs have been factored into the overall service delivery models as proposed via the various Local VW wards and remote monitoring hub.

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	Planned to be completed November 28th.
What are the implications of the EIA and what, if any are the mitigations	

Patient and Public Engagement and Communication	Some local virtual wards have engaged with health watch and the learning is to be incorporated into this service development. Virtual wards build responds to historical patient feedback and their desire to receive care closer to home and avoid being admitted. Patient feedback has also been built into the continual review process.

Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
	Finance and Planning Committee	Friday, 15 July 2022	Approved
	Virtual wards Programme Board	Monday, 26 September 2022	Approved
	SWL SMT	Thursday, 07 July 2022	Approved

Supporting Documents	SWL virtual ward and remote monitoring hub business case

South West London Integrated Care Board
Meeting Paper 17th October 2022

SWL virtual ward and remote monitoring hub business case

Executive Summary

Virtual wards are a safe and efficient alternative to NHS bedded care enabled by technology. Virtual support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home or place of residence. Virtual wards form part of the SWL transformation plans to address winter pressures and improving acute hospital flow by providing multidisciplinary care for patients at home.

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A SWL Framework for Governance, Service Delivery and Quality Improvement is outlined within this proposal to ensure all partners including the CRMH deliver high quality local virtual ward models that continue to evolve, learn, and improve.

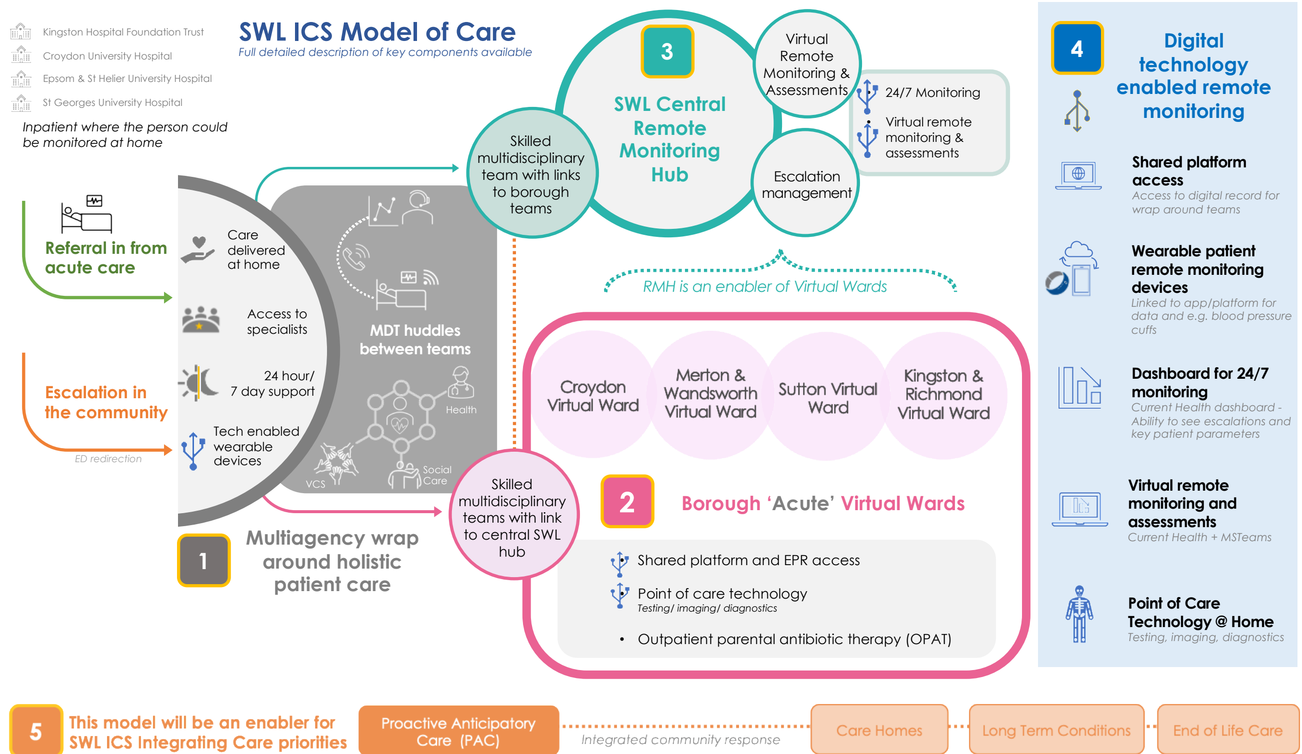
Our modelling indicates that local virtual wards enabled by a centralised RMH could potentially save a maximum equivalent of 31 acute hospital beds in the first year with the potential to increase to a maximum 111 beds in the second year. Financial modelling has identified up to of £21.6 million worth of efficiencies over two years could be realised if the maximum predicted bed days saved are achieved.

Background

In December 2021, NHS England outlined the national ambition of establishing 40-50 virtual ward beds per 100,000 population by December 2023. To support this ambition NHSE has made available national transformation money over 2 years, £200 million in 2022/23 and £250 million 2023/24. SWL's allocation for Virtual Ward development over the two years is £4.5m and £6m respectively. We have also supported the Virtual Ward roll out with capital funding of £1.3m to provide remote monitoring equipment and kit to enable antibiotics to be administered at home (OPAT).

SWL Virtual Ward Model

As a response to COVID-19 pandemic virtual SWL developed four virtual wards covering six boroughs (Croydon, Sutton, Kingston & Richmond, Merton & Wandsworth). Building on the success of the Virtual Wards and working with clinical leads across SWL we have further developed the model.



A key development in the Virtual Wards model is the establishment of the SWL CRMH supporting the four local virtual wards in Croydon, Sutton, Kingston & Richmond, and Merton & Wandsworth respectively. Key benefits of the CRMH are:

- Enabling earlier safe discharge of patients with higher acuity supported by 24/7 remote monitoring where previously they will have had to remain in an acute hospital bed.

- The ability to have a scaled model across SWL reducing the need for each local Virtual Ward developing their own CRMH. This will provide a more sustainable operating model and maximise the recruitment and retention of staff via developing new roles and ways of working.

Application of the SWL Virtual Ward Funding Allocation

The table below shows the allocation of the Virtual Ward funding across SWL ICB

		22/23	23/24	24/25		Previous 22/23	Previous 23/24
SWL Allocation		£4,508,750	£6,000,000	£0		£5,000,000	£6,000,000
Contribution to transformation team	-15%/-5%	(£676,313)	(£300,000)	£0			
VW Allocation for Distribution		**£3,832,438**	**£5,700,000**	**£5,700,000**		**£5,000,000**	**£6,000,000**
SWL CRMH - Pay		£386,034	£1,596,016	£1,596,016		£505,563	£1,323,105
SWL CRMH - Non Pay recurrent		£22,295	£50,960	£50,960		£278,120	£422,959
SWL CRMH - Non Pay non-recurrent		£2,138	£0	£0			
		£410,467	£1,646,976	£1,646,976		£783,683	£1,746,064
Infrastructure Costs		£760,628	£283,952	£283,952		£715,570	£459,650
Allocation to Boroughs		**£2,661,343**	**£3,769,072**	**£3,769,072**		**£3,500,747**	**£3,794,286**
Croydon		£644,741	£913,102	£913,102		£847,916	£919,210
Sutton		£492,756	£697,856	£697,856		£648,036	£702,524
Kingston & Richmond		£627,471	£888,643	£888,643		£825,203	£894,587
Merton & Wandsworth		£896,374	£1,269,472	£1,269,472		£1,178,845	£1,277,964
		£2,661,343	**£3,769,072**	**£3,769,072**		**£3,500,000**	**£3,794,286**

In determining the allocation to local systems, we have adopted the following principles:

- Local Baseline allocation on population (all ages)
- Secondary allocation on eligible population (for VWs) admissions rate
- Population percentage-based adjustments to account for higher admissions

We have identified the key financial risks for the programme

- The interim cost of servicing and maintenance of remote monitoring equipment whilst the logistics provider set up process is underway.
- The reduction in future funding for the boroughs and central monitoring hub may impact on the implementation trajectory i.e., impact the staffing and therefore the number of beds that can be supported.

Work is ongoing to identify action to mitigate against these risks.

Evaluation and Engagement

The evaluation and engagement approach of the SWL Virtual Ward programme is done as follows:

- *Dashboard with KPIs:* In line with the outcomes framework, KPIs across 4 levels (SWL, Place, Service & Inequalities) will be captured in a dashboard and reviewed monthly.

- *Reflecting through governance:* Key stakeholders for this programme of work will be updated monthly on progress, flagging key risks and support required to mitigate them.

- *Developing SWL infrastructure:* Scaling of virtual wards with identified cohorts outlined nationally forms the first step in utilising this remote monitoring infrastructure. Once this model is in the delivery phase and teething issues are addressed through a continuous quality improvement approach.

Next Steps

The planned 'go-live' of the CRMH service is the 28th November 2022 with the focus on supporting patient to access remote support via the respiratory and frailty pathways. but will also support other conditions such as heart failure and gastroenteritis.

Several other clinical conditions to be supported by the Virtual Wards are being identified by clinicians focussing on not just discharge but also avoiding admissions. Next year expansion opportunities include OPAT, surgery, and people with escalating signs of LTC 's.

Recommendation

The board are asked to approve the proposal and financial allocation for the virtual wards programme.

NHS South West London Integrated Care Board	
Date	Monday, 17 October 2022

Document Title	Board Assurance Framework		
Lead Director (Name and Role)	Karen Broughton, Deputy Chief Executive/Director of Transformation and People		
Author(s) (Name and Role)	Leigh Whitbread/ Ben Luscombe		
Agenda Item No.	08	Attachment No.	07

Purpose (Tick as Required)	Approve	x	Discuss		Note	

Executive Summary

The Board Assurance Framework (BAF) forms the basis for the Board to assess the risks facing the achievement of its corporate objectives. It uses principal risks to achieve those objectives as the foundation for assessment. It considers the current level of control alongside the level of assurance that can be placed against those controls.

Background:

Over the months leading to the transition to an ICB, the Risk Lead worked with teams across South West London (SWL) to discuss and review all current risks and confirm the agreed risk transfer from the CCG to the ICB. We are continuing to work with teams to capture the appropriate risks. However, the BAF is a living document and is continuously evolving. At this point in the life of the ICB our BAF is still developing as we work with our committees to ensure we are capturing and accurately reflecting our ICB risk profile.

Executive Directors, directors, and teams regularly review the risk register. The Risk Lead conducts face-to-face meetings with each team to assist with the review of scoring, narrative, and consideration for risks to be added or removed. In addition, the ICB's Senior Management Team and ICB Audit Committee review the risk register.

All risks on the CCG's risk register as of June 30 were reviewed as part of the establishment process to create the ICB. In determining the inclusion of risks for the ICB, each Board Committee agreed that the risks were scored accurately and that the controls, assurances, and mitigations were appropriate.

New Board Committees that have met since 1 July have reviewed its risks.

This paper provides detail on the Board Assurance Framework (BAF) risks. The ICB maintains a more detailed corporate risk register.

Purpose:

This paper informs the Board of the status of the current high-impact risks on the Corporate Risk Register, which are considered part of the BAF and those of significance we wish to draw attention to.

The BAF has been created from three core areas of the ICB's more detailed Corporate Risk Register:

- Risks with a significant residual score, i.e., those that score over 15;
- Those risks that we believe are either likely to be growing in significance or that we wish to flag to The Board as posing a risk to delivering essential areas of work; and
- Overarching risks that collate and summarise several more detailed risks on the risk register. For example, finance.

An NHS standard risk scoring matrix (CASU 2002) has been used to determine the impact and likelihood of adverse events scales. The scale is scored from 1-25 (with one being the least severe and 25 being the most).

Recommendation:

It is recommended that the Board discuss and approve Board Assurance Framework and offer.

Key Issues for the Board to be aware of:

In total, there are seven risks that we wish to bring to the Board's attention, six with a score of 15 plus. Those risks with a score of 15 and above are:

- RRSWL008 - Delivering Access to Planned Care;
- RRSWL060 - Failure to modernise and fully utilise our estates;
- RRSWL066 - Financial Sustainability;
- RRSWL112 - Workforce capacity well-being and availability;
- RRSWL118 - Mental health demand in SWL emergency departments (all ages)
- RRSWL128 - Urgent and Emergency Care

One risk is scored below 15 but is significant and should be identified on the BAF and brought to the Board's attention:

- RRSWL055 - Provider Quality Oversight (General);

Since the beginning of July, the following changes have been made:

Risks added:

Risk 118 - Mental health demand in SWL Emergency Departments (all ages);

Risk 128 - Urgent and Emergency Care

Closed and Removed:

RRSWL004 - Integrated Urgent Care (IUC) Contract - This risk is closed as the contract for the work has been awarded and is now BAU.

RRSWL106 - Increased nosocomial infection in SWL Providers, arising from inadequate estates - a revised risk covering IPC and healthcare-associated infections will be created and approved at the System Quality Panel in October 2022.

RRSWL115 - Collective Corporate Risk if SWL fails to Deliver ICS Activity Objectives - This risk has been closed as all transition activities were undertaken, and the transition to an ICS was successful.

Score Increased, added to the BAF:

RRSWL066 - Financial Sustainability; (Increase from 12 to 15)

The financial sustainability risk has been reviewed considering the organisation's new financial responsibilities as an ICB, the changes to the NHS financial frameworks (with the creation of new population-based allocations (including specialised services)), and the ongoing impact of the COVID-19 pandemic and the war in Ukraine. As a result of these, it is felt that the impact of the risk should be raised.

Note:

The BAF scoring under the Residual Risk Score will reflect the change in score from the previous reporting cycle in brackets.

The arrows to the right of the Risk Number reflect the trend of the score from the previous month.

Conflicts of Interest:

No specific issues or information giving rise to conflicts of interest are highlighted in this paper.

Some members responsible for raising risks from localities within SWL ICB have joint roles with provider organisations.

Mitigations for Conflicts of Interest:
Joint roles of locality Directors with provider organisations should be declared.

Corporate Objectives This document will impact the following Board Objectives:	Identifying risks is essential to delivering all the ICB's objectives.

Risks This document links to the following Board risks:	A summary of ICB risks is listed on the risk register.
Mitigations Actions were taken to reduce any risks identified:	This paper describes the work to develop the ICB risks for consideration by future Committees.

Financial/Resource Implications	None

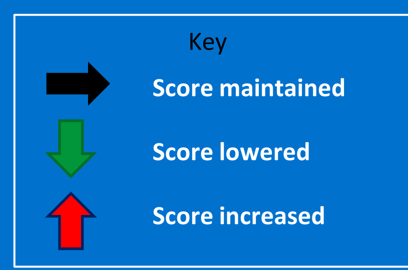
Is an Equality Impact Assessment (EIA) necessary, and has it been completed?	N/A
What are the implications of the EIA, and what, if any, are the mitigations?	N/A

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:
	Audit Committee	Tuesday, 04 October 2022	
	Quality Oversite Committee (QOC)	Wednesday, 10 August 2022	
	Senior Management Team (SMT)	Thursday, 22 September 2022	
Supporting Documents	South West London Board Assurance Framework – Board - October 2022		

Board Assurance Framework South West London ICB October 2022

Ben Luscombe



RRSWL128 NEW Risk Title: Urgent and Emergency Care Jonathan Bates

Inherent Impact	Inherent Likelihood	Inherent Risk Score	Residual Impact	Residual Likelihood	Residual Risk Score	Target Impact	Target Likelihood	Target Risk Score
5	5	25	4	5	20	3	3	9

Cause & Effect

Risk Description:
The ICS is unable to deliver a consistently effective and high-quality urgent and emergency care service (UEC) (spanning 111 services through to the Emergency Departments and admission to hospital), which meets national targets and minimises delays to patient care while balancing risks for people waiting to receive care against the risk of poorer care for those already in receipt of care. Staffing in all parts of the system is fatigued and less resilient to seasonal demand fluctuations.

Cause:

- The inability to discharge patients promptly from the hospital when their need for acute care has been met. The beds remain occupied by people ready to go home or onward care, meaning people waiting for a bed in ED cannot be admitted. Lack of space in the Emergency Department then leads to delays in the handover of patients from ambulance services and consequently impacts the ability of ambulance services to attend to those waiting for their services in the community.

- Difficulty recruiting and retaining a sufficient workforce, ranging from band four call handlers in the 111 services to nursing staff and middle-grade doctors, results in staff working under significant and constant pressure with little headroom for improvement or innovation. In particular intense competition for lower-banded staff from other sectors offering potentially less stressful jobs impacts the ability to recruit to these non-clinical but vital roles.

Effects:

- Patients are waiting too long to receive UEC services, and there is good evidence to show that long waits adversely impact patient outcomes.

- Staff morale is adversely impacted by delivering a poorer standard of care over a long period, resulting in high staff turnover and sickness rates.

- The system's ability to work in partnership and innovate to meet emerging patient needs is compromised, reducing the potential for efficiency and productivity gains.

Risk Control

- South West London has established a system-wide Urgent and Emergency Care Board and an A&E Delivery Board for each Hospital System with senior representation across hospitals, SWL boroughs and other work programmes (such as workforce and primary care) to ensure ongoing focus on performance improvement in this area.

- A winter plan has been co-developed across the system to alleviate the impact of the additional seasonal demand and includes additional investment into a wide range of hospital, community, local authority and voluntary sector organisations that will step up resources between November and February.

- A longer-term plan is being created to set out a series of ambitions for urgent and emergency care in South West London. This work will inform the UEC Programme and train longer-term actions to help address workforce and capacity issues.

- A "Harm Review" has been set in train by the Quality team across South West London to establish the broader impact of delays on patient care and to identify learning and opportunities for improvement across the system.

- Winter funding has been allocated to support winter plans this year.

Action Required

- Winter Plan actions are to be monitored for effectiveness and reported to the UEC Board.

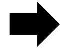
- The longer-term "UEC blueprint" and implementation plan to be finalised and the UEC Programme reorientated to deliver against the ambitions. This will include supporting programmes in developing and delivering aligned plans, including a further emphasis on improving discharge and flow through the hospital, workforce development, improving the urgent care response through 111 and primary care, reducing ambulance handover delays and a better understanding of the patient experience.

- New performance metrics to be collected and better forecasting implemented, providing greater insight into the nature of the problem to be solved

Person responsible: Caroline Morris
To be implemented by: 31 March 2023

- Complete the "Harm Review" process and feedback learning to the system

Person responsible: Justin Roper
To be implemented by: 31 January 2023

RRSWL008  Risk Title: Delivering access to care (NHS Constitution Standards) Jonathan Bates

Inherent Impact	Inherent Likelihood	Inherent Risk Score	Residual Impact	Residual Likelihood	Residual Risk Score	Target Impact	Target Likelihood	Target Risk Score
4	5	20	4	4	16	2	2	4

Cause & Effect

Risk Description:
Backlog and waiting times on service delivery for patients create a delay in patient treatment and an increase in waiting times. Providers will not meet national and local quality and performance standards. The ICS population does not have constitutional pledges honoured by providers, e.g. emergency Department waits, Cancer waits for standards, referral to treatment (RTT) waiting times and list size, healthcare-associated infections, improving access to Psychological therapy (IAPT) access and recovery rate.

Cause:
- Reduced capacity due to workforce issues (incl diagnostic).
- Cessation of non-urgent elective activity during the peak of the COVID-19 pandemic and a slow restart of elective activity while adhering to Guidance (limiting numbers of patients in areas for patient safety).
- Compromised recording systems in the implementation phase.
- Complexities and challenges of system implementation.
- Inaccurate and untimely reporting output.
- Reduced capacity for elective work due to management of Infection Prevention Control (IPC) limitations;
- Reduced patient appetite to attend hospital for elective treatment through concerns related to COVID-19 infection.
- Prolonged waits in primary care, prioritising newer patients over stable long-waiters.
- The underperformance of providers against quality and performance standards.

Effects:
- The impact of backlog and waiting times on patient service delivery.
- Patients wait longer than required for treatment, resulting in poor performance and potential harm to patients.
- Unable to provide accurate patient information to GPs.
- Decreased volume of patients seen.
- Poor performance and quality monitoring.
- Patient's reluctance to engage with services following COVID-19 may create a longer-term issue.
- Prioritising urgent newer patients over long waiters - deterioration and potential harm to the long waiters.
- ICB is not meeting constitutional, reputational, and performance standards that adversely impact patient care.

Risk Control

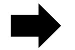
- Individual providers have validated their patients tracking lists and included clinical prioritisation for all patients on the surgical waiting list based on the recommendation of the Royal College of Surgeons. This ongoing work enables efficient prioritisation of patients for capacity in case of further surges.
- Clinical prioritisation is also taking place, following the recommendation by NHS England in July 2021 of patients on the diagnostic waiting list. Further work focussing on *Priority coding is ongoing, and weekly reviews at the Trust level of Priority 2s.
- Service changes have been implemented to enable adherence to IPC guidance. Providers have communicated these changes to the public and patients. These changes will remain part of business as usual until it is felt clinically appropriate to step these down.
- Tracking of actual weekly activity allowing monitoring against Business as Usual (BAU) activity levels (as per NHSE instructions) and implementing the locally agreed Elective Recovery Fund performance framework (including touchpoint meetings).
- Weekly monitoring of key Planned Care indicators (for example, long waiters, % activity levels) are being formally monitored and discussed with Provider and Recovery workstream leads and feed into the new ICB elective recovery governance process. This was previously being monitored on an 'unofficial' basis.
- Regular Performance, Quality meetings to monitor and manage performance against the Constitutional standards. Regular reports are produced for performance and quality, reviewed at this meeting and the ICB Board, and shared within the ICS.
- Quality and Service delivery are reviewed bi-monthly at South West London ICB Quality and Oversight Committee meetings.
- Long, medium and short-term operational and clinical opportunities are being explored and implemented as part of recovery to ensure improved and sustained achievement of constitutional standards.

Action Required

- Weekly meetings with acute provider collaboration and ICB Performance team to discuss risks/issues with providers to have early sight of any risks to trajectory/plan.
- Weekly conversations between provider recovery leads and the performance team to ensure managing long waiting patients.
- Data Quality improvement actions are being stepped up by establishing a weekly South West London-wide group meeting. The priority will be reducing data quality errors around long-waiters and the completeness of priority coding.
- South West London system-wide 2022/23 planning meetings and supporting analysis and trajectory setting are underway to deliver the national targets around elective recovery, including a 104% increase in elective work, 25% reduction of follow-ups (and delivery of targets around Advice and Guidance and Patient Initiated Follow-Up to support these plans).
- Regular review at Joint Recovery Delivery Group.

Person responsible: Suzanne Bates
To be implemented by: 31 October 2022

*Priority coding (a patient is assigned a priority between 1 and 4 depending on the nature of their condition).

RRSWL060  Risk Title: Failure to modernise and fully utilise our estates

Helen Jameson

Inherent Impact	Inherent Likelihood	Inherent Risk Score	Residual Impact	Residual Likelihood	Residual Risk Score	Target Impact	Target Likelihood	Target Risk Score
4	4	16	4	4	16	2	2	4

Cause & Effect

Risk Description:
If we fail to modernise and utilise our estate fully, the capacity of services may not be fully optimised, and the ICB could be liable for paying for void costs in return for no services being provided. There is also a risk that certain national accounting policies will be enforced, either leaving the ICS and Department for Health and Social Care (DHSC) with a significant capital budget hit or leaving the ICB with void costs on a longer-term basis. There is a risk that these policies will be slow to influence and change.

Cause:
- Historically, organisations have planned at a local level which could lead to ineffective use of space across the whole system.
- Current national Public Finance Initiative (PFI) and accounting policies limit expenditure and changes to the nature of use in PFI buildings - this may limit additional works to convert vacant space to make it fit for incoming services (e.g. Queen Mary's Hospital QMH)). If the National policy is triggered, the PFI building comes onto the balance sheet for the Whole Government Accounts and hits the DHSC capital budget, which may be passed down to SWL.

Effects:
- An increase in the cost of voids passed onto the ICB and the wider system, contributing to the challenging financial environment.
- Lack of flexibility in PFI space may limit the ability to enable service change.
- Significant impact on SWL ICS capital planning if national PFI policy is enforced.
- Old estate that is impacted by changes to infection control and ventilation guidance may lead to reduced patient activity or increased risk of infections

Risk Control

- The ICB is working closely with One Public Estate to explore opportunities across the wider public sector that could better utilise the existing footprint and that could better configure the colocation of services to serve the local population's needs
- An effective data collation exercise is underway to better understand our primary care estate and potential requirements. Place and Primary Care Networks (PCNs) could align to opportunities to better use our current estate and any vacant spaces.
- Regular conversations with NHS Property Services to review void space and associated opportunities
- We have agreed to work in partnership with St Georges to ensure that we manage the PFI contractual obligations as closely as possible with NHS Property Services and the PFI Provider. NHS Property Services is leading the discussions with DHSC and Her Majesty's Treasury (HMT) regarding the national policies that limit the conversion of space in PFI buildings
- Discussions are ongoing through the QMH Strategy Group and with membership from the ICB and providers regarding the potential use of existing and future void space, which may also serve as a supporting rationale for a change to PFI policy in national discussions.
- All capital prioritisation processes include critical infrastructure investment criteria to minimise the old estate's impact on patient care.
- Opportunities to address old are being sought via the New Hospital Programme and the targeted investment funds

Action Required

- Ensure that using QMH is built into any future recovery programme for SWL.

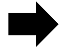
Person Responsible: Piya Patel
To be implemented by: Ongoing

- Link in with NHS Property Services to understand and influence progress with national colleagues

Person Responsible: Piya Patel
To be implemented by: 31 December 2022

- Working with NHSE to develop the ICS estates strategy that will support national guidance development and address local need.

Person Responsible: Piya Patel
To be implemented by: 31 March 2023

RRSWL112  Risk Title: Workforce capacity wellbeing and availability — Karen Broughton

Inherent Impact	Inherent Likelihood	Inherent Risk Score	Residual Impact	Residual Likelihood	Residual Risk Score	Target Impact	Target Likelihood	Target Risk Score
4	5	20	4	4	16	3	3	9

Cause & Effect

Risk Description:
South West London providers may not have the right number of staff to meet demand.

Cause:

- Staff sickness.
- Availability of trained staff.
- Supply routes of the workforce and the need to bring staffing numbers back in line with 19/20 figures.
- Current concerns in relation to the cost of living increases impacting: staff on lower bands; staff may opt to work in other sectors that pay more; and staff mental health and well-being.

Effects:
Patients won't receive timely care due to the availability of the workforce.

Risk Control

- Recruitment and retention/workforce committees in place in providers.
- Regular workforce reports are given to provider boards.
- Providers are adopting fast-track recruitment processes.
- Mutual aid culture and processes in place across South West London partners and digital passport to support the movement of staff.
- South West London infrastructure was developed and introduced earlier in the year to support the surge in activity; this can be reintroduced to enable the movement of NHS and primary care colleagues.
- Recruitment campaigns and activity is exhaustive – local, national and international campaigns in place.
- Trust's Human Resource Directors are working to determine priorities to support supply and retention, reviewing their approach to pay enhancements, bank and agency staff and reward systems.
- Health and wellbeing hubs in place across South West London.
- Trusts and management focus on health and well-being support and facilities (this includes financial well-being).
- Occupational Health and specialist support in place across all South West London provider organisations to support staff.
- South West London vaccination centres have sufficient capacity to vaccinate any currently unvaccinated staff.

Action Required

- Individual conversations among providers with senior leaders to understand their plans and further joint work to support supply across the system. A joint meeting with HR Department and Trade Unions is planned to explore this further.
- South West London workforce report will be shared at the SWL People Committee at each meeting.
- South West London ICB is working with the acute provider collaborative and HEE colleagues on two emerging workforce priorities, emergency department and diagnostic staffing, to identify creative supply routes and future workforce design to determine the future workforce requirement and plan for those two essential areas. Recent Ernst & Young workforce planning work will help shape our work programmes around planning and developing new roles/ways of working.
- Continued focus on staffing through the South West London People Committee and developing five ICB workstreams.
- Continued to focus on apprenticeship across the system; regular apprenticeship network meetings are held across South West London to increase uptake by sharing resources and levy usage.
- Continued to focus on nursing supply across South West London, including Return to Practice, Internationally Educated Nurses and Trainee Nurse Associates. An outline plan for the system has been devised and is being the ICS Chief Nurse.
- Regular meetings are held with staff counsellors and health and well-being leads across the system to share resources and material and identify issues impacting staff health and well-being and funding sources.
- Extraordinary Regional HR Director meetings have been organised to discuss how employers can support staff with the cost of living increases; suggested ideas/good practices will be reviewed and discussed within South West London and, where appropriate, suggested from implementation after the presentation SMT/People Board.

Person Responsible: Karen Broughton, Lorissa Page
To be Implemented by: 31 March 2023

RRSWL118 NEW Risk Title: Mental health demand in SWL Emergency Departments (all ages) Karen Broughton

Inherent Impact	Inherent Likelihood	Inherent Risk Score	Residual Impact	Residual Likelihood	Residual Risk Score	Target Impact	Target Likelihood	Target Risk Score
4	5	20	4	4	16	3	3	9

Cause & Effect

Risk Description:
Increase in people experiencing mental health problems across all age groups. National projections by the Institute for Public Policy Research predict that 2m more people will access mental health (MH) services in England by 2024. South West London estimated a 20 to 25% increase in demand due to the impact of the pandemic. Given the predicted rise in demand for mental health services, this could lead to an increase in people accessing all age mental health crises through South West London's emergency departments. This increase in demand could lead to poor patient experience and outcomes, increased morbidity and extra pressure on emergency department mental health crisis services.

Cause:
- Increased service demand across a range of areas, including crisis pathways.
- Limited availability of suitable crisis services.
- Out-of-area placements unable to meet patient needs resulting in additional crisis presentations.
- Issues with patient flow and capacity in emergency departments.

Effects:
- Poor patient experience and outcomes.
- Poor staff experience.
- Delays in the emergency department and emergency care pathway.

Risk Control

- Capacity in MH was maintained throughout the pandemic, and new and additional crisis services have been set up, including the Coral Crisis Hub and crisis lines. The rollout of NHS 111 Press 2 for mental health is planned for 22/23. It will enable people ringing 111 with a mental health concern to be connected directly with a mental health clinician to access support access to services other than Eds.

- A range of offers are in place to support children and young people (CYP) and their mental health and emotional well-being and help reduce the reliance on EDs. These include Mental Health Support Teams (MHST) and Kooth, a digital support offer.

- 2022/23 mental health planning confirms South West London's commitment to delivering Long Term Plan (LTP) trajectories in priority areas, and Mental Health Investment Standard (MHIS) for 2022/23 is focused on CYP mental health and reducing pressure on mental health crisis services.

- National Mental Health funding has been received to target actions to support Mental Health demand over winter.

Action Required

- Mental health strategy work is underway, including population health needs analysis and developing a delivery plan to account for current needs. The first stage of the work is now complete (needs analysis). Additional services put in place in response to the pandemic continue, such as the crisis line model. A review of service demand pressures has been undertaken as part of the 2022/23 annual planning process.

- Ongoing work with schools, particularly through the MHST work, to identify actions to support CYP and ensure timely access to onward referrals where required.

Person Responsible: John Atherton
To be implemented by: 31 December 2022

RRSWL066 Risk Title: Financial Sustainability — Helen Jameson

Inherent Impact	Inherent Likelihood	Inherent Risk Score
5	4	20

Residual Impact	Residual Likelihood	Residual Risk Score
5	3	15 (12)

Target Impact	Target Likelihood	Target Risk Score
4	2	8

Cause & Effect

Risk Description:
As the NHS financial framework changes with the creation of new population-based allocations (including specialised services), there is a risk that the ICB will be unable to deliver its strategy and the objectives of the Long Term Plan from within the financial envelope.

Cause:
- A new financial framework has been introduced in the NHS for 2022/23 and is continuing to be developed during the year, impacting the funding that flows to ICBs. This framework has been developed because COVID-19 countermeasures would no longer be required; there may be excessive inflation due to the current crisis in Ukraine, which has led to increased inflation in energy and fuel prices.

- As the healthcare system works to reduce the patient backlogs, this may have unintended consequences of increasing costs over and above those funded, partly due to the delivery of the services in line with the additional infection control guidelines due to the ongoing impact of COVID-19.

Effects:
- As funding allocations reduce back to pre-pandemic levels, costs are increasing through pay awards and inflationary pressures. This makes financial sustainability a much greater challenge. Consequently, the ICB and the system may have reduced flexibility to invest in priority areas during the year and beyond.

- The increased pressure may lead to the ICB breaching its control total, which could mean historic deficits are reinstated that will need to be addressed

Risk Control

- The ICB undertook a planning and budget-setting process to ensure resources were prioritised appropriately, including developing a savings programme to support the delivery of financial balance whilst minimising running costs. South West London ICB Finance Committee oversees the reported financial position and any mitigations required.

- The ICB reports the finances monthly through budget holders, the Senior Management Team meetings (including Place leads), and The Finance & Planning Committee to the Board. The ICB Board reviews the financial position at each meeting. Furthermore, monthly NHSE assurance meetings are held, and the Chief Financial Officer attends regional ICB meetings to assure assumptions and that the ICB approach aligns with the regional and national approaches.

- A Sustainability Board (chaired by a CEO) oversees the development and delivery of savings for the system, including the central ICB savings programme, and system forecasts will be developed to understand the exit run rate position for the ICB so medium long-term planning can be undertaken to ensure financial sustainability in the long term.

Action Required

- Ensure robust reporting and scrutiny are provided at the budget holder level, SMT and South West London ICB Finance Committee and oversight of the delivery of saving plans.

- Review updates to the financial frameworks 2022/23, understanding implications of ICB performance, including elective recovery funding and workforce controls.

- Complete the Healthcare Financial Management Association financial controls self-assessment to identify areas of improvement/ best practices to be implemented.

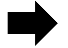
Person Responsible: Neil McDowell
To be implemented by: 31 October 2022

- The South West London ICB pharmacy leads weekly, informing finance leads when issues arise regarding price increases. Every month, the pharmacy leads in each borough communicate any financial risk or pressure to the Finance Leads. They then make the appropriate financial adjustments by considering the contingency reserve for this speciality. Funding for devices such as continuous glucose monitoring will come from reserves: active management of patients should lead to reduced patients being admitted/seen in the hospital.

Person Responsible: Neil McDowell, Nick Beavon
To be implemented by: 31 October 2022

- Close working with local boroughs to develop CHC and discharge controls and monitor expenditure.

Person Responsible: Geoff Price, Clover Fernandez, Jennifer Sinnot, Marion Johnson
To be implemented by: 31 October 2022

RRSWL055  **Risk Title: Provider Quality Oversight (General)** **Gloria Rowland**

Inherent Impact	Inherent Likelihood	Inherent Risk Score	Residual Impact	Residual Likelihood	Residual Risk Score	Target Impact	Target Likelihood	Target Risk Score
4	3	12	3	2	6	2	2	4

Cause & Effect

Risk Description:
If inadequate oversight of the quality of care delivered by SWL providers could lead to an unacceptable level of patient experience/ patient safety/ ineffective service delivery.

Cause:
- Failure to identify quality and performance at a provider level leads to remedial action delays.
- Failure to identify lessons learnt following adverse events.
- Insufficient sharing of best practices and lessons learnt across the system.

Effects:
- Patients experience a less than acceptable level of service delivery, which could result in patient harm and less favourable outcomes.
- Services fail to deliver a satisfactory patient experience or an unacceptable level of service delivery.

Risk Control

- South West London Chief Nurses meetings are held bi-weekly with ICB Chief Nursing Officer, escalations and mitigations are discussed at organisational and system levels.
- Through regional Joint Scrutiny and Oversight Group meetings, there is intelligence sharing with the Care Quality Commission and NHSE/I regarding provider concerns.
- Sharing of best practices and lessons learnt across the system.
- Weekly escalation meetings with quality directors and deputy directors on potential risks and areas for escalations.
- Joint alignment with the Clinical leadership forum and concerns around pathways or services are addressed through clinical networks.
- Patient Safety Partners appointed to ICB will support and improve patient engagement in the safety of their care.
- Strengthening reporting framework for South West London includes:
    - Quality reports for South West London to the Quality and Oversight Committee, ICB Board and the Quality Council.
    - Quality assurance of serious incident reports.
    - Make a Difference in reporting quality concerns regarding providers' service delivery.
    - Contract monitoring (quality and performance) through formal.
    - Informal communications & reporting of patient safety and serious incidents.
- Implementation of the quality dashboard for South West London ICB and partner organisations will be used to gather intelligence on potential quality issues across all providers.
- Ongoing development of system-wide quality oversight, governance, and operating framework.
- South West London Quality Management System and Peer review and assurance framework have been developed as an area of focus for system partners to implement in areas such as maternity, paediatrics Emergency Departments (ED), and mental health.
- Continued development of quality functions at Place, Primary Care and Provider collaboratives.
- SWL ICB Quality and Oversight Committee was established as a sub-committee of the ICB Board with oversight of system quality functions.

Action Required

- Transformation of clinical leadership and workforce for nursing, midwifery and Allied Health Professionals are being delivered with a focus on standardising bank rates for nursing staff.
- Ongoing development of Integrated oversight with Performance, Quality, Workforce and Finance.
- Implementation of quality escalation process at the system level.
- Quality Impact Assessments process developed for Place and ICB implementation.
- Develop and implement South West London ICS quality strategy to improve patient safety, experience, and outcomes.
- Patient Safety Partners and South West London Experience Group to be launched by July 2022 (1st Complaints Panel took place in April, and the formal launch of Experience Group will take place Oct 2022).
- Patient Safety Incident Response Framework implementation is currently in development across the ICS/ICB.

Person Responsible: Gloria Rowland
To be implemented by: 31 December 2022

NHS South West London Integrated Care Board	
Date	Monday, 17 October 2022

Document Title	Report from the South West London Integrated Care Partnership (SWL ICP)		
Lead Director (Name and Role)	Cllr Ruth Dombey, Co-chair SWL ICP		
Author(s) (Name and Role)	Andrew Demetriades, Programme Director : ICS Development		
Agenda Item No.	09	Attachment No.	08

Purpose (Tick as Required)	Approve	Discuss	Note √

Executive Summary

The South West London Integrated Care Partnership (SWL ICP) was established in July 2022. The ICP is a 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 holds quarterly meetings and held its second meeting on 5 October 2022.

The SWL ICP considered a range of business items at its meeting including:

1. Updated Terms of reference for the SWL ICP
2. Guidance and local approach to the preparation of Integrated Care Strategies
3. Supplementary ICP guidance on Health and Wellbeing Boards
4. Principles for Health Oversight and Scrutiny Committee engagement with ICPs
5. Principles for ICP engagement with the Adult Social care sector engagement
6. SWL ICP Investment Fund

Purpose:

The attached ICP update report highlights the main items of business that were considered at the meeting on the 5 October and the ICP seminar that immediately followed the meeting. The ICP seminar considered the emerging needs analysis that has been conducted by the ICP Needs Assessment Group which was established following the first meeting of the ICP in July.

A verbal update will be given at the ICB on items of interest arising from discussions that were held at both the SWL ICP public meeting and SWL ICP Seminar that followed.

Recommendation: The Board is asked to note the attached SWL ICP update report on its October business.
Key Issues for the Board to be aware of: The ICB is asked to note the main items of business that the ICP will consider and receive a verbal report from the SWL ICP Co-chair on proceedings, key items of interest and any specific actions that arise from the meeting.

Conflicts of Interest: There are no declared conflicts of interest. Any new conflicts of interest are declared at each meeting of the SWL ICP.

Mitigations for Conflicts of Interest: None identified requiring mitigation

Corporate Objectives This document will impact on the following Board Objectives:	The SWL ICP is a formally constituted and jointly convened statutory committee. Its role and functions are set out in its terms of reference and are locally agreed in line with national guidance and system wide responsibilities

Risks This document links to the following Board risks:	None are identified
Mitigations Actions taken to reduce any risks identified:	None are identified

Financial/Resource Implications	Financial issues have been considered in relation to available funding as allocated to the ICP in relation to proposed Investment funding for 2022/3

Is an Equality Impact Assessment (EIA) necessary and has it been completed?	No equality impact is required
What are the implications of the EIA and what, if any are the mitigations	None identified

Patient and Public Engagement and Communication	The

Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
	None	Click here to enter a date.	
		Click here to enter a date.	
		Click here to enter a date.	

Supporting Documents	Summary report from the SWL ICP

South West London Integrated Care Board (SWL ICB)

Report from the Integrated Care Partnership

October 17 2022

1. Introduction

The South West London Integrated Care Partnership (SWL ICP) was established in July 2022. The ICP is a 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 following report highlights the main items of business that were considered at the meeting the 5th October 2022 and following a SWL ICP seminar that immediately followed the meeting which considered the emerging needs analysis that has been conducted by the ICP Needs Assessment Group which was established following the first meeting of the SWL ICP in July.

A verbal update will be given at the SWL ICB on items of interest arising from discussions that were held at both meetings.

2. Terms of Reference for the ICP

The ICP is being asked to consider an updated version of the SWL ICP the Terms of reference which have been updated to reflect key amendments suggested at its meeting on the 13th July 2022.

The changes include specific references to the role of the SWL ICP in:

- Championing inclusion and transparency
- Ensuring the active role and participation of the voluntary and community sector
- Ensuring the voice of service users and carers is heard and the importance of co-production
- Actively promote place-based/neighbourhood engagement to gather local insights in the development of the Integrated Care Strategy.

Proposed sub-group arrangements have also been revised to provide flexibility in establishing future sub-group arrangements linked to the development of the Integrated Care Strategy and key workstreams which will be determined in due course.

The Terms of Reference will kept under review and will be revised accordingly in due course subject to any locally agreed changes to the role of the SWL ICP, planned changes in national guidance, proposed changes in membership and/or SWL wide governance arrangements. The Terms of Reference will be formally reviewed on annual basis.

3. Guidance on the preparation of Integrated Care Strategies

The ICP received a report on the Department for Health and Social Care (DHSC) produced guidance on the preparation of Integrated care strategies https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies The guidance covers an introduction to the strategy and its purpose; processes for producing the strategy; its content; and the publication and review of the strategy.

The ICP will be required to produce an Integrated Care Strategy to set the strategic direction for health and care services across the whole geographic area of the ICS, including how commissioners in the NHS and local authorities can deliver more joined-up, preventative, and person-centred care for their local population.

The guidance sets out that the integrated care strategy will be informed by local Joint Strategic Needs Assessments (JSNA's) and local Integrated care strategies are encouraged to focus on activity that can be delivered by systems at system (or cross-system) level, while Joint Local Health and Wellbeing Strategies (JLHWSs) – developed by Health and Wellbeing Boards (HWBs) – should focus on what can be delivered at 'place' and in communities.

ICPs should engage with local Healthwatch organisations; local people and communities; providers of health and social care services; the voluntary, community, and social enterprise (VCSE) sector; local authority and ICB leaders; and wider organisations and partnerships to ensure a wide range of people are able to engage and input into the production of the strategy. This process of engagement should be continuous and alongside the development of the integrated care strategy.

The government has recognised that the contents of the strategy will vary from system to system but expects agreeing shared outcomes within the ICS, quality improvement, and joint working under section 75 of the NHS Act 2006, to be important aspects of all strategies.

The guidance outlines some key areas to consider when producing the strategy, including: personalised care; addressing disparities in health and social care; population health and prevention; health protection; babies, children, young people and their families, and healthy ageing; workforce; research and innovation; health-related services; and data and information sharing.
To support the co-ordination and delivery of the Integrated Care strategy we will need to ensure there is a co-ordination and delivery group that reflects the key members of the partnership and ensure this is jointly led by executive leads from Health, Local Authorities and other key partners.

The SWL ICP received a proposal on the establishment of a Strategy Delivery Working Group to oversee the production of the strategy. This is likely to include joint executive leads (NHS/LA's) plus others who will have key inputs and ownership of specific elements of the development and authorship of the Integrated care strategy.

In line with the guidance, it is proposed that the SWL ICP develops an initial strategy discussion document setting out its high level strategic intentions and its initial priorities. The discussion document would be subject to process of engagement and consultation in the first quarter of 2023 prior to final publication.

The SWL ICP received a presentation on the proposed local approach to developing the SWL Integrated care strategy including the phases of development and engagement including timelines for its production. The phased approach will seek views on priorities as part of a continuous process of engagement and input from ICP members to ensure we gather evidence, opinions and insights across the partnership.

As part of the first phase of strategy development work, it is proposed that a SWL ICP seminar will be held later in November to consider the outcome of the needs analysis work that is in process as well as the views of ICP stakeholders so that the ICP can consider what might be its potential priorities.

4. Supplementary ICP guidance on Health and Wellbeing Boards

In July 2022, *Health and Wellbeing Boards draft Guidance for Engagement* was published by The Department of Health and Social Care. https://www.gov.uk/government/publications/health-and-wellbeing-boards-draft-guidance-for-engagement/health-and-wellbeing-boards-draft-guidance-for-engagement - questions-for-engagement. The engagement document's purpose is to align HWBs with the Health and Care Act 2022.

The publication focuses on the role of HWBs in enabling effective system and place-based working and provides clarification about their role within systems. The guidance recommends that systems build on the work of HWBs to ensure that action at a system-wide level adds value to what is being done at place.

The guidance suggests five principles for Partners to adopt when developing relationships, including:
- building from the bottom up
- following the principles of subsidiarity
- having clear governance
- ensuring that leadership is collaborative
- avoiding duplication of existing governance mechanisms

The document outlines that HWBs and ICPs are expected to work collaboratively in the preparation of the integrated care strategy to tackle challenges that are best dealt with at a system level. HWBs must consider whether to revise the JLHWS when they receive the integrated care strategy, and ICPs should use the insight and data held by HWBs when developing their strategy.

A series of questions are being asked by the DHSC of Health and Wellbeing Boards prior to final publication of the guidance.

Members of the SWL ICP are being asked to review the guidance and consider the relationship of the ICP to Health and Wellbeing Boards and whether there are any additional mechanisms that need to be put in place to strengthen ways of working and partnership arrangements.

The SWL ICP is being asked to consider the final response to engagement on the guidance once this is published including any responses from local Health and wellbeing boards.

5. Principles for Health Oversight and Scrutiny Committee engagement with ICPs

In July 2022, *Health overview and scrutiny committee principles* guidance was published by The Department of Health and Social Care. https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles/health-overview-and-scrutiny-committee-principles
The guidance sets out expectations for how Integrated Care Boards (ICBs), Integrated Care Partnerships (ICPs), local authority health overview and scrutiny committees (HOSCs) and other local system partners will work together to ensure that systems are locally accountable to their communities.

The guidance outlines five principles for effective partnership working to ensure the benefits of scrutiny are realised, which are:

- **Outcome-focused** – a strategic approach to consider the best way to scrutinise and evaluate the key strategies and outcomes of system partners.
- **Balanced** – ICBs and ICPs should take an inclusive and future-focused approach to agreeing scrutiny arrangements, while at the same time ensuring HOSCs can be reactive and responsive to issues in local communities.
- **Inclusive** – System partners should work with HOSCs to ensure local people's needs and experiences are considered when commissioning and delivering health services.
- **Collaborative** – communities, providers and planners of health and care services should help to inform the strategic direction of HOSCs in their areas.
- **Evidence-informed** – health and care providers and commissioners should respond positively and constructively to requests for information from HOSCs.

In South west London, we already have well established Place and ICB wide relationships with HOSCs where there is regular scrutiny on a range of health related issues. Members of the SWL ICP were asked to consider the guidance and consider if there are additional mechanisms the ICP should establish to strengthen effective partnership working with HOSCs.

6. Principles for ICP engagement with the Adult Social care sector engagement

In July 2022, *Expected ways of working between integrated care partnerships and adult social care providers* was published by The Department of Health and Social Care.
https://www.gov.uk/government/publications/adult-social-care-principles-for-integrated-care-

partnerships/expected-ways-of-working-between-integrated-care-providers-and-adult-social-care-providers
The guidance sets out a series of four engagement principles for Integrated Care Partnerships (ICPs) and adult social care (ASC) providers to guide their work together. It serves to ensure ASC providers are involved as essential partners within the SWL ICP and therefore the development of the integrated care strategy.

The principles at the centre of the guidance are:

- **Partnership** – ASC providers are critical partners in planning, delivering, and improving care and outcomes, and should be fully engaged in the strategic planning of the ICP.
- **Inclusion** – ICPs and providers should collectively support the whole ASC voice to be heard.
- **Subsidiarity** – ICPs and ASC providers should build on existing place-based partnerships and foster new working relationships within their local communities.
- **Knowledge sharing** – ICPs should share good practice across places and systems to improve health and care services.

Members of the ICP are being asked to consider the guidance and determine if there are additional mechanisms the ICP should establish to strengthen effective partnership working with HOSCs.

7. ICP Investment Fund

It is proposed that an Investment Fund is established which aims to give partners the opportunity to apply for funding for innovative projects and health inequality initiatives to improve the health and wellbeing, capturing community energy and enthusiasm for real health benefits.

The SWL ICP is being asked to consider the approach for the award of funds for the ICP Investment Fund in 2022/23 and a high level approach to the process to be potentially followed in 2023/24

In 2022, it is proposed that there are two elements to the Investment Fund which are both non-recurrent for the financial year 2022/23:

(1)The Innovation Fund (£4.9 million)

This is aimed at supporting innovation and sharing best practice across South West London.

(2) The Health Inequalities Fund (£2.7 million)

The Health Inequalities Fund has been awarded by NHS England to tackle Health Inequalities (Core20+5) across South West London. This funding is for implementing targeted health inequalities interventions for local populations. Place based partnerships within SWL will receive an allocation of the funding using a needs-based approach.

The ICP is being asked to support applications for 22/23 funding to support and increase sustainability and resilience over winter, for example, developing home escorting or settling services. The ICP is particularly keen to support voluntary sector-led initiatives. Each element of the fund has a separate application form, criteria and panel but both are aligned to the same dates.

Members of the SWL ICP are being asked to note ICP Chairs action for the approval of the 2022/23 Investment Fund Approach, endorse the high-level approach for 2023/24 and proposed timeline. It is proposed that an ICP working group is established to develop a detailed approach and determine the criteria for the allocation of funds for 2023/24

Cllr Ruth Dombey
Co-Chair : South West London Integrated Care Partnership
October 2022

NHS South West London Integrated Care Board	
Date	Monday, 17 October 2022

Document Title	SWL Urgent & Emergency Care Winter Preparedness		
Lead Director (Name and Role)	Jonathan Bates, Chief Operating Officer		
Author(s) (Name and Role)	Caroline Morris, Director of Collaborative Commissioning Michelle Woodward, Head of UEC		
Agenda Item No.	10	**Attachment No.**	09

Purpose (Tick as Required)	Approve	Discuss	Note ✓

Executive Summary

This paper outlines the plan developed by SWL ICB to address winter preparedness. It sets out the current position and context, addresses the local and national priorities for winter and highlights the key challenges. In addition, it reports the division of national winter funds across SWL for Urgent & Emergency Care.

Background:

The plan summarised in this paper has been developed in partnership across the system:

- NHSE winter funds are focussed on increasing bed capacity as the non-elective inpatient pathway is where flow is particularly challenged and causing delays.
- Each of the four hospital systems in South West London have an A&E Delivery Board chaired by a senior member of the system. These Boards have reviewed their local pressures within their system and through working with local authorities and social care, health partners and the third sector have developed a series of interventions. These interventions are designed to increase bed capacity, avoid the need for people to be in hospital where clinically not appropriate and enhancing other forms of urgent care over the winter period.
- Aligned to this local work, teams at South West London level have developed complimentary plans which seek to use the scale of the ICB to achieve additional capacity. Securing neuro-rehabilitation beds on behalf of the system is a good example of this.

- The plans are funded in two main ways. Firstly, there are aspects of existing transformation or efficiency plans which deliver additional capacity over winter. Secondly, the ICB has received £13.1m from NHS England specifically to fund schemes which increase the General and Acute bed base by 5% (or by the equivalent in the community or other settings). The attached paper shows at a high level the

schemes which have been identified, how they map onto the NHSE priorities for winter and the level of additional beds that will be delivered.

- Progress on delivery of the schemes and their impacts will be monitored by NHSE monthly. There is an expectation that ICBs will provide oversight on progress against the six key metrics described in the NHSE winter letter.

Purpose:

This paper is intended to inform the Board of the current position across South West London's Urgent and Emergency Care Services; outlines the plans to improve resilience and highlights the key areas of risk and challenge that remain. In addition, it reports into the public domain the way in which the Board has decided to allocate winter funding.

Key Issues:

- The UEC system is already experiencing challenges ahead of winter with concerns expressed nationally and locally about the impact on patients of Emergency Department and ambulance delays that potentially compromise patient safety.

- NHS England's additional Winter Funding has been focussed almost entirely on increasing General and Acute bed capacity this year, as the non-elective inpatient pathway is where flow is particularly challenged.

- SWL was allocated £13.1M to implement schemes to increase bed capacity. Actions set out in the attached paper and intended to free up bedded capacity.

- The plan has been built in partnership with local systems and key providers. It builds on long experience of winter preparedness planning, taking into account the different strengths and opportunities that exist in each place.

- In August, NHSE issued a letter outlining core objectives and key actions to increase capacity and operational resilience in UEC ahead of winter. This was accompanied by an assurance framework.

Conflicts of Interest:

Providers who receive a proportion of this financial allocation are conflicted.

Mitigations:

The 9th September Urgent & Emergency Care Delivery Board has overseen this process which is a system-wide partnership and reports to the ICB.

The meeting that made the recommendation was chaired by the ICB COO (who is not conflicted) and the recommendation to approve the funding came with the COO's support as the responsible executive director.

At the ICB held on 21st September '22, the conflicts were noted at this meeting. Providers who benefited from funding were allowed to remain in the room but not to participate in agreeing the proposals.

Recommendation:

The Board is asked to note the plans for winter and the decision regarding the allocation of winter funds.

Corporate Objectives This document will impact on the following Board Objectives:	The schemes will improve the health of SWL people over winter by improving waiting times, reducing delays and ensuring patients get to the high quality care they need.

Risks This document links to the following Board risks:	The key risks identified as part of this plan are: • The plans rely on increased staff numbers. Providers are flagging that recruitment of sufficient trained and experienced staff remains challenging. . • The delivery of additional capacity by increasing flow and discharge across each system requires the complex interaction of different interventions, not all components of which are readily quantifiable. • Given the pressures on the UEC system this summer, there is a risk that the additional capacity may not be sufficient to prevent unscheduled care impacting on other parts of the system such as the elective recovery workplans.
Mitigations Actions taken to reduce any risks identified:	South West London Urgent and Emergency Care Delivery Board, which meets every two weeks, takes ownership of the plan with the support of the A&E Delivery Boards. There is an NHSE Assurance Framework in place which will be monitored through the SWL UEC Board to identify any areas that require further support.

Financial/Resource/ QIPP Implications	Costs are covered through the NHSE winter funds.

Has an Equality Impact Assessment (EIA) been completed?	In general, urgent and emergency care services are available to all regardless of protected characteristic status. However, we do know that there can be variable access to urgent care services in certain communities. In developing this plan we have taken into account the needs of the local population through the work undertaken by each A&E Delivery Board.
Are there any known implications for equalities? If so, what are the mitigations?	There are no known implications.

Patient and Public Engagement and Communication	Our plans for this winter are informed by insight work undertaken with the public by the SWL Communications Team, which specifically focuses on how best to achieve the behaviour change needed to manage demand during the winter months. This insight work has helped us to define and then refine our messaging.

Previous Committees/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
	SWL UEC Delivery Board	Friday, 09 September 2022	Approved
	SWL ICB – Part 2	Wednesday, 21 September 2022	Approved
		Click here to enter a date.	

Supporting Documents	Paper 1 – Winter Preparedness

Preparations for Winter

2022/23

Executive Summary

NHS South West London

There has been sustained pressure on the UEC pathway for much of this year including through the summer months with **significant and unprecedented delays to ambulance handover and response to patients waiting in the community, longer waits in Emergency Departments (ED) and increased delays to discharging patients as well as high bed occupancy which impacts on flow across the whole pathway.** This has had a negative impact on both patient experience and outcomes as well as increased pressure on our workforce. Given the existing challenges, there is significant concern locally, regionally and nationally as to how UEC services will address the additional demands that come with the onset of Winter.

In June **ICSs were asked to put forward plans to increase bed provision by 5%** against the trajectories set in the Operating Plan submissions which could be actual beds or bed alternatives, often in a community setting. Funds were confirmed mid-August at £13.1M for SWL and our plans **at the peak time equate to an additional 150 beds**. The majority of this capacity will come from schemes to reduce length of stay and improve flow through the UEC pathway.

A **SWL UEC Re-set event was held on 8 July** with a large group of senior leaders and clinicians across all parts of the UEC pathway including acute, primary care, community, ambulance, 111 and mental health to consider what else we need to do to shore up our position ahead of Winter. These **priorities were agreed as Increasing Virtual Ward capacity and utilisation, additional capacity outside hospital, acute escalation capacity, improving flow and reducing length of stay and mental health alternatives to ED. In addition, an important theme around balancing clinical risk was identified along the UEC pathway**.

On 12 August **NHSE issued a letter outlining eight core objectives and key actions** to increase capacity and operational resilience in UEC ahead of Winter. This was accompanied by an assurance framework that includes monthly submissions on the progress of the demand and capacity bed schemes and updates on actions plans to support winter preparedness and system resilience, as well as an acute-focussed self-assessment checklist to be completed ahead of ahead of Winter and again in February. **The core objectives identified in this letter align with the key priorities to be taken forward as a result of the SWL UEC Re-set event.**

UEC in SWL

Activity numbers are an average month July 21- June 22

Now 2271

Mid-Winter 2428

General and Acute & Equivalent (G&A) Beds

1 in 4

Patients 7+ days Length of Stay

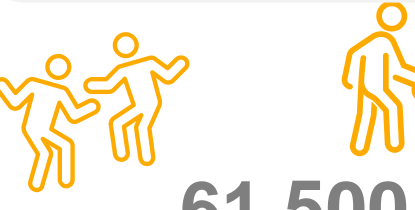
95%+

G&A Bed occupancy

£1.3 bn

40% of ICB budget

Non-Elective Spend



61,500
per month

People Attending ED

36000
per month

111 calls

13,400
Per month

Ambulance arrivals

700,000
per month

GP appointments

Social care
36,000
NHS
34,000

Workforce

39

Primary care networks

180+

GP Practices

7

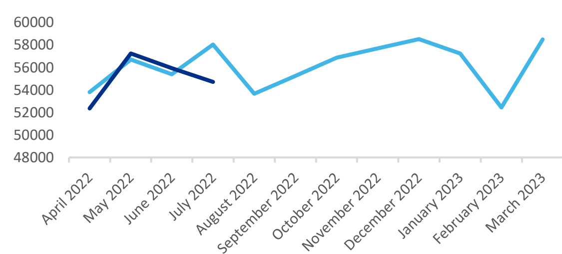
Acute and community providers

2

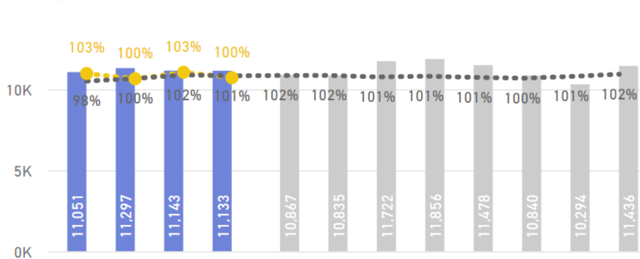
Mental health providers

Current UEC Performance

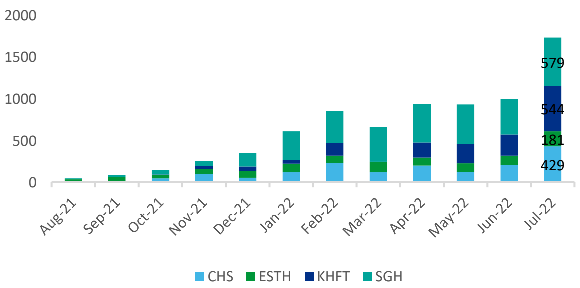
SWL A&E All Type Attendances against plan 2022 - 23



SWL ICS Actuals vs Baseline Achievement



12 Hour A&E breaches by provider

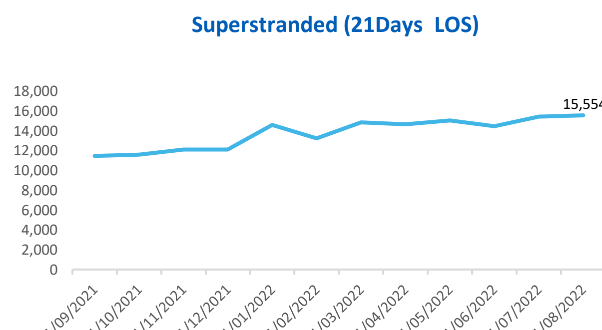


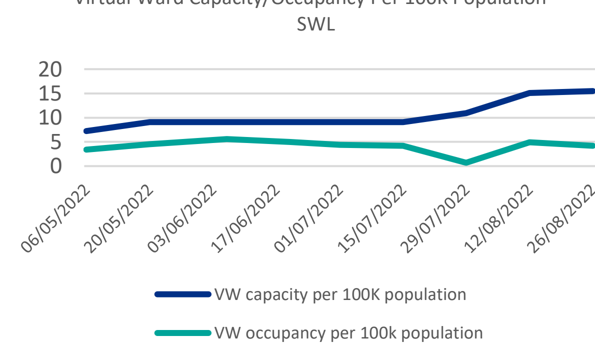
- Overall ED attendances are lower than planned at this point in the year. This is partly because of the implementation of new streaming services at the front door of ED, such as Same Day Emergency Care (SDEC) units, which means patients do not get counted as ED attendances. However, even taking that into account numbers are relatively static meaning there are no more patients attending ED than we saw pre-covid. At the same time, the actual number of non-elective episodes of care that we planned for at the beginning of the year are being realised.

- Despite this, the number of 12-hour breaches (patients waiting in ED for a bed after a decision to admit has been taken) reached 1733 in July and is indicative of the strain that hospitals are facing moving patients from ED into wards.

- At the same time, the number of people that have been in a hospital bed for more than 21 days (super-stranded patients) has increased from 11,451 bed days in August last year to 15,554 bed days in July. While some of these patients remain acutely unwell, many are waiting for discharge onto onward care.

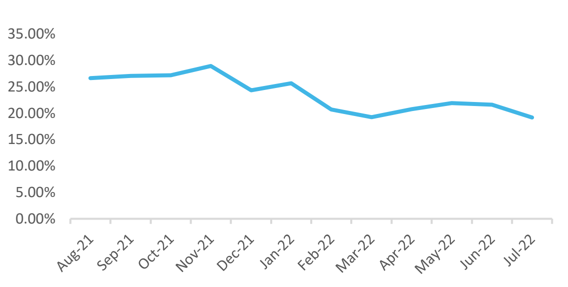
- SWL has implemented virtual ward capacity which allows those almost ready for discharge to be go home with ongoing support. This capacity is currently underutilised. The reasons for this include the need to change culture within clinical teams to support their patients into the care of the virtual ward and effective matching of capacity to patient need.



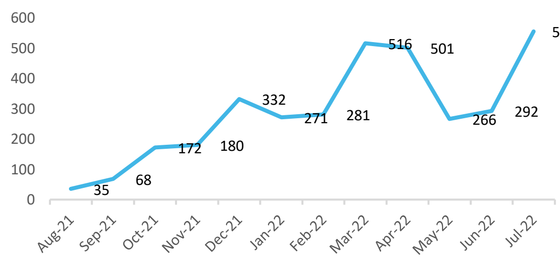


Current UEC Performance

SWL % Ambulance handover within 15 minutes



SWL 60 Minute Ambulance handover breaches



- Locally, ambulance handover is a core priority and considerable daily operational focus is spent on ensuring timely handover. This issue has also been much in the headlines recently and is one of the key priorities of the new Health Secretary.

- Ambulances that arrive at hospital under blue light are generally handed to ED staff almost immediately. However, for all others, which form the majority of arrivals, the NHS has a target to hand over the patient within 15 minutes of arrival. In August 2021, SWL achieved 27% against this target. In July 2022, we achieved 19%.

- Pre-covid, it was almost unheard of that an ambulance would wait longer than 1 hour to hand over a patient to an ED in SWL. Such an event would be considered so unusual that a root cause analysis was carried out on each one. However, since August last year we have seen the number of long delays rise by 158% to a high of 555 in July.

- The root cause of most long handovers lie in the inability of hospitals to discharge people in a timely manner to onward care whether in their own homes or to onward care homes. Beds remain occupied by patients waiting to go elsewhere, ED cannot move patients onto the wards and so there is no space for patients arriving by ambulance.

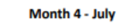
- The system had a concerted focus on improving ambulance handover which can be seen in the numbers of May and June this year, however what this showed was that maintaining improvement requires the whole system to step together to create flow.

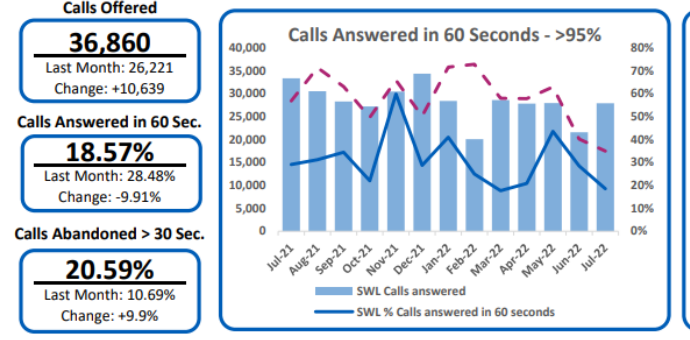
- 111 has also been in the news recently with stories about the length of time that it is taking to answer calls; all providers of 111 are struggling to recruit and retain the call answering staff they need as the number of calls to 111 rises month-on month.

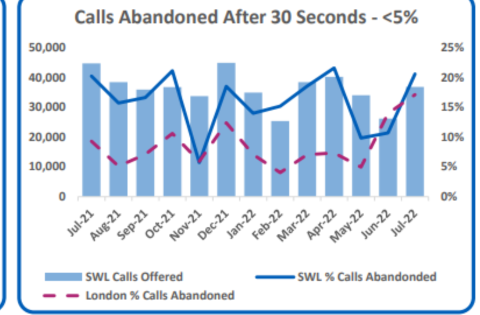
- SWL works with the other London ICS to offer the best service possible to our residents and visitors, however in June we answered 18.5% of calls within 60 seconds and just over 1 in 5 callers abandoned their call before it was answered.

- The average length of time a person had to wait for a call to be answered in July and August was 12 minutes.

South West London 111 Performance







NHSE objectives for ICS' this Winter

NHSE released a letter on 12 August **outlining core objectives and key actions to increase capacity and operational resilience** in UEC ahead of Winter.

1) Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.

2) Increase capacity outside acute Trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the Winter.

3) Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.

4) Target Category 2 response time and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform and direct support to the most challenged Trusts.

5) Reduce crowding in A&E departments and the target the longest waits in ED, through improving use of the NHS directory of services and increasing provision of same day emergency care and acute frailty services.

6) Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards and improvements elsewhere in the pathway.

7) Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100-day challenge'.

8) Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

UEC Assurance Framework

The NHSE letter was accompanied by an **Assurance Framework**. The primary elements include two returns that need to be submitted on a monthly basis: **a) demand and capacity return** against the June submission to increase bed capacity and b) an **UEC Action Plan** as well as c) a **self-assessment checklist focussed on acute trusts** to be completed in September and February. All these returns are submitted in aggregate by the ICB UEC team.

In addition, there are **six key metrics** that will be monitored on a monthly basis : 111 call abandonment, 999 call answering times, Category 2 ambulance response times, average hours lost to ambulance handover delays, adult non-elective bed occupancy, percentage of beds occupied by patients not meeting Criteria to Reside.

- 11-08-22 — Assurance Framework Published
- 11-08-22 to 26-08-22 — Co-design D&C assurance mechanism
- 29-08-22 — Demand and Capacity Assurance Returns
- w/c 26-09-22 — Self Assessment Checklist Returns to National Team
- w/c 26-09-22 — UEC Action Plans Progress Assurance
- From October 2022
- Monthly — National Performance Scorecard
- Monthly Week 4 — Demand and Capacity & UEC Action Plans
- 06-02-23 — ICB Self-Assessment Repeat Cycle

Winter Plans

1: Immunisations

Keeping our local population safe and protected is essential to reducing avoidable illness which in turn helps to reduce the pressure on our services. We currently have a SW London immunisations programme in place incorporating COVID-19, Flu, Polio Booster, Monkeypox and MMR vaccination.

Increasing Capacity and Resilience

- The **COVID-19 vaccination autumn programme is underway** across general practice, community pharmacy, mass vaccination sites, hospital hubs and a roving vaccination team. **100% of care homes have a date for vaccination of residents and staff**.
- The **annual flu programme began on 1st September** with GPs inviting patients for vaccination and appointments also available in local community pharmacies.
- We have **planned capacity to provide a booster vaccination to over 95% of our eligible population** with additional capacity for an evergreen offer for all ages.
- Vaccines used for the COVID booster programme will be the new bivalent products which will provides additional protection against the Omicron variant.
- Every opportunity is being made to **increase co-administration with the flu vaccination** and early numbers have seen an increase in this area.
- Front line staff across SW London Trusts will be offered both flu and covid boosters within the programme
- Our MECC (Making Every Contact Count) offer (on all sites) will continue into winter, linking in with other winter health initiatives and working with local partners to promote the staying health agenda.
- The **polio booster campaign** is underway in local GP practices and in our mass vaccination sites/ pharmacies. Uptake has been lower than expected and we are working with partners to maximise how we engage with parents on vaccine hesitancy.
- **Monkeypox vaccinations** continue in four South West London sexual health clinics. UKSHA have recently confirmed that second doses should commence, and we are currently working with partners to create a plan to deliver this as quickly as possible.
- **A national MMR campaign** has begun and will run until December 2022. The eligible cohort is children aged 1-6 years. Invites will ask parents to check their red book, to check other immunisations and to book an appointment with their local GP practice as quickly as possible.

Risks, Challenges and Support

- There may be a **lower or slower uptake from the public due to vaccine hesitancy**. Our communications and engagement plans are being developed to mitigate against this and encourage members of the public to engage in a wider health agenda.
- There is a risk that the **Polio booster programme and the Monkeypox programme**, which overlaps the Covid and Flu programmes, may reduce capacity across all delivery pillars.
- **Availability of the workforce** (registered and unregistered) to deliver the immunisations agenda across all pillars.

South West London

2: Increasing Capacity Outside Acute Trusts: Primary Care

Good access to Primary Care is an essential component of protecting the UEC pathway, ensuring patients with less urgent needs are seen in the right place, closer to home rather than attending UEC facilities, adding additional pressure to those services.

Capacity and resilience over winter:
The new Enhanced Access (EA) Service goes live on 1st October 2022:

- Delivering approximately 7,200 appts in total per week provided by PCNs across SWL. This is **an increase of 690 appointments per week** compared to the current offer.
- Most appointments will be provided during the Network Standard Hours (NSH): 6.30-8pm Mon-Fri and 9am-5pm Saturday, with some PCNs also providing appointments outside of these times such as early morning commuter clinics (before 8am) in line with patient need.

The primary care capacity that is currently provided between 5pm-8pm Saturday and 8am-8pm Sunday will be extended to fill the gap in service from 1st October:

- 190 appointments on Saturday and 410 appts on Sunday will be provided each week across SWL.
- Plus 8am-8pm coverage on the three bank holidays over Christmas and New Year.
- Funding has been made available from NHSE London to support this element of the service until March 2023.

A single number SWL Telephony Service to support NHS 111 and the wider system over Dec/Jan is being explored. This proved successful during busy periods and has previously supported a drop in ED attendances during the pandemic.

Challenges and Risks

- **Workforce:** Enhanced Access (EA) Service plans are currently being approved to enable PCNs to secure workforce and mobilise ahead of 1 October.
- **IT Interoperability:** Systems are not currently in place to fully support all elements of the EA Service specification – this is a national issue and work is ongoing identify solutions to mitigate this.

3: Increase resilience in NHS 111 and 999 services

NHS 111 is here to make it **easier and quicker for patients to get the right advice or treatment** they need, be that for their physical or mental health by going online or telephoning 111. London is experiencing increased pressure, with **111 being the first point of contact for patients**, causing the service to be less timely in its response. 999 services are specifically for emergencies, however a **large proportion of the Ambulance Services' work involves providing less urgent care** which could be redirected to other parts of the health system.

Capacity and resilience over Winter:

- **Demand and capacity planning sessions** have been set up weekly with regional overview and support using **weekly forecast and activity data**
- **Funding has been made available to increase staffing** above and beyond contracted requirements across all 111 competencies including service advisors, health advisors, clinical advisors and GPs
- The Single Virtual Contact Centre provides **resilience across London where a patient speaks to the next available agent**
- **LAS continue to provide 20% resilience support for front end calls in SWL** as well as Star Lines (support to health and care professionals), and clinical validation for Category 3 and 4 (i.e. lower acuity) ambulance patients
- The **Directory of Services is continually updated** to ensure downstream services are available for direct booking into such as Primary Care, Urgent Community Response (UCR), Urgent Treatment Centres (UTC), Same Day Emergency Care (SDEC), Mental Health and EDs
- The service is implementing **the next generation of electronic patient records shared across London**
- **24/7 urgent mental health helplines** for patients experiencing a mental health crisis are updated and that **services are being promoted**
- Through SWL communications, SWL aims to **promote NHS 111 online and alternative sources of health advice and care** such as Pharmacy
- LAS is delivering an improvement plan aimed at **increasing the speed of response to Cat 2** (urgent calls)
- As part of the move to a **new Computer Aided Dispatch (CAD) system** later in September, LAS is working with ICBs to **focus on reducing hours lost**
- Over winter there will be a focus on delivery of a Quality CQUIN reducing inequalities in access to ambulance services by targeting specific patient groups

Challenges and Risks:

- **Workforce:** recruitment, retention and sickness is an on-going issue across all 111 providers, who are struggling to recruit and retain to the expected headcount let alone exceed it over the winter period
- **Achieving the new national 111 IUC data set KPIs** such as the abandonment rate of <3% is particularly challenging. The risk is that patients would look for alternative solutions for healthcare such as walking into EDs

4: Target Category 2 response times and ambulance handover delays: ambulance

Ambulance delays have been at unprecedented levels nationally and locally this year both for patients awaiting handover outside EDs and for patients waiting for ambulances in the community and there is a clear correlation between these two aspects of the UEC pathway. Delays outside hospital are largely due to flow in the admitted pathway and crowding in the ED departments. During this year all SWL hospitals have been working closely with LAS to reduce the longest delays, implementing improvements and other interventions to alleviate pressure and reduce delays.

Capacity & Resilience:

- There are currently **Hospital Liaison Officers** (HALOs) in place at CUH and St Helier and plans to re-start the HALO role at St George's which was trialed earlier this year. These roles act as a key point of focus and escalation between the Trusts and LAS
- All Trusts have **robust escalation plans in place with triggers to enact increased capacity** such as through boarding (where additional patients may be sent to a ward), cohorting in ED (where certain patients are monitored by a nurse or paramedic), and Fit2Sit (patients well enough to sit in a chaired area)
- All **Trusts and ambulance services work closely with the SWL Opsroom in order to trigger higher levels of escalation** such as diverting conveyances and enacting the Rapid Release Protocol where certain patients can be left at EDs without full handover when waits become excessively long
- Progress has been made to **enable direct access to LAS crews for patients eligible for UTC and SDEC**.

Challenges & Risks:

- We are already experiencing delays and winter pressures are likely to exacerbate the problems
- Keeping patients in enclosed vehicles for an extended period of time introduces a number of new risks, including potential build-up of oxygen in the vehicle (when being delivered to a patient), and a risk of Covid-19, or other transmissible pathogens, being spread. Given these factors, it is even more important that ambulances are not held for longer than 30 minutes we are asking all systems to address this
- The ambulance trusts have limited **workforce availability and some staff are suffering fatigue**. Initiatives and pilots must have clearly identified benefits as these will be reliant on taking one member of staff from one service to another.

4: Target Category 2 response times and ambulance handover delays: Urgent Community Response

The **Urgent Community Response (UCR) services** have been stepped up over the course of 2022 and **provide the first point of escalation within the community setting for patients at risk of hospital admission**. It aims to prevent hospital admissions by offering higher acuity care in the community and so is an important part of the UEC pathway, **keeping patients at home where possible**.

Capacity and resilience over Winter:

- **The 2-hour UCR operates 7 days a week from 8am to 8pm,** with service performance currently at 87% of people seen within 2 hours, exceeding the 70% national target, and 810 people seen in July (the highest number reported in our system to date)
- UCR service pathways against 9 clinical indications are being streamlined across the system. There is **work in place to increase referrals from 999 and NHS 111 as pathways are currently underused**
- A **UCR car pilot delivered in partnership with LAS started on 3 October** with a paramedic and a community clinician, designed to increase utilisation of services.
- UCR services in SWL will see around 45 cases a day over the winter period **preventing a significant number of emergency attendances** and admissions.
- **Referral pathways from Care Homes to UCR have been established** as an alternative to other UEC services. UCR has been built into escalation plans for Care Homes across SWL

Challenges and Risks:

- **Workforce – recruitment and retention remain an issue**. Staff are being offered the opportunity to undertake upskilling training to enhance their skill set and enable working across teams
- Services currently vary by borough, however **streamlining the service delivery models** in SWL is currently underway **to reduce this variation**
- **Data availability and quality** – The national data set (CSDS) has a lag and so we are exploring local alternative to enable our local understanding of patient need and service usage.

5: Reduce crowding and target the longest waits in ED

Although overall attendances to UEC facilities has not increased compared to pre-pandemic levels, **waiting times in EDs** have continued to be consistently **well above the 4-hour target with unprecedented increases in 12 hour waits.** The main reason for this continues to be **the pressure on the admitted pathway** with bed occupancy at high levels and **delays to hospital flow at every part of the pathway**. To reduce the pressure on EDs, all opportunities to reduce the numbers of patients to avoid crowding in the department are being explored.

Capacity and resilience over Winter:

- **Segregation at the front door where possible**, with patients streamed to alternative services on arrival. This includes going directly to Same Day Emergency Care (SDEC) with all sites fully engaged in the regional programme work including the gold standard pathways and now moving towards using the London Exclusion Criteria i.e. SDEC unless the exclusion criteria apply
- **Other alternatives to ED** are also in place and being explored such as hot clinics where patients can be directed to see a specialty clinician away from ED
- UTCs continue to see the lower acuity patients
- All Trusts also **continue to support 111 bookings direct to ED** to help manage patient flow and two Trusts now also accept 111 referrals into SDEC
- The majority of Trusts also have **GP services available on site** so that appropriate patients can be directly referred to this provision.
- SWL is engaged in a procurement process to secure streaming and redirection software which will support the management of patients at the front door which is already in place at Epsom and is at the implementation stage at St Helier
- A recent **review of UTCs in SWL has identified opportunities to improve consistency** of service across all providers which will be taken forward through the SWL UEC Board
- Frailty pathways linked with LAS and 111 to ensure patients are not admitted and are supported at home

Challenges and Risks:

- There **is variation across SWL such as with some SDEC departments** open 24/7 and others not meeting the standard opening hours.
- **SDEC and UCR referrals from 111 remain low** due to clunky processes and sometimes poor user experience
- There is still a **tendency for EDs to absorb all urgent attendances** as the failsafe for all urgent care.

6: Reduce hospital occupancy

NHS South West London

In June NHSE asked that ICS's put forward plans to increase bed provision by 5% against the trajectories set in the Operating Plan submissions which could be actual beds or bed alternatives. Funds were confirmed mid-August at £13.1M for SWL which has been shared across the ICS based on local proposals. Additional beds/bed alternatives should make a significant difference to patient flow across the whole UEC pathway.

Capacity and resilience over Winter:

- The **majority of the proposals are to reduce Length of Stay and improve Flow** through the UEC pathway. At the peak, we will have the equivalent of an additional 150 beds above plan across SWL
- Plans were developed through AEDBs plus an **additional scheme for neuro-rehabilitation provision** and a small amount to continue two homelessness schemes at Croydon and St George's
- There will be **close monitoring of these schemes** through the demand and capacity element of the UEC Assurance Framework on a monthly basis
- Additional capacity should have a **positive impact on the most challenged parts of the UEC pathway** i.e. ambulance response and handover and waiting times in ED
- We are also looking at whether there is **scope to purchase additional step down Care Home Capacity** following a stocktake exercise that revealed a number of Care Home beds available in the wider system
- The **Virtual Ward model** is designed to support people out of hospital and **will support 228 beds** by the end of March 2023
- **Frail patients identified as a specific subset for integrated working** across health and social care so that patients can be managed at home
- **Frailty pathways** are also being developed to support people within virtual wards

Challenges and Risks:

- The majority of schemes are **workforce dependent** and so recruitment into these roles at pace is essential
- Bed alternative schemes **may not deliver the predicted bed capacity**
- Although we have **committed to delivering** additional capacity, this may not be enough to meet additional demand over Winter

7: Ensure timely discharge

NHSE London issued a "100 Day Challenge" to ICSs on 1 July, building on the work of the National Health and Social Care Discharge Taskforce which brings together partners across health and social care to focus on opportunities **to improve discharge**, and in particular to improve the outcomes of those patients who no longer meet the Criteria to Reside so they are discharged to more appropriate settings and **release capacity with the acute** providers. 10 best **practice initiatives were set out to be implemented in all trusts** over the following 100 days, **in preparation for Winter**.

Capacity and resilience over Winter:

- **All partners are working towards implementing the initiatives**, all of which were at least partly in place across SWL. These include early identification of complex discharges, setting expected date of discharge (EDD), consistency of in-hospital processes and documentation, seven-day working and demand and capacity modelling for local and community systems
- Local systems initially RAG rated themselves and are now **reviewing achievement against the 100-Day challenge identifying any opportunities to work across SWL on common areas of challenge**
- All systems have RAG rated themselves against the challenges presented and **progress tracked through the SWL Discharge Group** of Exec Leads which will move to weekly to support systems to deliver change and improvements against the key measures
- Transformation **programmes at place have been established** involving partners across health and social care and a workshop proposed for October to identify overlapping themes and initiatives that are best achieved by working at scale e.g. 7 day working, community workforce capacity management, discharge planning tools etc.
- SWL Discharge Group **exploring the viability of securing extra care home capacity** to support step up and/or step down
- Particular focus on increasing the number of weekend discharges, reducing the number of people who no longer meeting the criteria to reside remaining in a hospital bed and number of discharges by 5pm.

Challenges and Risks:

- **Seven-day working** is a further demand on a pressured and limited workforce and **has limited impact when only some services are working** every day e.g. if brokerage is available at the weekend but care homes are not accepting admissions, or patient transport is limited to a reduced service.
- There is still **significant in-hospital delays** to flow with inconsistency and delayed processes so discharges before 5pm and at the weekend are not optimal.
- In London**, Pathway 3 discharges (awaiting availability of a bed in a nursing or residential home) – representing 28% of all delays. Pathway 2 (awaiting a community rehab bed) is 19% and this is consistent with the picture in SWL although numbers are variable across** the patch.
- **Data quality on discharge required work** and this makes prioritising areas for action more difficult.

8: Provide better support for people at home

The **Virtual Ward programme's vision is to provide wraparound holistic multidisciplinary care for patents out of hospital**, enabled through technology, supporting people in their homes who would otherwise be receiving care in hospital through monitoring, treatment and management of escalations within the community. This service provides a new and valuable capacity to reduce the pressure on our acute inpatients services. There is also increased focus on patients with **High Intensity Use** (HIU) of service and those who are homeless and whilst relatively small in number in SWL, still **have a significant impact on services in terms of demand and often have poorer health outcomes** so a focus on addressing their needs has benefits for the whole system as well as for those patients.

Capacity and resilience over Winter:

- **Virtual wards and Croydon remote monitoring hub will be 'going live' in late November** and will increase capacity for earlier supported discharge by up to an additional 128 beds
- **The Virtual wards will provide up to 228 beds by March 2022**
- The new SWL UEC Clinical Forum made patients with HIU one of their first priorities, taking a **stocktake of what is in place across SWL, sharing learning and drawing on expertise from the national HIU team and engaging with the LAS Frequent Caller team**. There are **some well-established workstreams** in place to support patients who have HIU of UEC services such as in Kingston & Richmond who have **dedicated non-clinical support workers to engage with individuals and regular MDT meetings to agree plans for individuals**. Sutton has set up a dedicated workstream to focus on HIU with mechanisms to identify individuals and agree care plans, broadening the remit to encompass homeless patients. Croydon also has a dedicated workstream led by the LA and M&W is planning to re-start work in this area.
- There are **two Homelessness pilots at Croydon and St George's** where we have the highest number of patients in this cohort. These are designed to help identify and support this vulnerable group through their engagement with the UEC pathway, particularly on admission where outcomes is often poorer than for other cohorts.
- We have also engaged with our BI team to produce an **HIU dashboard to identify patients that meet agreed criteria** which also shows relevant information on individual health background and deprivation to support the work at place.

Challenges and Risks:

- **Virtual Ward capacity is not always fully utilised** across SWL and requires cultural change to increase acute clinician confidence to support transfer.
- In addition, the **Virtual Ward services are variable across SWL** both in terms of capacity and the types of service offered.
- **Funds for Homelessness pilots are time-limited** and presents a challenge to recruitment and retention and keeping up the momentum on project delivery.
- Reducing **HIU is very much on an individual basis** and **requires consistent focus.**

Additional priority areas in South West London

Mental Health

NHS South West London

In general, EDs are not the right place for patients with MH issues. A small amount of funding, £299K across SWL, has been allocated by NHSE and will be prioritised for schemes that support the UEC pathway either through preventative work or reducing inpatient length of stay to improve flow.

Capacity and resilience over Winter:

- Significant **recruitment effort** underway to provide skilled staff to support the number of patients in the system
- **Changing crisis pathway** to provide more appropriate management of patients to same/next day rapid care and avoid A&E/admission
- Maintenance of **step-down hostel beds and increasing block purchase** private acute beds (significant cost pressure)
- **Refresh of bed requirements** modelling showing mismatch of bed base and demand which informs additional bed purchase
- Working with NHSE to optimise visibility and use of HBPOS capacity avoiding A&E presentation
- Working to scope, design and mobilise **NHS111 press 2 for MH** and related telephone support enhancements over and above 24/7 all age crisis line
- Additional resource and new models of **integrated recovery support** for patients with a Serious Mental Illness (SMI)
- CAMHS transformation programme and investment into Tier 3 to support longstanding capacity gaps in community CAMHS support
- **Reducing Length of Stay (LoS)** to increase bed capacity and safely reducing demand through improved community and crisis services.

Challenges and Risks:

- Significant **cost pressure to meet demand through use of Out of Area Placements** and impact on quality of care/ LOS due to patients placed out of area
- **Delays to patient admission due to constrained capacity** leading to risk in A&E/community and delay to Mental Health Act Assessments (MHAA)
- **ICB support to address discharge flow as a system** and move patients to less restrictive (and less costly) settings
- **Support with discussion around AMPH capacity and transport**.
- **Coordination of crisis initiatives** to ensure well used and not overlapping/confusion
- Engagement to **consider coordinated action re HBPOS capacity and Private bed purchase** (reducing cost through collective purchase)

SWL Operations Room

NHS South West London

The Surge/ Winter team, Single Point of Contact and Emergency Preparedness, Resilience and Response (EPRR)/Business Continuity (BC) functions were merged into a single team a year ago, giving **enhanced system oversight and dedicated Incident Response Team**. We have reconfigured the leadership of the room to ensure there is **suitable, experienced leadership in place every day** to ensure adequate resilience and system response. The Operations Room is fully functional 8am-6pm Monday-Friday and 8am-5pm Saturday and Sunday with executive level support available 24/7, 365 days a year.

Room function in BAU:

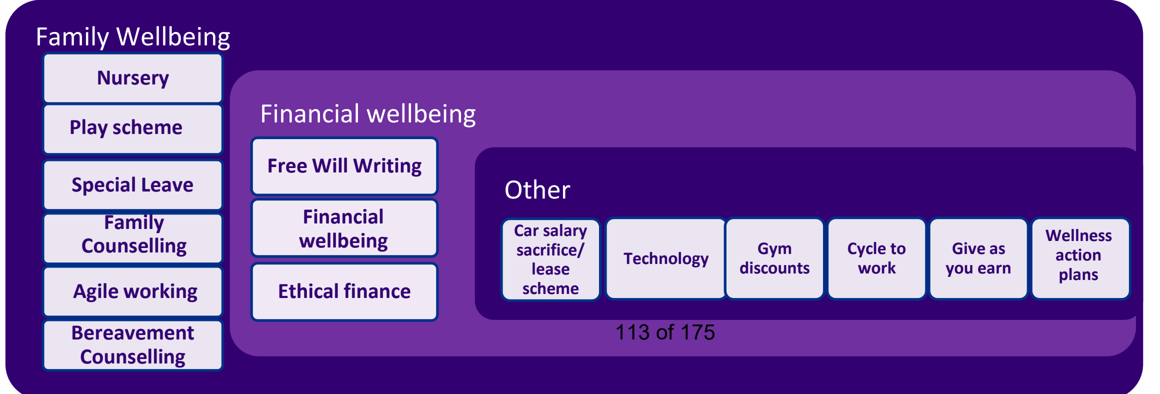
- Provides a **near live oversight of the system's performance**, developing and maintaining the escalation framework (OPEL) to support real time management of system pressures
- **Supports the UEC system with daily calls and escalating** where there are blockages in patient flow, including repatriation of patients
- Acts as a separate function to, but work closely with, the UEC programme developing the operational response as UEC reforms are implemented
- **Responds to and coordinate requests for information and action from NHSE** for SWL, cascading and monitoring responses as required including working with the UEC function to prepare and submit seasonal assurance for SWL
- Acts as a **first line of escalation** for system wide issues
- Provides the **strategic oversight, planning functions and preparation for our EPRR** response
- Acts as a **knowledge repository** for the system.

- The **emergency planning function will produce and ensure the Major Incident (MI) plan is up to date**, have up-to-date action cards, and will hold and maintain call out lists.
- The team **coordinates incident debriefs for SWL ICS**, liaising with the NHSE Emergency Planning team as required
- The Room acts as a Single, first, Point of Contact for:
    - NHS England National and London Region
    - Individual ICS organisations
    - Local Authorities/ Local Resilience Forums
    - Neighbouring ICBs

Workforce

Our current workforce is under immense pressure, compounded by vacancies and low availability of many staff groups putting stress on those who are in post.

- SWL has submitted a **bid for funding to support the upskilling of AHPs** in adult critical care competencies, to support the development of **enhanced and advance roles within the critical and emergency care environment**
- Across SWL, the Provider Trusts have registered to be involved in the **Digital Staff Passport,** which will **enable the movement of staff** across SWL to cover critical areas facing staff shortages
- The UEC Workforce Collaborative for London is developing an **Emergency Practitioner Framework for UEC settings** that will define the training and competencies for this workforce and which can be adopted across SWL
- Across SWL we are working to advance the levels of attainment on **e-job planning and e-rostering to optimise staff scheduling and deployment** to meet patient demand
- A key challenge within the SWL workforce has been the **increase in staffing as a result of the covid pandemic**. During the pandemic, we saw **enhanced elements of pay, reduced productivity and increased levels of turnover**. As a result, triangulation meetings involving finance, workforce and provider Trusts are occurring, aiming to identify, challenge and reverse the pandemic induced growth in WTE and to make significant inroads into the pay run rate.
- In addition, Workforce teams are placing an **emphasis on identifying recurrent workforce savings and transformation** to support next years' planning round to support system delivery
- In SW London, our **health and wellbeing approach** is designed to help protect workforce resilience by supporting every member of staff across health and social care with a **full range of support** including physical emotional, family and financial wellbeing:



Comms: Winter and engagement objectives

1 Behaviour change

Using communications to support with demand management

Integrated communications and engagement campaigns can encourage behaviour change in a target group - using a specific ‘call to action’ or providing information to support people to make an informed choice.

2 Workforce resilience

Making staff aware of support available and raising morale

During periods of strain on the services, staff are working harder under challenging circumstances to care for people - while subject to the same risks of winter illnesses. Health and care providers also employ local residents who can be key influencers.

3 Reassurance & confidence

Outlining the robust health and care system response to winter pressures

People’s perceptions of how the system is performing can also influence behaviour. When the NHS is under pressure nationally, we can reassure communities and stakeholders that the health and care system is working hard to prepare and respond. This can also help with staff morale.

4 Incident response

System communications response to incidents under EPRR framework

Providing strategic communications and engagement advice to inform the system response to incidents. Coordination across the system, ensuring C&E activities are consistent, clear and aligned with the wider system, regional and national approach.

Quality : Ambulance Handover & ED Delay Patient Harm Review

As described previously, we have seen unprecedented delays in ED, ambulance handover and ambulance response to patients in the community. Our Quality Team is planning a review to ensure we minimise the risk to patients this Winter as set out below.

Strategic Intent	**An exploratory review of the impacts of hospital ambulance handover delays and Emergency Department wait time delays** on patients and NHS staff in SWL; with a primary focus on harm (potential or actual) and experience (patient and staff).
Proposed Outcomes	1. To identify potential areas for development and quality improvement across the system. 2. A final review report that informs the SWL system whether or not there has been harm to patients over the last 12 months as a result of delays accessing UEC services. 3. A set of recommendations to UEC services and the ICS based on any learning identified.
Parameters	Review Timeframe: 12 months (July 2021 – June 2022) Demographics: Adults and children in SWL Delivery Timeframe: Data collation and review currently ongoing.
Engagement	Emergency Departments, Urgent Treatment Centres, Ambulance Services, Primary Care, Mental Health, Health Watch, SWL ICS teams, BI Teams, and more.
Methodology	• Recorded incident review (Patient Safety Incident Investigations, Datix reports, Root Cause Analyses, Structured Judgment Reviews, etc.) • Recorded experience review (complaints, Friends and Family Test, staff and patient surveys, Health Watch data, etc.) • New experience data (interviews, surveys, etc.) • Indirect impact review (performance data, harm linked to waits in the community, breaches, Length of Stay, risk register reviews, targeted pathway assessment, etc.)

Increasing Capacity this winter

SWL ICB Allocation of Funds

- System bids against NHSE Winter Funds were limited to bedded/bed alternatives to increase inpatient capacity in the UEC pathway.
- AEDBs were asked to work up their schemes and the initial SWL bid was for £16.9M revenue.
- This was subsequently reduced to £13.1M to come within the available regional funding envelope. This is reflected below.
- In September 2022, the ICB Board approved the spending plans in Part 2 of the meeting in order to give the System the longest possible time to implement the schemes, many of which require recruitment processes to be completed.
- The ICB is asked to note there is ongoing work on the potential to secure additional care home capacity which may result in some further adjustment to these allocations. This work will be overseen by the SWL Urgent Care Board.

	Allocation
Croydon	2695000
Kingston	2639500
M&W	4466000
Sutton	1570000
Neuro rehab	1540000
Homelessness	192500
Total	**13103000**

Summary of Capacity Plan

- Block purchase additional home care and reablement capacity, reopening TADD beds
- Purchase additional Neuro-rehab beds
- Purchase short term residential beds for use by local authority.
- Creation of "Medically Optimised For Discharge" ward capacity in residential setting
- Implement new 2 hour community response cars, delivered between LAS and community teams.
- Extend Hospital Ambulance Liaison Officer (HALO) support in ED
- Increase non-emergency transport provision to 12 hours a day 7 days a week
- Secure additional Discharge to Access, Transfer of Care and equipment delivery capacity
- Increase Same Day Emergency Care (SDEC) capacity and opening hours, including new frailty services and enhance ED capacity
- Implement Volunteer Scheme supporting discharge from ED
- Purchase new community and social care support including extending working hours and third sector support including welfare checks post discharge
- Open Sub-Acute bedded unit at St Helier Site
- Implement Integrated Discharge/ Admission Avoidance team (Surrey)
- Open winter escalation beds
- Employ additional ward liaison, therapy support and clinical pharmacists to support discharge
- Implement 100 Day challenge targeting patient flow and reducing length of stay
- Maximise use of virtual ward
- Implement enhanced Mental Health Discharge Pathway

Objective	Bed equivalent	Total beds at Jan '23
Increase capacity outside Acute Trusts	19	157.5
Target category 2 response times and ambulance handover delays	6	
Reduce crowding in A&E departments and target the longest waits	8	
Reduce hospital occupancy	59	
Ensure timely discharge	43.5	
Provide better support for people at home	12	

NHS South West London Integrated Care Board	
Date	Monday, 17 October 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 f Patient Outcomes, SWL ICB June Okochi, Deputy Director of Quality Improvement, SWL ICB		
Agenda Item No.	12	**Attachment No.**	10 a

Purpose (Tick as Required)	Approve	Discuss	Note
		✓	✓

Executive Summary

This report provides an overview of quality reporting in SW London for the months of July and August 2022.

The report provides key quality metrics highlighting safety, experience and well-led outcomes for Southwest London providers. The second part of the report outlines progress made on quality improvement plans at system level. The final part of the report provides a summary of exceptions, highlights and mitigations in place to address them.

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.
- Be assured that quality oversight and governance is effective and escalation processes are clear for partners to raise concerns where appropriate.
- Be assured that the development of quality functions and delivery within the ICB and wider ICS is being implemented at pace.

Key Issues for the Board to be aware of:
 	
• There are currently gaps in the process of automating and standardising quality metrics from providers. Our aim is to standardise the data reporting and collection approach for Trusts for quality metrics to support better trend analysis. This is long term plan, and the quality dashboard will be an enabler to achieving this.
 	
• As part of our plan to support the UEC pathway, deep dives have commenced in the following areas and reports will be available between Sept and Nov 2022.
  ○ Never events data (top themes and use of strong barriers)
  ○ UEC harm review and outcomes
  ○ Health inequalities in patient safety
 	
• 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 • 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:	• Quality risks are included in the SWL ICB Corporate risk register and escalated to the Board Assurance Framework where appropriate • Key areas impacting quality metrics for the Board to note include: (1) recent status of CQC ratings on some SWL General Practices, (2) quality risks on CHS at Merton and Wandsworth, (3) General workforce challenges specifically in urgent and emergency care services and (4) delayed 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/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
	SWL Quality Oversight Committee	Wednesday, 12 October 2022	Noted and assured
		Click here to enter a date.	
Supporting Documents	**SWL Quality Report**		

South West London Integrated Care Board
12th October 2022
South West London System Quality Report

Introduction

The report provides key quality metrics highlighting safety, experience, and well-led outcomes for South West London providers for the period of August 2022. The second part of the report outlines progress made on quality improvement plans at system level. The final part provides a summary of exceptions and associated mitigations.

Section1: **Key system quality metrics (Safe, Well led, Experience)**
Section 2: **Development of system quality oversight**

Section 1: SWL Integrated Care System (ICS) Key System Quality Indicators/Metrics

The indicators listed below are included in this report. These are some of the quality metrics required for ICSs to monitor to ensure effective quality oversight:

Safe	Experience	Well led	Effective
▪ Serious Incidents (SI's) & Never Events (NE) ▪ Quality alerts ▪ Mortality (SHMI/HMSR & Medical Examiner ▪ Infection Prevention Control (IPC) ▪ Harm Free Care: Falls & Pressure Ulcer (PU) ▪ Maternity Safety ▪ Medicines Management	▪ Provider Complaints ▪ ICB Complaints ▪ Friends and Family Test (FFT)-ED ▪ FFT-Inpatients	▪ Staffing: Vacancy & Turnover ▪ CQC inspections (Care Homes and Primary care	▪ Continuing Health Care (CHC)

Safety: *For people who use our services*

Avoid harm to people from care that is intended to help them

Safety Events- Never Events (NE)

- Four Never Events were declared between July and Aug 2022
  - Two wrong site surgery cases (reported by Epsom and St Helier University Hospital and Kingston Hospital NHS Foundation Trust)
  - One case of a retained foreign object and a case of administration of medication via a wrong route (reported by the Royal Marsden Hospital).
- SWL continues to be in the top two best performing ICS in London in terms of the number of never events.
- '**Retained foreign object'** and '**wrong site surgery'** are consistent themes.

Actions to improve:

- There is currently a system deep dive on top themes in review and development. A report will be presented to the System Quality Council by October 2022 and will be brought to the Quality and Oversight Committee subsequently.
- Further analysis will be carried out with specific focus on *barrier analysis* including next steps for implementation.
- We will strengthen system sharing learning as part of our Quality Management System and Quality Improvement (QI) approach.

Safety Events – Serious Incidents (SI's)

- SI number trend fluctuates ranging from 25-45 month on month (this is for SI's that SWL leads and for some provider it is for SWL borough patients only).
- 72 SIs have been declared in July and August since last report. Top three types of incidents reported for July and August remain: Self-harm (15), Falls (9) and diagnostic delays (11).
- Over the last 12 months (Jul 2021- June 2022), top 5 themes for SWL include; self-harm; infection control incidents; diagnostic delay, treatment delay and falls. Three out of the top five themes are consistent with London so this is not a unique position for South West London.

Actions to improve:

- We are currently undertaking themed deep dive across the system focusing on 'diagnosis and treatment delays' to guide the system in putting targeted plans in place to address the root causes.
- Explore further system level suicide prevention schemes working in collaboration with SWL's mental health alliance.
- We are sharing learning through our surveillance and ongoing Quality Council meetings.
- PSIRF was published 16th August and formally launched on 5th Sept 2022 by the national team. We have formulated ICS implementation plan and we are on track with going live date of 1st June 2023
- We have developed an action plan that ensures long standing SIs which remain open due to Clinical Commissioning Group (CCG) legacy arrangements are closed under the new ICB process – by end of 2022/23.

Infection and Prevention Control HCAI's

- Klebesiella spp infections remain within the threshold levels so far across all trusts
- The following are above threshold so far up to June 2022 for current year
  - SGH for C.Difficile
  - CHS and KHFT for E.Coli
  - Royal Marsden for P.aeroginosa

The increase in E-coli infections has also increased in comparison to the same period last year. This is as a result of the recent spate of very warm weather as dehydration and UTI's are key causes of E-coli infection. SWL IPC team are monitoring the data with a view to review a full month's activity to ensure levels are returning to normal.

Some of the key priorities/workstreams for SWL include:

- Weekly surveillance of community and provider prevalence and reporting of IPC events (including to NHSE and PHE).
- Care home support arrangements (variety of seminar/ information cascade).
- SWL level IPC group to review the support and action plans across SWL to establish common root causes of HCAI's focusing on GNBSI's.

Safety and quality alerts – Make A Difference (MkAD)

- A total of **252** MkAD safety alerts have been raised across SWL in the last 2 months (July and August) since last report
- Top themes in July – August 2022 were referral **process** (72 alerts), **discharge concerns** (59), **communication** (36 alerts), **medication** (32 alerts).

Actions to improve:

- SWL continue to utilise the intelligence from alerts to improve patient experience, safety and inform wider learning and improvement across the system.
- Promoting MkAD across Social Care Partners, by working with the Enhanced Healthcare in Care Homes (EHCH) initiative to increase awareness and uptake of MkAD across Care Homes.
- Strategic use of MkAD alerts to identify and address quality issues/concerns across the ICS through quality initiatives to facilitate change and improve across the system.

Mortality Summary Hospital Level Mortality and Hospital Standardised Mortality Ratio (SHMI/ HMSR)

- SHMI and HSMR figures are all within the average range in the reporting months for all Trusts except Epsom and St Helier Hospital (ESH).
- Both SHMI and HSMR at ESH have been rising since July 21 and are now hitting the threshold for a red alert. A deep dive has been undertaken to understand contributory factors. The number of observed deaths has not increased. However, the number of expected deaths has reduced. A clinical deep dive into CCS diagnosis with elevated mortality rates have not revealed any systemic concerns regarding clinical management but have raised questions regarding depth and accuracy of clinical coding for primary diagnosis and co-morbidities. The deep dive also revealed a temporal correlation between the number of deceased patients who had prolonged Emergency Department

stays (>4 hrs) and a further clinical review is underway to understand this position. Progress and outcomes will be monitored monthly at the Group quality committee in common.

Actions to improve:

- There is no existing SWL platform that collates the SWL picture for mortality in a comprehensive way. The plan is to develop a platform that will triangulate mortality reporting sources which will include (local trusts mortality monitoring, external mortality alerts, medical examiner, coroner alerts, child deaths panels and providers learning from death reports (learning from deaths (LfD) report). The aims are to monitor mortality themes, learning and identifying safety improvement areas.
- To include missing system partners data in future reports {i.e RMH, SWL StG, SLAM} and a consistent process for the ratio measures.

Harm Free Care - Pressure Ulcers (PU)

Reporting months data show St Georges' Hospital (SGH) having the highest number of PU's throughout the current financial year. Root cause analysis is carried out for all SGH PUs in category 3 and above to identify learning. Future figures will be based on PU's per 1000 bed days.

Harm Free Care – Falls

Reporting months data show SGH having the highest number of falls throughout the year. The Trust has action plans in place to prevent hospital related falls and continues to monitor performance, whilst learning from the root causes. Future figures will be based on falls per 1000 bed days.

Maternity Safety

Stillbirth Summary findings

- Southwest London's overall stillbirth rate has reduced in 2021/22 compared to 2020/21.
- 2021/22 data shows that Epsom St Helier and St Georges Hospital stillbirth rates are lower than the previous year. In a deep dive exercise, it was found that St Georges were submitting medical terminations in their stillbirth data. These cases have now been removed which saw a reduction in their stillbirth rate. This was found in December 2021.

Maternity Continuity of Carer (MCoC) June Update

- Ongoing National plans are currently underway reviewing each Trusts plans to roll out MCoC to achieve the National targets, however, we have received a letter from NHSE/I advising us to prioritise safer staffing and keeping maternity safe rather than targets.

Medicines Optimisation (MO) – Antimicrobial resistance

Based on May 2022 data, SWL generally remains below the threshold of 0.871 **for antibacterial items use** per STAR-PU in primary care but is trending upwards. Sutton is showing as generally higher use than other boroughs and in some months above the threshold. There has not been a specific reason identified why Sutton has this high trend over but there has been a lot of work being carried out in Sutton to include:

- Providing prescribing data to practices every month as well as detail of movement towards target compared with previous months. Discussions at General Practice meetings.
- Suggested review of antibiotics for COPD – rescue packs and azithromycin for prophylaxis to (a) ensure clinically appropriate and (b) reduce inappropriate antibiotic prescribing.
- Have several practices undertaking quality improvement projects relating to antibiotic prescribing as part of the primary care engagement scheme. When these are complete learning will be shared more widely.

Broad-spectrum antibacterial use in primary care trends have been up and down with some months where we are above the 10% threshold. Medicines optimisation teams are looking to identify GP Practices that are outliers for broad spectrum antibiotics and carry out audits to understand what is driving this and continue to reinforce Primary Care Antimicrobial Prescribing Guidelines to support GPs to prescribe narrow spectrum antimicrobials rather than broad spectrum ones

System wide actions

- Expand medicines support alignment further throughout the SWL ICS
- Continue to progress SWL MO Joint Formulary further
- Start Hydration pilot "Activating Aquarate in Care homes and the Virtual wards"
- Support implementation of the Community Pharmacist Consultation Service (CPCS) service with GPs and 111 referrals to triage patients
- Consider SWL Meds Optimisation business intelligence priorities.
- Review national and local monitored MO areas to determine the focus of future reports.

Current Identified System Risks & escalations	Planned mitigations
Antimicrobial usage - no clinical network focused on this workstream, capacity stretch die to focus on viral illnesses	ICB MO Team continue to closely monitor usage and promote guidelines at their assigned place teams and feed centrally
Staffing – fixed term recruitment may not attract high calibre candidates, vacancies and demands on workstreams on the increase	ICB MO lead to work with Senior Responsible Officer so that requests to continue to recruit to vacancies continue even as fixed term contracts.

Positive Experience: *For people who use our service*

Responsive and person-centred. Services respond to people's needs and choices and enable them to be equal partners in their own care

Friends and Family Test (FFT)

FFTs performance continues to be a challenge in Emergency Departments (ED) due to the national, regional and local ED pressures and long waits including ambulance handover delays for most acute services. This has been the case for a few months mainly due to waiting times due to operational pressures. Several Trusts are implementing new FFT systems to improve response rates and engagement, whilst others are outsourcing the FFT function to external providers.

System wide actions:

- The establishment of SWL'S Patient Experience and Engagement Network Panel. The panel will bring all Patient Experience and Engagement leads across all our providers together to discuss and review all open complaints, FFT analysis, PALS, compliments, and track system wide issues that could be emerging from our patients' concerns.
- Implement Patient Safety Partner role as well as ensure we have patient voice on our system quality groups such as Quality Council, Children and Young People (CYP) boards and other relevant committees.

SWL Provider Complaints

Overall, across SWL, the number of complaints continue to fluctuate. Future reporting will be benchmarked over time to support with better comparison, analysing figures per 1000 bed days to help with better understanding of the trends.

ICB Complaints

- In 2022/23 to date, the ICB has received **214 complaints** (including through MPs) and **315 PALS enquiries**. The highest volume of complaints relates to primary care and general health.

Current Themes

Data on emerging themes from PALS and Complaints is in its early stages, whilst the current methods record the category and the geographic area, the subcategory details of what the case is about are contained within the text of the case, not counted in metrics. This will be resolved with the implementation of Radar Healthcare software. Currently there is a manual process to outline consistent themes.

Actions to improve:

- Our Quality Complaints Review Panel has been established with the first meeting in April 2022. The plan is to launch this formally with system partners on 1st November 2022 as part of the Patient Experience and Engagement Panel.
- Implementation of a new data recording system for complaints, to support intelligent reporting.
- Roll out of revised complaints framework on how we learn and improve performance of closed complaints from within timescales from 67% to 80%.

Well- Led: *For those providing services*

Be open and collaborate internally and externally and are committed to learning and improvement

Staff Vacancy and Turnover

Vacancy and turnover rates continue to be a challenged picture across all our services and providers mostly because of the COVID pandemic and increased demand on services across the system. This has been an escalation point for quality and safety or the last three months across quality meetings and committees. The situation is not unique to SWL, impacting services regionally and nationally.

'Relocation' and 'work life balance' are now the top two most common themes for staff leaving Providers. CHS reported that staff leaving for 'work life balance' reasons has doubled since May 2021.

Actions to improve at system level:

- SWL ICS have appointed a Nursing Supply lead working with all SW London Trusts, primary and community care providers to support the system to increase nursing supply. The role will support both international recruitment and domestic supply work streams working closely with the SW London recruitment hub and other workforce initiatives that support recruitment. The role will also focus on the retention of nursing staff and nursing workforce wellbeing.
- All SWL Trusts have recruitment and retention programmes in place to ensure sufficient workforce capacity is in place.
- Over the coming months, work will commence with Acute Provider Collaborative and HEE colleagues on two emerging system workforce priorities to identify more creative supply routes and reviewing workforce design in Emergency Departments and Diagnostics to determine and plan the future workforce requirement for these essential services.
- SWL Chief Nurses are collaborating to review and act on nursing staffing challenges, including standardisation of bank and agency rates.

Provider Care Quality Commission (CQC) updates

SGH and CHS have services currently rated as 'Requires Improvement'.

- SGH: has completed all actions from the 2019 inspection and has five actions that are being managed as part of business as usual. CQC visited SGH in April 2022 to review interventional radiology services and CQC has given the Trust four improvements for cardiology and neuroradiology compliance with the Ionising Radiation Medical Exposure Regulations (IRMER) regulations, but none requiring regulatory action.
- CHS: action plan was incorporated into the main quality improvement plan and the Trust's plan to close the outstanding milestones against the CQC plan was achieved. The Quality Improvement Plan was closed.
- Your HealthCare CiC (YHC): Recent CQC outcome is reported as Good overall and Outstanding for Caring.

Actions to improve:

- Currently there is no central process for oversight of all non-NHS providers (excluding GP/Care homes) who are CQC registered in SWL. Our aim is to develop a process for Place, Provider collaboratives and ICS to support robust process for monitoring and oversight of CQC outcomes and action plans across the system for all providers by December 2022.

Care Home CQC updates

In SWL there are 343 care homes with 8472 Resident beds; consisting of 97 Nursing Homes, 59 Residential homes, and 187 Care Homes for people with mental health conditions or learning disabilities. 39 homes were identified as 'requiring improvement' at previous inspection, 1 rated as ‘inadequate’ and the rest are rated good or outstanding

Actions to improve:

- Ongoing support from Place Quality and Primary Care Quality Leads to support QI in care homes.
- The Ageing Well team continue to work on transformational programmes that improve outcomes for Care Home residents such as the Enhanced Care Homes Vanguard model and the Frailty programme.
- Care Homes Quality Oversight will be closer to the ICB Quality 22/23 with planned integrated oversight with Local Authority as part of our framework.

Primary Care CQC updates

There are 179 general practices in SWL, 3 have been rated as ‘Inadequate’ and 9 rated as ‘Requires Improvement’. The 12 practices rated ‘Requires Improvement’ or lower are receiving support due to contractual concerns identified by the CQC:

- **Croydon**: Auckland Surgery, South Norwood Hill Medical Centre, East Croydon Medical Centre, and Edridge Road Community Health Centre
- **Kingston**: Central Surgery
- **Richmond**: Hampton Wick Surgery
- **Merton**: Mitcham Family Practice
- **Sutton**: Beeches Surgery and Green Wrythe Surgery
- **Wandsworth**: Trinity Medical Centre, Bedford Hill Family Practice and Triangle Surgery

Village Surgery, Kingston, closed 18/08/22.

Effectiveness: *For people who use our services*

Providing services based on evidence that produce a clear benefit

Continuing Health Care (CHC)

We have made a significant progress in clearing our CHC back logs. In May 2022, the number of outstanding reviews across SWL was 303. The team have now completed 163 of those reviews, with 33 triggering a full DST, 5 confirmed for joint assessment with SW, with 28 remaining unallocated. We have recruited a Director of CHC Transformation to lead on the transformation program. We have also launched a system wide review into developing the future model for CHC in SWL.

Ongoing actions to address the backlog issues have been:

- 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.
- A dedicated CHC escalation team are in post and are working through the backlog.
- CHC direct have also been commissioned to support with carrying out reviews on backlog cases.

Section 2: Development of system quality oversight

System Quality Delivery

Areas of quality delivery progressing within the ICS include:

Item	Update
Place Quality / Quality Governance	Development and implementation of structures and roles has commenced this month (September 2022). This includes a revised escalation process for the team and monitoring of the overarching Quality improvement plan. A number of Place Quality Forum are in the process of being established/developed. The ICB is currently developing a primary care quality framework which will support in the delivery of improved outcomes and oversight where there may be challenges in service quality.

Nursing/AHP Workforce	SWL Chief Nurses are collaborating to review and act on nursing staffing challenges, including standardisation of bank and agency rates.
ICB Patient Safety Partners	Interviews have taken place and offers made for the appointment of two patient safety partners.
Urgent and Emergency Care (UEC)	A system review of harm and outcomes relating to UEC and ambulance handover delays is currently being undertaken.
Maternity	Trusts are delivering on the recommendations from the Ockenden Review, with assurance being provided against progress.
SWL ICB Care Quality Indicators (CQUINs)	The SWL baseline is completed for acute and community Trusts, aiming for delivery starting in Q3. The Cancer alliance are supporting quality with the cancer submission programme.
Children and Young People (CYP)	The CYP work programme is progressing with a focus on key areas, including asthma, neurodevelopment, and health inequalities.
Quality Dashboard	An early version of the dashboard has gone live this month and is currently under review.
Quality Strategy	System quality strategy consultation workshops were held on site on Friday 22nd July and virtually on the 3rd of August 2022 to consult system partners on the' 'vison statement'' as well as the 'quality priorities for SWL over the next five years. A copy of the strategy will published by November 2022.

Next Steps

We are currently undertaking deep dives in the following areas and reports will be available between September and November 2022.

- Never events data (top themes and use of strong barriers)
- UEC harm review and outcomes
- Health inequalities in patient safety

Our ultimate ambition is to mature and grow as a learning system, we will aim to do so by:

- Triangulating quality, performance and workforce data
- Supporting cross system learning
- Sharing best practice
- System quality improvement newsletter
- Standardising the data reporting and collection approach for Trusts for quality metrics to support better trend analysis. This is long term plan and the quality dashboard will be an enabler to achieving this.

Recommendations

The Board is asked to:

- Note the full report and the quality issues and challenges identified across the system
- Be assured that quality oversight and governance is effective and escalation processes are clear for partners to raise concerns where appropriate.
- Be assured that the development of quality functions and delivery within the ICB and wider ICS is being implemented at pace.

NHS South West London Integrated Care Board	
Date	Monday, 17 October 2022

Document Title	South West London ICB Performance Report (August 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.	12	Attachment No.	10 b

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 as well as other significant borough/Place level indicators.

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 activity:** SWL continues to deliver a relatively strong performance on elective recovery, though there are substantial ongoing challenges including a growing overall waiting list which has increased by 8% since April.
- **Long waiting patients:** 1,320 patients were waiting over 52 weeks for treatment in July, against a plan of 1,054. This is the strongest position in the capital. In the longer waiting cohorts, 48 patients were waiting over 78 weeks in mid-August.
- **Cancer:** 2-week wait performance was below the national standard of 93% (82.9% in June 2022). On the 62-day standard (85%), SWL was the highest performing sector in London, with 74.1% in June.

- **A&E 4 Hour Waits:** At an ICS level, 75.2% of patients were seen within 4 hours in July. The percentage of 111 calls answered in 60 seconds in July was 18.6%.
- **Physical care 12 Hour A&E Breaches:** 1,733 patients waited over 12 hours from decision to admit to admission in July. SWL had the highest number of 12 Hour breaches in London this month and the fourth highest nationally. A patient safety review is being undertaken across the ICS led by chief nurses and medical directors.
- **Mental Health 12 Hour A&E Breaches:** Unvalidated figures show that in July 2022, 85 12-hour breaches were reported for MH patients, mainly waiting on a bed. This is a decrease for the second consecutive month.
- **Learning Disability Health checks:** At the end of Month 4, the Annual Health Checks (AHC) are ahead of previous years' activity.
- **Mental health Improving Access to Psychological Therapies:** Provisional data for June 2022 shows 3,015 clients entering treatment, below the monthly target of 3,300. Providers are continuing to implement actions to increase numbers of referrals in line with action plans.
- **Severe Mental Illness Health checks**: Final submitted data for Q1 22/23 showed a slightly improved performance at 40.5%. The ICS has established a dedicated SMI health checks programme for 2022/23 to build on the good work in 2021/22 and continue improvement towards the 60% national standard.

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)	N/A

necessary and has it been completed?	
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:
	SMT	08/09/2022	Contents noted
	Quality and Oversight Committee	Wednesday, 12 October 2022	
		Click here to enter a date.	
Supporting Documents	Attached ICB Performance Report – August 2022		

South West London ICB Performance Report

August 2022 (Month 4 data)

South West London ICB Performance Report

Commentary on contents and data

- 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.
- Diagnostic and elective activity is based on data reported until the end of June. Following a change in the reporting process, weekly provisional data is not yet available for July 2022.

South West London ICB Performance Report

Key Findings

- **Planned Care:** Diagnostics was 113% of Business as Usual (BAU 2019/20) in June 2022. There are backlog challenges for Echocardiology, mainly at Croydon Healthcare Services (CHS) and Kingston Hospital Foundation Trust (KHFT) and for Non Obstetric Ultrasound (NOUS) particularly at KHFT. SWL achieved 107.0% in outpatients activity in June against a trajectory of 103%. First appointments were 107.5% of BAU, while Follow ups were 106.5% BAU. There were 12,010 day case procedures in June (102.0% of BAU), and for ordinary electives, 2,258 inpatient stays equated to 79.1% BAU; the 'Awesome Autumn' initiative by Trusts and the Acute Provider Collaborative aims to bring up these activity levels. At the time of writing, the SWL PTL (waiting list) has grown by 12.5k (8.4%) since April. This is higher than the London average of 6.6%, mainly driven by St George's (SGH) and Epsom & St Helier (ESTH). The APC (Acute Provider Collaborative) is developing a waiting list cleansing and validation plan with support from the ICB.
- **52 Week Waits:** 1,320 patients were waiting over 52 weeks for treatment in July (against a plan of 1,054). For the week ending 14/08/22, there were 48 patients waiting over 78 weeks against a trajectory of 26 for July, the majority (41 patients) at SGH within General Surgery, Cardiology and Plastics.
- **Cancer:** Performance against the 2-week wait (2WW) standard was below the national standard of 93% (82.9% in June 2022). Against the 62 Day standard of 85%, SWL was the highest performing sector in London, with an outcome of 74.1% in June. SWL Integrated Care System (SWL ICS) performance on the 2WW symptomatic breast pathway was 60.1% in June, the second-lowest performing ICS in London. Performance on the 28 Day faster Diagnostic Standard (FDS) was 74.2% in June against the standard of 75%. This was the second highest performance in London.
- **A&E and IUC Waits:** At an ICS level, 75.2% of patients were seen within 4 hours in July. In July attendances were 59.3k, down from 60.3K in June. The percentage of 111 calls answered in 60 seconds in July was 18.6%. The Service provider are experiencing difficulties in mobilising a fully staffed service which is impacting on performance.
- **Physical care 12 Hour A&E Breaches:** 1,733 patients waited over 12 hours from decision to admit to admission in July, up from 997 in June. SWL had the highest number of 12 Hour breaches in London this month and the fourth highest nationally. In terms of London Ambulance Service (LAS) handover breaches, there were 964 X 30 minute breaches and 555 X 60 minute breaches, an increase on recent months. Regional escalation calls occur across London plus discussions via the A&E Delivery Board (AEDB). The UEC reset event on 8 July identified a number of opportunities to improve flow through A&E and reduce further risks. A follow up event is planned for September 2022.
- **Mental Health 12 Hour A&E Breaches:** Unvalidated figures show that in June, 85 X 12-hour breaches were reported for Mental Health (MH) patients, mainly waiting on a bed. Further actions will occur via the Urgent and Emergency Care (UEC) Board to consider the next steps.
- **Learning Disability (LD) Health checks:** Clinical leads in our boroughs continue to work with individual practices to maximise the number of people with a learning difficulty who have their Annual Health Check. SWL ICS remains on track to deliver against plans.
- **Mental health Improving Access to Psychological Therapies programme (IAPT)** – Provisional data for June shows 3,015 clients entering treatment and below the monthly target of 3,300. The common factor affecting access levels for all SWL providers remains reduced capacity due to staff vacancies and difficulties recruiting to these posts. Action plans are in place across all providers.
- **Severe Mental Illness (SMI) Health checks**: The latest data available is Quarter 1 (2022/23), which shows and outcome of 40.5% for SWL ICS, with 6,706 SMI patients having received all six annual health check elements. SWL ICS has established a new dedicated SMI health checks programme for 2022/23 to build on the good work in 2021/22 and continuing improvement towards the 60% national standard.

South West London ICB Performance Report

Performance Horizon scanning

UEC and Integrated Care

- **Extensive winter planning is underway across the system** given the very significant pressures faced over the summer months that are not expected to abate this autumn and winter. **Plans to invest delegated winter funds** have been drawn up with local partners and an extensive assurance process by NHSE is in place.
- A winter resilience letter from NHSE was published on 12th August, with guidance for bolstering resilience in key areas. The letter specifies the ICBs' empowerment to lead on winter resilience, noting the opportunity to test the new ways of working. Six specified KPIs will be reported through each ICB's Board Assurance Framework.
- **The follow up to the July UEC reset event was held on 30 September** to think through what needs to happen in the medium to longer term to move to a more sustainable urgent care system. Key focus areas were the approach to the front door (getting people to the right place at right time), workforce resilience, timely flow through the system and our PCN urgent care offer. Underpinning these was consideration of patient experience, and how we can promote and socialise our care offer to patients.
- SWL is fully engaged in the **LAS urgent care response pilot car** due to start in September which is intended to reduce the number of frail, older patients, who are often the most vulnerable cohort attending ED, where possible. There is a well-established discharge programme in place and the wider SWL system is currently undertaking a review against the 10 points included in the 100-day challenge issued by the National Health and Social Care Discharge Taskforce. As well as building on existing work, we are looking at how to optimise existing capacity, such as the Virtual Wards to reduce admission as well as accelerate discharge, which in turn should help reduce the high numbers of 12-hour trolley breaches in ED.
- A **patient safety review** is underway taking account of chief nurse and medical director views to ensure we understand the patient safety implications of the current access and delivery issues.

Planned and Cancer Care

- **National assurance has been sought on delivery of improved long waiter position (78 weeks) and on 62-day cancer performance**. Two provider collaboratives, the APC and RMP have worked together to develop a joint assurance plan. The ICS expect to see ongoing improvements in the 78 week wait cohort through the autumn. Discussions continue between Trusts to maintain higher activity levels through September/October with an initiative being referred to as 'Awesome Autumn'. This will support clearance of long waiters, with a local ambition of clearing High Volume Low Complexity (HVLC) 78ww by the end of October.
- **Plans on 62 day cancer performance** are not yet fully assured with challenges at a number of providers, most notably Croydon Health Services. A touch point was held on 4th August with CHS and RM Partners, to review their recovery plan for the 28-day Faster Diagnosis Standard and the 62-day standard. The plan addresses workforce shortages, productivity and aims to get FDS and 62-day performance back on plan by end November.
- 2 Week Wait **breast pathway access** remains a significant challenge, with performance on the breast pathway being 60.1% in June (167 breaches out of 278 pathways). The challenges remain at St. George's and Royal Marsden. Although Royal Marsden Partners (RMP) and the ICS are working to develop a solution, this remains a key risk to the sustained delivery of Faster Diagnosis Standard (FDS), 31 and 62-day targets by Q1 22/23.
- **The London region has the largest RTT PTL nationally and the fewest long waiters, with SWL ICS a positive outlier for both measures.** However, SWL has seen a relatively higher PTL growth in recent months. To address this, there is increased focus on data quality (validation) and waiting list removals without treatment, which may indicate that some referrals should be redirected to more appropriate care settings.

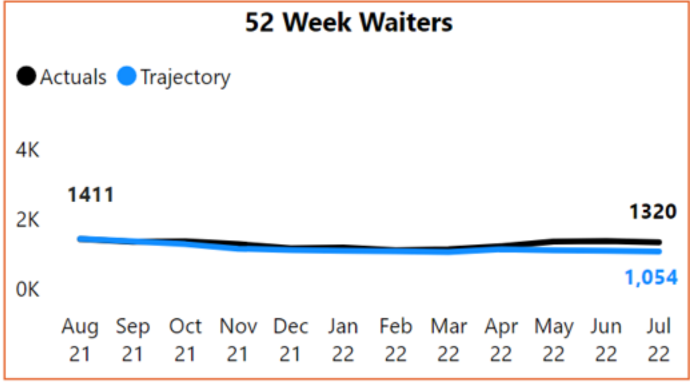
Mental Health

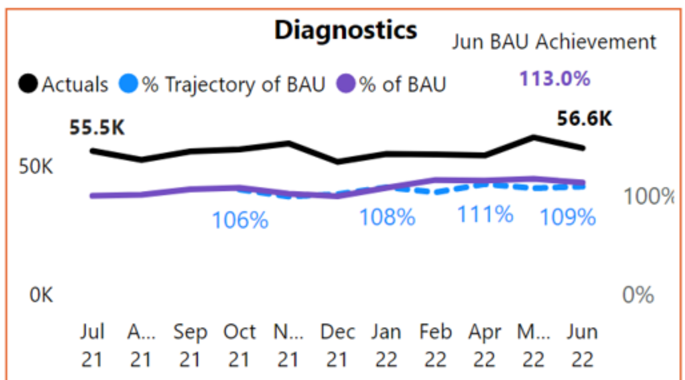
- **IAPT performance remains challenged** despite the actions being taken. The ICS is actively working to improve the position. There are also **significant growing pressures on MH** services more generally as referral and activity levels increase which has presented challenges on delivering a number of aspects of the operating plan including reducing out of area placements.

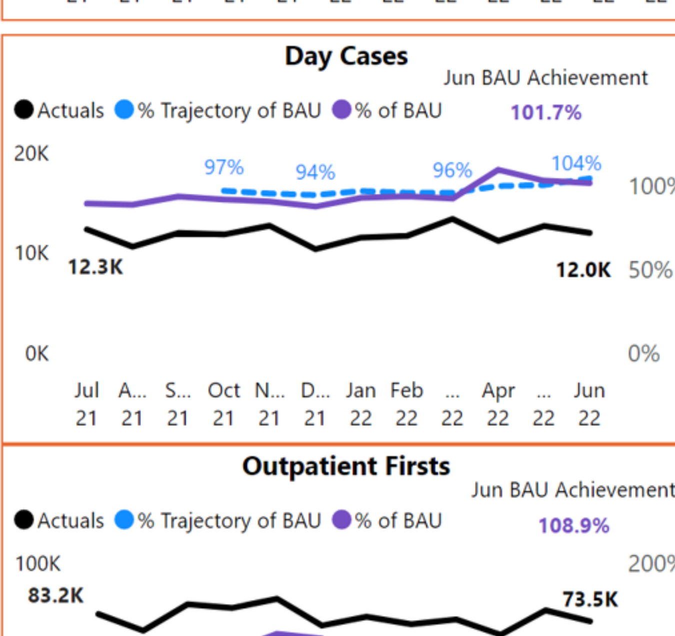
South West London ICB Performance Report

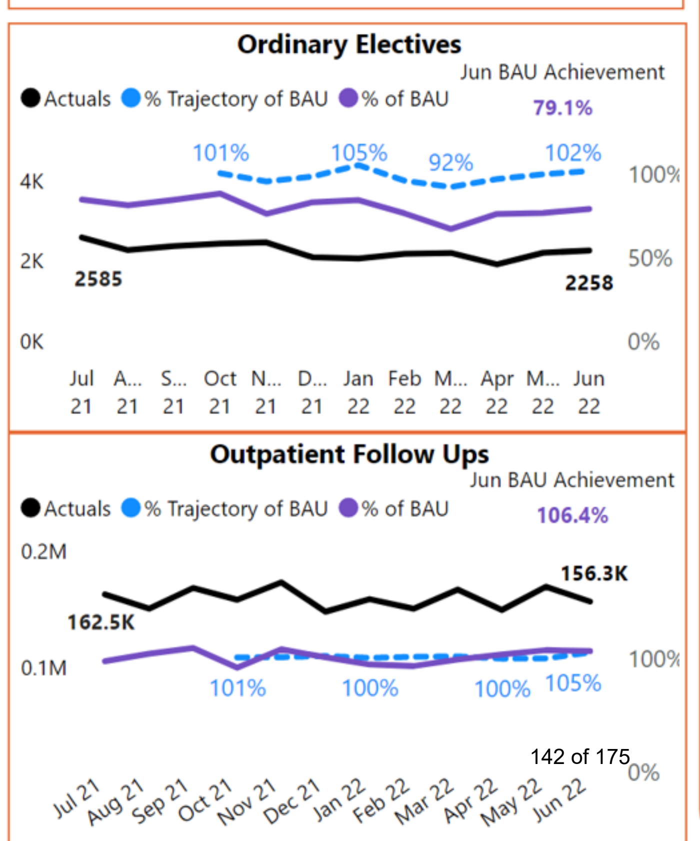
Planned Care

BAU Achievement is comparing activity in the recent month against the corresponding month of 2019/2020.
SRO: Jacqueline Totterdell









Over 52 Week Waiters – July

1,320 patients were waiting over 52 weeks for treatment in July, against a plan of 1,054. The non admitted challenged specialties are – ENT, cardiology and neuro surgery with admitted challenges within cardiology, general surgery and plastics. The weekly Elective Recovery Group oversees improvement actions across workstreams supporting the reduction of long waiters, such as Mutual Aid, PTL assurance, aligning access policies and Outpatient transformation. For the week ending 14/08/22, there were 48 patients waiting over 78 weeks against a trajectory of 26. The majority (41 patients) at SGH are within Cardiology, General Surgery and Plastic surgery. A single 104ww remains at SGH. Discussions continue between Trusts to maintain activity levels achieved in summer through September/October with an initiative being referred to as 'Awesome Autumn'. This will support clearance of long waiters, with a local ambition of clearing High Volume Low Complexity (HVLC) 78ww by the end of October.

Diagnostics – June

Diagnostic activity was 113% (56,631) of BAU (19/20) in June 2022. Imaging and Echocardiography were above 19/20 BAU whilst Endoscopy continued to be slightly below, although on an upward trajectory that is continued in latest weekly data. SWL continues to have backlog (6+ week waiters) challenges for Echocardiography, mainly at Croydon Healthcare Services (CHS) (1,219) and KHFT (1,038), with weekly data showing that this position has now stabilised. Independent Sector (IS) capacity is now being sought for the next 6 months to address this and should the Kingston CDC business case be successful this will increase capacity at Kingston. A challenge continues to be seen in Non Obstetric Ultrasound (NOUS) particularly at Kingston Hospital Foundation Trust (KHFT) (1,546) driven by high demand and staff vacancies. This is being addressed via Waiting List Initiatives (WLI) and use of agency staff however the backlog remained at 1,468.

Elective Day Case and Ordinary Electives – June

There were 11,965 day case procedures in June (101.7% of BAU). For ordinary electives, there were 2,258 inpatient stays (79.1% BAU). A stronger mix of day case activity over the last few months for electives is delivering close to BAU in totality. For June the aggregated total was 96%. Most providers are facing challenges linked to workforce planning (absence through sickness and leave), particularly at CHS where delivery plans were 110% of BAU and reporting indicates 92% achievement. CHS are implementing the NHSE elective improvement and productivity programme (IECCPP) to increase activity.

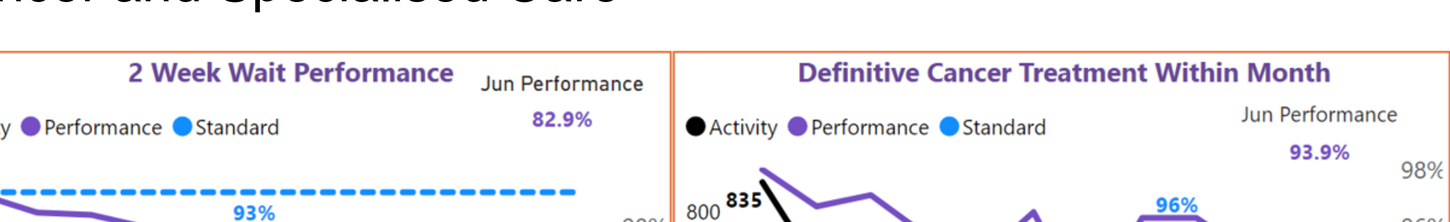
Outpatient First and Follow-Up Attendances – June

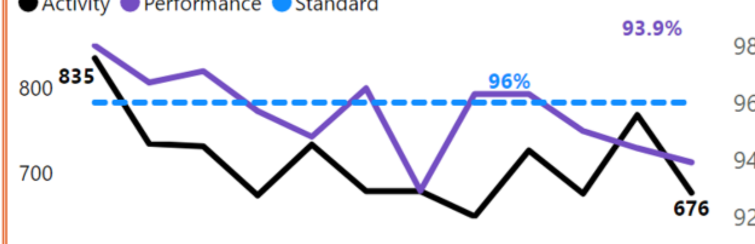
Overall, SWL achieved 107.0% activity in June against a trajectory of 103%. SWL First appointments totalled 73,477, which was 108.9% of BAU. There were 156,338 Outpatient Follow Up appointments which was 106.4% of BAU. Normalising for the inclusion of swabs reduces Outpatient First performance to levels closer to 99% of baseline activity. Gynae has shown significant growth in line with increased referrals. Follow-up activity has remained above 100% as providers address backlogs. Additionally, changes to national methodology has resulted in a number of Cardiology and Urology procedures being coded as Follow-ups (previously classified as Outpatient Procedures). Cancer follow-up activity has performed at 121% of baseline levels, growth in this area is as expected, and in line with planned growth.

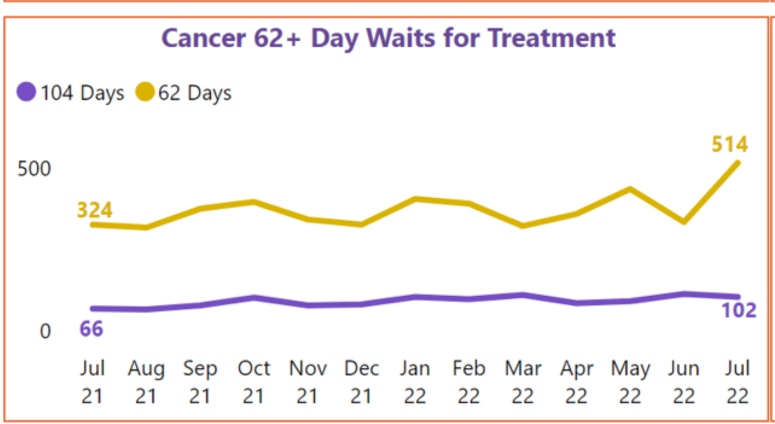
South West London ICB Performance Report

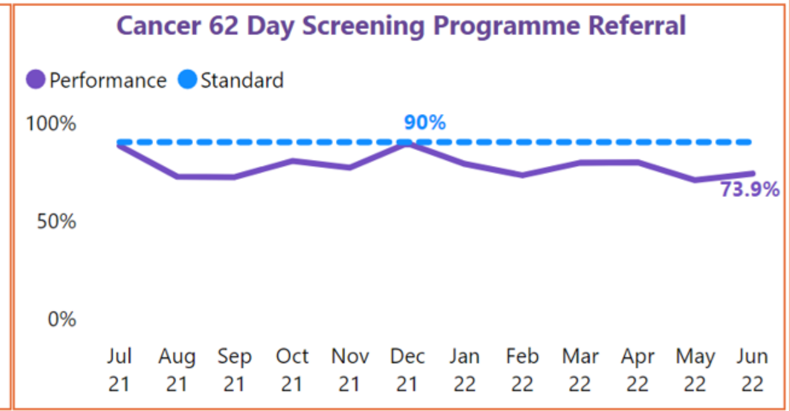
Cancer and Specialised Care

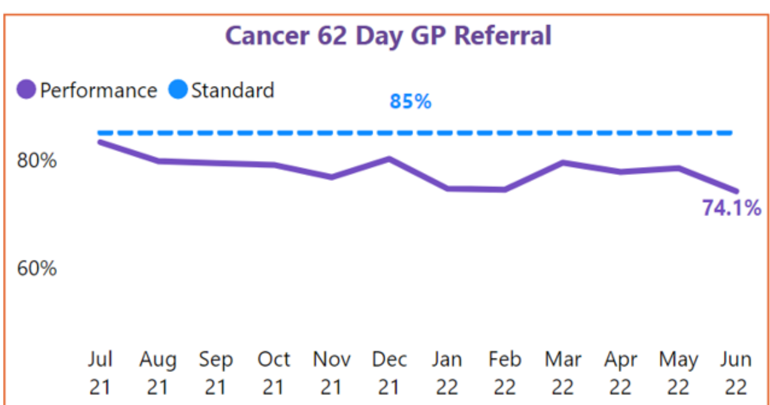
SROs: Jonathan Bates and Susan Sinclair

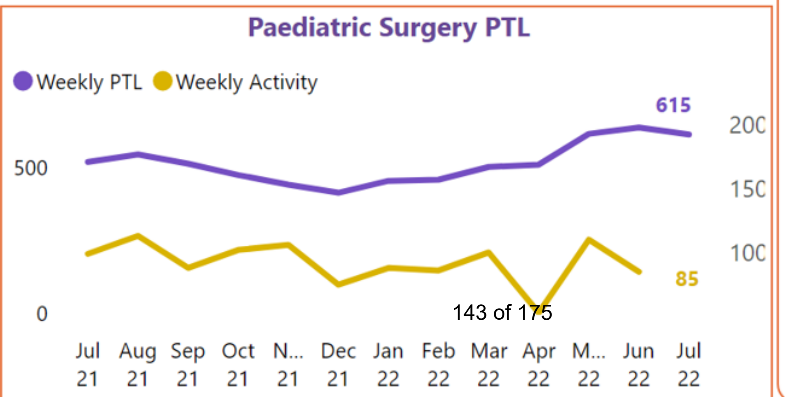












2 Week Wait Performance (all SWL Providers)
SWL ICS 2WW June performance remains challenged due to a 17% increase in referrals compared to BAU, with a performance of 82.9%. Croydon Health Services (CHS) reported 2WW performance in June at 75.5%, with particular challenges in Gynaecology & Lower GI. Royal Marsden Hospital (RMH) reported 2WW performance at 61.6% in June. The Trust continued to work through a 2WW backlog and received 22% more 2WW referrals in comparison to BAU. Kingston Hospital (KHFT) and RMH have internally approved their Breast Business Cases and have begun recruiting to clinical posts to support sustainable Breast recovery.

SWL ICS was the second highest performing in London with 74.2% against the Faster Diagnosis Standard (FDS). All Trusts with the exception of CHS reported a compliant FDS position above the 75% threshold. Performance at CHS in particular remains challenged, and the Trust is working to a Recovery Plan developed with support from RMP.

Definitive cancer treatment within the month
SWL performance was 93.9% in June, below the 96% standard.

Patients Waiting Over 62 Days for Cancer Treatment
The number of patients waiting over 62 days at the end of July (week ending 31/07/22) was 514, against the 2022/2023 Operating Plan trajectory of 412. More recent data indicates that the backlog has decreased to 480 (week ending 07/08/22).

Cancer 62 Day Screening Referral to Treatment Performance (Screening Programmes)
Breast, Bowel and Cervical Screening programmes continue to operate as BAU. SWLBSS is utilising £633k of national funding towards initiatives, including Health Promotion uptake and coverage, education and training (National Breast Education Centre), as well as workforce to support backlog and return to round length recovery. SWL ICS will be working with the London Regional Screening Team to support Provider Colposcopy performance sustainability.

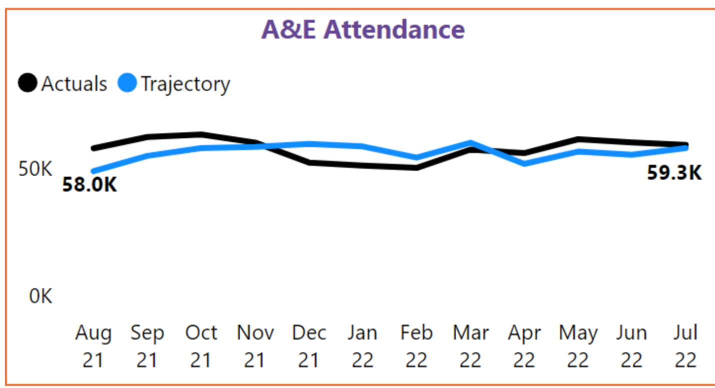
Cancer 62 Day Referral to Treatment Performance (GP Referrals)
SWL Providers were the highest performing in London, at 74.1% in June. However, this was below the Constitutional Standard of 85%.

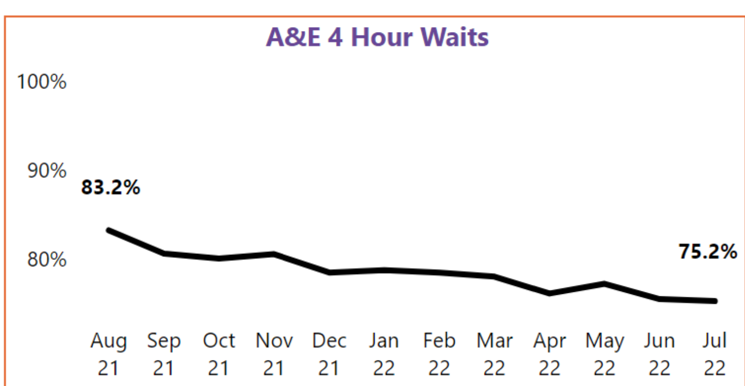
South West London ICB Performance Report

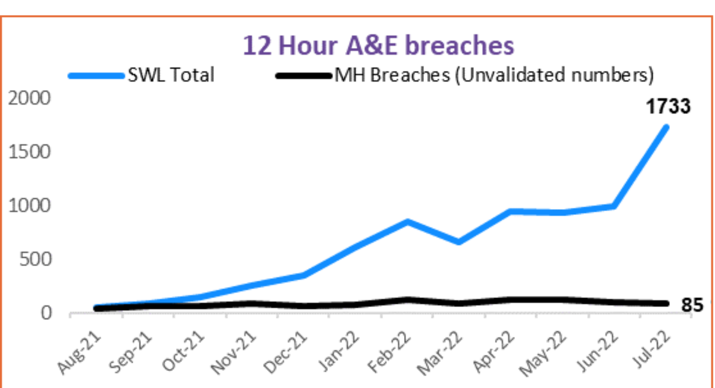
Urgent and Emergency Care

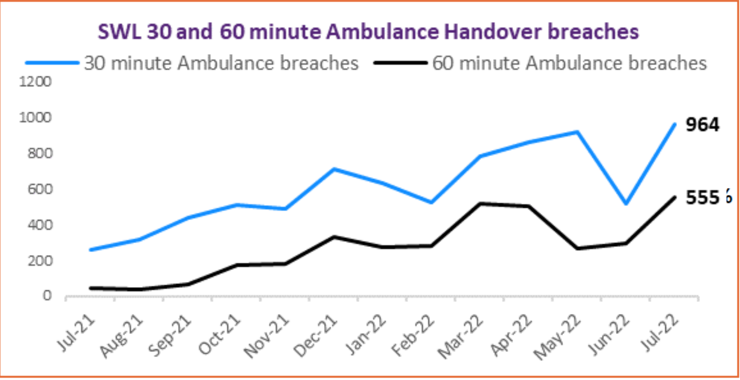
SROs: Jonathan Bates and Matthew Kershaw

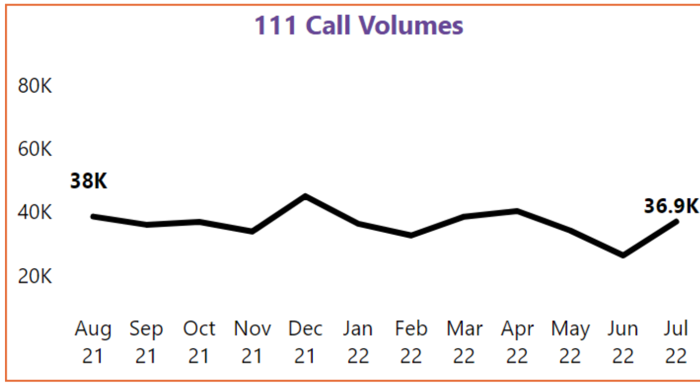
NHS South West London

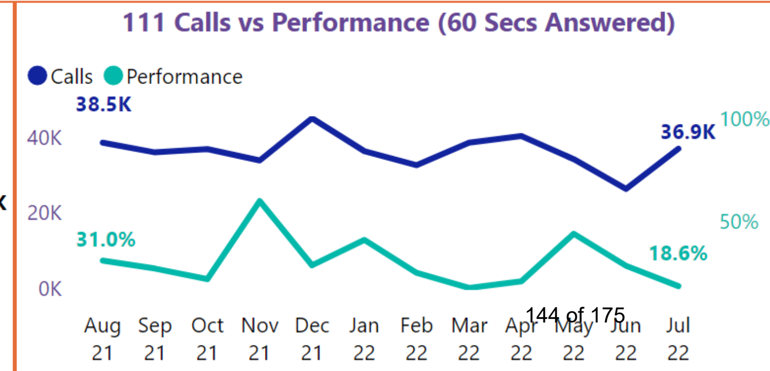












A SWL UEC Re-set event was held on 8 July with a wide range of senior stakeholders across SWL, with a focus on immediate actions for Winter as well as the longer-term. A further event is planned on 30 September. SWL submitted a successful bid to NHSE for Winter funding. The majority is for schemes to free up hospital beds by reducing length of stay and improving flow through increased capacity in the supporting services, in and out of hospital; £13m funding was received.

Attendance to A&E is still below pre-pandemic levels. The greatest pressure is on the admitted non-elective pathway; high bed occupancy is driven by high numbers of patients not meeting the criteria to reside. There continues to be a large number of patients awaiting discharge to the community. Delays are generally due to a lack of capacity in social care and the right placements for more complex patients. All systems continue to focus on discharge planning and escalating delays through regular interfaces with the relevant stakeholders and are working on the"100 day challenge" issued by NHSE which set out 10 improvement areas that need to be addressed ahead of Winter.

A&E 4 Hour Waiting Times The target was not met by SWL Providers in July (75.2%) but remains steady and aligned with June. The most significant cause of delay across all EDs continued to be the pressure on the non-elective admitted pathway, with a sustained high number of 12-hour breaches, all of whom were awaiting a bed whether for MH or at the acute hospitals. SWL had the highest number of 12- hour breaches in London and 4th highest nationally.

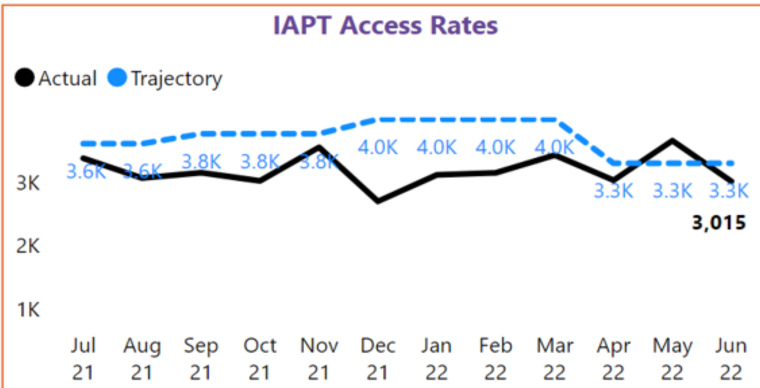
Ambulance Handover Although conveyances were down on the previous month, the number of 60-minute breaches increased. There continued to be over 75% of patients waiting longer than the 15-minute standard. All trusts continue to work on reducing delays to handover including adopting rapid release protocols, boarding, Fit2Sit and direct access to SDEC and UTC. LAS is also working on improving digital competency of crews to support better use of Alternative Care Pathways.

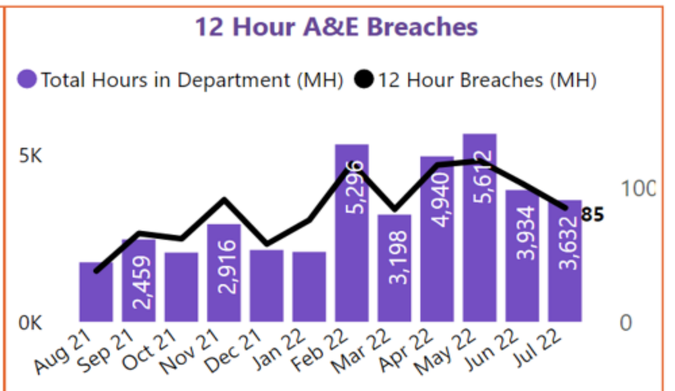
111 Calls rose significantly in July from 26.2K to 36.9K and this does not include the calls LAS is taking as a resilience partner. All 111 services are currently challenged with workforce gaps. This has compounded the difficulties for the 111 provider in building a fully staffed service. The 111 provider had initially advised they would be fully staffed for health advisors by September but this has slipped to December. Communications have been sent out to medical students and primary care in SWL as part of the recruitment campaign. In the meantime, weekly performance meetings are being held with the provider and a joint recovery plan across London is in development.

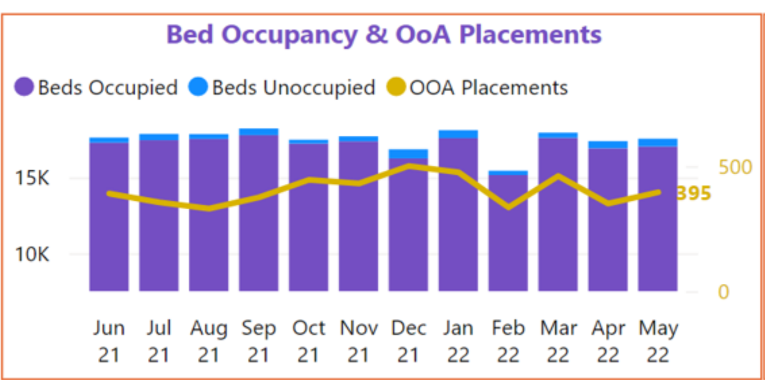
South West London ICB Performance Report

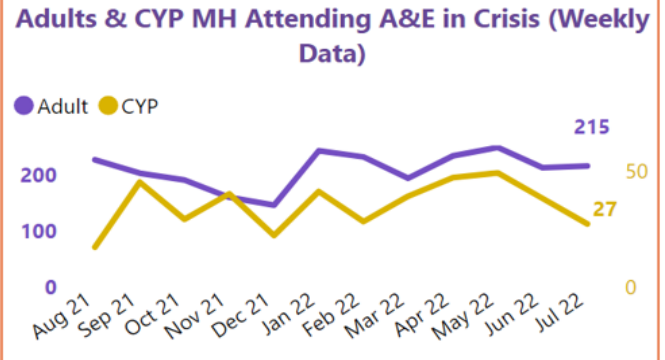
Mental Health

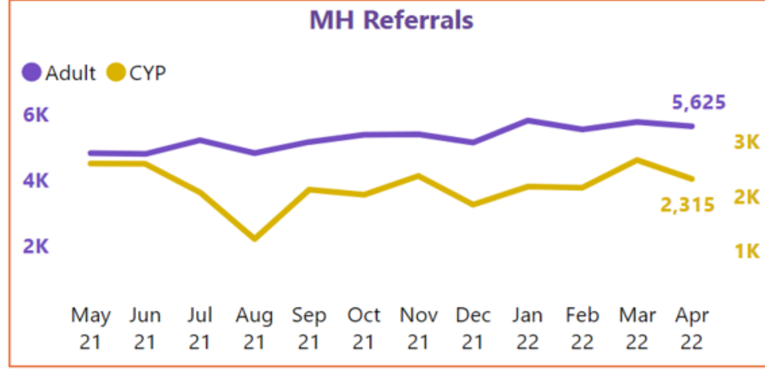
SROs: Vanessa Ford and Tonia Michaelides

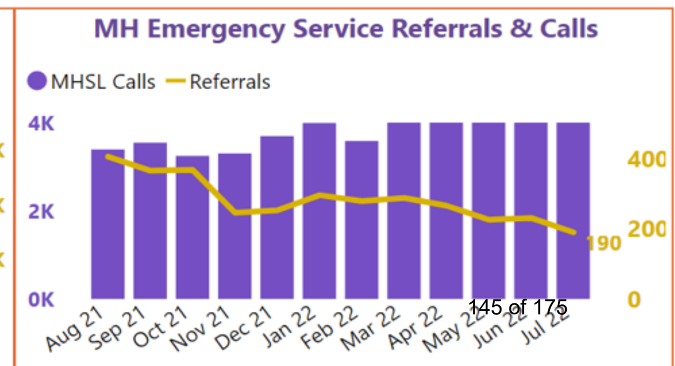












IAPT Access Rates

Provisional data for June 2022 shows 3,015 clients entering treatment, representing a decrease of 640 clients (18%) compared with the previous month and below target trajectory of 3,300 clients per month. Providers are continuing to implement actions to increase numbers of referrals in line with action plans.

12 Hour A&E Mental Health Breaches

The 12-hour mental health breaches decreased for the second consecutive month to 85 in July 2022. The number of hours in the department (MH) reduced to 3,632. Mental health provider bed availability and delayed transfer of care continues to impact performance.

Bed Occupancy and Out of Area Placements (May 2022 is the most up to date data)

There were 395 out of area placements reported in May 2022 for SWL. Demand and Mental health provider bed availability impacts performance. Work continues to reduce 'out of area placements' in line with planned/agreed trajectories.

Adults & Children and Young People (CYP) MH attending A&E in Crisis (weekly data)

The number of adult attendances in July 2022 is 215. The CYP attendances have reduced for the second consecutive month to 27 in July 2022.

Mental Health Referrals (Latest data April 2022)

The latest figures show adult referrals were 5,625 in April 2022. The CYP referrals decreased by 13.0% in April 2022 to 2,315 compared to the March 2022, reflecting the impact of the Easter holiday school break. Activity levels alone do not reflect levels of acuity being experienced in some services.

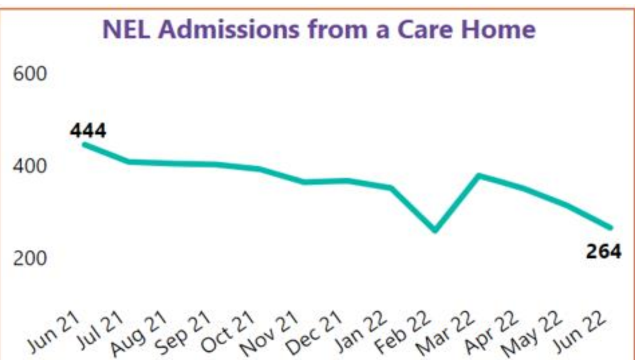
Mental Health Emergency Service Referrals, Coral Mental Health Crisis Assessment Hub

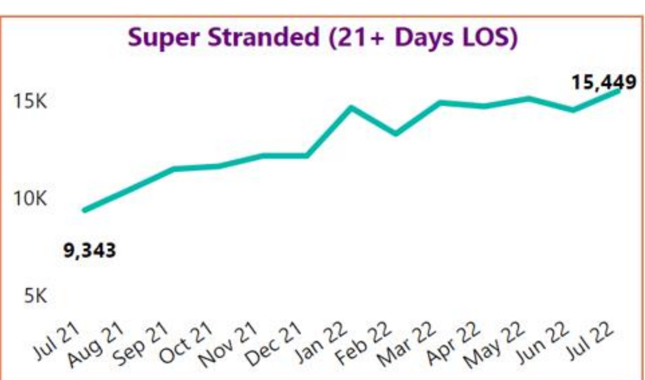
The number of Mental Health Support Line (MHSL) calls in July 2022 has remained steady over the past 5 months. The referrals to the Coral Crisis Hub were 190 in July 2022, a 21.6% reduction from the previous month.

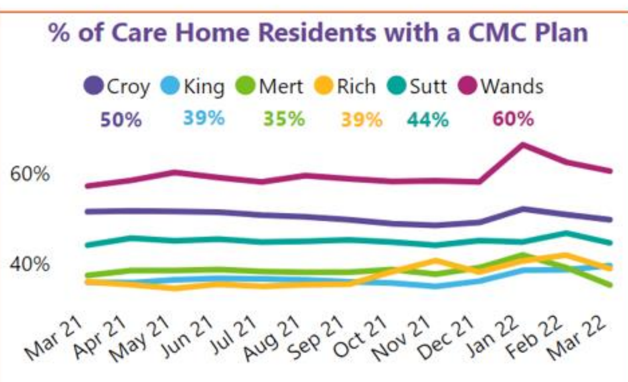
South West London ICB Performance Report

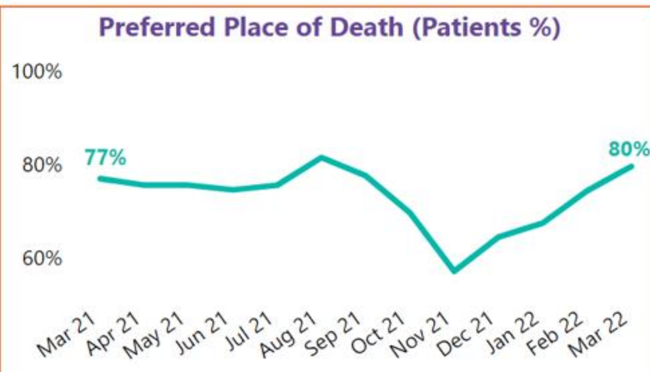
Integrated Care

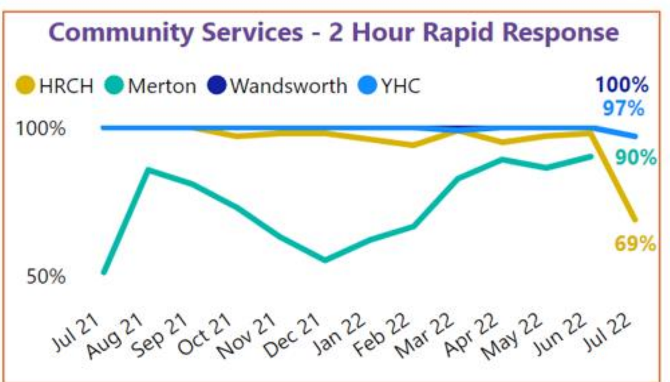
SROs: Tonia Michaelides and Ian Thomas

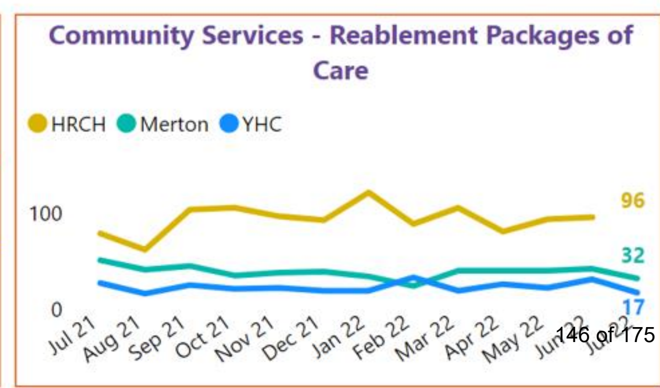












Non-Elective (NEL) Admissions from a Care Home

This indicator remains on a downward trend with 40.5% fewer NEL admissions than the same period in 2021. All Enhanced Health in Care Homes (EHCH) workstreams contribute to this outcome. Community Services and Care Home Support Teams support residents to stay in their Care Homes across SWL, for example through the Urgent Community Response. The new London Urgent Care Plan went live on 27th July. Digital transformation for Care Homes continues through 2022/23 and includes remote monitoring, eRedBag, digitising social care records, use of sensor-based falls technology and a pilot to give care homes access to the London Shared Care Record.

Super Stranded (Over 21 Days Length of Stay)

Discharges remain a significant concern for leads across the system. The national 100-day challenge has presented an opportunity to review the local transformation programmes, and there is a clear appetite to deliver transformational change in order to improve flow and facilitate earlier discharges. A workshop has been planned to review discharges across SWL during Q3 and Q4 and actions required to meet these transformational ambitions.

% of Care Home Residents with a Co-ordinate My Care (CMC) Plan (March 2022 is the latest data available)

The contract for the service provided by Coordinate My Care (CMC) ended on 31 March 2022. The new London Urgent Care Plan went live in July. Care Homes with access to CMC have been supported to access the UCP. Currently no reports are yet available - UCP reports are due to be published in September.

Preferred Place of Death (Patients%) (March 2022 is the latest data available)

We are not currently receiving data reporting on preferred place of death while London is transferring from using CMC to the new Urgent Care Plan. Next reporting expected mid-September. The new Urgent Care Plan went live 27 July 2022 and is now operating as required across SWL..

Community Services –2 Hour Rapid Response and Reablement Packages of Care

All providers across SWL have 2hour Urgent Community Response (UCR) services in place running 8am-8pm, 7 days a week, with 2H UCR data being submitted. Total activity is lower than projected, however this is mainly due to data quality rather than actual activity. Aim is for SWL System to perform at 70% from Q3, which they are on track to deliver. HRCH had a slight decrease in performance, which is likely due to an increase in activity and improved data quality – we are doing work to improve this through the community data working group.

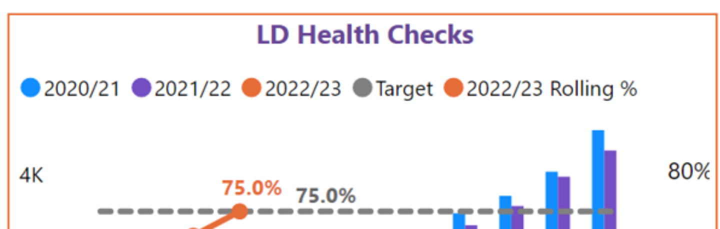
Virtual Wards

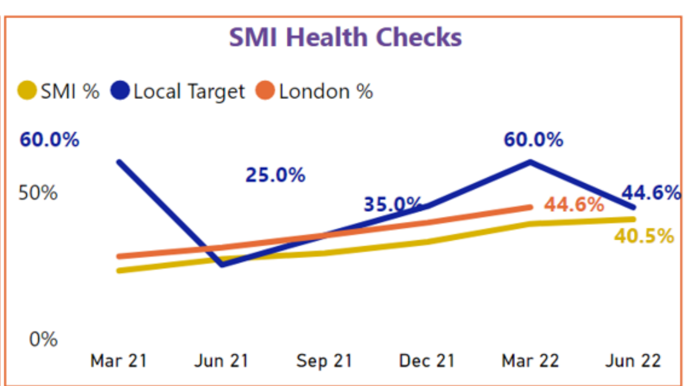
The planned October / November gradual launch is at risk due to slippage in the recruitment timetable. Work is underway to identify possible solutions. Work has just commenced to identify and prepare a suitable site for the Hub and Identify resource to deliver the digital solution. A highlight report is now available providing details on key achievements, work underway, risks and key actions.

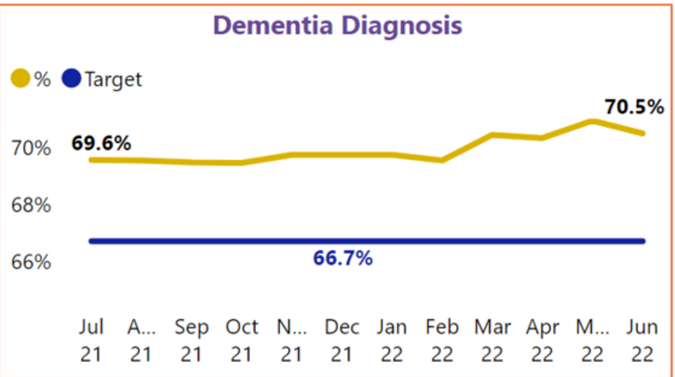
South West London ICB Performance Report

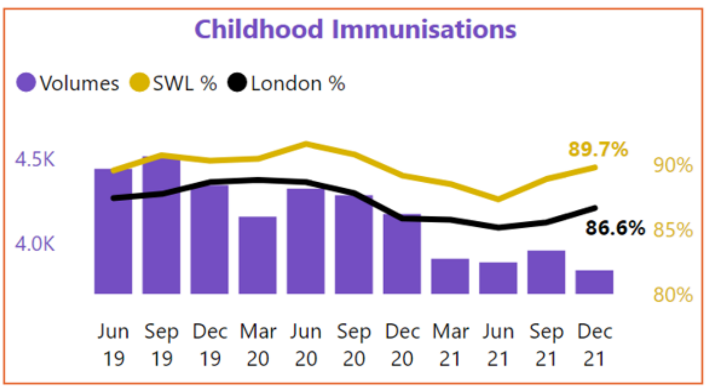
Primary Care

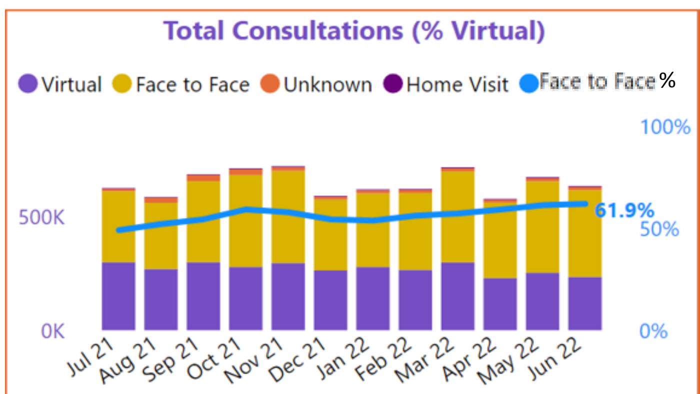
SROs: Mark Creelman and Nicola Jones

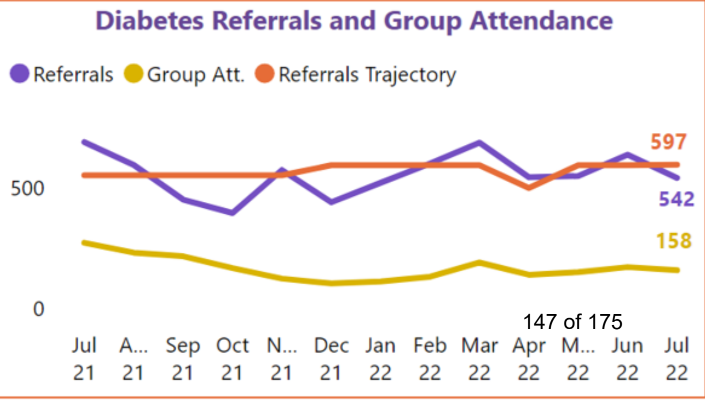












LD Health Checks

The rolling 12-month performance to July 2022 was 75%. The ICS continues with a strong focus and alignment with primary care, supported by GP Clinical Leads in each borough working with individual practices to maximise rates. The plan to achieve the national directive is to contact every person on the GP LD register who has not had an AHC (annual health check) within last 12 months as of March and offer an AHC by the end of September 2022. We continue to have a small number of practices where the data is not flowing and as such our performance is understated.

SMI Health Checks

Latest data available is Quarter 1 (2022/23), which reported a performance position of 40.5% for SWL ICS, with 6,706 SMI patients having received all six annual health check elements. SWL ICS has established a new dedicated SMI health checks programme for 2022/23 to build on the good work in 2021/22 and continuing improvement towards the 60% national standard.

Dementia Diagnosis

SWL CCG continue to maintain good performance levels which exceed the national benchmark threshold of ensuring that over 66.7% of people with suspected dementia are diagnosed. Current performance for Jun-22 shows the ICS also met the 70% milestone ambition with performance at 70.5%.

Childhood Immunisations

The focus over the summer has been polio given the Isolates of vaccine derived polio have been identified in North London. All London borough are asked to offer Polio vaccinations to children 1-9 to either complete their primary course or to boost protection and prevent cases of paralysis. Preliminary numbers stand at 170,000 children to vaccinate, of which 20,000 are unvaccinated. Capacity to deliver in Mass Vaccination Centres (MVCs) and Community Pharmacies is currently being worked through to support delivery.. Most routine childhood vaccination are offered by general practice and it is anticipated they will make the offer to children aged 1-4.

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 52% to 62%

.

Diabetes Referrals and Group Attendance

There was a slight dip in referrals in July, but only due to a successful NDPP referral campaign in Croydon borough throughout June. There are no issues or concerns moving forwards. A new NDPP framework is starting at the beginning of October, so a comms campaign is underway to improve referral numbers to coincide with the resumption of face-to-face session delivery

NHS South West London Integrated Care Board	
Date	Monday, 17 October 2022

Document Title	South West London ICB Finance Report month 5		
Lead Director (Name and Role)	Helen Jameson CFO		
Author(s) (Name and Role)	Neil McDowell/Joanna Watson – Deputy CFO		
Agenda Item No.	12	Attachment No.	11

Purpose (Tick as Required)	Approve	Discuss X	Note X

Executive Summary

The report includes the ICB internal budget for months 4 to 12. The ICB internal budget forms part of the overall South West London (SWL) NHS system plan; alongside the other SWL NHS organisations.

The attached report also shows the SWL NHS system position at month 5.
The overall SWL NHS system position is forecast to be breakeven by the end of the year. The year-to-date plan at M5 is profiled to be £55.4m deficit, with actuals of £54.5m deficit, therefore, giving a £1.0m favourable variance.

The report identifies that there are significant risks attached to the delivery of the financial plan across SWL, due largely to the scale of the savings target and inflationary pressures.

Purpose:

This report is brought to the Board to:
1. present the ICB internal budget covering months 4 to 12 of 2022/23,
2. update the ICB on the SWL system financial position and
3. highlight the risks to achieving the plan.

Recommendation:

The Board is asked to:
- Approve the ICB internal budget for months 4 to 12 and note the change in profile across Q1 vs Q2-4
- Note the ICB internal month 5 position in particular risks relating to prescribing and CHC.
- Note the NHS system revenue month 5 position, in particular risks relating to the increase in efficiencies required in the latter half of the year and trajectory of spend on staffing
- Note the NHS system capital month 5 position.

Key Issues for the Board to be aware of:
• All organisations are planning breakeven, apart from The Royal Marsden (£3.0m surplus) and South West London ICB (£3.0m deficit). • A large increase in efficiency delivery is required in the second half of the year and this remains a significant risk to achieving the SWL system plan. • General price inflation is currently running at c.10%, significantly higher than the national assumption used in planning for non-pay cost inflation at 5%. This alongside pay inflation poses a risk to the deliverability of the SWL system plan. • There is uncertainty over the National elective recovery fund and whether a clawback of income will be enforced in this financial year where activity is below planned levels.

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 breakeven financial plan; scale of savings target, elective recovery funding and inflation being the most significant. See page 14 of the report.
Mitigations Actions taken to reduce any risks identified:	• Strengthening oversight by increasing efficiency reporting. • The finance efficiency working group meets weekly and has been set up to focus on the efficiency challenge. • All organisations completing and implementing, where appropriate, Monitor Grip and Control tool and HFMA self-assessment. • 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. • NHS 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/ Groups Enter any Committees/ Groups at which this document has been previously considered:	Committee/Group Name:	Date Discussed:	Outcome:
	Finance and Planning Committee - Month 5 position only	Tuesday, 27 September 2022	The Committee considered the month 5 position and the risks to the forecast outturn
	Senior Management Team – Month 5 position only	Thursday, 22 September 2022	Senior management team noted the month 5 position and the risks to the forecast outturn
		Click here to enter a date.	

Supporting Documents	SWL ICB Finance Report Month 5

SWL NHS System Finance Report

October 2022

Contents

- Introduction
- ICB internal budget months 4-12
- ICB internal position at month 5
- SWL NHS system revenue position at month 5
- SWL NHS system capital position at month 5
- Summary

Introduction

When describing the financial narrative we can define the ICB budget in 2 ways; ICB internal budget and SW London (SWL) NHS system budget

- The ICB internal budget covers the costs of running the organisation as well as the NHS services commissioned for the local population. The majority of these NHS services are delivered in the 6 place's but some services will be commissioned from NHS organisations outside the SWL patch. These NHS services include hospital services, community services, continuing healthcare, local primary care services and prescribing.
- The SWL NHS System budget comprises of the SWL Providers (6 in total) budgets for treating patients from SWL and beyond, as well as the internal ICB budget. ICB's commission services from these providers based on a fixed fee (block) contract. With some expensive highly specialised services funded based on actual activity. Planned hospital care is able to earn additional income for activity levels above those funded in the fixed fee. This additional income is called the elective recovery fund (ERF)
- The total SWL NHS system budget is c£4.7bn which is broadly split £3.3bn for SWL NHS Providers, £0.6bn for out of SWL NHS Providers, £0.6bn with the SWL Places and £0.2bn with delegated primary care.
- The SWL delegated NHS capital budget can only be utilised by NHS organisation (£128m). There is a further £2.6m available from the NHS England for GP IT and primary care improvement grants in 2022/23. These budgets could be further supplemented in-year by additional funds secured through national NHS capital bidding processes.

The finance paper presented is a high level view covering:

1. The ICB internal budget for months 4 to 12.
2. The ICB internal position at month 5.
3. The SWL NHS system revenue position at month 5
4. The SWL NHS system capital position at month 5.

When reading the report the Board is asked to be mindful of any further information it may require or any changes in the way the information is presented.

The ICB internal budget months 4-12

2022/23 ICB internal annual finance allocation

	SWL CCG - M1 to M3	SWL ICB - M4 to M12	Total
Breakdown by places			
SWL	£232,533,050	£1,676,942,005	**£1,909,475,055**
Croydon	£120,374,961	£133,682,219	**£254,057,180**
Kingston	£78,874,668	£52,738,402	**£131,613,070**
Merton	£22,869,586	£68,608,757	**£91,478,343**
Richmond	£29,989,939	£90,484,690	**£120,474,629**
Sutton	£94,284,574	£52,126,207	**£146,410,781**
Wandsworth	£132,995,184	£104,136,720	**£237,131,904**
Total	**£711,921,961**	**£2,178,719,000**	**£2,890,640,961**
High level breakdown by areas of spend:			
Acute	£383,382,588	£1,227,102,343	£1,610,484,931
Community Health Services	£50,068,809	£131,723,828	£181,792,637
Continuing Care	£40,966,250	£121,283,900	£162,250,151
Corporate	£7,383,068	£22,044,051	£29,427,119
Mental Health	£78,842,008	£235,531,513	£314,373,521
Other commissioned services	£5,646,725	£15,440,868	£21,087,593
Other programme services	£19,613,991	£53,634,107	£73,248,099
Primary Care	£126,018,522	£371,958,389	£497,976,911
	£711,921,961	**£2,178,719,000**	**£2,890,640,961**

- The 2022/23 budget (£2.9bn) was submitted to NHSE on 20 June 2022 and brought to the CCG Governing body where the first quarter spend was approved (3/12th).
- Since this time NHS England updated the financial framework for the closedown of the CCG. This has changed the phasing of the budget, moving any underspend from the CCG to the ICB to ensure funding was not lost between the 2 organisations in year (due to timing of spend). This resulted in £10.75m budget being added to the ICB budget.
- The table shows the updated phasing whilst the overall budget of £2.9bn remains unchanged for the year.
- This changing in phasing presents no risk to the ICB and has no impact on the actual spend expected in year
- ***The Board is asked to approve this updated budget*** noting that it is set within the allocation received and reconciles back to the SWL ICB Plan national submission on 20 June 2022.

For noting the 2 tables are presenting the same data one shows the split by Place and the other by service category.

The ICB internal position at month 5

ICB internal financial overview

2022/23 Month 5

Key Messages:

1. The overall ICB plan position year to date is £2m surplus predominantly driven by the underspend due to elective activity being lower than planned reducing the elective recovery fund payable (ERF £10m). However new national guidance is expected about the fund which will allocate the spend to providers – this adjustment would be £1m favourable to plan due to delivery of non recurrent savings earlier than planned.
2. Continuing Healthcare (CHC) is running ahead of the plan year to date expenditure and there have been pressures reported in Wandsworth which are being investigated. There has been an upside in Merton CHC to partially offset this.
3. There is a timing lag in receiving prescribing data so the position is based on 3 months of data. With this limited data we can see an increase in spend which has been forecast to continue. Short of stock supplies in generic medicines appears to be one of the drivers.
4. Mental health placements across most places has seen an increase in cost with Wandsworth in particular. Discussions with South London Partnership to mitigate some of these cost pressures are ongoing.
5. Delegated Primary Care - the underlying recurrent deficit in this area seems to be improving although work on understanding the split by Borough is ongoing. Will be concluded at month 6.
6. Savings are broadly, with £2.5m currently unidentified efficiencies. These are currently being covered by non recurrent means in parallel to work to identify new schemes or stretching existing ones.

Targets

1. Mental Health Investment Standard is being met and due to placements may even be exceeded.
2. Running costs are within the target set (£30m full year, £22.5m M4 to M12).
3. Cash balance at month end is within the permitted 1.25% of the cash drawn at the beginning of the month
4. The Better Payments Practice Code (BPPC) states that 95% of invoices should be paid within 30 days which we are achieving for both NHS and non NHS Organisations.

ICB Internal financial overview

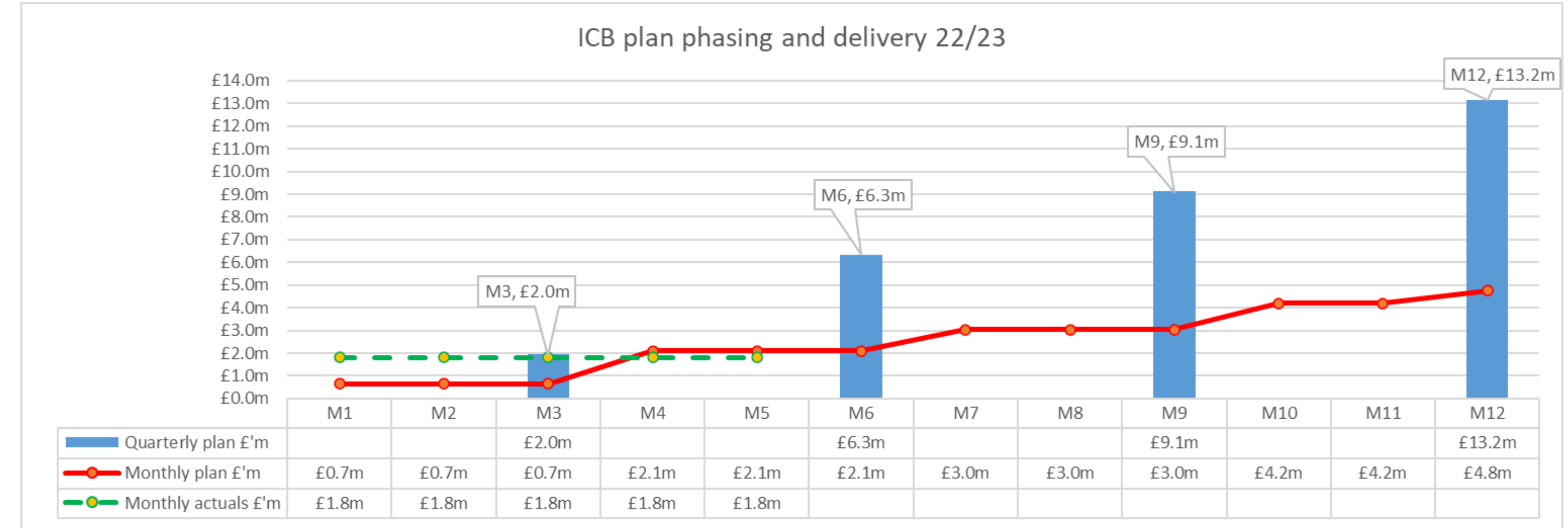
2022/23 Month 5

Areas of spend	Sum of M4-5 Allocation £000s	Sum of M4-5 Actual £000s	Sum of M4-5 Variance £000s	Sum of M4-12 Allocation £000s	Sum of Forecast Outturn M4-12 £000s	Sum of Forecast Variance M4-12 £000s
ACUTE	274,520	265,888	8,633	1,240,864	1,241,496	-633
COMMUNITY HEALTH SERVICES	29,461	29,880	-419	134,227	134,183	43
CONTINUING CARE	23,273	27,962	-4,689	122,850	123,505	-655
CORPORATE	4,610	4,944	-334	22,044	21,946	98
MENTAL HEALTH	52,512	52,732	-221	235,694	238,293	-2,600
OTHER COMMISSIONED SERVICES	3,409	5,051	-1,642	15,341	15,040	301
OTHER PROGRAMME SERVICES	9,377	8,758	619	45,824	42,706	3,118
PRIMARY CARE	81,847	81,775	72	373,154	375,827	-2,673
Grand Total	**479,009**	**476,990**	**2,020**	**2,189,997**	**2,192,997**	**-3,000**

SWL Overview: (-adverse/favourable variance)

- To note that the total allocation above is the updated phased allocation (slide 5) plus additional allocations received since submission of the budget.
- Additional allocations are to fund specific projects and therefore have equal and opposite spend so wont affect the outturn position
- We have reported £2m YTD surplus which is mainly due to:
    - £9m target deficit across the areas where efficiency savings are coming out later in the year.
    - £10m underspent against ERF
    - £1m surplus for recovering excess non recurrent benefits
    - All other areas broadly net off

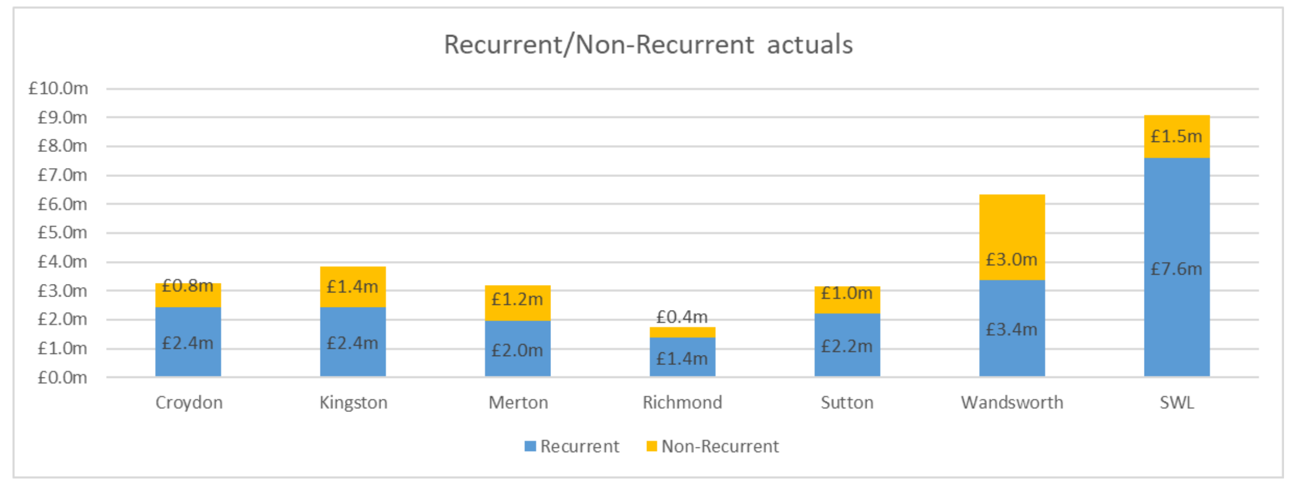
ICB efficiency 2022/23

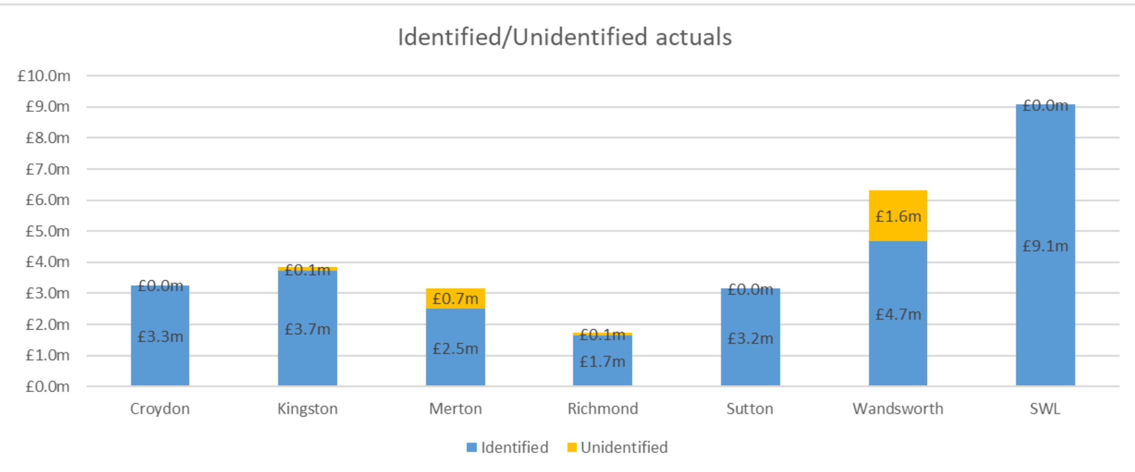


	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Quarterly plan £'m			£2.0m			£6.3m			£9.1m			£13.2m
Monthly plan £'m	£0.7m	£0.7m	£0.7m	£2.1m	£2.1m	£2.1m	£3.0m	£3.0m	£3.0m	£4.2m	£4.2m	£4.8m
Monthly actuals £'m	£1.8m	£1.8m	£1.8m	£1.8m	£1.8m							

Narrative:

- The phasing plan shows the scale of the challenge increasing as we go through the year.
- We are ahead of the plan up to month 3 mostly because of non recurrent benefits banked earlier and then operating to broadly to plan for months 4 & 5.
- The plan for the year was to deliver £21.4m of the £30.5m savings target recurrently. We are currently behind delivering recurrently but this is being mitigated with non recurrent benefits.
- We still have around £2.5m of unidentified savings left to find.





The SWL NHS system revenue position at month 5

SWL NHS System Revenue Position

2022/23 Month 5 (M5)

- The overall SWL NHS ICS system position is forecast to breakeven by the end of the year; the year to date plan at M5 is profiled to be £55.4m deficit, with actuals showing a £1.0m favourable variance.
- The Trust position is showing an adverse variance of £10.0m mainly driven by elective recovery fund (ERF) clawback assumption (£10.0m) due to delivery of lower activity levels than in the plan. Other variances relate to income favourable to plan at Royal Marsden Hospital (£1.9m) and adverse position to plan at Epsom & St Helier Hospital (£1.8m).
- The plan deficit position M1-5 is due to reverse during the second half of the year in line with the profile of savings which is a significant challenge for the system and remains the key risk to delivery of the plan
- The ICB position is £11.0m favourable due to the ERF clawback income assumption; which offsets the trust position (£10m) and efficiency delivery ahead of plan (£1m).

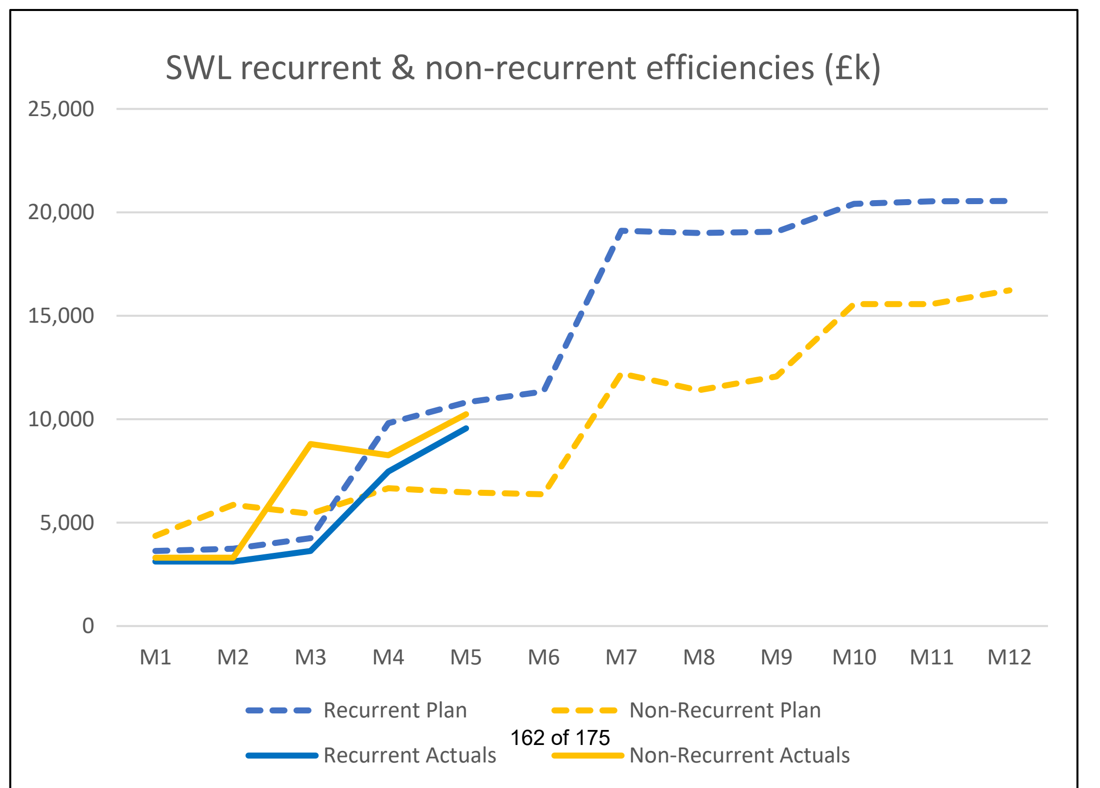
MONTH 5	YEAR-TO-DATE Surplus/(deficit) for the purposes of system achievement			FORCAST OUTTURN Surplus/(deficit) for the purposes of system achievement			
£m	YTD Plan	YTD Actual	YTD Variance	Plan	FOT Actual	FOT Variance	Total Annual Income/ Allocation
Croydon Hospital	-3.8	-4.7	-0.9	-0.0	-0.0	-0.0	407
Epsom and St.Helier Hospital	-12.0	-17.3	-5.3	0.0	0.0	0.0	583
Kingston Hospital	-9.0	-9.0	-0.0	0.0	-0.0	-0.0	359
St. Georges Hospital	-19.9	-25.7	-5.7	0.0	-0.0	-0.0	1,029
Hounslow & Richmond Community Healthcare	0.1	0.1	0.0	0.0	0.0	0.0	119
South West London & St. Georges Mental Health	-1.4	-1.4	0.0	-0.0	-0.0	-0.0	252
The Royal Marsden Hospital	-0.4	1.5	1.9	3.0	3.0	0.0	576
Trusts Total	**-46.4**	**-56.4**	**-10.0**	**3.0**	**3.0**	**-0.0**	
South West London Integrated Care Board (ICB)	-9.0	2.0	11.0	-3.0	-3.0	0.0	2,916
South West London System	**-55.4**	**-54.4**	**1.0**	**-0.0**	**-0.0**	**-0.0**	

SWL NHS System Efficiency

2022/23 Month 5

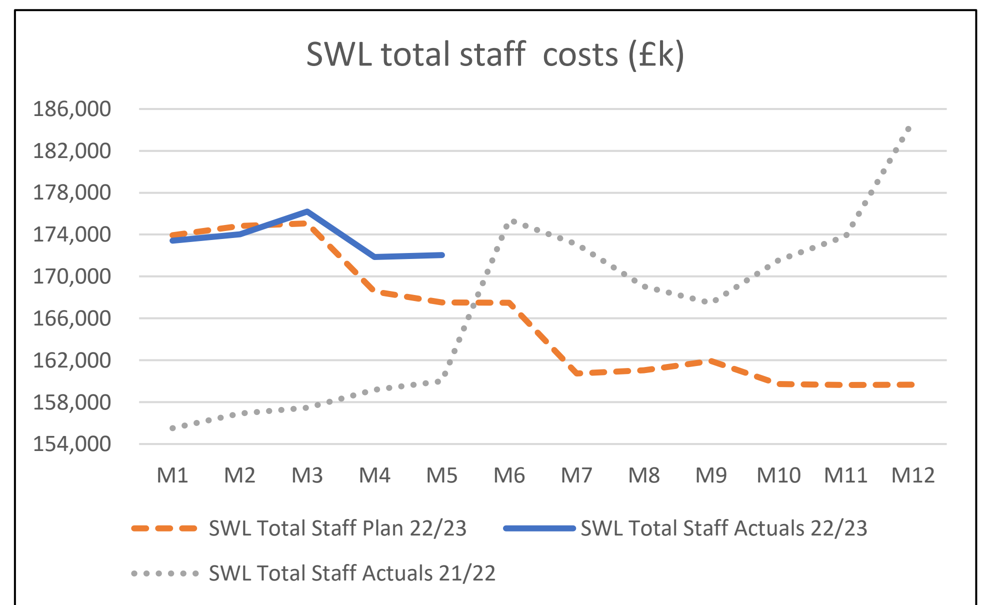
NHS South West London

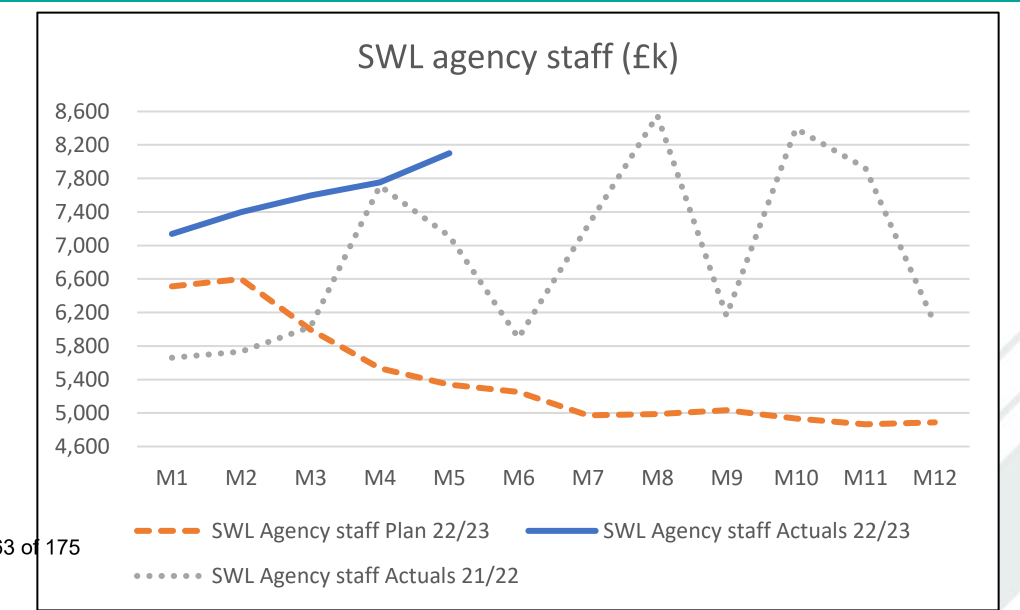
- The total system planned efficiency for the year is £280.6m and delivery remains the systems key risk.
- Year to date delivery @M5 is as follows:
    - £60.8m efficiency has been delivered in total against a plan of £61.0m (£0.2m, 0.3% adverse)
    - £26.9m has been delivered recurrently against a plan of £32.2m (£5.4m, 17% adverse)
    - £33.9m has been delivered NR against a plan of £28.8m (£5.1m, 18% favourable)
- FOT efficiency is showing to plan, however, this will require a significant increase in delivery over the second half of the year.



SWL NHS System Workforce

- Workforce is the key area of spend for the system, and a focus of the system saving programme
- To date workforce costs are £7.5m adverse to plan. This is made up of substantive costs £21.4m favourable to plan, bank costs £20.9m adverse to plan and agency costs £8.0m adverse to plan.
- As part of additional controls **NHSE has introduced an 'agency cap' which sets the maximum spend on agency staff in each year.** This is calculated at a system level.
- **The SWL system agency cap has been set at the plan spend** level for the year of £64.3m.
- Agency spend to month 5 is £38.0m, this is £8.0m adverse to plan and the spend is forecast to be £9.2m adverse by year end.
- Agency costs above plan are being driven by both higher usage than planned, in part to backfill substantive vacancies, and the cost of agency shifts.
- Work is underway to review and enhanced pay controls with the aim of bringing the pay run rate down including reviewing the scope of vacancy panel and analysis of the drivers of agency usage.





SWL NHS System Revenue Risks

Risk	Description	Mitigation
Financial sustainability - due to non delivery of efficiencies and workforce controls	• A significant increase in efficiency delivery is required in the second half of the year to achieve the plan. • At present, 32% of the system efficiency plan is RAG rate 'red' and a further 16% is rated 'amber'. • If workforce controls (e.g. agency price controls) are not effective, unplanned costs will be incurred and add further risk to the efficiency programme.	• A series of system actions have been agreed, including: ➢ Rapidly progress efficiency identification, including reduction of Covid costs and enhancing grip & control actions; ➢ Develop and prioritise a list of new initiatives; ➢ Improve consistency of system level reporting.
Impact of Covid and increased acuity of patients on productivity – leading to increased costs and reduced activity / Elective Recovery Fund (ERF) income	• Planned system activity delivery is below the planned levels, which may result in clawback of ERF income currently estimated at £10.0m. • There is uncertainty over the National ERF regime and whether clawback will be enforced for Q1 and Q2 as the operating environment is different to that expected during planning e.g. In line with national guidance the plan does not assume any Covid case number surges, if these occur it is likely that unplanned costs will arise.	• Continue to maximise delivery of in scope elective activity. • Work with NHSE to understand the evolving ERF framework. • Implementation of revised Covid IPC standards. • Workforce planning to manage higher absences.
Inflation and winter pressures	• General price inflation is currently running at c.10%, significantly higher than the national assumption used in planning for non-pay cost inflation at 5%. • The costs of additional winter capacity may exceed the plan	• Continue to manage costs through supplier contract renewals / negotiations as they arise. • System winter resilience planning has begun and will continue over autumn.

The SWL system capital position at month 5

SWL NHS System Capital Position – M5 2022/23

- The system is permitted to spend up to a certain limit against the DHSC's Capital Departmental Expenditure Limit (CDEL). SWL's ICS delegated provider CDEL limit is £128m in the current year and £113m in 2023/24 and 2024/25. The system can spend on further capital investment via additional CDEL allocations from national programmes in-year and through charitable donations and capital grants which don't impact the DHSC budget.
- The SWL CDEL plan for our trusts was developed and agreed under the established SWL capital prioritisation framework with providers via the Capital Prioritisation Group. CDEL is allocated to providers during the planning process, but is closely monitored for redistribution as needed throughout the year.

- The SWL NHS CDEL forecast is reported on plan at M5, with a YTD underspend of £11.8m across the trusts.
- FOT assumes national approvals of large schemes in the SWL CDEL plan and other centrally funded programmes are received to enable delivery in-year, and as such, there is some slippage risk in the forecast position.
- Mitigating actions are under review to accelerate spend as well as to respond to risks in the FOT position. The SWL Capital Prioritisation Group will recommend any redistribution of CDEL to the ICB Finance & Planning Committee.

Month 5	YEAR-TO-DATE (YTD)				FORECAST OUTTURN (FOT)			
Provider capital	YTD plan £'m	YTD spend £'m	YTD Variance £'m	YTD Variance %	Full year plan £'m	FOT £'m	Over/ (under) spend vs. plan £'m	FOT Variance %
Croydon Hospital	9.8	8.4	(1.4)	(14%)	32.1	32.1	-	-
Epsom and St.Helier Hospital	11.8	11.0	(0.8)	(7%)	46.7	46.7	-	-
Kingston Hospital	4.8	2.9	(1.9)	(40%)	35.2	35.2	-	-
St. Georges Hospital	17.9	16.9	(1.1)	(6%)	45.3	45.3	-	-
Hounslow & Richmond Community Healthcare	0.8	0.5	(0.2)	(28%)	2.0	2.0	-	-
South West London & St. Georges Mental Health	10.4	8.5	(1.8)	(18%)	24.0	24.0	-	-
The Royal Marsden Hospital	10.0	5.4	(4.6)	(46%)	24.1	24.1	-	-
Trusts Net CDEL (SWL & National)	**65.5**	**53.7**	**(11.8)**	**(18%)**	**209.5**	**209.5**	**-**	**-**
IFRS16 technical adjustment	20.5	16.3	(4.2)	(21%)	34.7	34.7	-	-
Trusts CDEL after national technical adjustment	**86.0**	**70.0**	**(16.0)**	**(19%)**	**244.2**	**244.2**	**-**	**-**
Grants, donations and peppercorn leases	20.3	22.5	2.1	11%	44.3	43.7	(0.6)	(1%)
Trusts Net capital expenditure	**106.4**	**92.5**	**(13.9)**	**(13%)**	**288.5**	**287.9**	**(0.6)**	**-**

Net CDEL Breakdown:

SWL CDEL	**51.1**	**41.0**	**(10.1)**	**-20%**	**144.7**	**146.5**	**1.8**	**1%**
Disposals (SWL CDEL impact)	**0.0**	**0.0**	**0.0**	**0%**	**0.0**	**(1.8)**	**(1.8)**	**0%**
National CDEL	**14.4**	**12.7**	**(1.7)**	**-12%**	**64.8**	**64.8**	**0.0**	**0%**
Trusts Net CDEL	**65.5**	**53.7**	**(11.8)**	**-18%**	**209.5**	**209.5**	**0.0**	**0%**

**Primary care capital allocation of £2.5m for GP IT and improvement grants excluded above – London region is managing and reporting these funds*

Summary

Summary

- The Board is asked to:
  - Approve the ICB internal budget for months 4 to 12 and note the change in profile across Q1 vs Q2-4
  - Note the ICB internal month 5 position in particular risks relating to prescribing and CHC.
  - Note the ICS revenue month 5 position, in particular risks relating to the increase in efficiencies required in the latter half of the year and trajectory of spend on staffing
  - Note the ICS capital month 5 position.

The Board is also asked to consider if any additional information should be presented in future finance reports.

NHS South West London Integrated Care Board	
Date	Monday, 17 October 2022

Document Title	Board Committee updates		
Lead Director (Name and Role)	Mercy Jeyasingham; Dick Sorabji; Martin Spencer		
Author(s) (Name and Role)	Jitendra Patel, ICB/ICP Secretary		
Agenda Item No.	15	**Attachment No.**	12

Purpose (Tick as Required)	Approve	Discuss	Note ✓

Executive Summary

The report provides a summary of the activity and items that have been discussed within the committees that report directly to the ICB Board, since its last meeting held in public on 1 July 2022.

The updates reflect the discussion, agreement and actions at respective Committee meetings and are brought to the Board to provide an update on the progress and work of the committees.

Recommendation:

That the Board note the key points discussed and decision making at respective Committee meetings.

Key Issues for the Board to be aware of:

As noted within the Committee update reports.

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	N/A

Actions taken to reduce any risks identified:	

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	**a.** Board Committee Updates

Quality and Oversight Committee update

1. The Committee met on 13 July 2022 and the meeting was quorate. Following consideration and discussion of key items at the meeting, the updates below are highlighted.

2. The Committee discussed the following areas:

Terms of Reference and Membership

- Noted the Terms of Reference, approved at the inaugural Board meeting.
- Considered the membership and noted that lay members with lived experience were in the process of being appointed as members of the Committee.

Forward Plan and Ways of Working

- Noted the contents of the SWL CCG committee handover report.
- Agreed that there was a need for a forward plan for the Committee, including a set of deep dive topics.

Performance update

- Were advised that work is ongoing with Place Leads and the three provider collaboratives, to reflect the breadth of responsibilities of the ICS to achieve an aggregation of the performance reports.

Quality update

- Noted that a quality dashboard for the ICS was under development.
- Noted the Performance and Quality reports.
- Noted that quality place forums engage with local providers, and along with provider collaboratives provide avenues for discussion with providers.
- Agreed that the Chair of the Committee will be invited to attend the System Quality Council.

Risk Register

- Noted the Quality and Performance Risk Register.
- Were assured that there is oversight of providers' risks through quality governance processes.

Finance and Planning Committee update

3. The Committee met on 15 July 2022 and 30 August 2022, both meetings were quorate. Following consideration and discussion of key items at the meetings, the updates below are highlighted.

4. On 15 July 2022, the Committee discussed the following areas:

Terms of Reference and Membership

- Noted the Terms of Reference approved at the inaugural Board meeting.
- Considered the membership, noting the need to ensure the appropriate representation and which supported effective decision making.

Forward Plan and Ways of Working

- Noted the contents of the SWL CCG committee handover report.
- Discussed how the Committee should work in the future.
- The Chair summarised the following points as areas for consideration:
    - To add a section of the agenda that explicitly considered the implications of strategic change on finance and planning matters to deliver ICB outcomes in a manner that could inform the Board.
    - Investigate ways to provide further assurance on spending decisions through the work of other forums.
    - Review the committee membership. Whilst relying on the Chief Nursing Officer and Chief Medical Officer to provide a link to the work of the Quality Committee.
    - Ensure reports seeking funding approval, summarise options and give clear costs for options in the covering report.
- Agreed that there was a need for an annual forward plan to help inform the planning of the Committee.

Finance and Planning updates

- Noted the SWL ICS 2022/23 Plan submission, including context on the approach taken to setting the plan, the engagement of the Finance and Activity Committee and CEOs, and the associated risks.
- Noted the SWL ICS Performance Plan 2022/23.
- Noted the Month 2 finance report.

Business Cases and Contract Awards

- Reviewed and agreed the recommendation for Board approval of the Virtual Wards business case.
- Reviewed contract awards in line with the ICB governance arrangements and responsibilities of the committee.

5. On 30 August 2022, the Committee discussed the following areas:

Committee Forward Plan

- Agreed the draft annual workplan, noting that it will be revisited continually due to the nature of the planning cycle and receipt of guidance from NHSE.

System Intelligence Hub

- Reviewed and noted the proposal to develop a SWL System Intelligence function, with updates agreed for future meetings as the hub develops.

Finance and Planning updates

- Noted the NHS financial environment and proposed changes to the national framework, including the significant challenges facing the ICS due to the increasing levels of complexity and reductions in funding at a time of high levels of inflation and cost of living crisis.
- Noted the SWL 2022-23 system operating plan letter from NHSE which closed down the planning process.
- Noted the Month 4 ICB and NHS System Finance reports.
- Noted the Quarter 1 review report, summarising progress and risks against the submitted plan.

Contract pipeline and awards

- Noted the ICB contract pipeline report.
- Reviewed contract awards in line with the ICB governance arrangements and responsibilities of the committee.

Audit and Risk Committee update

6. The Committee met on 22 August 2022 and the meeting was quorate. Following consideration and discussion of key items at the meetings, the updates below are highlighted.

7. The Committee discussed the following areas:

Terms of Reference and Membership

- Noted the Terms of Reference approved at the inaugural Board meeting.
- Considered the membership, noting the need to ensure the appropriate representation which supported effective decision making.

Forward Plan and Ways of Working

- Agreed the need for alignment with the Finance and Planning Committee and the Quality and Oversight Committee.
- Noted the contents of the SWL CCG committee handover report.
- Agreed that an annual workplan will be developed to inform the planning of the Committee.
- Agreed that meetings will alternate between online and in-person, and that:
    - Agendas will highlight items for approval and those presented for information and/or assurance.
    - Aim to streamline the volume of paperwork.
    - Papers will be distributed at least 5 working days before the meeting.

Risk Management

- Noted the Corporate Risk Register and Board Assurance Framework.
- Agreed that further discussion was required on risk appetite and the ICB's strategic objectives.

Financial reporting

- Noted the process for the close down of the CCG Q1 accounts.
- Noted the first draft of the Annual Report and Accounts.

Internal Audit

- Noted the Internal Audit Progress Report and Annual Report and approved the Internal Audit Plan for the ICB subject to regular review of the plan.
- Agreed that the workplan should reflect all significant risks to assure the Board that there is the right level of assurance in place to enable the strategic

objectives for the ICS to be delivered. Further consideration was agreed on how workforce issues may be incorporated into internal audit planning.

External Audit

- The 2021/22 External Audit Annual report, including value for money opinion, was presented, with assurance that there are no significant issues.

Counter Fraud

- Approved the Local Counter Fraud workplan, noting the content of the progress report and Reactive Investigation benchmarking report.

Service Auditor Reports

- Noted the Service Auditor Reporting Bridge Letters for the closedown of the CCG.

Single Tender Waivers (STWs)

- Noted there had been seven STWs approved from April 2022 to July 2022.