NHS South West London
Integrated Care Board

Meeting Pack

South West London Integrated Care Board

18 September 2024 - 14:00 – 17:00

120 The Broadway, Wimbledon, SW19 1RH

NHS South West London
Integrated Care Board

SWL Integrated Care Board Meeting

18 September 2024 - Agenda

Time: 14.00 – 17.00

Venue: 120 The Broadway, Wimbledon, SW19

Date of next meeting: Wednesday 20 November 2024

The ICB has four core purposes:

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

Introduction

14.00: Item 1: Welcome - verbal update

Chair

1.1 Apologies for absence

1.2 Declarations of Interest

1.3 To approve minutes of the Board Meeting held on 17 July 2024

1.4 Action Log

Standing Items

14.05: Item 2: Decisions Made in Other Meetings

Sarah Blow

14.10: Item 3: Chair's Report

Mike Bell

In Focus

14.15: Item 4: Urgent and Emergency Care Update

SWL UEC Winter Plan 2024/25

Jonathan Bates

Responding to Patient Safety in Pressurised Services

Jonathan Bates/Elaine Clancy

SWL UEC Two-Year Plan

Jonathan Bates

15.00: Item 5: The South London Mental Health and Community Partnership (SLP) – Achievements to date and work in SWL

Vanessa Ford

For Decision

15.30 Item 6: Amendments to South West London ICB's Constitution

Ben Luscombe

15.35 COMFORT BREAK

Items for Information

15.45: Item 7: Green Plan: progress update 2024/25

Helen Jameson

16.10: Item 8: Creation of a SWL Missions Board and the development of a long-term Service and Organisational Transformation Strategy for the NHS in SWL

Sarah Blow

16.20: Item 9: Board Assurance Framework

Ben Luscombe

16.25: Item 10: Board Committee Updates and Reports

Item 10a: Finance and Planning Committee Update – Helen Jameson
Item 10b: Month 4 Finance Report – Helen Jameson
Item 10c: Quality & Performance Oversight Committee Update – Mercy Jeyasingham
Item 10d: Quality Report – Elaine Clancy
Item 10e: Performance Report – Jonathan Bates
Item 10f: Remuneration Committee Update – Mercy Jeyasingham

16.40: Item 11: Chief Executive Officer's Report

Sarah Blow

16.45: Item 12: Any Other Business

All

16.50: Item 13: Meeting Close

Chair

16.51: Item 14: Public Questions by Email

Chair

Members of the public are invited to ask questions relating to the business being conducted today. Priority will be given to those received in writing in advance of the meeting.

SWL ICB Board Declaration of Interests downloaded 5.9.24

Employee	Role	Interest Type	Interest Category	Interest Description (Abbreviated)	Provider	Date Arose	Date Ended	Date Updated
Alyssa Chase-Vilchez	SWL Healthwatch ICS Executive Officer	Nil Declaration				29/06/2023		
Alyssa Chase-Vilchez	SWL Healthwatch ICS Executive Officer	Nil Declaration				19/08/2024		
Annette Pautz	Deputy Borough Chair & Chair of Membership	Declarations of Interest – Other	Financial	Partner at Holmwood Corner Surgery, New Malden	Holmwood Corner Surgery	01/04/2021		02/05/2024
Annette Pautz	Deputy Borough Chair & Chair of Membership	Declarations of Interest – Other	Financial	Member of Kingston General Practice Chambers Ltd	Kingston General Practice Chambers Ltd	01/04/2021		02/05/2024
Annette Pautz	Deputy Borough Chair & Chair of Membership	Declarations of Interest – Other	Financial	Board Member of NMWP PCN	NMWP PCN	01/04/2021		02/05/2024
Annette Pautz	Deputy Borough Chair & Chair of Membership	No Change to existing declarations				25/07/2022		
Cally Palmer	CEO, The Royal Marsden NHS Foundation Trust	Declarations of Interest – Other	Financial	Chief Executive The Royal Marsden NHS Foundation Trust	The Royal Marsden NHS Foundation Trust	03/04/2023		23/04/2024
Cally Palmer	CEO, The Royal Marsden NHS Foundation Trust	Declarations of Interest – Other	Financial	National Cancer Director since April 2015.	NHS England/Improvement (national)	03/04/2023		23/04/2024
Cally Palmer	CEO, The Royal Marsden NHS Foundation Trust	No Change to declaration				30/06/2023		
Charlotte Gawne	SWLSMT006 Executive Dir of Communications & Engagement SWL	Nil Declaration				01/11/2021		
Charlotte Gawne	Exe Dir of Comms E&S Stakeholder Relationships (Designate)	Nil Declaration				30/05/2022		
Charlotte Gawne	Exe Dir of Comms E&S Stakeholder Relationships	Nil Declaration				05/09/2023		
Charlotte Gawne	SWLEMT04 Exe Dir of Stakeholder Partnership Engagemt&Comms	Nil Declaration				01/04/2024		
Elaine Clancy	SWLEMT05 Chief Nursing Officer	Declarations of Interest – Other	Non-Financial Personal	School Governor- Langley Park School for Girls	Langley Park School for Girls	01/04/2023		16/04/2024
Elaine Clancy	SWLEMT05 Chief Nursing Officer	Declarations of Interest – Other	Non-Financial Personal	Trustee for the 1930 Fund for District Nurses	1930 Fund for District Nurses	01/04/2023		16/04/2024
Elaine Clancy	SWLEMT05 Chief Nursing Officer	Declarations of Interest – Other	Indirect	Son is an employee of Croydon Health services	Croydon Health Services	01/07/2023		16/04/2024
Helen Jameson	Chief Finance Officer	Nil Declaration				18/07/2022		
Helen Jameson	SWLSMT003 Chief Financial Officer SWL	Nil Declaration				03/04/2023		
Helen Jameson	SWLEMT03 Chief Finance Officer	Nil Declaration				16/05/2024		
Jacqueline Totterdell	CEO, St George's University Hospitals NHS FT and Epsom and St Helier University Hospital NHS Trust	Declarations of Interest – Other	Financial	Group Chief Executive Officer of Provider Trust in SWL since August 2021.	St George's, Epsom and St Helier University Hospitals and Health Group	03/04/2023		16/04/2024
Jacqueline Totterdell	CEO, St George's University Hospitals NHS FT and Epsom and St Helier University Hospital NHS Trust	Declarations of Interest – Other	Non-Financial Professional	Trustee of this Charity	Aspergillosis Trust	01/04/2023		16/04/2024
James Blythe	SWLSMT008 Executive Locality Director Merton & Wandsworth	Declarations of Interest – Other	Indirect	Wife is an employee of St George's University Hospitals NHS Foundation Trust	SWL CCG	01/04/2021		
James Blythe	Managing Director, Epsom and St Helier University Hospitals NHS Trust	Declarations of Interest – Other	Financial	Managing Director , Epsom and St.Helier University Hospitals Trust since February 2022.	Epsom and St.Helier University Hospitals Trust	03/04/2023		23/04/2024

James Blythe	Managing Director, Epsom and St Helier University Hospitals NHS Trust	Declarations of Interest – Other	Indirect	Spouse is a consultant doctor at Surrey & Sussex Healthcare NHS Trust since January 2022.	Surrey & Sussex Healthcare NHS Trust	03/04/2023		23/04/2024
Jeremy de Souza	DASS LB Richmond	Declarations of Interest – Other	Financial	I am employed as Executive Director of Adult Social Care and Public Health by Richmond and Wandsworth Councils	Richmond and Wandsworth Councils	14/05/2024		
Jeremy de Souza	DASS LB Richmond	Declarations of Interest – Other	Non-Financial Professional	I am a Non-Exec Director of Achieving for Children, a Community Interest Company providing Children's Services in Kingston, Richmond and Windsor & Maidenhead.	Achieving for Children	14/05/2024		
Jo Farrar	Chief Executive of Kingston Hospital and Hounslow and Richmond Community Healthcare NHS Trust, Kingston and Richmond Place Executive Lead	Declarations of Interest – Other	Financial	CEO of Provider Trust since September 2019	Kingston Hospital NHS Foundation Trust	03/04/2023		01/05/2024
Jo Farrar	Chief Executive of Kingston Hospital and Hounslow and Richmond Community Healthcare NHS Trust, Kingston and Richmond Place Executive Lead	Declarations of Interest – Other	Financial	CEO of Provider Trust since December 2021	Hounslow and Richmond Community Healthcare NHS Trust	03/04/2023		01/05/2024
Jo Farrar	Chief Executive of Kingston Hospital and Hounslow and Richmond Community Healthcare NHS Trust, Kingston and Richmond Place Executive Lead	Declarations of Interest – Other	Non-Financial Personal	Partner is the Practice Manager (from 11/9/2023)	Churchill Medical Centre GP Practice	05/09/2023		01/05/2024
John Byrne	Executive Medical Director	Nil Declaration				01/07/2022		
John Byrne	SWLSMT012 Executive Medical Director	Nil Declaration				29/08/2023		
John Byrne	SWLSMT012 Executive Medical Director	Nil Declaration				22/09/2023		
John Byrne	SWLEMT06 Chief Medical Director	Nil Declaration				30/04/2024		
Jonathan Bates	SWLEMT07 Chief Operations Officer	Declarations of Interest – Other	Non-Financial Personal	Spouse provides primary care consultancy and interim support to a range of organisations.	Primary care consultancy	01/10/2020		28/05/2024
Jonathan Bates	SWLEMT07 Chief Operations Officer	Declarations of Interest – Other	Indirect	Ongoing - spouse provides primary care consultancy and interim support to a range of organisations.	Spouse	01/04/2021		28/05/2024
Jonathan Bates	SWLSMT005 Chief Operating Officer (Designate)	No Change to existing declarations				31/05/2022		
Karen Broughton	SWLSMT007 Exe Dir of Strat and Transf'n/Dep SRO SWL HCP SWL	Nil Declaration				01/04/2021		
Karen Broughton	Dep Chief Exe Officer/Dir of People & Transfo'n (Designate)	Nil Declaration				01/04/2022		
Karen Broughton	Dep Chief Exe Officer/Dir of People & Transfo'n	Nil Declaration				06/09/2023		
Karen Broughton	SWLEMT02 Deputy CEO/Exe Director of Transformation & People	Nil Declaration				16/04/2024		
Mark Creelman	SWLSMT008 Executive Locality Director Merton & Wandsworth	Nil Declaration				03/04/2023		
Mark Creelman	MWP01 M&W Place Lead	Nil Declaration				30/07/2024		

Martin Spencer	Non-Executive Member	Declarations of Interest – Other	Financial	Non Executive Director and Chair of the Remuneration Committee at the NHS Counter Fraud Authority	NHS Counter Fraud Authority	22/08/2022	30/06/2024	26/12/2023
Martin Spencer	SWLNEN05 Non- Executive Member	Declarations of Interest – Other	Financial	Non-Exec Director and Chair of Audit and Risk Committee for Ofsted	Ofsted	22/08/2022		26/12/2023
Martin Spencer	SWLNEN05 Non- Executive Member	Declarations of Interest – Other	Financial	Non-Exec Director and Chair of Audit and Risk Committee for Achieving for Children	Achieving for Children	22/08/2022		26/12/2023
Martin Spencer	SWLNEN05 Non- Executive Member	Declarations of Interest – Other	Financial	Civil Service Commissioner	Civil Service Commission	22/08/2022		26/12/2023
Martin Spencer	SWLNEN05 Non- Executive Member	Declarations of Interest – Other	Financial	Chair of Education Skills and Funding Agency	Education Skills and Funding Agency	22/08/2022		26/12/2023
Matthew Kershaw	Interim -	Declarations of Interest – Other	Financial	Chief Executive - Position of Authority in an organisation in the field of health and social care	Croydon Health Services NHS Trust	01/10/2019		17/04/2024
Matthew Kershaw	Interim -	Declarations of Interest – Other	Non-Financial Professional	Recently made a Visting Senior Fellow at the Fund, having previously worked full time in the Policy team - Position of Authority in an organisation in the field of health and social care	The Kings Fund	01/10/2019		17/04/2024
Matthew Kershaw	Interim -	Declarations of Interest – Other	Non-Financial Professional	I am Chief Executive of a provider Trust in South West London and thereby am involved in delivering care that is discussed and planned and ultimately commissioned by SWL CCG.	Chief Executive of NHS provider organisation - Croydon Health Services	01/04/2021		17/04/2024
Matthew Kershaw	CHS CE and Place Based Leader for Health	No Change to existing declarations				10/06/2022		
Matthew Kershaw	CHS CE and Place Based Leader for Health	Declarations of Interest – Other	Financial	Chief Executive of a provider Trust in SWL since October 2019.	Croydon Healthcare Services NHS Trust	03/04/2023		17/04/2024
Mercy Jeyasingham	SWLNEN03 Non- Executive Member	Declarations of Interest – Other	Financial	Non-Executive Director at Medicines & Healthcare Products Regulatory Agency	Medicines & Healthcare Products Regulatory Agency	03/10/2022		02/10/2023
Mercy Jeyasingham	Non-Executive Member	Nil Declaration				07/05/2024		
Michael Bell	SWLNEN01 Independent Non Executive Chair	Declarations of Interest – Other	Financial	Chair of Lewisham and Greenwich NHS Trust since July 2022.	Lewisham and Greenwich NHS Trust	03/05/2023		

Michael Bell	SWLNEN01 Independent Non Executive Chair	Declarations of Interest – Other	Financial	Director at MBARC Ltd (Research and consultancy company which works with central and local government and the NHS). Current clients are: •Welsh Government – Financial inclusion and Social Justice services – 2013 ongoing •NCL ICS – Primary Care development – May 2022 to 2023 •Visiba Health Care – Chair UK Advisory Board – Jan 2022 ongoing •Surrey Physio – Strategic Adviser – Feb 2023 ongoing •WA Communications – Strategic Adviser –Mar 2023 ongoing •DAC Beachcroft – Strategic Adviser – April 2020 ongoing •ZPB - Strategic Adviser – 2018 ongoing •Rinnova - Strategic Adviser –2022 ongoing •University Hospital Birmingham NHS Foundation Trust – Consultancy services – 2014 ongoing •NCL Training Hub – Ad-hoc facilitation – 2022 to 2023 •Baxter Healthcare Corporation – Chairing meeting – 2024	MBARC Ltd	03/05/2023		
Mike Jackson	Chief Executive, London Borough of Richmond and London Borough of Wandsworth	Declarations of Interest – Other	Financial	CEO of Richmonad & Wandsworth LA	Richmonad & Wandsworth LA	03/04/2023		18/04/2024
Mike Jackson	Chief Executive, London Borough of Richmond and London Borough of Wandsworth	Nil Declaration				30/06/2023		
Nicola Jones	SWLWSCL01 Clinical Director Primary Care	Declarations of Interest – Other	Non-Financial Professional	Joint Clinical Director, Brocklebank Primary Care Network	Brocklebank Primary Care Network	17/12/2021		01/05/2024
Nicola Jones	SWLWSCL01 Clinical Director Primary Care	Declarations of Interest – Other	Financial	My practices are part of Battersea Healthcare (BHCIC)	Battersea Healthcare	17/12/2021		01/05/2024
Nicola Jones	SWLWSCL01 Clinical Director Primary Care	Declarations of Interest – Other	Financial	Managing Partner - The Haider Practice (GMS)	The Haider Practice	17/12/2021		01/05/2024
Nicola Jones	Clinical Programme Lead - CVD	Declarations of Interest – Other	Financial	Managing Partner Brocklebank Practice and St Paul's Cottage Surgery (both PMS).	Brocklebank Practice and St Paul's Cottage Surgery	17/12/2021	07/12/2022	
Nicola Jones	SWLWSCL01 Clinical Director Primary Care	Declarations of Interest – Other	Financial	Convenor, Wandsworth Borough Committee	SWL ICS	01/06/2022		01/05/2024
Nicola Jones	SWLWSCL01 Clinical Director Primary Care	Declarations of Interest – Other	Financial	Clinical Director Primary Care, SWL ICS	SWL ICS	01/06/2022		01/05/2024
Nicola Jones	SWLWSCL01 Clinical Director Primary Care	Declarations of Interest – Other	Financial	Partner Brocklebank Practice and St Paul's Cottage Surgery (both PMS).	Brocklebank Practice and St Paul's Cottage Surgery	07/12/2022		01/05/2024
Sara Milocco	South West London Voluntary Community and Social Enterprise Alliance Director	Nil Declaration				29/06/2023		
Sarah Blow	SWLSMT001 SWL Acccountable Officer SWL	Nil Declaration				02/11/2021		
Sarah Blow	SWL ICB Chief Executive Officer (Designate)	No Change to existing declarations				07/06/2022		
Sarah Blow	SWLEMT01 Chief Executive Officer	Declarations of Interest – Other	Non-Financial Personal	My son is a member of staff at Royal Marsden	LAS	06/08/2024		

Shannon Katiyo	Director of Public Health, Richmond and Wandsworth Councils (Wandsworth Place ICP Representative)	Nil Declaration				21/11/2023		
Shannon Katiyo	Director of Public Health, Richmond and Wandsworth Councils (Wandsworth Place ICP Representative)	Nil Declaration				19/04/2024		
Vanessa Ford	Chief Executive, SWL and St George's Mental Health NHS Trust	Declarations of Interest – Other	Financial	Chief Executive SWL & St Georges Mental Health NHS Trust and a CEO member of the South London Mental Health and Community Partnership (SLP) since August 2019.	SWL & St Georges Mental Health NHS Trust	03/04/2023		26/04/2024
Vanessa Ford	Chief Executive, SWL and St George's Mental Health NHS Trust	Declarations of Interest – Other	Non-Financial Professional	Merton Place Convenor and. SRO for Regional NHS 111 programme for Mental Health	Merton Place	03/04/2023		26/04/2024
Vanessa Ford	Chief Executive, SWL and St George's Mental Health NHS Trust	Declarations of Interest – Other	Non-Financial Professional	Mental Health Representative on the ICB	SWL ICB	03/04/2023		26/04/2024

Minutes – NHS SWL Integrated Care Board

Minutes of a meeting of the NHS SWL Integrated Care Board held in public on Wednesday 17 July at 2 p.m. at 120 The Broadway, Wimbledon, SW19 1RH

Members

Chair
Mike Bell

Non-Executive Members
Ruth Bailey, Non Executive Member, SWL ICB
Mercy Jeyasingham, Non Executive Member, SWL ICB
Martin Spencer, Non Executive Member, SWL ICB

Executive Members
Sarah Blow, Chief Executive Officer, SWL ICB
Elaine Clancy, Chief Nursing Officer
Helen Jameson, Chief Finance Officer, SWL ICB
Karen Broughton, Deputy CEO/Director of People & Transformation, SWL ICB
John Byrne, Executive Medical Director, SWL ICB

Partner Members
Dame Cally Palmer, Partner Member, Specialised Services
Dr Nicola Jones, Partner Member, Primary Medical Services
Vanessa Ford, Partner Member, Mental Health Services
Jacqueline Totterdell, Partner Member, Acute Services

Place Members
Dr Annette Pautz, Place Member, Kingston
Jeremy de Souza, Place Member, Richmond
Mark Creelman, Place Member, Merton
James Blythe, Place Member, Sutton

Attendees
Jonathan Bates, Chief Operating Officer, SWL ICB
Charlotte Gawne, Executive Director of Stakeholder & Partnership Engagement

Observers
Alyssa Chase-Vilchez, SWL HealthWatch Representative
Sara Milocco, SWL Voluntary Sector Representative

In attendance
Ben Luscombe, Director of Corporate Affairs
Maureen Glover, Corporate Governance Manager

Apologies
Mike Jackson, Participant, Local Authorities
Matthew Kershaw, Place Member, Croydon
Shannon Katiyo, Place Member, Wandsworth
Jo Farrar, Partner Member, Community Services

1 Welcome and Apologies

Mike Bell (MB) welcomed everyone to the meeting and apologies were noted. With no further apologies the meeting was quorate.

1.1 Declaration of Interests

1.1.1 A register of declared interests was included in the meeting pack. There were no further declarations relating to items on the agenda and the Board noted the register as a full and accurate record of all declared interests.

1.2 Minutes, Action Log and Matters Arising

Minutes

1.2.1 The Board **approved** the minutes of the meeting held on 15 May 2024.

1.3 Action Log

1.3.1 The action log was reviewed, and it was noted one action remained open regarding the ICP Investment Fund which was due to be closed week commencing 15 July.

2 Decisions Made in Other Meetings

2.1 Sarah Blow (SB) presented the report.

2.2 The Board **noted** the decisions made in the SWL ICB Part 2 meetings on 15 May and 19 June 2024.

3 Chair's Report

3.1 MB introduced the report highlighting a number of key areas from the paper.

The Board **noted** the Report.

4 Engaging with our communities who face health inequalities, in partnership with Voluntary, Community, Social Enterprise Sector (VCSE)

4.1 Following an introduction by Mercy Jeyasingham (MJ), Chair of the SWL People and Communities Engagement Group, a joint presentation was given by Charlotte Gawne (CG) Sara Milocco (SM).

4.2 Board members discussed the report noting the excellent work undertaken in partnership with the VCSE to engage with communities who face health inequalities.

4.3 The meeting discussed the issue of trust between different sections of society and Health and Care, noting the role VCSE could play in building these relationships, trust and access to Health and Care services.

4.4 The Board noted that there were other areas where the VCSE could help engage with communities and these included: how inequalities within the 3rd and voluntary sector are also addressed to give the greatest reach into organisations; how successful VCSE projects could be rolled out across SWL; planning ahead and engaging earlier with the VCSE to give them more time to develop solutions; and how the output of conversations with the VCSE could help inform the views of the Urgent and Emergency Care Board with regard to the use of winter monies.

The Board **noted** the report and it was agreed that an Annual Report on the VCSE would be brought to the Board.

5. SWL NHS Infrastructure Strategy

5.1 Helen Jameson (HJ) presented the report.

5.2 Board members discussed the report noting the significant amount of work that had undertaken to bring digital, workforce and estates together under one Infrastructure Strategy, but also some of the challenges that also existed across estate and infrastructure

5.3 During the discussion a number of points were raised including: that the local digital pathway and timetable need to connect and align with both regional and national thinking, consider avoiding the use of expensive hot hospital sites for services that could be located in other places; exploring health in the high street by locating health facilities to sites where there were good communication and transport lines and where vacant retail spaces could be utilised; and the excellent uptake of the NHS app in SWL.

The Board **approved** the SWL NHS infrastructure strategy and supported the submission to NHS England by the end of July in line with the national deadline.

6 Review of the Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation

6.1 HJ presented the report.

6.2 Martin Spencer (MS), Chair of the Audit and Risk Committee, noted that the Committee had reviewed the Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation and had recommended them to the Board for approval.

The Board **accepted** the recommendation by the Audit and Risk Committee and **approved** the updated Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.

7 Annual review of the Remuneration & Nominations Committee Terms of Reference

7.1 Ruth Bailey (RB) presented the report, noting the main changes that had been made to the Remuneration Committees Terms of Reference.

The Board **approved** the Remuneration Committee Terms of Reference, having received the recommendation from the Remuneration Committee.

8 2024/25 Operational Plan

8.1 Jonathan Bates (JBa) presented the Report.

The Board **endorsed** the SWL 2024/25 Operational Plan.

9 SWL ICB Financial Plan 2024/25

9.1 HJ presented the report, noting that it had been endorsed by Ann Beasley, Chair of the Recovery & Sustainability Board and Dick Sorabji, the previous Chair of the Finance Committee.

9.2 In response to a question, HJ advised that for future reports, the tables presenting the deficit position of the Trusts would be expressed in percentage of turnover, recognising that the Trusts were not the same size and had different financial challenges.

The Board **approved** the SWL ICB Financial Plan 2024/25.

10 Update on Workforce

10.1 Karen Broughton (KB) presented the report.

10.2 During the following discussion Board members noted: that the best practice and learning from, the new approach to recruitment led by St Georges should be shared with other partners; the importance of improving the quality of training of middle managers and developing tool kits for all levels of managers to use; developing a flexible working policy that included standardised decision making for such requests; sharing learning and best practice on how to develop roles for career progression across health and social care; and how to capitalise on each other's development programmes and training across the sector.

10.3 It was noted that two trusts in London had led work on team rostering, which Chief Nursing Officers in SWL were interested in piloting. This would be brought back to the Board at an appropriate point as part of a workforce update report.

The Board **noted** the progress on our system-wide workforce transformation programme and system workforce report.

11 SWL Integrated Care Partnership Update

11.1 SB introduced the report.

11.2 Following the retirement of Ruth Dombey it was noted that an announcement would be made within the next few weeks about the new Co Chair.

11.3 Following a number of apologies, the SWL ICP Board meeting scheduled for 24 July has been cancelled and the next meeting will be in October. Work will continue outside of the Board, working together across partnership to deliver the strategic aims.

12 Board Committee Updates and Reports

Finance & Planning Committee Update

12.1 In the absence of a Chair of the Finance & Planning Committee, the report was noted for information.

Month 2 Finance Report

12.2 HJ presented the report, highlighting that the SWL system was reporting a year to date £0.2m favourable position to plan and, for the first time, the system was under the agency cap trajectory.

Quality & Oversight Committee Update

12.3 MJ presented the report and gave an overview of the key issues discussed at the Quality & Performance Oversight Committee on 15 May 2024.

Quality Report

12.4 Elaine Clancy (EC) presented the report noting: the Patient Safety Incidents Response Oversight Framework (PSIRF) & Policy had been agreed; the establishment of Place

Quality Groups across the six boroughs in line with the new structures; and the new potential quality risk regarding long waits for children's therapies.

Performance Report

12.5 JBa presented the report, highlighting areas of success and challenge. It was noted that there had been a drop in Virtual Ward utilisation and it was agreed that this would be an area to explore further with CEs from the Trusts and that it would be good to have a Board seminar discussion at a future date.

Audit & Risk Committee Update

12.6 MS presented the report and gave an overview of the key issues discussed at the Audit & Risk Committee on 11 June 2024.

Remuneration and Nominations Committee Update

12.7 RB presented the report and gave an overview of the key issues discussed at the Remuneration and Nominations Committee meetings on 4 July 2024.

The Board **noted** the Committee updates and reports.

13 Chief Executive Officer's Report

13.1 SB presented the report and passed on her thanks to everyone for their efforts during the recent industrial action to minimise disruption and where possible ensure continuity of services. SB also thanked staff in St Georges who provided mutual aid to those South East London hospitals affected by the cyber-attack, while they worked to recover their services.

The Board **noted** the report.

14. Any Other Business

14.1 There was no other business.

15 Public Questions

15.1 One written question was received from Roger King, Chair of the Board of Trustees, Croydon Youth Information and Counselling Service. Mr King referred to the Standing Financial Instructions v2.0, Section 6.1 which states "payments for goods and services is made in accordance with prompt payment practice" and asked: for the period ending June 2024 what was the total of outstanding unpaid invoice sum for contracted work; how many complaints have been received regarding non-payment of contracted work invoices; and what was the impact of the non-payment of contracted work invoices having on contracted service organisations?

15.2 HJ responded to Mr King and advised that circa 71,000 non NHS invoices were received per annum, which were required to be paid within a month. In June, 6,618 invoices were paid, of which 99% were within the required time period. The importance of making prompt payments to ensure organisations have the appropriate cash to afford their own bills was recognised. The ICB had not received any complaints regarding late payments in the last year, although when enquiries about payments were received the ICB tried to act on them as quickly as possible to resolve the issue.

15.3 In response to a question from Wendy Micklewright's (WM), MB noted that there was currently a special housing project being established which would look at Housing First. This work would report through the Integrated Care Partnership Board.

15.4 WM also raised issues relating to Electro Convulsive Treatment (ECT), responses received from FoI requests and noted the sad death of a friend who had been involved in the Mental Health system since the age of 15. On behalf of the Board, Vanessa Ford (VF) offered her condolences and thanked her for reminding the Board of the significant inequalities of outcomes for Mental Health patients. VF noted that, much work had been undertaken to reduce restrictive practices, although there was still more to do. This work was reported through South West London and St George's Quality Committee and VF would consider whether this could be shared with WM.

Next meeting in public: Wednesday 18 September: 120 The Broadway, Wimbledon, London SW19 1RH.

ICB Board - Part 1 Action Log - 6 September 2024

NHS South West London
Integrated Care Board

Date of Meeting	Reference	Agenda Item	Action	Responsible Officer	Target Completion Date	Update	Status
			ALL ACTIONS ARE CLOSED				

NHS South West London
Integrated Care Board

Decisions made in other meetings

Agenda item: 2

Report by: Sarah Blow, Chief Executive Officer, SWL ICB

Paper type: Information

Date of meeting: Wednesday, 18 September 2024

Date Published: Wednesday, 11 September 2024

Content

Purpose

To ensure that all Board members are aware of decisions that have been made, by the Board, in other meetings.

Executive summary

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.

On 17 July 2024 the Board discussed and approved recommendations for the award of NHS core contracts, including their value and contract term, under the Provider Selection Regime.

Recommendation

The Board is asked to:

- Note the decisions made at the Part 2 meeting of the Board on 17 July 2024.

Governance and Supporting Documentation

Conflicts of interest
N/A.

Corporate objectives
This document will impact on the following Board objectives:

- Overall delivery of the ICB's objectives.

Risks
N/A.

Mitigations
N/A

Financial/resource implications
N/A

Green/Sustainability Implications
N/A

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

Patient and public engagement and communication
N/A

Previous committees/groups
N/A

Committee name	Date	Outcome

Final date for approval
N/A

Supporting documents
N/A

Lead director
Sarah Blow, Chief Executive Officer

Author
Maureen Glover, Corporate Services Manager (ICS)

NHS South West London
Integrated Care Board

Chair's Report

Agenda item: 3

Report by: Mike Bell, Chair

Paper type: Information

Date of meeting: Wednesday, 18 September 2024

Date Published: Wednesday 11 September 2024

Content

Purpose

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

Executive summary

At each Board meeting in public the Chair provides a brief verbal and/or written update regarding matters of interest to members of the Board and members of the Public.

Key Issues for the Board to be aware of

Annual General Meeting

We will be holding an Annual General Meeting (AGM) on Monday 30 September at 2pm when we will formally present our annual report and accounts. Members of the public will be welcome to attend to hear about the progress and key achievements of the ICB over the last year, along with some of our future plans.

More information about the AGM will be shared on our website www.southwestlondon.icb.nhs.uk/events/.

Recommendation

The Board is asked to:

- Note the contents of the report

Governance and Supporting Documentation

Conflicts of interest
Not applicable

Corporate objectives
This document will impact on the following Board objectives:

- Overall delivery of the ICB's objectives.

Risks
Not applicable

Mitigations
Not applicable

Financial/resource implications
Not applicable

Green/Sustainability Implications
Not applicable

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

Patient and public engagement and communication
Not applicable

Previous committees/groups
Not applicable

Final date for approval
Not applicable

Supporting documents
Not applicable

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NHS South West London
Integrated Care Board

Urgent and Emergency Care Update

Agenda item: 4

Report by: Jonathan Bates

Paper type: In Focus Item

Date of meeting: Wednesday, 18 September 2024

Date Published: Wednesday, 11 September 2024

Content

Purpose

This item is to update the Board on three key areas for Urgent and Emergency Care (UEC) in South West London (SWL):

1. **SWL UEC Winter Plan 2024/25**
2. **Response to the NHS England letter 'Maintaining focus and oversight on quality of care and experience in pressurised services'**
3. **SWL UEC Two-Year Plan**

Executive summary

1. SWL UEC Winter Plan 2024/25

Planning started in the Spring to prepare the system as early as possible for the challenges ahead, reviewing learning from last Winter and how funds would be spent. The ask was set out to the SWL UEC Board in early June referring to the national letter UEC Recovery Plan Year 2: Building on Learning from 23/24, as well as the 2024/25 operational planning guidance (which focussed on the two key targets to improve 4-hour Emergency Department performance and reducing Category 2 Ambulance Response times). In addition, there was a focus on the operational planning guidance priorities to maintain bedded capacity, increase productivity of acute and non-acute services, improve flow, Length of Stay reduction and clinical outcomes as well as develop services that shift activity from acute hospital settings to community settings.

Local systems were asked to complete a template featuring the key areas outlined above, aligned to their Length of Stay reduction plans which had been completed in May. Recognising the breadth of UEC and the impact of other parts of the service on our ability to deliver the ambitions of the UEC

Recovery Plan, we have included all parts of the system in our Winter Plan including Primary Care, Mental Health, Communications, the System Coordination Centre, Workforce, Out of Hospital, 111, Vaccinations and Immunisations, and our Critical Care Network. Their contributions to supporting the UEC pathway, such as through preventative work with RSV vaccinations or increased capacity in Primary Care, have been reflected in the plan.

The plans include investment of £13.8m in non-recurrent resources to deliver the best outcome for patients this winter. These plans have been through rigorous review, reflecting on learning for last year, national priorities, local priorities and alignment with both other funding allocations such as the Adult Social Care Discharge Fund and strategic system plans on Length of Stay reductions. These plans have been reviewed and supported by the Finance & Planning Committee.

The plan has been iterated over the last few months, has been shared and commented on widely and signed off by the SWL UEC Board on 30 August.

2. Response to the NHS England letter 'Maintaining focus and oversight on quality of care and experience in pressurised services' dated 26 June 2024

The letter emphasised that corridor care, or care outside of a normal cubicle environment, should be an exception rather than the norm. If needed, it should be provided in the safest and most effective manner possible, for the shortest period of time possible, with patient dignity and respect being maintained throughout and clarity for all staff on how to escalate concerns on patient and staff wellbeing. The letter asked every Board across the NHS to assure themselves that they are working with system partners to do all they can to prevent avoidable overcrowding of Emergency Departments (EDs) and hospital ward beds via transformation programmes to provide alternatives to emergency department attendance / admission and maximise in-hospital flow.

The 6 areas of assurance in the letter are:

1. Implementation of the actions set out in the UEC Recovery Plan Year 2 letter (admission prevention, in-hospital flow and discharge).
2. Basic CQC standards of care.
3. Whole system engagement in supporting flow out of ED and hospital.
4. Board visibility of the Seven Day Hospital Services audit results.
5. Visible executive leadership and appropriate escalation protocols in place at trust and system level.
6. Regular non-executive director safety walkabouts where patients are asked about their experience, and this is relayed back to the Board.

The South West London ICB teams have worked with the local acute and mental health Trusts to formulate a systemwide self-assurance of the above, structured around six key areas specified in the letter.

3. SWL UEC Two-Year Plan

Our ambition is to look ahead to take forward proactive transformational change to prepare our Urgent & Emergency Care services for our future population needs and to reduce the pressures within the pathways of care for our patients and staff.

This plan outlines the national and local context and has been built over the last two years, listening carefully to a wide range of professionals and patients and taking into consideration our experience coming out of pandemic response mode. Our clinical workforce across primary, community, mental health and hospitals report that we are seeing patients who are, more often, presenting with more acute and complex conditions. Patients are often staying longer in hospital, meaning almost all our beds are occupied all the time.

The themes and interventions outlined in this plan reflect the need for our system to adapt to this new reality, as well as being as efficient and effective as possible, using all our resources wisely. It seeks to move our efforts to transform urgent and emergency care in the medium term, so we are thinking ahead while deliver services during continuous pressure.

The plan is based around four core themes: Accessing Urgent & Emergency Care, Patient Flow and Discharge, Supporting and Developing our Workforce, delivering Productivity and Efficiency.

We will seek to deliver the Key Measures of our Success whilst taking forward the actions outlined across the themes.

Key Issues for the Committee to be aware of

1. SWL UEC Winter Plan 2024/25

The Winter plan builds on existing work ongoing in the system, particularly on patient flow, Length of Stay Reduction and Community services designed to avoid attendance to Emergency Departments and hospital admission. There are some new challenges and mitigations this year which have been set out in a specific slide " What is new this year?".

The NHSE Winter letter is still pending but we expect it to align with our plans to meet current national objectives as set out in the national UEC Recovery Plan, the update letter UEC Recovery Plan Year 2: Building on Learning from 2023/24, and the Operational Planning Guidance for 2024/25.

2. Response to the NHS England letter 'Maintaining focus and oversight on quality of care and experience in pressurised services' dated 26 June 2024

As well as the existing escalation protocols, and UEC programmes addressing admission prevention, in-hospital flow and discharge, Trusts and the system have done more to maximise patient safety at this time:

- Strengthened governance and processes, with clear escalation triggers and named contacts/owners, and non-executive and executive walkabouts in addition to increased ward-to-board feedback.
- Improved processes and monitoring of patients following risk-assessments and quality impact assessments.

- Increased staffing, with dedicated staff monitoring patients in out-of-cubicle areas, providing at least basic observations, hydration, nutrition and pain management.
- System meetings with Chief Operating Officers (COOs), Chief Nursing Officers (CNOs) and Chief Medical Officers (CMOs) focused on quality and safety in Emergency Departments.

3. SWL UEC Two-Year Plan

The two-year plan is a live document which we expect to be iterated as new guidance and challenges occur, particularly with the expectation that we will need to plan to recover further, in performance and quality terms, when the new NHS plan is published in the Spring.

Recommendation

1. SWL UEC Winter Plan 2024/25

The Board is asked to:

- **Endorse** the plans in place and associated investment to support the SWL system to prepare ahead of Winter, seeking to deliver a safe standard of care for our patients over this period.

2. Response to the NHS England letter 'Maintaining focus and oversight on quality of care and experience in pressurised services' dated 26 June 2024

The Board is asked to:

- **Endorse** the assurance report and note the associated significant risks, mitigations and challenges faced by front line staff and patients on a day-to-day basis.

3. SWL UEC Two-Year Plan

The Board is asked to:

- **Endorse** the plans for Urgent & Emergency Care services in SWL over the next two years, recognising that new guidance is expected in the Spring that may further refine the priority themes set out in the document.

Governance and Supporting Documentation

Conflicts of interest
No conflicts of interests to report

Corporate objectives
Meeting the performance, quality and safety standards and access requirements from NHS England.

Risks
Quality, performance and patient safety risks are included in the SWL ICB Corporate risk register and escalated to the Board Assurance Framework where appropriate.

Mitigations
Included in papers

Financial/resource implications
Investment of non-recurrent winter monies as outlined in the paper.

Green/Sustainability Implications
No impact

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

Patient and public engagement and communication
There has been patient engagement in the development of the two year plan.

Previous committees/groups

Committee name	Date	Outcome
SWL UEC Board	30 August 2024	SWL Winter Plan - signed off
SWL UEC Board	30 August 2024	Response to the NHSE Letter - signed off
SWL UEC Board	6 September 2024	2 year Plan - signed off
SWL SMT	5 September 2024	Supported all three papers
Finance & Planning Committee	119 July 2024	Supported financial commitments

Final date for approval
As set out in the papers

Supporting documents
SWL UEC Winter Plan 2024/25
Responding to Patient Safety in Pressurised Services
SWL UEC Two-Year Plan

Lead director
Alison Pirfo

Author
Alison Pirfo

NHS
South West London

Urgent & Emergency Care: South West London Preparations for Winter

2024/2025

Contents

NHS South West London

Executive Summary

NHS
South West London

- **This Winter Plan represents the outputs of a whole-system approach to considering what needs to be in place to support our services, patients and staff through what is going to be another challenging Winter period**. It describes in some detail the plans for each part of the pathway. It is designed to provide the Board with assurance that there has been a **comprehensive and considered examination of what we are already doing, what is different this year and what more we need to do**. **It is a live plan and will continue to be iterated as new guidance and challenges appear**.
- Many of these interventions form part of existing programmes of work, such as those described in the community sector; some are specific to this time of year, for instance the flu vaccination programme and in some cases, we have described further steps we need to take to build resilience over the coming months. **We have drawn them into this document to represent the full scope of activities underway to support capacity building and transformation that better supports demand management and alternatives to acute hospital care, where appropriate**.
- The scale of the challenge within SWL this Winter is clear throughout this document. Patients, with both physical and/or mental health needs, continue to present with increasing acuity, often resulting in longer stays in hospital and greater needs on discharge. We have begun to see early signs of progress in reducing length of stay in some of our Trusts, which is of benefit to patients and staff, as well as being more efficient but there is so much more to do to secure universal progress.
- The potential for industrial and/or other collective action such as that currently taking place in primary care may also impacting adversely on service provision, further impacting workforce morale and with implications for elective care as well as urgent care. We also go into the Winter period with a number of unknowns that may have a negative impact on the system such as the level of Covid infections alongside possible flu outbreaks.
- **The plan has been developed in the Spring and completed in the Summer, allowing more time to mobilise additional activities and where necessary recruit effectively into short term Winter roles.** Early notification of the funds available to the system has been welcomed with the UEC Board running a process to ensure that the £13.8m received has been allocated fairly across the system and spending prioritised against approaches with tangible benefits. In addition, the Adult Social Care Discharge Funding has also been distributed between NHS providers and local authorities to improve discharge capacity and processes.

What is new this year?

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- **A real, intensive focus on Length of Stay** through the reduction programme to facilitate patients to go home as soon as they are well enough to do so
- **Single point of access to Mental Health support** via 111
- **A more resilient 111 provider** with improved performance so patients receive a timely service
- **Respiratory Syncytial Virus (RSV) vaccination** for those over 75 years old and women over 28 weeks pregnant
- A key initiative to **stop ambulance crews waiting more than 45 minutes to handover to hospitals** is now business as usual
- **New challenges**, such as GP collective action and the national focus on 72 hour Mental Health waits
- Roll-out of draft plans to introduce the **OPEL** (Operational Pressures Escalation Levels) **framework to primary care, community partners and Mental Health trusts**
- **A new situational awareness dashboard** in the System Co-ordination Centre (SCC) with close to real-time information on pressures in the system that facilitate and support conversations with our partners across the system which continues to be developed
- Learning from previous years, **prioritisation of winter funding into primary care and community** for primary care hubs, as well as End of Life and Urgent Care Response pilots
- Learning from last year, **investment in our hospitals such as through supporting nurses at the front door to help the timely handover of ambulance patients and expanding frailty services**

Introduction

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- Preparing for the coming Winter Period has involved all parts of the Integrated Care System in a period of reflection and action planning to ensure that the services we provide are in the best possible shape for the expected increase in demand.
- It should be note that this is a SWL-level plan and local Winter plans have been developed to meet local needs in partnership with local services and agencies such as with Local Authorities and the VCSE sector.
- Urgent and Emergency Care Services are at the centre of this planning and in this paper we look in detail at the arrangements that have been made to date.
- We started our planning in the Spring with final financial notifications being shared with providers in June and July. In order to make the most of these allocations, we have aligned our plans with Local Authorities to ensure we maximise the money and resources available. We have also worked to carefully triangulate our Length of Stay reduction plans with these Winter Plans and with the Adult Social Care Discharge Fund plans. We have also reflected on the learning from last Winter, for example, we have decided to systematically invest in primary care capacity over the festive period now, rather than responding when pressures spike in the days before the holiday season begins.
- With that in mind, local systems developed plans for the year with maintaining bedded capacity and improved ambulance response times has a priority. These plans were reviewed at ICB level to confirm that they aligned with the national priorities and 2024/25 operating plan guidance, and the SWL priorities for reducing Length of Stay.
- Planning how to spend the funds earlier in the year has meant we can prepare sooner, recruiting staff earlier to avoid spending more on agency and bank staff.

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UEC in Context

Urgent and Emergency Care in Context

NHS South West London

(Activity numbers are an average per month Aug 23- July 24)

2589

General and Acute & Equivalent (G&A) Beds

12%

Patients not meeting Criteria to Reside

95%+

G&A Bed occupancy

76.9%

achieved March 24

ED 4 hour Waits

59,000
per month

People Attending ED

35000

111 calls

97,000
last 12 months (LAS)

Ambulance arrivals

700,000 +
per month

GP appointments

Social care **36,000**

NHS **34,000**

Workforce

415

Virtual Ward Beds available by March '24

340

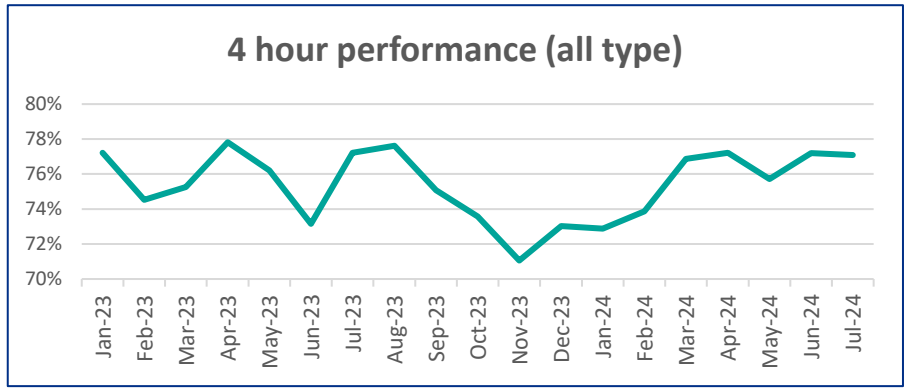
Urgent Community Response call outs

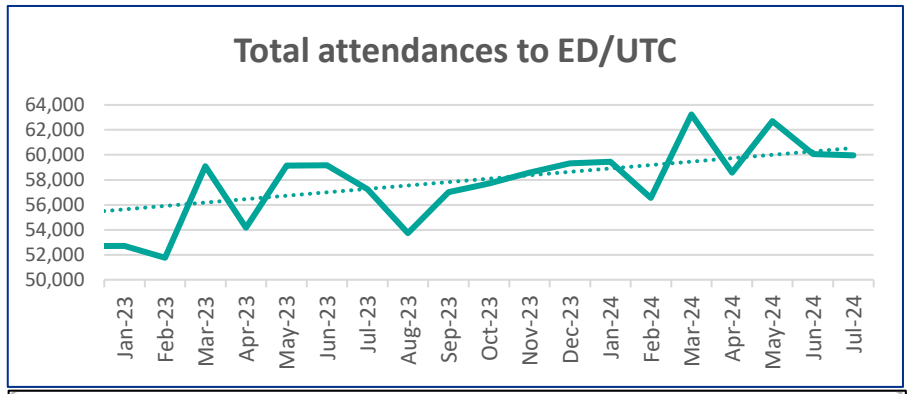
7,900

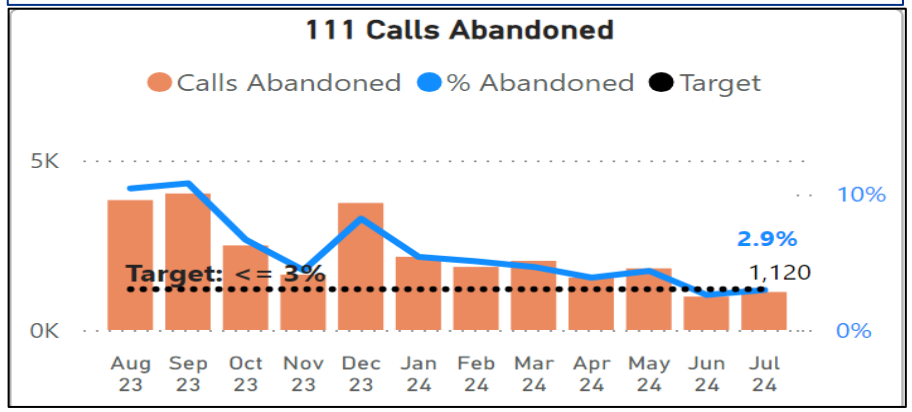
Non-Elective Admissions from ED

Current UEC Performance

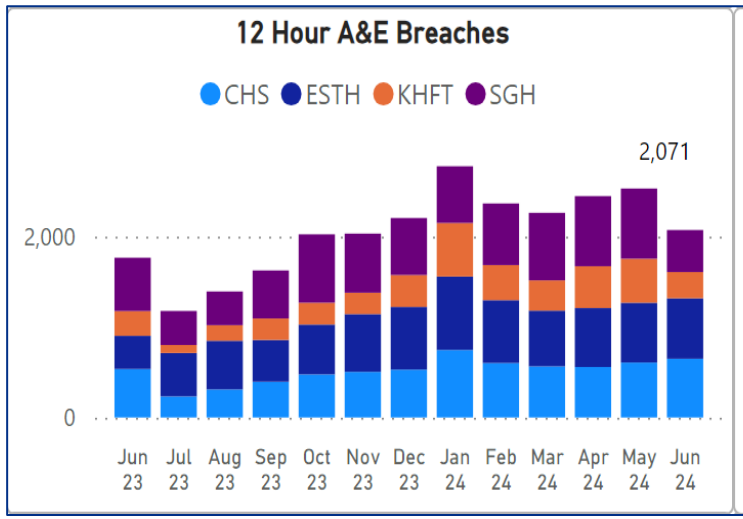
South West London

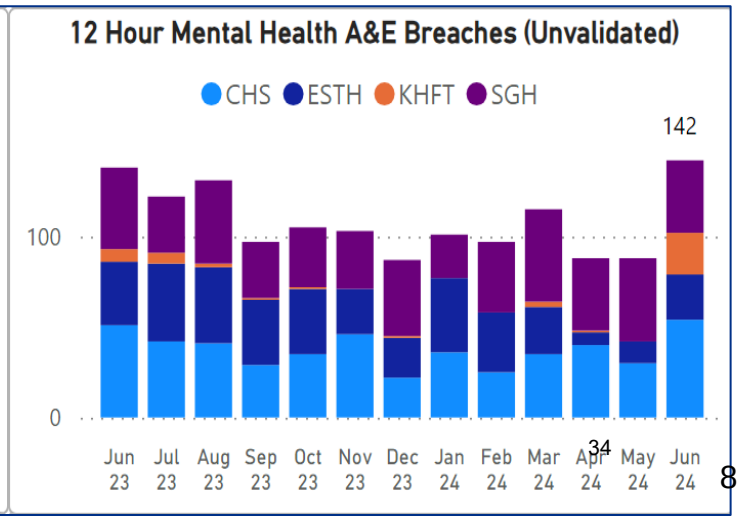




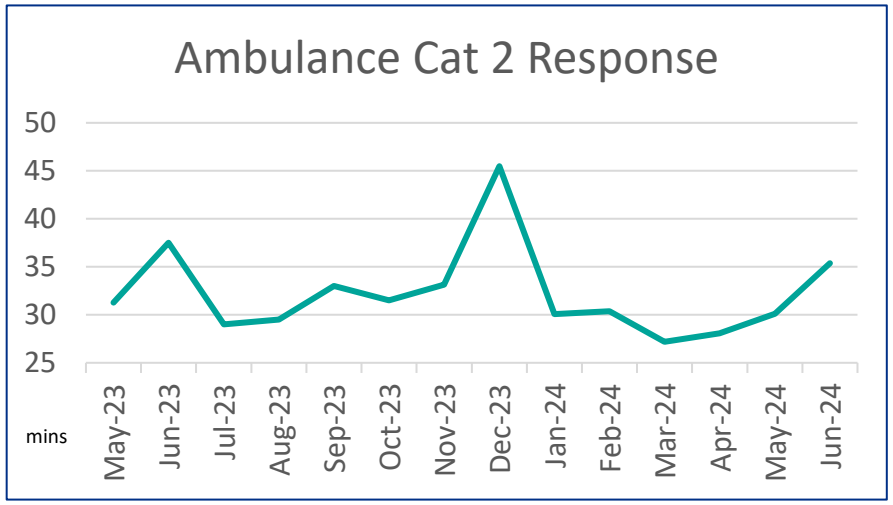


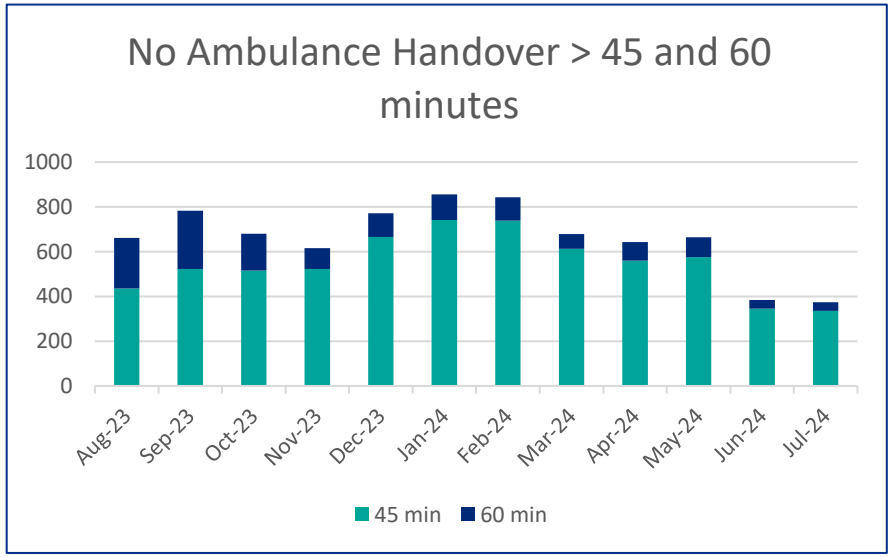
- Following intensive work, this Summer the ICS **is seeing year on year progress on the proportion of attendances being treated within 4 hours,** which is encouraging after the trend in recent years**.**
- **However, Emergency Department attendances have been rising steadily**, and coupled with flow pressures within hospitals and with timely discharged from hospital, the pressure continues to rise in the UEC pathway.
- **The number of patients waiting in the Emergency Department for more than 12 hours** after a decision to admit remains high and continues to be an area of focus for the whole system for both physical and mental health.
- As noted previously, we continue to support handover of patients from ambulance crews to allow them to be released back to the community and **have seen significant reductions in very long ambulance delays**.
- **Improved 111 performance with faster response times** and fewer abandoned calls.





Ambulance Handover and Response Times





- In SWL, we recognise that very sick people waiting in the community for an ambulance are amongst our most vulnerable cohort of patients. We support the national ambition to reduce those waiting times and so ambulance handover to release crews back into the community remains a core priority for SWL. Considerable daily operational focus is spent on reducing delays at the front doors of our hospitals.
- Improving these waiting times has meant balancing risk at times and making difficult decisions when hospital flow is under pressure. We have continued to enact triggers including boarding and cohorting of patients waiting to be handed over by crews to help facilitate patients leave the hospital sites sooner.
- In Autumn last year, our hospitals started to work with LAS on 45-minute handover which is essence means that no patient should be kept waiting more than 45 minutes to be handed over from ambulance crews to the hospital. Whilst this has put additional pressure and risk on the hospitals, we continue to support the principle. Our hospitals have committed an amount of Winter funding for nursing staff to manage and care for patients in these cohorts.
- Importantly, we continue to see waiting times in the community for the sickest patients generally lower than the 30-minute target and usually the best in London, however, this is still a long way from the 18-minute national standard.

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Key objectives for this Winter

Key objectives for SWL this Winter

NHS South West London

Historically, NHSE Winter letters have been published in the Autumn so there may be additional national expectations as the year progresses. For now, we are focussing on the **NHSE UEC 2 year Recovery Plan, and the letter *Urgent and Emergency Care Recovery Plan Year 2 - Building on learning from 2023-24* published in May 2024**. The level of ambition for 2024/25 was also set out in the NHS priorities and operational planning guidance with a specific focus on:

- improving A&E performance with 78% of patients being admitted, transferred or discharged within 4 hours by March 2025
- improving Category 2 ambulance response times relative to 2023/24, to an average of 30 minutes across 2024/25

This operational planning guidance asked systems to focus on three areas to deliver these ambitions:

1. Maintaining the capacity expansion delivered through 2023/24
2. Increasing the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes
3. Continuing to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge.

In addition, and supporting the national ambitions, we have agreed an **overall 1.5 day Length of Stay Reduction** across SWL in 2024/25. Achieving this ambition is dependent on our partners and stakeholders across the UEC pathway, building on and accelerating existing work. This is ambitious given the movement in recent years has been to ever increasing average lengths of stay, but we are seeing real commitment across the system and some early signs of good progress in some organisations.

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SWL Winter Preparations

Same Day Emergency Care

NHS
South West London

Progress on Same Day Emergency Care (SDEC) continues to be made with further opportunities for learning across the system. SWL is currently the only London ICB with all its hospitals receiving patients directly from LAS without a clinician having to call the service first through the Trusted Assessor model. Until recently, we were the only ICB in London meeting the standard to have SDEC services available 12 hours a day, 7 days a week, but that has slipped slightly due to the pressure on beds and space. SDEC has seen continual expansion and growth in SWL and we know there is still potential to do more to increase care on the day for patients who can then go. We are looking at maximising links between other services such as with Urgent Community Response and Virtual Wards. The SWL SDEC Group is working together on this, sharing learning as well as providing a focus for regional and national priorities.

Increasing Capacity and Resilience

- As SDEC has become embedded, sites have been reporting the need to review casemix as capacity becomes strained and the need to ensure the right patients are being treated in the department. This has resulted in recommendations such as running hot clinics for certain specialties.
- Expansion of services, particularly Surgical SDEC, is underway at several hospitals.
- The 111 service is actively promoting and supporting SDEC within their service including bringing in clinicians to explain to advisors what the service is about to encourage utilisation and work with services to make improvements, such as on the quality of referrals.
- Two sites have Trusted Assessor in place with 111 so patients can be referred without a clinician-to-clinician call.

Risks, Challenges and Support

- Bedding of some SDEC units has increased over the last year due to pressures on flow and physical capacity with significant implications for flow.
- Increased use of ambulance cohorting has put further pressure on SDEC space.
- SDEC services increasingly being used for patients who need treatments such as infusions.
- There are ongoing issues with consistent data reporting across SWL because of technical issues with the hospital IT systems.

Increase access to frailty pathways

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South West London

Levels of frailty and complexity are growing in all SWL boroughs putting pressure on emergency services and hospital beds. Of the SWL population, 21% are deemed at risk of frailty using the electronic frailty index (eFI). For those with frailty risk score of Moderate or Severe there were 213,070 A&E attendances in the last 12 months representing 36% of all A&E attendances in SWL. Data highlights that two key opportunity areas are the prevention of increasing frailty in the mild to moderately frail group and optimising care for those already at higher risk. Our data also shows that the most deprived 20% of the population have increased rates of frailty and a higher utilisation of services, making this cohort a key focus. Frailty has been agreed as a priority by the SWL UEC Board because there is a significant opportunity to improve the prevention of frailty, reduce avoidable admissions through more proactive care (1 in 5 admissions are deemed avoidable), reduce wait times, and deliver a more holistic, coordinated and personalised response.

Capacity and resilience over Winter:

- To help support the emerging needs of our frail population, a model of care has been developed for implementation across SWL. The model comprises four main inter-related zones: Promoting independence and wellbeing, Proactive Care Plus, Integrated intermediate care and Frailty-attuned hospital care.
- Proactive care programmes operate in each of the SWL Places and via primary care routinely focus on early identification of patients using standardised frailty tools and action plans co-produced to manage risk, deterioration, escalation and avoid reactive and acute episodes. Community assets such as social prescribers, voluntary sector groups and pharmacists have been engaged and will work with local teams to help coordinate care.

Challenges and Risks

- There is variation in the service offer across SWL, with most having limited frailty services due to estate restrictions and costs of implementing or expanding dedicated services in the right place.

Improve Inpatient flow and reduce Length of Stay

NHS South West London

We know that patients staying in hospital beds longer than they need to is detrimental to their health. It also impacts severely on hospital flow with sick patients in Emergency Departments waiting for a hospital bed and we have seen our 12 hour breaches at levels we have never seen before. Reducing Length of Stay (LoS) is therefore a key priority for SWL this year, with a system wide commitment to reduce overall LoS by 1.5 days over the course of 24/25. This will be achieved through improvement work in the areas of In-Patient flow, Frailty and Out of Hospital including community services, mental health and links with local authority services. A senior LoS Working Group was established to agree a delivery plan to achieve the target reduction and a scorecard has been developed to provide clear oversight by the SWL UEC Board of progress against the plan.

Capacity and resilience over Winter:

- All SWL Acute Trusts have work programmes dedicated to improving continuous flow with specific projects aimed at reducing length of stay. Much of this work is established and on-going and there is a drive now to make the mechanisms to support flow more robust and sustainable, such as increasing review meetings, encouraging patients and families to participate in discharge planning, improving data quality and regular reporting, clear escalation triggers and processes. This includes reducing patients with a length of stay over 14 and 21 days.
- Internal standards and processes have been reviewed in order to highlight improvements in in-hospital efficiencies with a particular focus on improved MDT working and discharge planning.
- All local systems have set out clear plans to deliver the 1.5 day LoS reduction which have been reviewed and agreed by the SWL UEC Board.
- All Trusts are maintaining bedded capacity, supported by Winter Funds.

Challenges and Risks:

- The 1.5 day reduction is challenging and is dependent on all partners across the UEC pathway to contribute and work together.
- Data quality is very variable across SWL and requires improvement. There is significant inconsistency in how data is recorded and reported.
- Much of this work is ongoing and requires additional focus and momentum to make sustainable progress.

Adult Critical Care

NHS
South West London

The strategy is to optimise our capacity for those who need it most through initiatives such as enhanced care beds, timely discharges from critical care and supporting patients on wards. The focus is to maintain business as usual through efficient use of current bed base, reducing length of stay, early escalation of capacity concerns, minimizing delayed discharges and following the SWLACCN escalation process when required. There is a strong emphasis on preserving elective activity and flexing additional critical care capacity intermittently. SWLACCN has a baseline of 124 critical care beds.

Capacity and resilience planning over the Winter period has the following components:

1. **Review past Winter data to identify trends in critical care demand**
2. **Capacity planning**
    - Identify potential areas for surge expansion across SWLACCN (as per SWL critical care surge plan)
    - Work with individual Trusts and the wider SWL ICB to plan for Winter surge and identify any concerns
    - Minimise delayed discharges and non-clinical transfers
    - Robust planning to predict and manage elective activity
3. **Equipment and supplies -** early engagement with medical physics to ensure an adequate supply of critical care equipment
4. **Workforce Management**
    - Each Trust will look at training, development / upskilling and competencies of staff to support the delivery of this plan
    - Plan for staffing needs including recruitment of staff to fulfil medical and nursing needs if surge/escalation areas open
    - Consider modifying staff to patient ratio with risk assessments where appropriate
5. **Challenges and Risks**
    - Patient flow and available General & Acute bed capacity
    - Workforce and staffing of critical care units (staff sickness; workforce resilience)
    - Delayed discharges or repatriation from critical care
    - Avoiding cancellation of elective surgery requiring critical care
    - Delays in access to specialist services due to lack of critical care beds in specialist centres

Reablement and intermediate care services

NHS South West London

There has been work ongoing across SWL to review services and identify what is needed to support flow and discharge including modelling of demand, consideration of single points of triage, service specifications and workforce requirements to enable proposed changes. The service offer is variable across SWL and the offer, particularly where there are planned improvements, is tailored to local needs and how this works with partner organisations and services.

Capacity and resilience :

- For this year, Kingston has purchased additional intermediate care capacity to support packages of care for health provision in Kingston and also to provide for social care needs of those requiring bridging from the Virtual Ward step-down capacity.
- In Richmond there is additional intensive short-team bedded rehabilitation delivered by a Multi-disciplinary Team to support discharge.
- In Merton and Wandsworth, there is work ongoing to review Pathway 2 and Pathway 3 patients to support commissioning and service re-provision and to re-establish the “step-up” pathway for admissions to Queen Mary’s rehabilitation ward from the community.
- In Sutton, work continues to maximise flow and throughput of the new Reablement Unit led by Sutton Health & Care.
- Croydon, as part of the development of the frontrunner programme that include new/improved reablement service, earlier identification in discharge planning and support around step-down beds and step-down for social care issues.
- Further consideration to be undertaken for the potential extension of the proactive care programme across all localities, using existing opportunities and use additional funding where this becomes available.

Challenges and Risks: .

- Data access to support discharges is progressing within the SWL system but there is more to do to standardise the quality of data capture and quality of recording. All NHS-commissioned community bed providers being registered and submitting regular data to the Community Discharge SitRep will provide better visibility to the wider system to support discharge and flow.
- Ongoing staffing issues which are variable across the boroughs

Hospital at Home/Virtual Wards

NHS South West London

Hospital at home/Virtual Wards provide a safe alternative to a hospital stay, with SWL services providing the equivalent of 415 beds capacity over the Winter period, working towards 425 by March 2025. This capacity provides admission avoidance and early supported discharge pathways for high-acuity patients, with at a focus on supporting heart failure, respiratory and frail patients. Care is delivered within patients' own homes, supported by technology and face to face interventions to ensure they can safely stay at home. The whole of SWL is covered by four local virtual wards: Croydon University Hospital covers Croydon (community led), Sutton Health & Care delivers the virtual ward in Sutton (community led), Central London Community Healthcare delivers the virtual ward in Merton and Wandsworth, and in Kingston and Richmond hospital at home is delivered by Kingston Hospital (acute led).

Virtual Wards all have step up (admission avoidance) and step down (supported discharge) pathways capacity, working closely with other admission avoidance services, most notably through Urgent Community Response. Through significant work, progress has been made over the last year in making optimal use of this capacity.

The hospital at home services run 7 days a week 8am – 6pm, and is supported 24/7 by the Central Remote Monitoring Hub.

Capacity and resilience over Winter:

Expanding on both scale and utilisation from last Winter, 415 beds are available for acute and community services to refer into.
There are admission avoidance and step-down pathways working closely with Urgent Community Response, Same Day Emergency Care services and Emergency Department and acute speciality wards to enable earlier discharge home.

Challenges and Risks
Optimising bed utilisation for this Winter across the system remains an area of considerable focus.
Financial constraints and the future service options into the future need careful consideration.

Urgent Community Response

NHS South West London

SWL has one of London's best performing 2-hour Urgent Community Response (UCR) services. Since April 22/23, UCR services have been fully operational across all six SWL boroughs, provided by five organisations. These services run seven days a week from 8 am to 8 pm, with Sutton offering 24/7 coverage. Referrals come from diverse sources, including self-referrals, Care Homes, GPs, Community Health Services, 111, London Ambulance Service and more. The primary goals of these services are to enhance the volume and consistency of referrals, improve patient care, alleviate pressure on ambulance services and avoid hospital admissions. UCR services address nine nationally prescribed clinical areas such as falls, frailty, palliative/end-of-life crisis support, confusion/delirium, and urgent catheter care.

Capacity and resilience over Winter:

- Winter funds will be utilised to extend UCR services so that all boroughs have an extended minimum service running 7 days a week, 8am-8pm (last referrals 6pm) as a minimum.
- Although the UCR service is well-utilised, ongoing efforts aim to streamline referral processes and improve direct pathways from various sources, including 111 and ambulance services.
- Collaboration with the Directory of Services (DOS and MIDOS) is vital to enhance the visibility of UCR services and work directly with providers, including primary care and eligible patient cohorts to raise awareness.
- The objective for the Winter period is to increase the overall number of referrals accepted into UCR services. A significant focus will be on more successful collaboration with LAS and 111 services as well as encouraging self-referrals, ensuring people to remain in their place of residence rather than relying on ambulance services.

Challenges and Risks

Securing sufficient UCR Workforce - Potential capacity issues due to an inadequate number of UCR staff.
Navigation Difficulties - Referrers may struggle to navigate the UCR service because pathways are not yet fully standardised across SWL, with each service having slightly different protocols.
Ensuring good communication across services to keep patients in the community wherever possible.

Enhanced Health in Care Homes

NHS
South West London

There are approximately 340 Care Homes in SWL for Older People's Nursing and Residential Care, People with Learning Disability and People with Mental Health conditions. A work programme is in place to further improve SWL compliance with the national Enhanced Health in Care Homes framework, with a particular focus on digital integration, hospital flow and training.

Increasing Capacity and Resilience

- From previous winter funding, a Falls Prevention training programme is continuing along with dementia training.
- Support to improve capability for detecting and managing signs of early deterioration in conjunction with Remote Monitoring.
- Support to the London Shared Care Record which is showing promising results to improve discharge along with further embedding the Red Bag pathway.
- Work has also been undertaken to improve referral pathways between Care Homes and Urgent Community Response, with SWL being one of the highest referring areas from Care Homes.
- The Intensive Support Service (ISS) is planned to run for a third winter, helping to facilitate the placement of patients with challenging behaviours.

Challenges and Risks:

- Not all Care Homes have been able to take up training offers due to limited funding.
- The programme has largely been funded by Ageing Well and Digital non-recurrent funding programmes.
- The Red Bag pathway is dependent on Acute and LAS involvement.
- Scope to expand MDT meetings in Care Homes to reduce pressure on Urgent & Emergency Care pathways.

End of Life Care

NHS
South West London

End of Life Care (EOLC) is delivered collaboratively by Primary Care, Community Services, Acute Hospitals and four Hospices with support from the voluntary sector. While SWL has high levels of use of the Urgent Care Plan (UCP), there is scope for this to increase. SWL is focused on: developing the interagency collaboration; improving identification of people at EOL; bereavement mapping and services; increasing UCP use, particularly in Care Homes and addressing medication issues. An EOLC winter project is being supported by winter funds this year.

Increasing Capacity and Resilience

- Winter project funding to improve primary care's level of identification and coding, rapid primary care access, improving UCP use and community medication delivery.
- Work has been initiated with the Hospices to agree models of care based on the national service specification.
- In collaboration with the Enhanced Health in Care Homes programme, a project is underway to increase Care Home use of the UCPs through clinical training and support alongside digital support.
- SWL roll out of the Bereavement pilot undertaken in Kingston & Richmond.

Challenges and Risks

- The programme has largely been funded by Ageing Well and Digital non-recurrent funding.
- Financial fragility of Hospices is recognised and may impact on service delivery.
- Limited capacity to support EOLC pathways.

Increase Primary Care capacity

NHS
South West London

The majority of urgent care encounters over the Winter period happen in primary care and pressure on primary care services in terms of access or capacity has a direct impact on other parts of the UEC system, particularly Emergency Departments, Urgent Treatment Centres and ambulance services. This will particularly be the case in the event of a significant flu or covid outbreak, or a sustained period of very cold weather. Primary Care have secured additional Winter funds this year to provide additional capacity across each Place over Winter. Plans are being developed based on previous learning and in agreement with local UEC Delivery Boards. Approval has been sought earlier this year to allow Place teams time to mobilise plans sooner to alleviate challenges such as filling rotas.

Capacity and resilience over Winter:

- GP Practices open 5 days per week during core hours (8am-6.30pm) and Primary Care Network services open as a minimum Mon-Fri 6.30-8pm and Sat 9am-5pm.
- Plans are currently being developed to cover the period of mid-December to early January via hub sites in each borough, along with additional surge capacity for w/c 23 and 30 December in-line with local need.
- Pharmacy First services will be actively promoted as a key component of Winter communications plan.

Arrangements are in place to dynamically monitor demand and provide resilience, including through the delivery of the Primary Care Recovery Plan e.g. supporting practices to move to a Modern General Practice Model, increasing support for self-directed care, expanding pharmacy first services, improving the primary-secondary care interface.

Challenges and Risks

- GP Collective Action means there is uncertainty as to the extent of the impact of this action on patient care and the knock-on to UEC services.
- Funding – limited funding to provide services, though dedicated funds have been made available early for the first time.
- Workforce – being able to fulfil rotas due to competing services ramped up for Winter.
- Information flow – capacity to support booking into the service and review patient needs proactively.

Ensure sufficient capacity in the 111 Service

NHS South West London

The 111 service, provided by Practice Plus Group (PPG) with support from London Ambulance Service, is a first port of call for patients to get the right advice or treatment they need, for their physical or mental health. Patients are assessed and can be directly booked into a face-to-face service such as to GP practices, Urgent Treatment Centres, SDEC, urgent community response services and mental health crisis services. It is vital that this service works well to ensure patients' access the right care and to minimise the number of patients visiting Emergency Departments when other services would better support their needs. Our 111 service has made significant progress in the last year in meeting the timely needs of patients.

Capacity and resilience over Winter:

- Ensuring the right level of staffing is the most significant area of focus to ensure patients receive a fast and appropriate response to their call. Recruitment and training is on constant offer to achieve sufficient rota fill for clinicians and non-clinicians and Staff Advocates are being appointed to support staff during recruitment and their first three months in the role to improve retention. New roles that specifically target hard to fill shifts at weekends and overnight are being trialled. The service is increasing the number of Mental Health First Aiders to support call handling staff. Over the Winter period, enhanced rates of pay will be offered to target hard to fill shifts such as week.

- Over the next period, a review of existing systems and processes is being undertaken to ensure that they are fit for purpose this Winter. For instance, amongst other initiatives, SWL is leading a London-wide review of Emergency Department validation pathways during September to ensure pathways and reporting are consistent across all 111 providers as well as working to ensure that pathways and reporting of Ambulance Category 3 and 4 validations are consistent across all 111 providers.

- In the event of a surge of calls in South West London, PPG is able to call on 111 National Resilience Arrangements which balance call pressures across the country.

Challenges and Risks:

- The key risk is maintaining the workforce needed to achieve service levels, particularly for quick call answering times. SWL commissioners meet with PPG weekly to ensure issues are addressed and plans for improvements are delivering the expected outcomes.

Covid & Flu Immunisations

NHS
South West London

Maintaining high levels of vaccination rates amongst our population remains a key priority for the system. Preventing both staff and our most vulnerable patients from becoming unwell is a cost-effective intervention that the ICS can make to reduce demand on services over the Winter.

Capacity and resilience over Winter:
Covid-19 vaccinations was open to expressions of interest and 160 sites signed up to deliver, an increase of around 40 on last winter. The Programme is confident that it can deliver to ambulatory patients and respond to surge requirements. Housebound and care home patients will be vaccinated primarily through Practices/Primary Care Networks. We will also utilise a hybrid model which will include selected pharmacies, community services and our SWL Roving Team. A new national deployment model was introduced to supply Covid vaccine to all sites. It is automated with a front loading of vaccine according to geographical demand and past uptake. Deliveries can now be made multiple times per week for any site.

Every opportunity is being made to increase co-administration with the flu vaccination and encourage eligible cohorts to receive both. There will be an emphasis on the 2-3 year olds in early September to reduce the spread of flu .

Front line staff across SW London Trusts will be offered both Flu and Covid boosters early within the programme.

Alongside Covid and flu, Respiratory Syncytial Virus (RSV) Vaccination will be offered from 1 September 2024 for those over 75. RSV will also be provided to pregnant women from 28 weeks and maternity units in London have been commissioned to provide the vaccine from 1 September.

Challenges and Risks
- There may be a lower, slower uptake from the public due to vaccine fatigue. Our communications plans will mitigate against this.
- Work has continued to mitigate against potential measles and pertussis outbreaks in London.
- Provision of RSV vaccinations will place additional pressure on practices, as it is not recommended to given at the same time as flu or Covid-19.

Mental Health

NHS
South West London

There are a growing number of people with complex mental health needs accessing emergency services when they need support and care in a crisis and sustained increases in demand for mental health services. In most cases, emergency care is not the best environment for people to receive mental health support. Rightly, there is a national focus on addressing long waits for patients presenting at acute hospitals with significant mental health needs. There are a number of different mental health crisis services and there is work with all Trusts to look at what else can be done to support patients and staff.

Capacity and Resilience

Patient Response

- The 111 "Press 2 for Mental Health" service is live, alongside existing Crisis Lines all running 24/7; a further phase of work is planned to streamline and optimise the service for patients
- Rapid Access Clinics and Mental Health front-door triage services are being trialled at St George's and Kingston Hospitals and have the potential to support the 72 hour position.

Changes to S136 Pathway

- The Right Care Right Person programme and S136 advice hub are working to improve patient experience and appropriateness of care on the S136 pathway. Further work is planned to consider Health Based Place of Safety capacity and alternative services for people in Mental Health crisis.

Reducing Length of Stay to improve flow:

- Hostel beds purchased to support people in crisis as an alternative to admission, as well as stepdown from inpatient care.
- The Interface Team is working with partners to deliver proactive planning for timely discharges for our more complex patients.
- Work continues to review housing and supported accommodation options for Mental Health patients through collaboration with Local Authority partners; patient complexity remains high and support for people with the right levels of care, particularly as a bridging solution, is limited.

Challenges and Risks:

- Demand for mental health inpatient beds continues to be high, impacting on patient waiting times in crisis and particularly for those waiting to be admitted from Emergency Departments. Complexities in the discharge process continue to extend length of stay.

SWL System Coordination Centre

NHS
South West London

The SWL System Coordination Centre (SCC) provides a 24/7 system oversight function and dedicated Incident Response Team covering across 365 days a year. The SCC is responsible for supporting interventions across the ICS on key systemic issues that influence patient flow, quality and safety. This includes a concurrent focus on both UEC and the system's wider capacity from health and social care providers across our SWL ICS footprint, and the wider London region. The SCC also contains the SWL ICBs Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity functions, alongside a Single Point of Contact (SPoC) for correspondence and queries into the ICB.

SCC role

- The service maintains **near live oversight** of the system's UEC position, working in partnership with a variety of health and social care organisations to support real time mitigation of system pressures.
- **Supports the UEC system** with daily system calls and escalating barriers to patient flow, including repatriation of patients and admission to specialty & Mental Health organisations.
- Works in **conjunction with the UEC programme** developing the operational response as UEC reforms are implemented.
- **Represents the SWL ICB** to NHS England's Regional Operations Centre (ROC)
- Acts as a **first line of escalation** and facilitation for system wide issues
- Provides the **strategic oversight, planning functions, preparation and response coordination for our EPRR** response
- The EPRR team lead the planning for Industrial action across the ICS, and represent the ICB to Region and National leads.
- Acts as a **knowledge repository** for the system.
- The team **coordinates incident debriefs for SWL ICS after involvements in incident management**, liaising with the NHSE Emergency Planning team as required.
- The SCC acts as a **Single, First, Point of Contact for a range of organisations**, including, NHS England, individual ICS organisations, Local Authorities/ Local Resilience Forums and neighbouring ICBs.

Workforce

NHS South West London

SWL ICS's plans for workforce management are critical to ensuring capacity and resilience this Winter. These plans are set against a challenging backdrop, with the expectation to reduce the workforce this financial year due to the financial challenges of the system and the ongoing need to improve productivity. Despite these challenges, the ICS is committed to securing high standards of care and operational efficiency through strategic recruitment, advanced training and innovative support mechanisms.

Capacity and resilience over Winter:

- **Common Bank Rates**: Implementing a common approach to bank rates, rate escalation, and pay awards may help stabilise the workforce, ensuring adequate coverage without over-reliance on costly agency staff. This measure can improve capacity by making temporary staffing more affordable.
- **Proactive Hiring Campaigns**: for both clinical and non-clinical staff to counteract attrition and fill essential positions.
- **Flexible Shift Patterns**: Implementing more dynamic shift patterns to adapt to periods of high demand, ensuring a robust staff presence during critical Winter times.
- **Active Recruitment and Retention**: Ongoing efforts in international and national recruitment, along with initiatives to make SWL an inclusive and equitable employer, help fill critical vacancies and retain staff. This builds a stable and resilient workforce capable of meeting Winter demands.
- **Departmental Cross-Training**: Offering training in other departments to enhance the ability to redirect resources during crunch periods.
- **Resource Redeployment**: Agile staff redeployment from less critical areas to urgent and emergency care as needed to maintain workforce efficiency.
- **Continued Mental Health Support**: Ongoing mental health and wellbeing support through Employee Assistance programmes to reduce sick leave and burnout, maintaining a resilient workforce.
- **Ongoing Training and Performance Monitoring**: Providing training and using performance monitoring tools to address productivity bottlenecks.

Challenges and Risks

- **Low Morale and Burn-out**: impacting the physical and mental health of staff working in these pressured services is significant.
- **Financial Constraints**: Addressing the financial constraints and ensuring strategic budget management to maintain workforce stability.
- **Improving Workforce Productivity**: A key challenge is enhancing the productivity of the workforce to effectively deliver Winter plans. This requires continuous efforts in training, process optimisation and technology adoption to ensure that staff can meet the increased demands during this period.

NHS
South West London

Communications and Engagement

Communicating together as a system

NHS South West London

Communications and engagement colleagues across health and care partner organisations in SWL collaborate and meet regularly. We discuss our approach to plans together and look at where we can share materials and resources.

Provider communications leads/NHSE

Representation from all SWL NHS providers

Fortnightly meetings to share information, discuss plans, shared priorities and acute collaborative projects

Weekly link to NHSE London and national comms teams

Borough communications and engagement professional network

Place partner teams: NHS organisations, Council, local community and voluntary organisations and Healthwatch
meeting to discuss shared objectives and co-ordinate activity for Place Committee

Local authority communications leads meeting

Representation from all SW London Council communications teams.

Meeting bi-weekly to share information and discuss shared objectives across SWL, and how we can support each other

Winter communications and engagement activity

NHS
South West London

1 Behaviour & insight

Behaviour change campaigns and community insights to support demand management

Working with community and voluntary sector networks, with a focus on health inequalities. Integrated 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. Gathering insights to inform service design and delivery.

2 Workforce resilience

Making staff aware of support available and raising morale

During challenging periods for services, staff are working harder to care for people and can experience the same risks of winter illnesses – there are also recruitment and retention challenges. Many staff working in our health and care providers are local residents too and are influencers and trusted for advice in their neighbourhoods.

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 ensure people in need seek help, and can also help with staff morale.

4 Incident response

System 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.

Community conversations

Our winter grants programme - working with VCSE partners

NHS South West London

- **Small Grants pots (maximum £500) for VCSE led activities** - organisations design events they know local people will be interested in to maximise engagement and attendance
- **Two-way information flow** – organisations gather insights on identified topics and share information about services and prevention

How the Grants programme works:

1. **Invite organisations to bid for funding** – the process has been honed over two previous years
2. **Collaborate with VCSE Alliance** – a key partner for promoting the fund and supporting smaller organisations, receiving applications and distributing funds
3. **Sharing information** – questions for discussion to gather community insights and materials to inform good conversations about services and prevention
4. **Support and reporting** - offer information sessions and materials to support VCSE-led conversations in the community, and reporting templates
5. **Analyse, theme and report on insights gathered** – present to programme teams and decision-making meetings

Impacts of last year's Winter Grant programme 2023/24

Over **7,000** conversations

90 community and voluntary organisations funded

42% were new connections for the NHS

37% engaged with parents of children under 12

68% engaged with people over the age of 65

84 We engaged with people from 84 ethnicities

74 shared leaflets

59 had one-to-one conversations

56 had group discussions

29 had guest speakers

As a result of activities people said they…

- ✓ Use community pharmacies, NHS 111 and mental health services
- ✓ Feel more confident using local services
- ✓ Would go and get a vaccination

We translated information – including **Tamil, Urdu, Gujarati, Polish and Somali**

Behavior change - areas of focus this year

NHS South West London

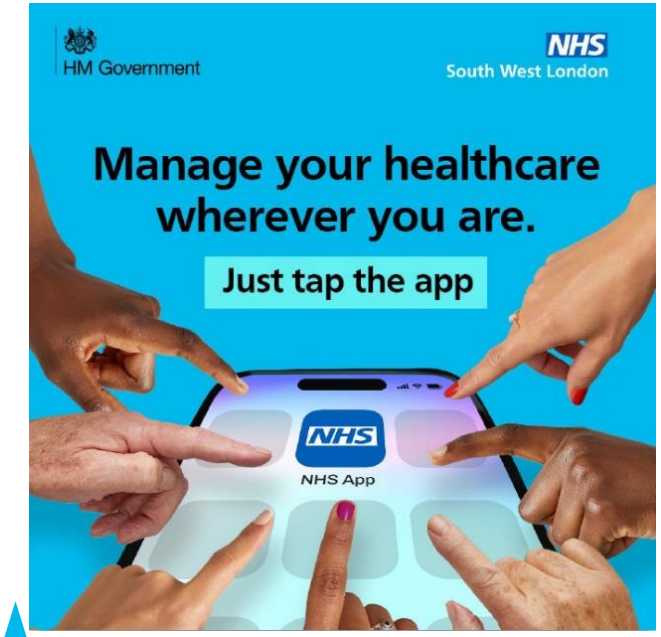
Vaccinations & imms

Eligibility and how to book appointments (addressing key concerns)

In 2023/24, we bucked the trend improving uptake in all our target audiences – our most seen campaign due to highest level of investment

NHS app

For prescriptions and online booking – in line with national messaging



Last year, logins to the app increased by 83% during the life of the campaign – our most targeted and cost-effective campaign to date

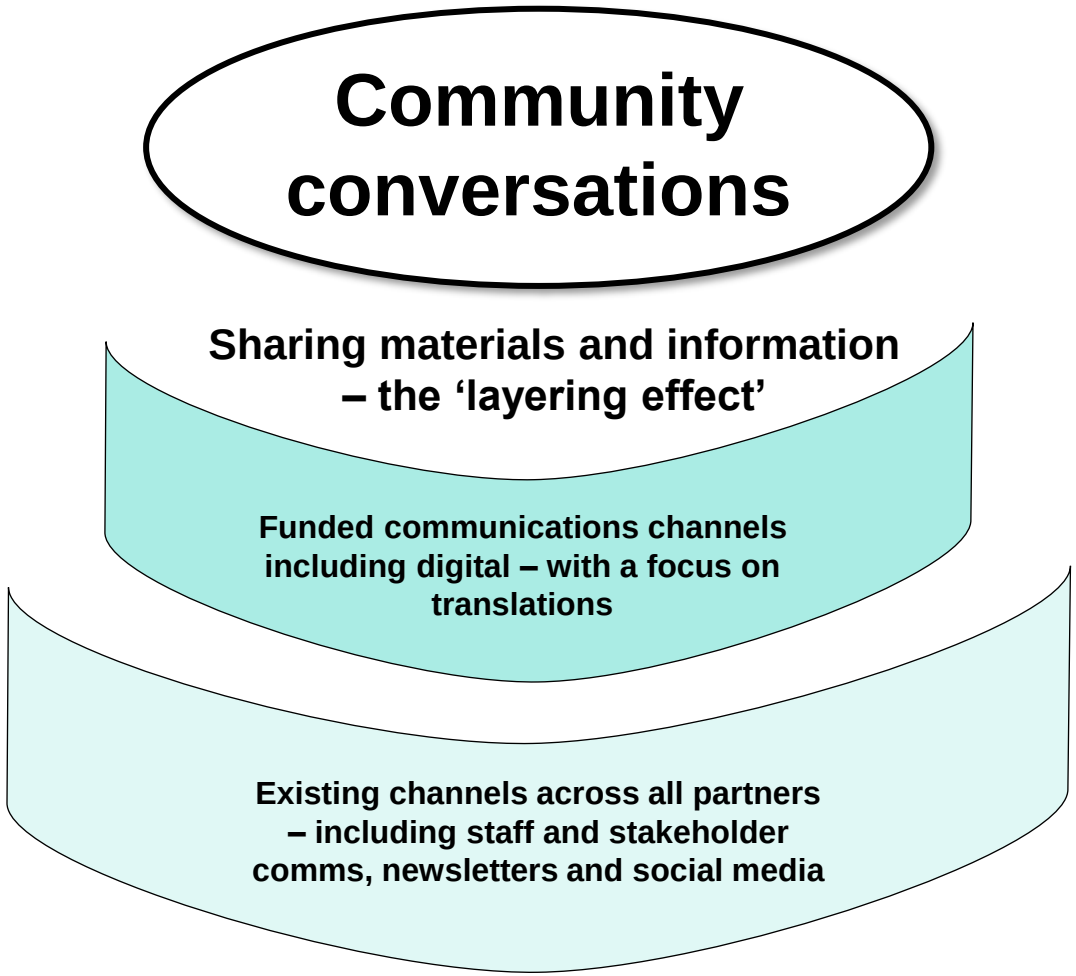
Pharmacy First

Highlighting support available – in line with national messaging

Our previous campaign was shown to make someone 4x more likely to visit a pharmacy – and was particularly effective with core20 communities last winter

Our SWL behaviour change approach – increasing effectiveness

South West London



1. Listening - understanding our communities

Listening to our local communities by collecting rich insight to help us shape and design effective campaign materials and understanding what matters to local people, including what they are searching online. We focus on health inequalities.

2. Local - we take a borough-focused targeted approach

People are more interested in something that feels like it's been created for them – from always including borough names to featuring authentic local spokespeople. We make sure people see what's most relevant to their lives – tailoring our campaigns throughout their lifespan. Our focus on translations, based on data and local knowledge, is valued by our local communities.

3. Long term - SWL has invested over many years

We've built our approach over time and some campaigns have been running for several years – this increases impact and allows us to tackle more complex behaviour change topics. We maximise our reduced budget each year by pooling funds and working smarter. Building on previous work with the voluntary sector, we're now delivering a year-round programme.

4. Layering engaging content – using the EAST methodology

Our content is regularly shared by the national team – we use creativity and best-practice to reduce costs and achieve big results. Our engagement levels are higher than industry average. We focus on targeted messaging and create fresh local content, informed by the Government Communications Service EAST methodology (Easy, Attractive, Social, Timely).

NHS
South West London

Winter Funds

Winter UEC Funds

NHS South West London

UEC non-recurrent funds for SWL are £13.8m for 2024/25. The SWL UEC SROs (SWL ICB Chief Operating Officer and the Chief Executive Officer and Place Lead for Croydon) have led this process through the SWL UEC Board. Each local system was assigned a proportion of funds based on population in line with arrangements for 2023/24 and a proportion of these funds was allocated to G&A beds as per 2023/24. Similarly, £1.3m has been allocated to Mental Health and £1.96m to SWL-wide schemes. There remains a small contingency (at SWL and local level) which will be reviewed in September 2024 at the SWL UEC Board to ensure that funds are appropriately utilised in-year.

Each local UEC system proposed schemes within their allocation which were subject to meeting agreed criteria including alignment with national UEC targets and cross-referencing with other available funding to ensure there is no duplication. Similarly, schemes for Mental Health and SWL-wide UEC schemes were proposed and reviewed by the UEC joint SRO and ICB UEC and Integrated Care Leads. All schemes were reviewed and agreed by the SWL UEC Board.

To prepare for Winter 2024/25, it is important that funds were made available to plan and implement schemes as soon as possible, especially where these include the recruitment of additional staff. Schemes are focussing on maintaining and improving patient flow across the UEC pathway in order to reduce waiting times in Emergency Departments, reduce pressure on beds and, in turn, improve ambulance handover and ambulance community response times which are the national priorities for UEC this year.

The detail of these schemes is in Appendix A.

Adult Social Care Discharge Fund

NHS
South West London

The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care, in a way that supports person-centred care, sustainability and better outcomes for people and carers. Across SWL, there are a range of initiatives in place to ensure full and appropriate use of the monies to support patient flow that is managed by the Local Authority and signed off at the Health and Well-Being Board. This is submitted to NHSE for an assurance and governance process to ensure effective utilisation of funding; in 2024/25 this has gone forward without any queries from NHSE. The demand and capacity and the initiatives are monitored and considered at the SWL Discharge meeting.

Final Grant Conditions for the Adult Social Care Discharge Fund (ASCDF) were released 17th April 2024 for both ICBs and Local Authorities:
Local areas were asked to use this funding to continue to support investments made in services from previous Discharge Funds (2022/2023 and 2023 /2024) but **cannot use the new discharge funding in 2024 to 2025 to replace existing expenditure** on core social care and community services. Spend must:

- Meet condition 1 of the Better Care Fund (agreed plan between ICB and Local Authority, signed off by Health & Well Being Boards (HWBB)).
- Use this funding, in conjunction with wider funding (including relevant Better Care Fund investment) to **build additional** adult social care and community-based reablement capacity to **reduce hospital discharge delays** by delivering sustainable improvements to services for individuals
- Must work with **local providers** to determine how best to **build the workforce capacity** needed for additional services.
- Deploy the funding in ways that support the principles of **'Discharge to Assess',** to enable timely discharge from hospital with appropriate short-term support, where needed, pending assessment of long-term care needs.

A recipient HWBB **must not**:

- Use this funding to compensate for **expenditure already incurred, activities for which the local authority has already earmarked or allocated expenditure, or to fund inflationary pressures.**
- Use this funding for activities which do not support the primary purpose of this grant, such as **admissions avoidance**. Each Local Authority and Place team have been working together to review and to refresh the ASCDF plans in addition to increases related to existing schemes include proposals to use additional monies for short term residential care, neuro rehabilitation capacity and technology enabled care to fund demonstrated additional demand (as opposed to budgetary overspends, which is prohibited by the grant conditions).

NHS
South West London

Appendix

Appendix A: Deployment of Winter Funding (1/2)

NHS South West London

The ICB received £13.8m to support seasonal pressures this year. Working through the UEC Board, this funding was allocated specifically to support the maintenance of General & Acute bed capacity and to support initiatives that improve flow in Emergency Departments. The ICB Finance & Planning Committee has also reviewed and supported these proposals.

Provider	Summary Schemes	Value (rounded)	Benefits
Merton & Wandsworth	• 7 day ED Frailty offer • Additional Majors Surge capacity • Extend Transfer of Care hub • Nursing to support cohorting	£3.26m	Schemes increase capacity in ED, reduce admissions where there are community alternatives for frail people; speed up discharge processes, reducing internal delays, support patient safety.
Sutton	• Out of hours frailty hub in ED • Primary Care Streaming at the Front Door and 4 EA Hubs in the community • Nursing to support cohorting	£2.19m	Schemes support management of the Front Door including streaming and directly bookable appointments into Primary Care, expansion of the frailty service, capacity and patient safety within ED.
Croydon	• ED frailty nursing • Admission and Discharge Unit • 24/7 GP in hospital • 24/7 emergency surgery cover • Nursing to support cohorting	£2.68m	Schemes Improve front door flow into ED, supporting ambulance handover and maximising utilisation of alternatives such as extend hours UTC provision. Improves management of patients presenting in frail condition seeking early discharge. Additional surge beds reduce number of DTAs in ED. Finally additional surgical capacity ensures prompt assessment of surgical emergencies.

Appendix A: Deployment of Winter Funding (2/2)

NHS South West London

Provider	Summary Schemes	Value (rounded)	Benefits
Kingston and Richmond	• Improved inpatient senior clinical capacity • Increased capacity in ED • Increase community therapy and rehab capacity • Escalation beds • Additional community response	£2.4m	Schemes supporting ED capacity and managing patients closer to the front door, more therapy and rehabilitation support in the community to increase earlier discharges as well as transport capacity, admission avoidance through additional community response capacity.
Mental Health	• Increase Psychiatric liaison input and coordination into EDs • Improve intersite transfer arrangements	£1.3m	Reduces the time that patients with a predominantly Mental Health presentation spend in ED, improving outcomes
ICB	• Winter Engagement and Communications campaign • Primary and Community support • Additional Neuro-rehab beds • Contingency	£1.96m	Supports and engages with communities to use services wisely, promotes alternatives to ED especially Pharmacy First. Community Schemes include greater support for End of Life patients and extending the UCR service hours. The investment in neuro-rehabilitation beds will increase capacity for the most complex discharges improving outcomes and reducing Length of Stay for these patients.
TOTAL		**£13.8m**	

NHS
South West London

Maintaining focus and oversight on quality of care and experience in pressurised services

Response to the NHS England letter dated 26 June 2024

Context

NHS South West London

Following the Channel 4 Dispatches documentary on Urgent and Emergency Care (UEC) services at Royal Shrewsbury Hospital, NHS England (NHSE) issued the letter *Maintaining focus and oversight on quality of care and experience in pressurised services* to all ICBs, ICPs, Trusts, NHSE regional directors and copied to local authorities.

The letter asked every Board across the NHS to assure themselves that they are working with system partners to do all they can to prevent avoidable overcrowding of Emergency Departments (EDs) and hospital ward beds by:

- **Providing alternatives to emergency department attendance and admission**, especially for those frail older people who are better served with a community response in their usual place of residence
- **Maximising in-hospital flow** with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility

The letter emphasised that corridor care, or care outside of a normal cubicle environment, **should be an exception rather than the norm**, initiated via executives based on joint trust-system risk assessment (through the OPEL framework). If necessary to implement, it should be provided in the safest and most effective manner possible, for the shortest period of time possible, with patient dignity and respect being maintained throughout and clarity for all staff on how to escalate concerns on patient and staff wellbeing.

The South West London UEC Board has worked with its four acute Trusts and two mental health Trusts to formulate a systemwide self-assurance of the above, structured around six key areas specified in the letter.

The suggested assurances in the NHSE letter are mostly focussed on basic operational functions and the longer-term solutions, such as the well-established programmes to avoid hospital overcrowding.

In addition to these, the ICB and local Trusts are taking actions to improve the immediate quality and safety of our UEC services at a time of unprecedented demand.

South West London's headline message: We are working hard to provide the best care, privacy and dignity possible and that we work to minimise and manage any patients experiencing corridor care

NHS South West London

Whilst we have the right governance and processes in place to know what is going on in our Urgent and Emergency Care (UEC) services, the NHS is currently challenged in terms of finance and UEC demand, with high activity volumes seen in March-July this year. At times of significant pressure, quality and patient experience could be compromised in some cases, **but patient safety remains our Trusts' primary objective**.

Corridor care is not what we want for our patients and staff, and all South West London trusts avoid it wherever possible. To tackle overcrowding, we continue to focus on our programmes around admission prevention, care in the community, in-hospital flow and discharge. However, at times of increased pressure, Trusts are having to initiate corridor care to ensure that they manage ambulance handovers and treat patients needing urgent care; this is initiated via formalised escalation and executive agreement.

Increased pressure does not just mean increased demand; it is also a function of our *health and social care system's* ability to prevent emergency admissions/attendances and to promptly move patients fit for discharge back home or out to the community.

In order, **to deliver our emergency services safely, we have risk-assessed our corridor care processes and regularly evaluate quality and safety to make improvements as necessary.** This has resulted in our Trusts actively making changes, such as:

- **Increasing staff numbers** in Emergency Departments so that there are dedicated staff monitoring corridor care patients doing **at least basic observations, hydrating and feeding patients and actioning any pain management/escalating needs**.
- **Adding corridors to bedboards and other electronic patient systems**, with the line of sight to monitor patients effectively
- Establishing processes, eg St George's have developed a **corridor care checklist**

The NHS England letter asked that systems assure themselves in the following areas:

NHS South West London

1. Organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter (admission prevention, improved flow and discharge)
2. Basic standards of care, based on the CQC's fundamental standards, are in place in all care settings
3. Services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund
4. Executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance
5. There is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level
6. Regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board
7. In addition, NHS England ask to see the governance process at Trust level

1. Organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter (admission prevention, improved flow and discharge)

NHS South West London

All four acute Trusts have well-established improvement programmes in place to implement all the areas of the national *Urgent and Emergency Care (UEC) Recovery Plan year 2 letter*; with the Mental (MH) Trusts and other stakeholders fulfilling their part in delivering the objectives within the four local UEC Delivery Boards and the South West London system UEC Board providing opportunities for collaboration, joint working and oversight.

Within the letter there are three main areas of the operational planning guidance requirements:

- **Maintain the capacity expansion delivered through 2023/24.** General and acute bedded capacity and ambulance capacity has been maintained in line with plan whilst continuing to deliver against access performance indicators in 2023/24 & 2024/25 i.e. 4-hour A&E Target and the Category 2 Ambulance Response Target. However, challenges around flow mean we have a relatively high volume of physical and mental health patients waiting over 12 hours in the Emergency Departments for bedded capacity.

- **Increase the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes.** There is a remaining challenge on length of stay and the number of patients still in hospital beyond their discharge ready date that inhibits flow across the patient pathways. The main drivers are difficulties in coordinating NHS and social care, internal provider and system processes, higher levels of complexity and acuity of need, and finance/workforce pressures across the system (again, both health and social care).

- **Continue to develop services that shift activity from acute to out of hospital settings for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge.** Examples of this are Urgent Community Response (UCR) and Virtual Ward (VW) community services in SWL are accessible and working well. Same Day Emergency Care (SDEC) and Frailty Services are in place in the acute Trusts. A Mental Health example would be that South London and the Maudsley in Croydon has a Clinical Assessment Unit with an SDEC approach.

2. Basic standards of care, based on the CQC's fundamental standards, are in place in all care settings

NHS South West London

All Trusts are committed to meeting these standards and are generally achieving the fundamental standards, however, Emergency Department clinicians have expressed concerns about patient safety and the experience of being managed outside a normal cubicle area. Whilst all Trusts avoid it wherever possible, when corridor care is stepped up, **they are doing everything they can to manage patients as safely as possible**, with mitigations in place.

All Trusts have increased staffing to safely care for additional patients, due to the element of unpredictability of the emergency care patient flow.

SWL ICB are assured that there is 24/7 nutrition and hydration across our Emergency Departments with use of the MUST tool, and that patients in corridors get **basic observations, regular clinical assessment and pain management.** Patients are relocated as soon as possible out of corridor care.

There is **regular review** of mental health patients by **Emergency Department Mental Health Patient Liaison Nurses**

Trusts are protecting patients' dignity through use of allocated cubicles for personal hygiene: There can be particular restrictions around personal care at some sites, e.g. offering patients shower facilities at some sites is difficult. **There is Infection Prevention & Control oversight** of the risks associated with corridor care and these are mitigated wherever possible.

All Trusts are clear that they have visibility of patients in non-designated patient care areas using their electronic patient systems to track location and waiting times for these patients. **There are dedicated staff overseeing patients waiting in these areas**.

3. Services across the whole system are supporting flow out of the Emergency Department and out of hospital, including making full and appropriate use of the Better Care Fund

NHS South West London

Each of the four local systems has a well-established patient flow programme for all services across Urgent and Emergency Care in place, which have **senior clinical leadership** and key performance indicators that are monitored closely at local, SWL and regional level. There is a **system-wide programme of work to deliver a reduction in length of stay** which is delivered at local level by all partners across the SWL.

The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care, in a way that supports person-centred care, sustainability and better outcomes for people and carers. Across SWL, there are **a range of initiatives in place to ensure full and appropriate use of the monies** to support patient flow that is managed by the Local Authority and signed off at the Health and Well-Being Board. This is supplemented by the Adult Social Care Discharge Fund, with enhanced and detailed reporting in 2024/25 to demonstrate the impact of each initiative in improving flow and outcomes for residents. **NHS England assure this process for effective utilisation of funding; in 2024/25 this has gone forward without any queries from NHS England**.

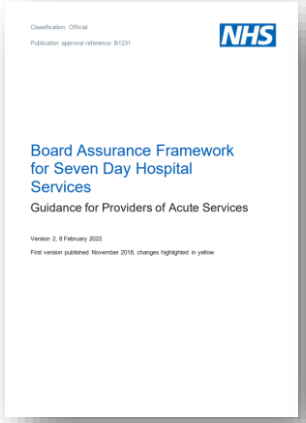
The demand and capacity and the initiatives are monitored and considered at the **SWL Discharge meeting**. **Each Place has an UEC Board** that brings together all health and social care partners to ensure that integrated health and care plans are sufficiently ambitious and focussed in the right areas; and that delivery is supported across organisations to ensure improvement in outcomes and experience.

4. Executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance

NHS South West London

All four acute trusts in South West London have confirmed that this in place.

The Seven Day Hospital Services Clinical Standards support acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. Examples include multidisciplinary team review or shift handovers. External assurance is provided by the Care Quality Commission as it is part of the inspection regime.


Classification: Official

Publication approval reference: B1231

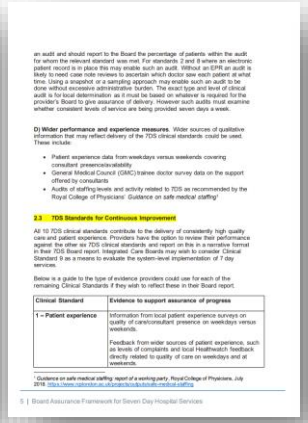
NHS

Board Assurance Framework for Seven Day Hospital Services

Guidance for Providers of Acute Services

Version 2, 8 February 2022

First version published: November 2018, changes highlighted in yellow


an audit and should report to the Board the percentage of patients within the audit for whom the relevant standard was met. For standards 2 and 8 where an electronic patient record is in place this may enable such an audit. Without an EPR an audit is likely to need case note reviews to ascertain which doctor saw each patient at what time. Using a snapshot or a sampling approach may enable such an audit to be done without excessive administrative burden. The exact type and level of clinical audit is for local determination as it must be based on whatever is required for the provider's Board to give assurance of delivery. However such audits must examine whether consistent levels of service are being provided seven days a week.

D) Wider performance and experience measures. Wider sources of qualitative information that may reflect delivery of the 7DS clinical standards could be used. These include:

- Patient experience data from weekdays versus weekends covering consultant presence/availability
- General Medical Council (GMC) trainee doctor survey data on the support offered by consultants
- Audits of staffing levels and activity related to 7DS as recommended by the Royal College of Physicians' Guidance on safe medical staffing[1]

2.3 7DS Standards for Continuous Improvement

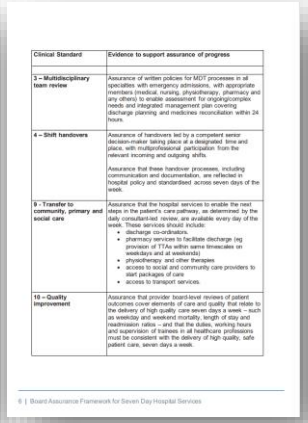
All 10 7DS clinical standards contribute to the delivery of consistently high quality care and patient experience. Providers have the option to review their performance against the either six 7DS clinical standards and report on this in a narrative format in their 7DS Board report. Integrated Care Boards may wish to consider Clinical Standard 9 as a means to evaluate the system-level implementation of 7 day services.

Below is a guide to the type of evidence providers could use for each of the remaining Clinical Standards if they wish to reflect these in their Board report.

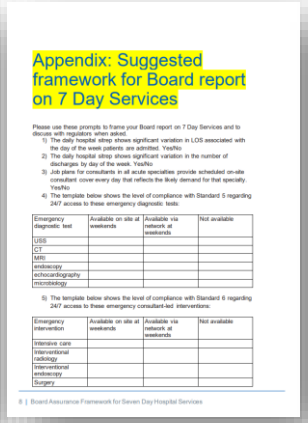
Clinical Standard	Evidence to support assurance of progress
1 – Patient experience	Information from local patient experience surveys on quality of care/consultant presence on weekdays versus weekends. Feedback from wider sources of patient experience, such as levels of complaints and local Healthwatch feedback directly related to quality of care on weekdays and at weekends.

[1] Guidance on safe medical staffing: report of a working party. Royal College of Physicians, July 2018. https://www.rcplondon.ac.uk/projects/outputs/safe-medical-staffing

5 | Board Assurance Framework for Seven Day Hospital Services


Clinical Standard	Evidence to support assurance of progress
3 – Multidisciplinary team review	Assurance of written policies for MDT processes in all specialties with emergency admissions, with appropriate members (medical, nursing, physiotherapy, pharmacy and any others) to enable assessment for ongoing/complex needs and integrated management plan covering discharge planning and medicines reconciliation within 24 hours.
4 – Shift handovers	Assurance of handovers led by a competent senior decision-maker taking place at a designated time and place, with multiprofessional participation from the relevant incoming and outgoing shifts. Assurance that these handover processes, including communication and documentation, are reflected in hospital policy and standardised across seven days of the week.
9 - Transfer to community, primary and social care	Assurance that the hospital services to enable the next steps in the patient's care pathway, as determined by the daily consultant-led review, are available every day of the week. These services should include: • discharge co-ordinators; • pharmacy services to facilitate discharge (eg provision of TTAs within same timescales on weekdays and at weekends); • physiotherapy and other therapies • access to social and community care providers to start packages of care • access to transport services.
10 – Quality improvement	Assurance that provider board-level reviews of patient outcomes cover elements of care and quality that relate to the delivery of high quality care seven days a week – such as weekday and weekend mortality, length of stay and readmission ratios – and that the duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high quality, safe patient care, seven days a week.

6 | Board Assurance Framework for Seven Day Hospital Services


Appendix: Suggested framework for Board report on 7 Day Services

Please use these prompts to frame your Board report on 7 Day Services and to discuss with regulators when asked.

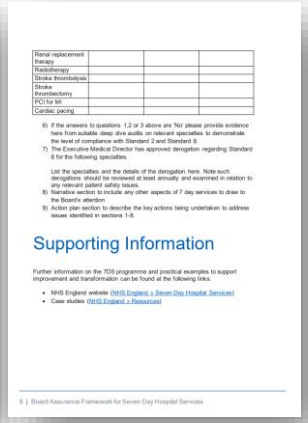
1) The daily hospital sitrep shows significant variation in LOS associated with the day of the week patients are admitted. Yes/No
2) The daily hospital sitrep shows significant variation in the number of discharges by day of the week. Yes/No
3) Job plans for consultants in all acute specialties provide scheduled on-site consultant cover every day that reflects the likely demand for that specialty. Yes/No
4) The template below shows the level of compliance with Standard 5 regarding 24/7 access to these emergency diagnostic tests:

Emergency diagnostic test	Available on site at weekends	Available via network at weekends	Not available
USS			
CT			
MRI			
endoscopy			
echocardiography			
microbiology			

5) The template below shows the level of compliance with Standard 6 regarding 24/7 access to these emergency consultant-led interventions:

Emergency intervention	Available on site at weekends	Available via network at weekends	Not available
Intensive care			
Interventional radiology			
Interventional endoscopy			
Surgery			

8 | Board Assurance Framework for Seven Day Hospital Services


Renal replacement therapy			
Radiotherapy			
Stroke thrombolysis			
Stroke thrombectomy			
PCI for MI			
Cardiac pacing			

6) If the answers to questions 1,2 or 3 above are 'No' please provide evidence here from suitable deep dive audits on relevant specialties to demonstrate the level of compliance with Standard 2 and Standard 8.

7) The Executive Medical Director has approved derogation regarding Standard 8 for the following specialties.

List the specialties and the details of the derogation here. Note such derogations should be reviewed at least annually and examined in relation to any relevant patient safety issues.

8) Narrative section to include any other aspects of 7 day services to draw to the Board's attention:

9) Action plan section to describe the key actions being undertaken to address issues identified in sections 1-8.

Supporting Information

Further information on the 7DS programme and practical examples to support improvement and transformation can be found at the following links:

- NHS England website (NHS England » Seven Day Hospital Services)
- Case studies (NHS England » Resources)

9 | Board Assurance Framework for Seven Day Hospital Services

5. There is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level

NHS South West London

The Trusts have strengthened the governance and escalation mechanisms in place in the context of corridor care. **These ensure a regular ward–to-board feedback loop, giving executives full oversight of how the situation is changing throughout the day and week.**

UEC **situation updates** and **quality concerns** are regularly discussed with executives and escalated via **Trust, system** and **regional quality and operational governance structures**.

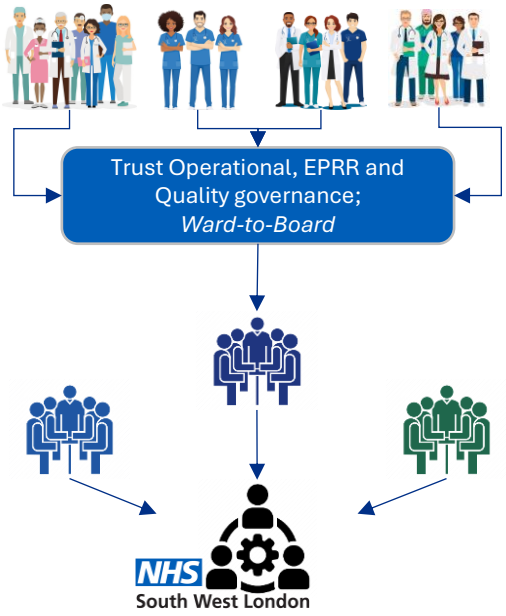
There are regular Trust and system meetings with CMOs, CNOs and COOs to ensure quality and safety in Emergency Departments.

There are daily cross organisational calls for each acute trust with the SWL System Coordination Centre in the ICB; this includes the mental health Trusts to facilitate patient flow and mutual aid. The system works with wider stakeholders on a sector-wide basis.

There are **triggers for escalation, and clear guidance on who should be informed** to make decisions and take actions is in place across Trusts.

Some Trusts have set up a complex discharge review panel with senior clinicians and managers to ensure that patients who have been in hospital for over 45 days are supported to be discharged.

There are full Emergency Preparedness Resilience and Response plans (EPRR) including surge plans, business continuity and major incident plans, all of which are supported by escalation routes to senior leadership.



6. Regular non-executive director safety walkabouts take place where patients are asked about their experiences in real-time and these are relayed back to the Board

NHS South West London

All acute Trusts and the MH Trusts have confirmed that these walkabouts are in place to talk to patients and staff, often happening ahead of the Trust Board meetings. **It is important that Board members, particular NEDS, are reviewing patient experience data, and triangulating this alongside their in-person visits, and reports from Healthwatch. All have reported that there are regular executive and non-executive walkarounds**.

Example feedback from one of our Trust's non-executive walkarounds was that the reports they read do not reflect how hard A&E staff work and the challenges they face on a day-to-day basis.

The ICB Quality Directorate, in their oversight and support role, have an ongoing programme of engagement and support, including visits to Emergency Departments (EDs) and Urgent Treatment Centres (UTCs). A recent visit to St George's ED and UTC had **overwhelmingly positive feedback from patients in the waiting area** and gave assurance of good clinical processes.

7. In addition, please state the governance process at Trust level

NHS South West London

Each acute Trust has clear internal governance arrangements for overseeing UEC services and improvement work as well as external-facing local **UEC Delivery Boards and the SWL UEC Board**.

Internal committees include quality, safety, operational, transformational groups, all reporting into their Trust Boards.

There is a **Quality Dashboard across Trusts** to ensure **visibility of Emergency Department performance**.

All Trusts have assured us that their **boards are very aware of the issues** caused by pressures in their services, particularly relating to corridor care and long waits within the Emergency Department **with regular review of the mitigations** to address these pressures.

"There is a regular ward-to-board feedback loop; we talk about quality and safety regularly across our governance structures and we monitor it all the time."

The response to the NHSE letter has been / will be assured by each organisation's board as follows:

- Croydon Health Services NHS Trust – 18/09/2024
- St George's University Hospitals NHS Foundation Trust will meet as a group board with Epsom & St Helier University Hospitals NHS Trust - 05/09/2024 which has been the new arrangement from May 2023.
- Kingston Hospital NHS Foundation Trust – 15/08/2024
- South West London & St George's Mental Health Trust – 12/09/2024
- South London and Maudsley NHS Foundation Trust – 17/09/2024

8. Conclusion: Whilst trusts are taking the right actions to maximise the safety in Emergency Departments, *a systemwide health and social care approach* is required to prevent corridor care

NHS South West London

The Board is asked to note that all Trusts are taking the right actions to ensure that safety and quality is upheld across our Emergency Departments.

However, clinical and managerial staff across South West London have raised concerns about the current significant pressures and the impact it could have on delivering consistently safe and appropriate care.

Workforce morale has been affected, and there has been an increase in violence and aggression towards staff in our Emergency Departments.

Our colleagues continue to work exceptionally hard to ensure they deliver the highest standard of safe care possible.

Whilst this report highlights the individual actions that Trusts are taking, **they are also working in place to ensure the necessary system wide approach to Urgent and Emergency Care is followed. This includes primary care access, specialist community provision, partnership working with local authorities to support discharge and community and acute mental health provision.**

Looking forward, winter planning and funding is in place for the system to provide further support to pressurised services.

Appendix: NHS England letter, dated 26 June 2024

NHS South West London

Classification: Official-Sensitive

NHS England

To:
- Integrated care board:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Integrated care partnership chairs
- NHS trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Regional directors

CC:
- Local authority chief executives

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2024

Dear colleagues,

Action required: Maintaining focus and oversight on quality of care and experience in pressurised services

Thank you for everything that you and your teams continue to do to provide patients, the public and people who use our services with the best possible care during the period of sustained pressure that colleagues in all health and social care services are experiencing.

Despite the hard work of colleagues, and everything they are achieving in the face of these challenges, we would all recognise that on more occasions than we would like, the care and experience patients receive does not meet the high standards that the public have a right to expect, and that we all aspire to provide.

However busy and pressurised health and care systems are, people in our care – as well as their families and carers – deserve at all times to be treated with kindness, dignity and respect. This week's Channel 4 Dispatches documentary, filmed in the Emergency Department at Royal Shrewsbury Hospital, was a stark example of what it means for patients when this is not the case. While Urgent and Emergency Care (UEC) is facing real pressures as a result of increasing demand, lack of flow and gaps in health and social care capacity,

Publication reference: PRN01417

the documentary highlighted examples of how the service some patients are experiencing is not acceptable.

We are therefore asking every Board across the NHS to assure themselves that they are working with system partners to do all they can to:

- provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence
- maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on

These interventions are clearly set out in the UEC recovery plan year 2 document, and it is evident from the data that those systems with fewer patients spending over 12 hours in an emergency department are doing a combination of all of them, consistently, with direct executive ownership.

In addition, wherever a patient is receiving care, there are fundamental standards of quality which must be adhered to. Corridor care, or care outside of a normal cubical environment, must not be considered the norm – it should only be in periods of escalation and with Board level oversight at trust and system level, based on an assessment of and joined up approach to managing risk to patients across the system (through the OPEL framework). Where it is deemed a necessity – whether in ED, acute wards or other care environments - it must be provided in the safest and most effective manner possible, for the shortest period of time possible, with patient dignity and respect being maintained throughout and clarity for all staff on how to escalate concerns on patient and staff wellbeing.

While these pressures are most visible in EDs and acute services, they are also wider issues which need whole-system responses, including local authorities, social care and primary and community services. There is therefore a shared responsibility to ensure that quality (patient safety, experience, and outcomes) is central to the system-level approach to managing and responding to significant operational pressures.

In achieving this, Board members across ICS partners should individually and jointly assure themselves that:

- their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter
- basic standards of care, based on the CQC's fundamental standards, are in place in all care settings
- services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund
- executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance
- there is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level

- regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board

In line with the NHS operating framework, regional COOs, chief nurses and chief medical directors will continue working with ICB colleagues across systems (CMO, CNO, COO/CDOs) and trusts to support a planned approach to clinical and operational assessment of system pressures and risks, ensuring an integrated approach to any tactical response and balancing clinical risk across the system. This collaboration should include provider CEOs, system executives, local authority, and third sector partners where applicable.

Where any organisation is challenged we will work with you to use the improvement resources at our disposal, including clinical and operational subject matter expertise from the highest performing organisations, GIRFT, ECIST and Recovery Support. We also have a joint improvement team with the Department for Health and Social Care for complex discharge led by Lesley Watts, CEO of Chelsea and Westminster. If you are unclear how to ask for help in any of these areas, please do so via your regional COO in the first instance.

We recognise that all colleagues across health and social care are working extremely hard in very difficult circumstances, and that UEC is not the only pathway in which this is the case. However, there are interventions and standards that do make a difference and can address much of the variation in quality and waiting times across the country, and it is incumbent on us all to do everything we can to ensure that the poor quality of care we saw on Monday evening is not happening in our own organisations and systems.

Yours sincerely,

Sarah-Jane Marsh
National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer
NHS England

Dr Emily Lawson DBE
Chief Operating Officer
NHS England

Professor Sir Stephen Powis
National Medical Director
NHS England

Dame Ruth May
Chief Nursing Officer
England

NHS
South West London

Improving Urgent and Emergency Care in South West London
Two Year Plan
2024 – 2026

Contents

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Executive Summary

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Our ambition within the plan is to look ahead to take forward proactive transformational change to prepare our Urgent and Emergency Care (UEC) services for the future and to reduce the pressures within the pathways of care for our patients and staff.

This plan outlines the national and local context and has been built over the last two years, **listening carefully to professionals and patients and taking into consideration our experience coming out of pandemic response mode.** Our clinical workforce across primary, community, mental health and hospitals report that we are seeing patients who are, in general, presenting with more acute and complex conditions. Patients are often staying longer in hospital, meaning almost all our beds are occupied all the time.

The themes and interventions outlined in this plan reflect the need for our system to adapt to this new reality, as well as being as efficient and effective as possible, using all our resources wisely. It seeks to move our efforts to transform urgent and emergency care in the medium term, so we are thinking ahead while delivering services during continuous pressure.

Our anticipation for our new two-year UEC "live" plan is that it will largely align with the national requirements likely to emerge from the new Government. Like predecessor national plans, we expect the plan will prioritise Urgent & Emergency Care and set the ambition to return to high quality, timely access for patients. We will review the South West London plan when the national expectations for the future are clear.

The plan is based around **four core themes**: **Accessing Urgent & Emergency Care, Patient Flow and Discharge, Supporting and Developing our Workforce, delivering Productivity and Efficiency.**

We will seek to deliver the Key Measures of our Success whilst taking forward the actions outlined across the themes.

The Next Steps explore our view for making progress against the four core themes during the next two years for Urgent and Emergency Care services across the SW London system.

South West London UEC Context

NHS South West London

5 EDs open 24/7 – 6 UTCs open at least 12 hours every day

4 Hours

SWL was one of a few ICBs to meet the 76% target in March 2024 with St George's reaching the stretch target of 80%

Between Jan and June 2024, an average of 101 Mental Health patients waited longer than 12hrs in an ED to be admitted

1150

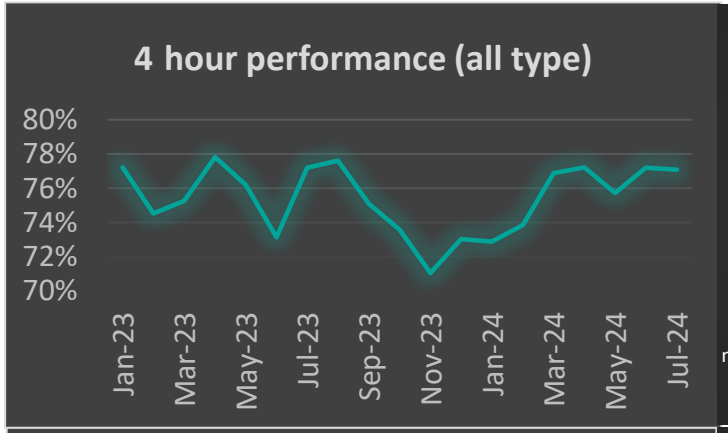
On average **1150 patients a month** have been seen in our two-hour community response services in the last year. Most patients were over 65

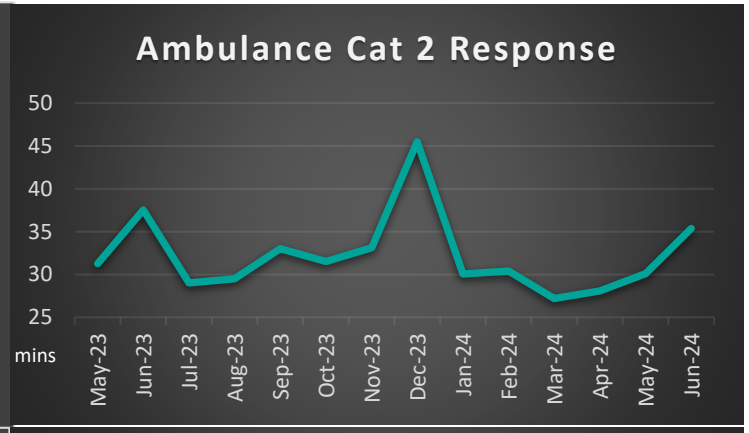
2,300 acute beds, Our hospital beds have patients in them almost constantly and almost 1 in 4 patients are there for more than 21 days.

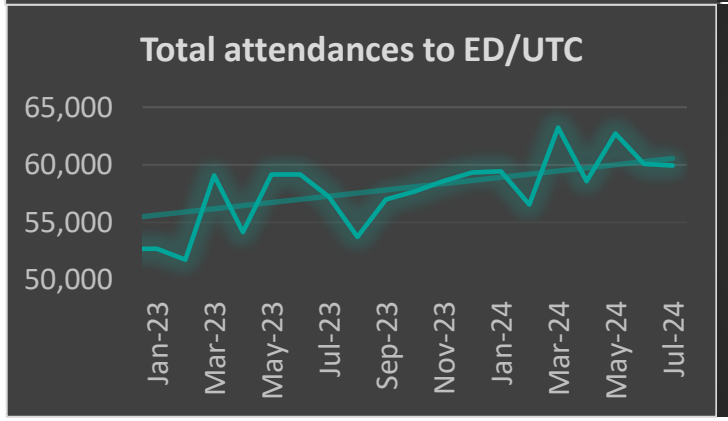
On average **59,000** emergency department attendances a month Of which around 14% were admitted to hospital

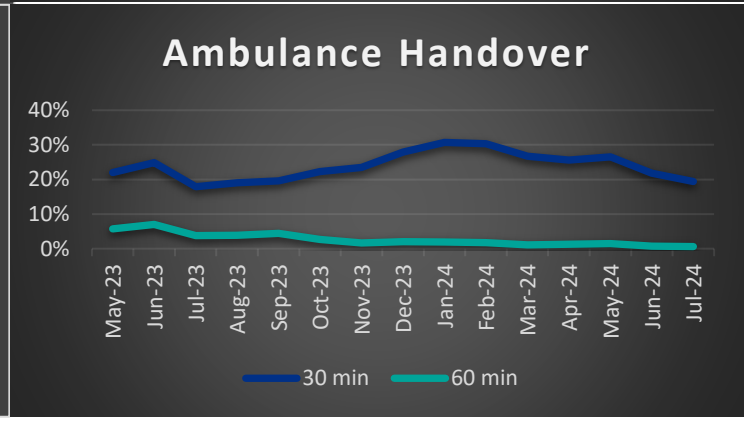
Our Emergency Departments receive around 100,000 ambulances each year

On average there are 700,000 primary care appointments a month and this will reach more than 1 million a month by 2026









People and communities tell us

Praise for the care and kindness of staff in South West London urgent and emergency care services.

There were variations in satisfaction with urgent and emergency care services for women, younger people, those from Black, Asian, and other ethnic minority backgrounds, and those with disabilities.

Some reports of reduced confidence in urgent and emergency care services, which was attributed to people's experiences of care, particularly waiting times, and the view that the NHS needed to invest in more staff. There were some concerns around staff not having the time to listen to people about their symptoms.

A high number of people use A&E for their mental health, and some people suggested better signposting to mental health crisis services.

Mental health 'crisis cafés', (Sutton as an example) reduced pressure on A&E for some service-users, who said they would otherwise have attended A&E. There was a desire to see those crisis services in the community expanded, particularly during weekends.

People valued GPs but waiting times for a GP appointment caused some people to look elsewhere for support, such as the A&E, or not to seek further support. Some people made the choice to go to A&E because they felt their injury was too serious to be seen outside of hospital, or for their children it is their first choice in accessing urgent and medical care.

Some of the reports suggested the need for better communication and joining-up between NHS services to improve the urgent and emergency care experience, and that sharing patient-data between organisations, for example, pharmacies, GPs and GP hubs could help this to happen.

NHS Policy Context

NHS South West London

Urgent and Emergency Care remains a key priority for the NHS, with the recovery of the 4-hour standard and reducing ambulance delays two key areas of focus for improvement.

The National Urgent and Emergency Care Recovery Plan published in 2023 and subsequent update letter in May 2024, asks ICBs:

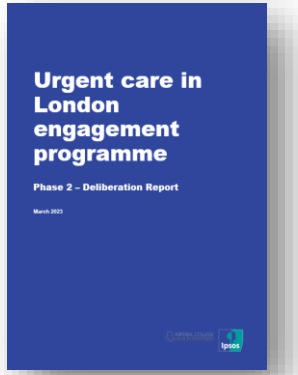
- To increase and standardise urgent and emergency care capacity across hospital and ambulance services
- To improve discharge processes, and increase the care provided in the community
- To increase the size and flexibility of the workforce – particularly ambulance and 111
- To help people get the right care first time

Supporting these ambitions, the NHS Operating Plan for 2024/25 requires the ICB to:

- see patients more quickly in Emergency Departments, with the ambition to improve to 78% of patients being admitted, transferred or discharged within four hours by March 2024.
- get to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2024/25 towards pre-pandemic levels.

The Operating Plan will be refreshed in 2025/26 and any ambitions will be reflected in an iterated version of this plan.

In addition, as part of development work, we have also looked at the available research on the way in which people experience urgent and emergency care services. We have used the insights from this work to help us consider what changes we should make to improve patient experience.



During 2023, NHSE London commissioned an intensive engagement programme on UEC which resulted in a number of “deliberations” where patients had been consulted on potential changes to how they access UEC services if a digital from door was introduced to help manage demand and reduce delays. This included 111 First, e-triage, streaming and redirection, scheduled urgent care and resulted in findings that clarified what patients would accept and under what conditions.

In a national survey coordinated by Healthwatch in 2022…

- Less than 40% of respondents were confident that they would get an ambulance in a reasonable time
- Less than 40% of respondents thought they would be seen in Emergency Department in a reasonable time
- Just under 60% thought they would get through to 111 in a reasonable time
- Nearly two thirds of people felt confident they would receive high quality care when they used emergency services such as the Emergency Department
- People who had not used urgent and emergency care services were much less likely to be confident than those who did.

Source: What are people's experiences of urgent and emergency care? | Healthwatch

How we developed our plan

NHS South West London

The South West London Urgent Emergency Care (SWL UEC) Board held a series of facilitated workshops, drawing people together across the system to review the urgent and emergency care landscape and begin the process of developing shared ambitions. This included a wide range of health, social care and patient representatives.

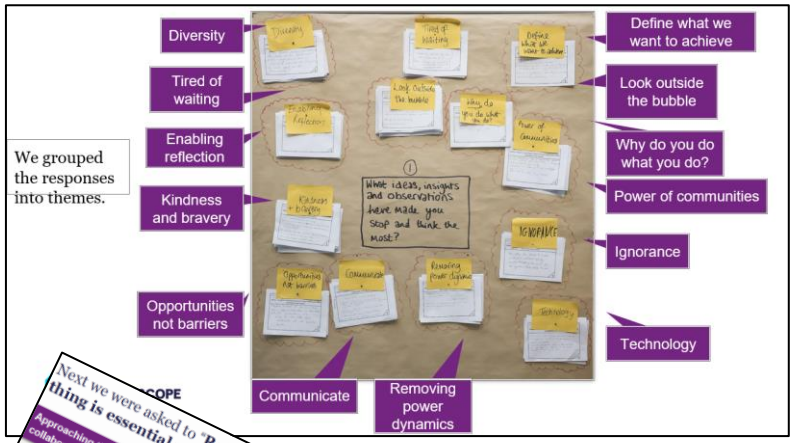
Throughout 2023, we crafted the core elements of an Urgent and Emergency Care Plan, building on and aligning with national guidance. We continue to build on NHSE national and regional priorities as they emerge and will continue to iterate our plans to reflect the operational realities in our system ensuring that we deploy our resources to maximum effect.

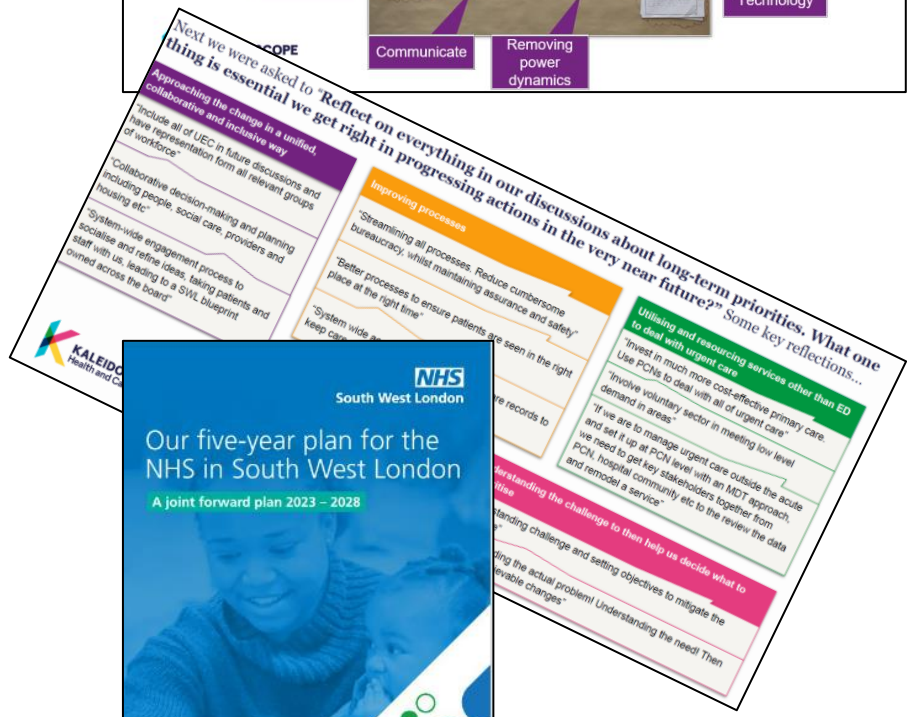
We collated insights from patient feedback from across the system, building on the work that Healthwatch and others have already done, including our own communications and engagement work to draw out insights from patients and the wider public. This has been supplemented by a review of the available research into the way in which patients experience and interact with urgent and emergency care services.

We also set up several short-term specialist groups made up of a mixture of clinicians, managers and patient representatives to rapidly refine workstream goals and outcomes.

This work has resulted in a series of key questions that we collectively felt the plan needed to address :

- How can patients and staff supporting patients make good decisions about the kind of care they need? From the point at which someone thinks they need help, how do they find the information they need, and decide whether to call 111/access 111 online, contact their GP, attend an UTC, ED, or call an ambulance ?
- How we can make our hospital processes as efficient as possible from the point a person is urgently admitted to hospital through to discharge. For patients who need to be in hospital, how do we make that stay as effective as possible, ensuring that people can go home as soon as they are ready and how are they are then supported in the community if needed ?
- How do we ensure we have the right workforce, particularly how we secure the right number and type of clinicians and other professionals to deliver timely and effective urgent and emergency care ?
- How do we enhance efficiency and productivity to deliver for patients, staff and the wider public within the resource constraints we face?





Our Ambition, Themes and Key Outcomes

NHS South West London

Our Ambition

Through partnerships between 111, acute, community and mental health, primary care, social care and the voluntary sector, we want responsive urgent and emergency care services that are understood by local people and that provide more care in people's homes, gets ambulances to people more quickly when they need them, see people faster when they go to hospital and help people safely leave hospital, having received the care they need.

Our Four Themes

We will do this working through four themes which capture the key elements that we need to transform and improve for patients and our population needs.

- Accessing Urgent and Emergency care
- Patient Flow and Discharge
- Supporting and Developing our Workforce
- Productivity and Efficiency

Our Key Outcomes

- ✓ Increased access to same-day primary care and urgent community services, so that patients can have confidence in receiving care close to home
- ✓ 111 calls answered promptly and delivering the service patients' need
- ✓ Reduced number of ambulances waiting over an hour to handover patients to ED to zero, and significantly increased the number handed over within 30 minutes
- ✓ Fewer patients waiting longer than 4 hours in our EDs before being treated or transferred to a hospital bed, and fewer patients waiting longer than 12 hours from arrival at ED to being admitted to a hospital bed
- ✓ Reduced number of patients in Mental Health Crisis waiting in acute Emergency Departments
- ✓ Reduced number of people in hospital who are ready to be discharged
- ✓ Increased patient satisfaction with services
- ✓ Increased staff satisfaction and their sense of wellbeing

Theme 1: Accessing Urgent and Emergency Care

NHS South West London

Through partnerships between 111, London ambulance service, acute, community and mental health, primary care, social care and the voluntary sector, we want responsive urgent and emergency care services that are understood by local people and that provide more, and better, care in people's homes, get ambulances to people more quickly when they need them, sees people faster when they go to hospital and helps people safely leave hospital, having received the care they need.

Equity of access to urgent and emergency care services.	• Map urgent and emergency care services to highlight key areas of variation and investigate these to understand local need and opportunities to develop greater consistency and reduce inequalities. • Make best use of the information we have through patient engagement, Healthwatch reports, and provider patient insight to ensure that we hear and act on what people are saying about our services. • Utilising the 111 Directory of Services, ensure that all our Urgent and Emergency Care services are equally accessible across South-West London so that ambulance crews and other care professionals can take a patient to the right service quickly rather than to emergency department, if appropriate.
Development of the 111 service model, including the implementation of digital solutions.	• Continue to work with our 111 service to ensure it is fully and sustainably staffed to enable a fast, high standard of service to our population so that they feel confident to access when needed. • Implement digital solutions to transform call handling within 111 services and make it easy for services to book a patient into the most appropriate service. • Our 111 provider will work to place the right number of call handlers at the right time and consistently review the clinical resource rota fill in context of maximising the potential for 111 to return patients' calls in a timely manner.
Access to General Practice and the Urgent and Emergency Care system.	• Create timely access and options to same day primary care, ensuring all patients contacting a GP practice or hub are assessed or signposted at first contact with the practice • Increase the use of the NHS App so that by 2026 patients use this facility as a first port of call when seeking urgent care with effective input from Primary Care Networks for good coverage and enhanced hours. • Review the out of hours service, linking more closely with primary care, including the development of all of our urgent treatment centres to fully meet the expected national standards.

Theme 1: Accessing Urgent and Emergency Care

NHS South West London

Enhance the out of hospital services, Proactive Care Programme, Urgent Community Response and Virtual Wards across South West London to support patients at home before seeking treatment at an acute hospital for admission avoidance.	• Further consideration to be undertaken for the potential extension of the proactive care programme across all localities, Increasing the number of people who have recorded and shared crisis plans in place. • Developing the urgent community response and virtual ward services to support a wider array of conditions and complexity of patients that it can safely manage for all of our population as a facility for admission avoidance. • Recruit and develop clinical champions to support culture change outside the acute hospital environment for the utilisation of these services ensuring support from the alignment of their capacity to the demand for the services and continued technological improvements and funding.
Further embed same day emergency care services and urgent treatment booking, with ED streaming to increase the number of patients who do not need to be admitted to a hospital bed.	• Implement access to Same Day Emergency Care (SDEC) for all suitable patient pathways by building on the Trusted Assessor model and increasing the number of acute sites offering direct access to SDEC services. • Enabling efficient Emergency Department (ED) front door streaming supported by digital tools for presenting patients and for the workforce to book patients effectively into alternative services whilst maintaining ambulance handover times. • Ensuring that Alternative Care Pathways are easy to access and consistently delivered with effective referral and patient transfer processes are in place to get the most effective model.
Introduce new approaches to the Emergency Department's front door for people in mental health crisis from building on system-wide dialogue to improve urgent care access.	• Encourage our communities to use mental health crisis services by sharing information with our communities using a variety of channels including our community and voluntary sector relationships and networks, using social media platforms and our 111 provider. • Developing capacity and resilience to respond to patients, initiatives such as rapid access clinics and mental health front door triage services at the acute hospital sites. • Enhancing patient flow through mental health acute inpatient beds to support access for patients to mental health urgent and emergency pathways as demand continues to be high across South-West London.

Theme 2: Patient Flow and Discharge

NHS South West London

Delays in admitting people from our EDs are a signal that all the hospital beds we have are occupied almost all the time. This theme tackles the areas of improvement required to increase flow through those beds, ensuring patients spend time in hospital only as long as it is necessary to support their recovery or onward care. Work in this area focuses on reducing the numbers of patients flowing into hospital, by putting in place new community services that support people to receive care in their own homes, improving systems and processes so that when patients do attend hospital their admission is as short as possible. Finally, when they are ready to go home, they do so quickly efficiently and with the right support in place.

Patient outcomes and experience	• Work with system partners to develop our insight into patient experience using patient experience surveys, complaints or patients' satisfaction measures, actively seeking to put the patient at the centre of our transformation and improvement programmes. • Assess the impact of the improvements that we are making and so we will establish baseline satisfaction levels with a view to improving patient experience and satisfaction. • Work with Public health and the Health Improvement Team or other system experts to identify variations in outcomes that affect protected groups and use associated data and/or feedback to inform programmes of work that enable parity with the wider population.
Maximise opportunities linked to admission avoidance	• Develop integrated pathways between intermediate care services and the front door of emergency departments e.g. Urgent Community Response services, step up and/or step down capacity (bedded or virtual), Same Day Emergency Care (SDEC) and UTCs. • Develop integrated pathways within intermediate care services and the front door of ED. • Recognising the importance of preventing unnecessary admissions as a means of improving the pressures on ED i.e. aligning pathways such as SEDC, UCR and VW to improve flow.
Improving discharge processes - Reducing the number of people in acute beds who no longer meet the criteria to reside.	• Introduce digital tools that help discharge planning and processes by improve communication across system partners. • Improving the data capture across the system i.e. ensure that digital systems and/or operational processes are in place to help staff quickly and consistently capture patient information including Discharge Ready Date (DRD) across trusts in SWL. • Fully utilise the earlier supported discharge opportunities, including tech enabled care, within our virtual wards so that patients can continue recovery with clinical oversight in their residential setting.

Theme 2: Patient Flow and Discharge

NHS South West London

Further reduce length of stay and improve flow	• Further reduce length of stay and improve flow by developing centralised case management and coordination processes to help identify and pro-actively reduce the number of stranded and super stranded patients, and complex discharges • Work with system partners to establish models of care that support the principles of the Frailty model i.e. embedding proactive community care supported by appropriate intermediate and acute care that prevents unnecessary admissions and enables timely discharges. • Work with partners, including Local Authorities, to better align demand to capacity and improve use of community based services to support people to return home as soon as they are ready.
Patient Choice – Right care, Right time	• Embed a SWL approach to managing choice of discharge destination for patients, families and carers across all Trusts in SWL. • Train and empower ward staff in the use of the SWL choice policy using a train the trainer approach to manage staff turnover. • Develop and embed a SWL escalation process to ensure disputes are resolved in less than 21 days. • Embed digital tools that support earlier discharges including the ability to record ready for discharge dates, assess care or nursing home capacity and access packages of care in a timely manner.
Developing and implementing a SWL Frailty Strategy	• Implement a community first approach to increasing capacity in services particularly intermediate care as outlined in the SWL frailty model and to include Rockwood scores for all frailty patients . • Increase the range of population segments which are served by proactive interventions within the model of care, such as those who have long term conditions and escalating complexity. • Enable a timely, seamless and patient centred approach to the delivery of proactive care to avoid unnecessary attendances, admissions and support more timely discharges. • Establish frailty hubs across SWL linked to integrated pathways to SDEC, UTCs virtual wards and proactive care. • Identify and support the most deprived 20% of the population who are evidenced to have increased rates of frailty and a higher utilisation of services. • Create opportunities to better involve family and carers as well as making greater use of the voluntary sector.

Theme 3:Supporting & Developing our Workforce

NHS South West London

From working in collaboration with our partners whilst looking at the breadth of staff required to deliver urgent and emergency care; the creation of a strong clinical network to support our urgent and emergency care leaders across South-West London to recruit and retain an urgent and emergency care staffing model for the growing levels of population demand. Together undertaking detailed workforce planning whilst recognising our challenges for the need to support and develop our workforce; enhancing health and wellbeing to create resilience for times of pressures at the front-line.

Establish a South-West London Urgent and Emergency Care clinical network to support clinical leaders	• Identification of clinical leaders for urgent and emergency care for South-West London to gain stronger clinical input that supports decision making in strategic change and transformation of services. • Formalising an Urgent and Emergency Care Clinical Network. • Creating a leadership model that will develop and design the urgent and emergency care services by involving staff and patients.
Further improvement of workforce planning and modelling specifically around Urgent and Emergency Care	• Gain a detailed understanding of workforce challenges in urgent and emergency care across all partners to develop a specific plan around the services and future strategic modelling for the next two years that supports the predicted growth and demand with integration of a detailed plan into the annual operational planning cycle. • Facilitate the system planning through the UEC Board to gain cross fertilisation and learning across South-West London to ensure urgent and emergency care is promoted for areas and people. • Improving workforce forecasts to support the changes and future needs of the pressurised areas for all of our clinical and non-clinical roles.
Recruitment and Retention of the workforce is a priority for the urgent and emergency care system	• Develop a workforce framework and dashboard approach for workforce around a staffing model of substantive wte's, bank and agency utilisation to gain an overview of the position of the urgent and emergency care staffing to gain an understanding of the position, needs and opportunities across the system. • Ensure that Urgent and Emergency Care is engaged in national recruitment, hosting career fairs and open days across the four acute trusts for their emergency departments and services in the patient journey. • Primary Care, as an example, will continue to increase its overall workforce, maximising the additional role reimbursement scheme(ARRS) whilst working in collaboration with the South-West London training hub.

Theme 3:Supporting & Developing our Workforce

NHS South West London

Motivate the urgent and emergency care workforce within the acute patient pathways through training and development to ensure that everyone can reach their potential with support and new opportunities	• Working with national bodies to ensure as opportunities arise for apprenticeship programmes and further education; the urgent and emergency care workforce is part of initiatives to support their development and skills. • In developing the workforce plan; review the training need of the workforce or new roles that will encourage retention and assist with recruitment. • Assisting with the reduction of temporary staffing from appropriate continuing professional development for all of the workforce across the South West London system from active participation to avoid disparities. • Increasing student placements for third year nursing students; to gain interest from newly qualified nurses selecting urgent and emergency care as a place to work.
Develop a clearer understanding of what support people working in urgent and emergency care services need, building a health and wellbeing offer that is tailored to staff working in this high paced environment	• Listening to the workforce to provide health and wellbeing support opportunities for their needs. • Supporting the adoption of flexible working options, to recognise the challenges of the pressures within urgent and emergency care, and resilience of an acute front-line workforce in South-West London. • Investing in infrastructure: modern good working environments improve moral with good working conditions. • Improving connections between the urgent and emergency care workforce and existing health and wellbeing programmes to improve the health and wellbeing of urgent and emergency care staff. • Increasing the members of staff across the UEC pathway being trained in coaching to be better placed to provide members of the team with pastoral support.
Further increase the utilisation of digital technology and innovation as an enabler for access to services and enhancing processes to assist the workforce in their roles	• Continue with investment in digital tools to support efficiencies across urgent and emergency care that can assist the workforce on a daily basis. • Implement more efficient digital systems and services to eliminate long waits and queuing across the system, so that the workforce is less pressurised and stressful for people; for patients to wait less time for an ambulance and that we can reduce the time that people wait in the urgent and emergency care pathways. • Enable people to make the right choice when feeling unwell through digital communications which assists the workforce within their job roles .

Theme 4: Productivity & Efficiency

NHS South West London

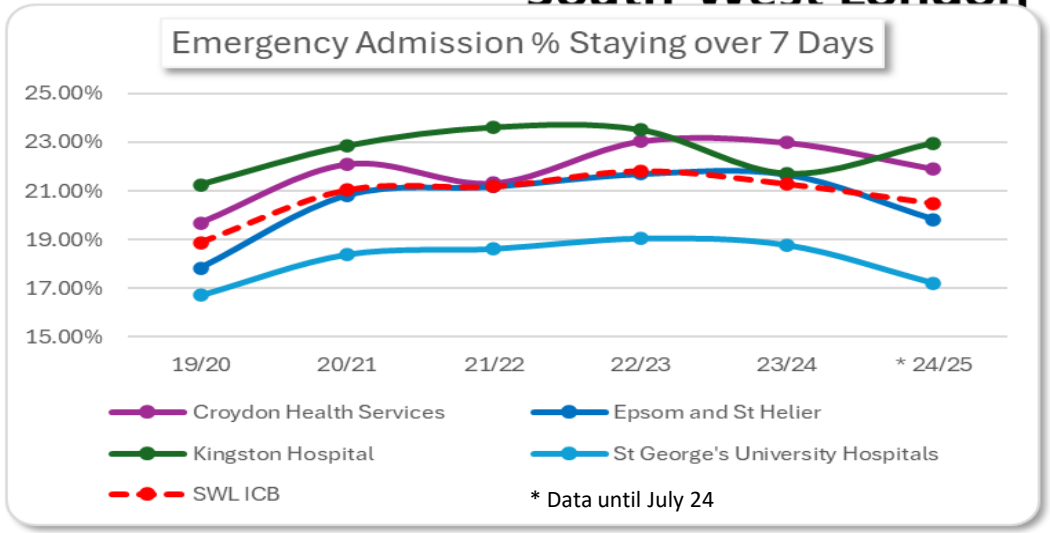
The NHS faces significant financial challenges for the future. In our acute hospitals we commit considerable spend to emergency care for our population and we want to ensure that we deliver more for patients with the resources that we have; therefore our fourth theme is to have an on-going focus on improving productivity in urgent and emergency care pathways.

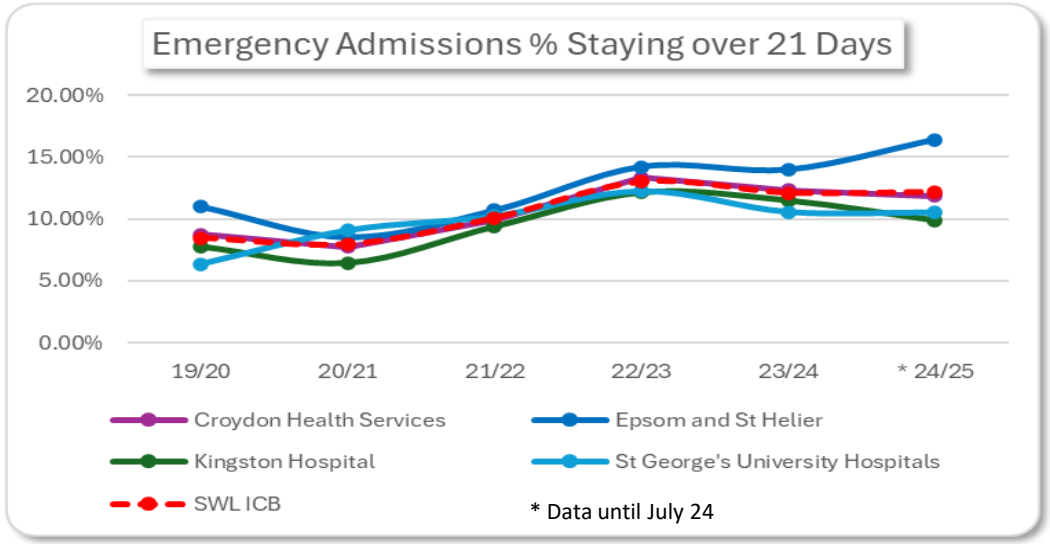
Across South West London we know that, since the start of the Covid-19 pandemic, the number as well as the length of time that people stay in hospital following an emergency admission has increased. Whilst there are a number of drivers of this we know that the number of patients who are medically fit for discharge has also increased in this timeframe suggesting that delayed discharge is resulting in longer length of stays for patients.

The increase in length of stay for emergency patients has made flow through our hospitals more difficult and as a result patients are experiencing long trolley waits with increasing volumes of patients waiting to be admitted.

Not only does this result in sub-optimal patient experience; it is also likely to result in higher costs of care across the system. We have increased the numbers of G&A beds open since 2019/20 with a corresponding increase in staffing costs. Similarly additional costs are incurred by providers to look after patients whilst they are waiting for a bed.

We currently measure productivity in emergency care through a set of core metrics which focus on our length of stay in acute organisations. As part of the two year plan we will review these and expand them so that we reflect the full urgent care pathway. We will take actions to optimise our operational productivity as part of this work.





Exclusion Criteria is available if required

Theme 4: Productivity & Efficiency

NHS
South West London

Our financial recovery plan identified a significant opportunity from within the urgent and emergency care pathway, including opportunities with respect to community care, in-hospital flow and discharge. The earlier themes set out in this document all play a role in improving productivity in emergency care in SWL. These are included in the two year plan productivity initiatives set out below together with further work that the system will progress to enhance efficiency further.

Continued focus on reducing non elective length of stay	• As set out in theme 2, work is underway across all our SWL providers and systems to reduce our non elective length of stay by 1.5 days, with a focus on reducing the number of patients who no longer meet the criteria to reside. • Working with our acute, community providers and social care to improve discharge processes in our trusts and reduce the numbers of patients who no longer need to be in hospital. • Improving flow through centralised case management and coordination i.e. stranded and super stranded patients, and complex discharges.
Optimise our use of community care	• Continue to build on the work in place, as set out in theme 1, to enhance the out of hospital services, Integrated Neighbourhood teams, Proactive Care Programme, Urgent Community Response, SDEC and Virtual Wards across South-West London to support patients at home before seeking treatment at an acute hospital. • Enhance and standardise evidence based initiatives across SWL such the Kingston and Richmond proactive care approach to increase the cohorts of patients supported e.g. people over the age of 65 with 2 or more long term conditions. • Develop a system wide process for evaluating existing schemes and services based on patient experience and outcomes, quality and safety and integration to assess right-sizing of strategic initiatives.
Review system capacity to match current and future demand, optimising our available resources	• Develop a demand and capacity model to ensure that patients are treated in the right place at the right time, preventing unnecessary admissions to hospital, and utilising our resources most effectively. As well as considering the optimal out of hospital model this should also consider how we maximise the use of technological/ digital enhancements. • Review the existing funding streams (including the use of UEC winter monies, Aging well, Better Care and Discharge fund allocations across the system to provide a more holistic approach to support the agreed service model.

Key Measures of Success

NHS
South West London

Urgent and Emergency Care is an arena with a number of formal metrics of success which will be critically important to continue to focus upon from a patient care perspective. These include:

- **Improving 4-hour waiting times** in Emergency Departments and Urgent Treatment Centres for decision on admission
- **Reducing the number of patients who spend 12 hours or more in Emergency Departments**, **for both physical and mental health issues**
- **Improving call response times in Integrated Urgent Care** (111) services
- **Improving Ambulance response times**, with a particular focus on Category 2 patients
- Continuing to **improve ambulance handover times** for patients at the front door of the hospital, significantly increasing the number handed over within 30 minutes
- **Reversing the trend in recent years of increasing inpatient length of stays**, building on the early signs of progress made so far in 2024
- Enhancing the quality of information and making in-roads to **reduce the number of non-criteria to reside patients in hospital**

In addition, we recognise that this plan will require careful thought on a range of additional metrics that demonstrate a commitment to staff and patient wellbeing and increasing productivity. Each of the critical themes will need to hone their priorities further, but the key measures of success must include:

- **Increased patient satisfaction metrics**, as for example, demonstrated through Healthwatch surveys
- **Increased staff satisfaction** demonstrated though the national staff survey but also through effective feedback loops within Trusts, including to Board members
- **Transparent alignment between progress on efficiency and financial impact**, such as progress on reducing hospital length of stay or reducing corridor care or financial modelling of the benefits associated with effective community-based alternatives to hospital care.

Initial Next Steps (1/2)

NHS South West London

The plan to improve Urgent and Emergency across South West London will be taken forward by our stakeholders. **Oversight of delivery and governance will be provided by the SWL Urgent & Emergency Care Board for each of the four themes on a quarterly basis**. **Much of the practical implementation will need to take place through the four UEC Local Delivery Boards** and arrangements have been put in place to ensure closer alignment between local and SWL-wide decision making. As a 'live' document it is recognised that the document will evolve as the next steps are developed by the groups.

Theme 1 **Accessing Urgent & Emergency Care**	• **Utilise our information and data** to consider what is the right model for our services, particularly in the community, to match our population needs; for our patients to access Urgent and Emergency Care pathways access across our system and into the future. • **Assessing the optimal use of the out of hospital space** - such as community services, virtual wards and primary care across SWL to address equity of access and service provision; whilst considering demand and capacity in its broadest sense to utilise our resources most effectively. • **To scope this work and discuss further with stakeholders** to agree and develop the UEC 2-year plan for future design and sizing of services across the system.
Theme 2 **Patient Flow and Discharge**	• **Optimise care for those who are at higher risk of frailty** as a high proportion of UEC services are utilised by those who are frail. Improving the model of care for those who are frail to increase effectiveness, productivity and outcomes. • **Considering the links between vulnerable patient cohorts and equity of access**; such as the frail and those requiring end of life care, those with learning disabilities and/or mental health needs. • **Maximising the use of technological and digital enhancements** as centralised funding becomes available.

Initial Next Steps (2/2)

NHS South West London

Theme 3 **Supporting and Developing our Workforce**	• **Identify alignment with existing Workforce programme**. Reviewing the UEC Workforce plan to identify which items align with ongoing programmes of work undertaken by the SWL Workforce Transformation Team and with SWL Joint Forward Plan; documenting these alignments to ensure integration and avoid duplication of efforts. • **Determine outstanding actions**, identifying any remaining actions that are not yet covered by existing work within the UEC programme or workforce transformation programmes. Clarify where responsibility and oversight for these actions will sit within each stakeholder organisation. • **Review Governance Structures**, assess the current governance structures around accountability and reporting of the UEC workforce plan. Evaluate how workforce planning and transformation in relation to the operational plan are featured within the UEC Board and the wider UEC governance framework. Recommend any necessary adjustments to enhance governance and ensure effective oversight. • **Socialise the Workforce Plan**, engage with key stakeholders to socialise the UEC workforce plan, ensuring widespread understanding and buy-in. Develop more detailed provider-level workforce plans that align with and feed into the overarching Pan-SWL UEC workforce plan. • **Identify Key Metrics for Success** and define key metrics that will be used to measure the success of the developed workforce plans. Establish a framework for regular monitoring and evaluation of these metrics to track progress and inform future decision-making.
Theme 4 **Productivity and Efficiency**	• **Reflecting upon the 1.5 days reduction in length of stay programme for 2024/25**, for successes, improvements and further opportunities for 2025/26 across patient journeys. This could be around further length of stay reductions, occupancy rates or reduction in the numbers of patients awaiting discharge as some examples for stakeholders to consider in partnership. • **Developing further a senior lead discharge workstream;** the need for SW London, external or national support could also be reviewed for additional subject matter expertise. To plan to sit alongside our existing peer group for efficiencies and productivity whilst setting out our future ambitions together as a system.

NHS South West London
Integrated Care Board

The South London Mental Health and Community Partnership (SLP) – achievements to date and work in SWL

Agenda item: 5

Report by: Vanessa Ford

Paper type: In Focus item

Date of meeting: Wednesday, 18 September 2024

Date Published: Wednesday, 11 September 2024

Content

Purpose

This paper provides an update on the South London Mental Health and Community Partnership (SLP), its delivery structure and successes to date.

The paper also illustrates how the developing South West London Mental Health Provider Collaborative links to the SLP and the steps we are taking during this year to implement this.

The paper is provided for information.

Executive summary

The South London Mental Health and Community Partnership (SLP) began in 2017 and is a collaborative venture between South West London and St George's (SWLSTG), South London and Maudsley (SLaM) and Oxleas NHS Foundation Trust with the aim of advocating for mental health and collectively improving quality of care for people with mental health needs. The SLP covers a 3.7 million population footprint across 12 boroughs and aims to deliver clinically-led transformational change. SLP operates with a formal governance structure and now holds delegated commissioning responsibilities across £180m of budgets in secure care, Child and Adolescent Mental Health Service

(CAMHS), adult eating disorders and mental health rehabilitation. The SLP has achieved a range of successes and reinvested in mental health pathways. A number of challenges exist and we are actively tackling these. The clinical leadership and effective partnership working between the three Trusts boards are critical ingredients for this success.

There are solid foundations to collaborative working in mental health in SWL. Following the review that was commissioned by the then SWL CCG, that recommended the movement towards a SWL mental health provider collaborative and the development of the SWL strategy, good progress has been made. The SWL Mental Health Strategy is now in the second year of delivery and the SWL Mental Health Partnership Delivery Group continues to act as the core forum for discussing mental health in our system.

We are now considering the development of a SWL Mental Health Provider Collaborative (SWL MHPC). There are a number of benefits of extending the SLP, South London wide approach to more specific, formalised, collaborative working focused on SWL level around mental health:

1. Offers a way of focusing on standardisation with partners coming together to tackle unwarranted variation across the six boroughs and ensure that no matter where you live in SWL you are able to access the same type of services and quality of care.

2. Provides opportunities for people and organisations to work together to focus on system level priorities – for example urgent and emergency/ crisis care.

3. Enables us to allocate resources to areas and communities to meet needs.

4. Brings a range of organisations and groups to come together to define the change needed and then collectively implement improvements.

We will be able to work more effectively with local partners – including place and Voluntary, community and Social Enterprise (VCSE) colleagues – to tackle core local issues.

The developing SWL MHPC involves, initially, SWLSTG and SLaM with a proposed move to closer a collaborative working model for mental health for these services from April 2025. The SWL MHPC aims to focus on ensuring that we have equitable service offers and access, outcomes and experience for mental health across all six boroughs in our system and to improve the strategic planning approach to mental health. The SWL MHPC is a collaboration that will sit within the existing SLP architecture and -- whilst beginning with SWLSTG and SLaM - has an ambition to broaden to include voluntary and community sector organisations. Learning around MHPC development is available from other systems across England.

Key Issues for the Board to be aware of

The development of the SWL MHPC over 2024/25 offers an opportunity to drive positive change for mental health in SWL in the context of rising demand, complexity of needs and focus on quality and delivery. The Board is asked to note that progressing this work will require input from ICB, SWLSTG and SLaM teams over the coming six months.

Recommendation

The Board is asked to:

- Note the progress around the SLP and the development of the SWL MHPC and support the outlined direction of travel.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
N/A

Corporate objectives
This paper supports work around the development of partnership working and the development of provider collaborative models. New ways of working support the ICB to meet its four key purposes.

Risks
N/A

Mitigations
N/A

Financial/resource implications
N/A

Green/Sustainability Implications
N/A

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
EIAs will be carried out on proposed changes at the appropriate points.

Patient and public engagement and communication
Individuals with lived experience are part of the SWL Mental Health Partnership Delivery Group.

Previous committees/groups

Committee name	Date	Outcome
SWL ICB Senior Management Team	5 September 2024	Supported with additional inclusions to the slides and cover sheet

Final date for approval
N/A

Supporting documents
The South London Mental Health and Community Partnership (SLP) – achievements to date and work in SWL – Powerpoint slides

Lead director
Karen Broughton, Deputy CEO, SWL ICB

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The South London Mental Health and Community Partnership (SLP) – achievements to date

Development of the SWL Mental Health Provider Collaborative (MHC)

South West London Integrated Care Board
18 September 2024

Context for this paper

This paper aims to provide an overview of the South London Mental Health and Community Partnership (SLP). The pack highlights how the SLP works and aims to note and celebrate the improvements that have been made in the context of increasing demand and complexity of needs within mental health and national focus on quality and delivery.

This paper also outlines the development of the South West London Mental Health Provider Collaborative (SWL MHPC) in light of the proposed move to a lead provider model in April 2025.

The South London Mental Health and Community Partnership (SLP)

Background and context: the development of SLP

The SLP started from a belief that we would more effectively meet the needs of people with mental health conditions is we worked collaboratively to drive system–level, clinically-led change.

- Started in 2017 as a collaborative venture between South West London and St George's (SWLStG), South London and Maudsley (SLaM) and Oxleas with the aim of advocating for mental health and collectively improving quality of care for people with mental health needs
- Covers a 3.7 million population footprint across 12 boroughs
- Began with implementing clinical led change and transformation including a Nursing Development Programme and three New Models of Care in Adult Secure Care (Forensic) and CAMHS Tier 4 (inpatients), Adult Eating Disorders (inpatients) and then secured three of just 10 original NHSE specialist mental health Provider Collaboratives
- Has evolved to include:
  - Formal governance (including MoU, business rules, commissioning hub and committee-in-common structures)
  - A shared leadership structure which also includes lead provider roles to hold delegated commissioning responsibilities and budgets
  - Strengths in defining and delivering clinical improvements change through programme structures
- Now has seven programmes and enables clinically-led, service user-informed collaborative commissioning of £180m+ specialist mental healthcare services annually
- Transformation at scale: mobilising new partnership programmes, quality assurance and monitoring, supporting innovation in new care models, driving innovation and value in partnership commissioning
- Our partnership working now includes service users, ICBs, health, social care, NHSE, housing providers, VCSE, Police forces, Mayor of London and others to transform specialist and complex mental health services, improve outcomes and value, and improve the lives of highly vulnerable south London patients

Aims, vision and goals

SLP's aims are to:

- Share pathways, resources and knowledge
- Influence national policy and Integrated Care Systems (ICSs)
- Take on commissioning budgets to transform patient outcomes

SLP's vision is:

- Right care, right time, right place - for each patient as an individual
- Mental health services working together efficiently to deliver seamless, patient-centred pathways

SLP's goals are to:

1. Increase population health
2. Significantly decrease the gap between years of life
3. Agree best practice approaches across the partnership and roll them out using QI methodology
4. Ensure no one will be sent out of area
5. Ensure everyone has access to care in good time
6. Deliver savings by working in partnership

Reducing health inequalities underpins all of the work that we progress.

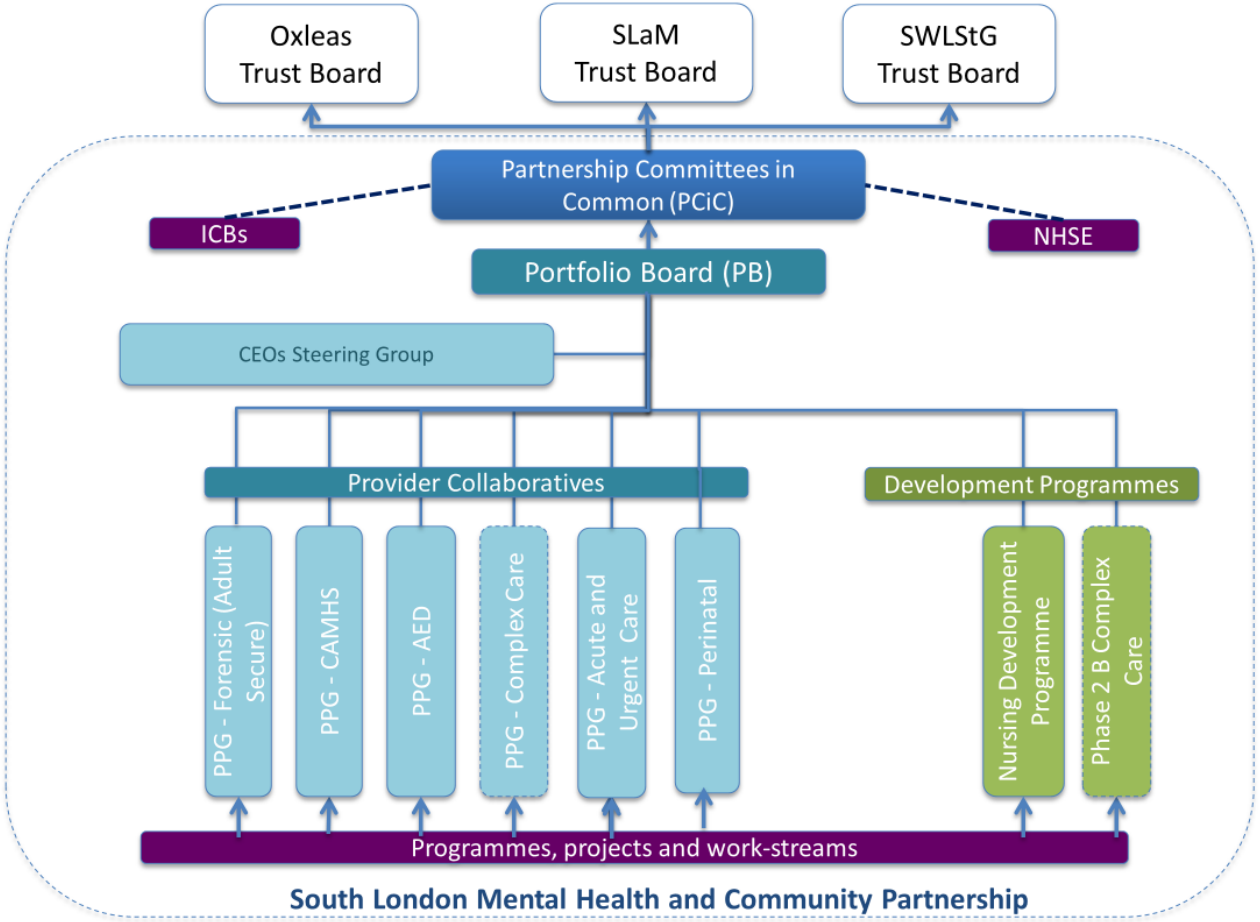
Through our partnership we operate as a formal group of providers which takes responsibility for budget and pathways, working together to share resources, improve pathways and outcomes, and drive value through collaboration at scale

Governance

SLP has a well-established governance structure to provide robust oversight. This includes the following key groups:

- Partnership Committees in Common – meets bi-monthly and chaired on rotation by a Non-Executive Director from each of the Trusts
- Portfolio Board - meets monthly and chaired on rotation by a CEO from each of the Trusts
- Programme Partnership Groups (PPGs) for each programme - meet monthly and chaired by programme Senior Responsible Officer (SRO)

In addition, there are regular Directors of Strategy and Senior Finance Group meetings which bring together Director-level and other senior leads to progress key strategic items.



PPG = Programme Partnership Group

Programme and commissioning budget scale

SLP now holds delegated commissioning responsibilities and budgets for five major areas covering a population of 3.7 million.

NHSE is proposing to delegate secure, CAMHS and AED budgets to ICBs from April 2025. The SLP will work with NHSE and the SWL ICB to ensure a smooth transfer and to continue to enable programme delivery across a south London footprint

Delegated income budgets	**2024-25 £m**
Adult Secure (Forensic)	97.2
CAMHS	29.2
AED	7.2
Perinatal	3.7
Provider Collaborative budgets (delegated by NHSE)	**137.3**
Complex Care (phase 1)	27.6
Complex Care (phase 2 - SWL only)	16.1
SLP delegated budgets (total)	**180.9**

Programmes and focus

Programme	• Key Focus
Forensic (Adult Secure)	• Reducing out of area placements and reducing overall inpatient admissions • Significant focus on reducing LDA patients cared for out of area (50% achievement to date)
Children and Adolescent/Children and Young People's (Tier 4 inpatient services and new Tier 3.5 services)	• Reducing the number of CYP cared for out of area • New crisis services reducing admissions + readmissions, pioneering Family Ambassadors embedded • Enhancing community services to reduce overall inpatient bed days
Adult Eating Disorders (inpatient services and some elements of day care/outpatients)	• Continuing to ensure that no south London patient is admitted out of area • Reducing length of stay • Enhancing community offer to ensure viable and robust alternatives to inpatient admission where appropriate and reduce bed use
Perinatal (inpatients – with connection to community pathways)	• Reducing out of area admissions • Addressing health inequalities • Developing system-wide partnerships including with VCSE partners
Acute and emergency care	• Reducing service delivery variation and improving access including: ➢ NHS 111 for Mental Health - commissioned by SWL ICB and SEL ICB jointly; mental health trusts delivering 24/7 telephone care and support ➢ Police Clinical Advice and Guidance Line - reduced number of public detained under Section 136; reduced A&E attendances; more people in crisis getting the right care, quicker
Complex care	• New system and place-based collaboration in highly specialist services: ➢ Joint health and social care budgets pilot in SW London ➢ Unique step-down 12-bed accommodation in Richmond, partnering with VCSE ➢ Local joint panels to assess and commission onto new pathways • New care models, reinvestment in local services, closer to homes and communities via multi-partner working: ICBs, LAs, VCSE, housing = transformed patient outcome
Nursing Development	• More nurses from ethnic minority backgrounds in management and leadership roles

Reinvesting in local services

SLP has been successful in delivering efficiencies which have enabled reinvestment into a range of south London services. This means that local people with complex and specialist mental health conditions enjoy better quality of life in less restrictive environments, closer to home, with high quality local care delivered by innovative new partnership services.

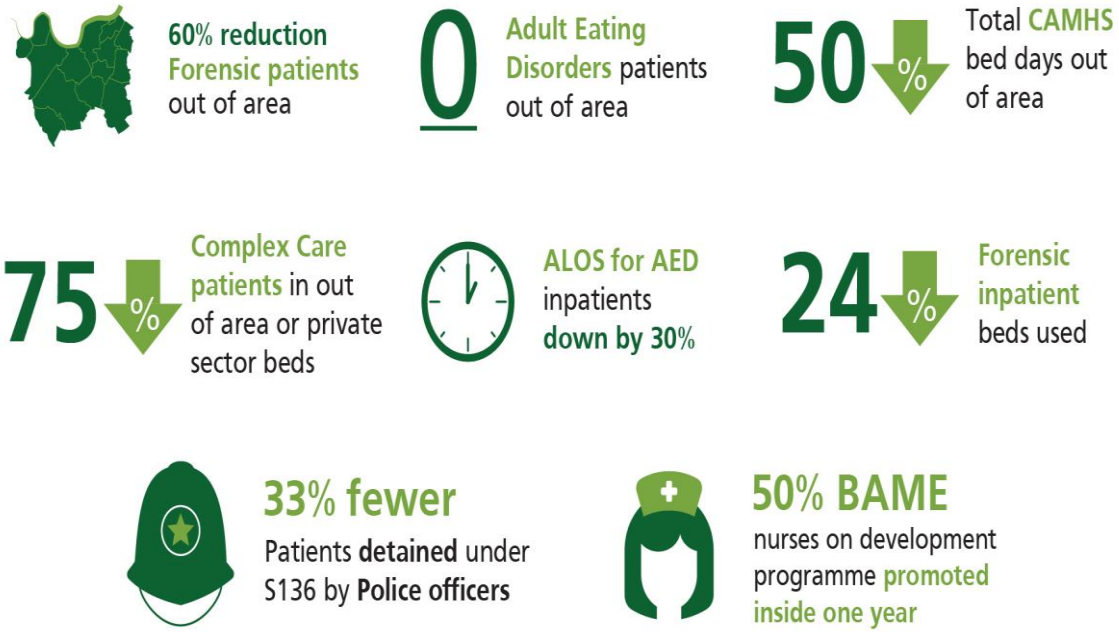
More than £26 million of savings have been reinvested in local south London services.

New services established to date through this reinvestment include:

- CAMHS Crisis Care: community, crisis response, and telephone helpline
- CAMHS Dialectical Behaviour Therapy (DBT)
- CAMHS Forensic Service
- Adolescent Outreach Teams
- Community Forensic Outreach and Support+
- Community Forensic Learning Disability and Autism (LDA)
- Supported specialist step-down accommodation for women in secure Forensic settings
- AED Enhanced Treatment Team
- Peer Support Worker professional roles integrated into AED services
- Integrated Community Rehabilitation Service: step-down accommodation for Complex Care patients in Kingston
- Complex Emotional Needs (CEN) and Co-Occurring Mental Health Alcohol and Drug Rehabilitation Team (COMHART) services for Complex Care patients
- Support for placement reviews across boroughs as part of the Complex Care programme

Delivery and achievements to date

There have been a number of tangible achievements and outcomes through SLP programmes to date. For example:



In addition, SLP has:

- Achieved national sector recognition; influencing policy and approaches
- Tackled health inequalities:
  - 33% fewer people detained by Police under S136 - reducing criminalisation and improving life chances
  - Increased community-based care and support + independent living for people with SMIs (NHSE Core20PLUS5 focus)
  - Improved outcomes for ethnic minority background Forensic patients (over-represented in cohort): 62% of patients repatriated from out of south London have ethnic minority background; now represents just 22% of people out of area
  - Addressed Forensic LDA inequalities: 50% reduction in patients cared for out of area
- Continued to focus on reduction of restrictive practises.

In terms of local work, the SLP has been able to successfully implement an approach to NHS 111 which takes account of SWL services and provides consistency and efficiency.

What challenges exist?

Collaborative and partnership working is complex and not without challenges. We actively seek to address the following issues through SLP:

1. **Time and capacity.** We have invested in specific roles and formal partnership structures but capacity can be stretched. Clinical engagement and leadership is critical to our work. We have implemented development sessions and workshop approaches to provide the time for leaders and wider clinicians to come together to work out the best way of working together. We also focus on Quality Improvement as a methodology to help us achieve change.

2. **Finances.** Two of our provider collaborative programmes do not have adequate commissioning budgets and cost pressures exist in some areas.

3. **Demand and complexity.** We are seeing people with more complex needs presenting to our services and we need to ensure our offer is designed to meet these needs. We have successfully implemented new services as can be seen on slide 9, however, it is not always clear what the future clinical model should be. We work not only with our clinicians but with other provider collaborative areas and NHSE to try to address this.

4. **Balancing quality issues.** In some circumstances there is a lack of local provision and we then need to consider the development of bespoke care packages or securing a placement outside of south London. Ensuring people receive care in area is something we are fully committed to and proud of having achieved in the most part. These circumstances present challenges in balancing quality elements around experience, access and outcomes.

What makes SLP successful?

There are a number of key elements to successful working – ultimately the positive working relationships across the three boards and the principle that the work is clinically driven

SLP Commissioning Hub

- Provider-informed, clinically-led, commissioning collaboratively with service users and partner organisations to develop new models of care for specialist mental healthcare services - and transform patient outcomes
- Manages large-scale commissioning budgets and funded programmes in partnership, including SWL and SEL ICBs, NHSE centrally (Specialist Commissioning), NHSE London Region, Local Authorities
- Active commissioning enabling more personalised care, innovative new pathways and focus on providing community-based care for complex and challenging specialist cohorts of patients
- Innovative new commissioning initiatives with SWL ICB including
    - AED Community Enhanced Treatment Team (MH Transformation Funding)
    - Complex Care (specialist health budgets)
    - NHS 111 for Mental Health (commissioning of new mental health trusts-delivered local service)
    - Perinatal (joining-up inpatient and community pathways)

Strong governance, aligned goals and partnership culture

- Joint governance at programme and overarching level with SWL ICB and other key partners
- Identifying and developing new joined-up care models with wider commissioners
- Enabling innovation and collaboration by three Trusts, service users and partners

Quality Assurance Framework and contract monitoring: robust, collaborative and proactive for all programmes
Service User Involvement Strategy: lived experience representation and co-design embedded

Developing our SWL Mental Health Provider Collaborative

Developing partnership working and collaboration in mental health in SWL

There are solid foundations to collaborative working in MH in SWL. Following the review that was commissioned by the then SWL CCG that recommended the movement to SWL mental health provider collaborative and the development of the SWL strategy good progress has been made. The 3 core components that we continue to work on are outlined below:

1.SWL Mental Health Strategy

- Launched in July 2023
- Developed involving all partners utilising data and hearing views and feedback from nearly 1,000 people
- Acts as a focus for us to identify priorities, respond to challenges, drive forward transformation and address population health needs
- Key aims focus on prevention/ early support, increasing equity, tackling workforce issues, CYP mental health, integrated care and co-production.
- Our Mental Health Strategy for South West London - NHS South West London Integrated Care Board (icb.nhs.uk)

2. SWL Mental Health Provider Collaborative (SWL MHPC – in development

- Hosted within the governance of the highly successful South London Mental Health and Community Partnership (SLP)
- Brings together partners to transform services, share learning and take on defined responsibilities and functions in agreement with the ICB
- Described in a Partnership Delivery Agreement which sets out the range of responsibilities, service areas and key metrics that the SWL MHPC is expected to take ownership of.

3. SWL Mental Health Partnership Delivery Group

- Launched in Sept 2022 and led by the Partner Member for Mental Health on the SWL ICB Board
- Brings together senior system leaders across ICB, local authorities, places, providers , people with lived experience and the VCSE to oversee transformation and improvement around mental health
- Aims to create consensus and energy around positive change and oversees the delivery of both the Strategy and the MHPC.

SWL Mental Health Strategy

We have made good progress on the delivery of our SWL Mental Health Strategy. We have a delivery group in place which meets monthly to oversee the work. The group includes workstream leads from the ICB, trusts and a local authority and also connects to the SWL Integrated Care Partnership Strategy which includes a priority around ‘positive mental wellbeing’.

During 2023/24 we had a number of positive achievements including:

1. Expanding perinatal services, mapping services available for children and young people (CYP) and developing a communication protocol between CAMHS and schools
2. Fully implementing the Community Mental Health models of care defined in the Community Mental Health Framework and investing further in both VCSE provision and peer support roles across all six boroughs
3. Developing a model for reviewing investment in CYP and the impact that this has had
4. Agreeing an approach to public mental health and signing up to the Prevention Concordat
5. Reviewing outcome measures in use across NHS mental health services
6. Further developing the governance to ensure we can delivery the strategy

In 2024/25 we are focused on using this foundation to develop core offers for CYP and adults in mental health and to further move forward with strategic planning and our understanding of investment and impact. We know that waiting times (especially for CAMHS) are a key local issue. The work on the core offer will support us to address these by identifying standards that need to be in place for all boroughs and by identifying where we need to secure more resources to meet demand.

Benefits of developing a SWL Mental Health Provider Collaborative

There are a number of benefits of extending the SLP, south London wide approach to more specific, formalised, collaborative working focused on SWL level around mental health:

1. Offers a way of focusing on standardisation with partners coming together to tackle unwarranted variation across the six boroughs and ensure that no matter where you live in SWL you are able to access the same type of services and quality of care
2. Provides opportunities for people and organisations to work together to focus on system level priorities – for example urgent and emergency/ crisis care
3. Enables us to allocate resources to areas and communities to meet needs
4. Brings a range of organisations and groups to come together to define the change needed and then collectively implement improvements

We will be able to work more effectively with local partners – including place and VCSE colleagues – to tackle core local issues.

SWL Mental Health Provider Collaborative – context and next steps

Building on the success of work to date, we are further developing the SWL MH Provider Collaborative (MHPC) with a view to supporting the delivery of the SWL MH Strategy and with the aim of delivering sustainable MH services for SWL in the long term.

The SWL MHPC is a collaboration of SWLStG and SLaM with a focus on the 6 SWL boroughs. It exists within SLP governance and can be considered as a 'subset' of SLP whereby the two SWL-facing MH Trusts collaborate with a focus on improving MH access, outcomes and experience for the population of SWL.

The SWL MHPC has an aligned set of priorities for SWL and aims to make improvements across a range of core service areas – such as community services for adults with SMI and CAMHS services.

During 2024/25, work is progressing to move towards a closer collaborative model for MH provision in SWL from 25/26. The two trusts are developing a formal agreement that describes in detail how new arrangements will deliver the aspirations for standardisation of care across the boroughs and bring an increased focus to addressing health inequalities and variation across the ICB. This will build on the successful model of clinically led transformation, informed by lived experience, that has delivered results across the SLP portfolio of services in previous years.

While the scope of this work is currently focused on the 2 SWL MH Trusts, we have an ambition to include wider partners - for example the voluntary sector, place teams – and we are learning from the Black Country and Birmingham and Solihull who have well established models for this. For example, we are in discussion with our SWL VCSE Alliance around setting strategic objectives and vision and developing a framework to move this forward.

SWL Mental Health Provider Collaborative – 2024/25 priorities

In 2024/25 there are a range of priority workstreams being progressed by the SWL MHPC. These include:

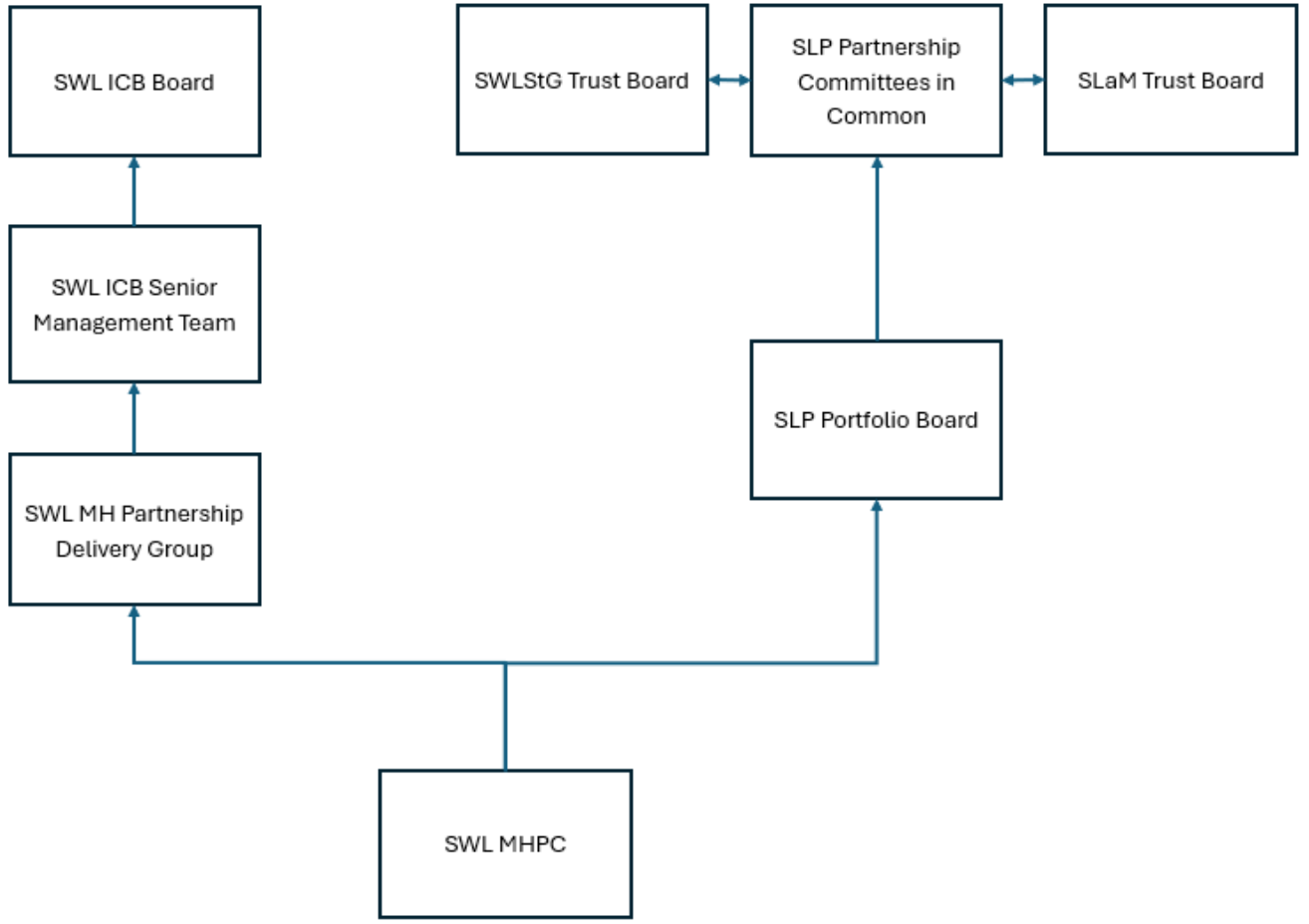
- Governance and due diligence work to support the development of a collaboration agreement between the Trusts as well as wider due diligence work between the ICB and the Trusts.
- Development of assurance approaches a) between the Trusts through MHPC governance and b) between the MHPC and the ICB.
- Development of integrated and aligned planning processes between the MHPC and the ICB for 2025/26 and beyond.
- Collaborative design of future models and core offers in key areas such as CAMHS and adult community services – working with partners as appropriate.
- Developing VCSE partnerships and shared ambitions between the SWL MHPC and SWL VCSE Alliance.
- Maintaining strong connections and developing local approaches with partners at place to enable local issues to be identified and tackled.

We will be working with local places through the SWL MH Partnership Delivery Group and as part of the annual planning round to consider needs and investments.

SWL Mental Health Provider Collaborative – connections to SLP

As referenced on slide 12, the SWL MHPC is hosted within SLP governance, which allows two of the three south London MH Trusts to collaborate on programmes of work as required.

The SWL MHPC reports jointly through existing governance routes into both SLP (through the SLP Portfolio Board and Partnership Committees in Common) and SWL ICB (via the SWL MH Partnership Delivery Group) and onward into the Senior Management Team and Board.



Suicide prevention

The SWL suicide prevention programme is a multi-agency programme bringing together partners across health, care and wider organisations. The objectives of the programme are to:

- Decrease self-harm and suicide rates in SWL
- Gather and analyse real-time data on suspected suicide cases for insights
- Provide better support to those affected by suicide
- Facilitate strategic cooperation among agencies
- Implement initiatives to prevent suicide and self-harm.

To date, the programme has implemented a range of initiatives including:

- Men's Sheds in each SWL borough (aimed at tackling loneliness and isolation in men)
- Staff training and training for wider organisations such as schools
- Bereavement support
- Suicide awareness and public engagement sessions.

A delivery plan is in place for 2024/25 which covers a range of groups including men, CYP, neurodiversity and LGBTQI+. There are also plans to improve awareness and understanding in primary care around crisis pathways.

The programme has been led to date through fixed-term resource hosted by the ICB. Discussions are underway to ensure smooth transition when this resource ends in September 2024 and the SWL MHPC will pick up a leading role.

Appendix

More information

- Five Year Impact Report: www.slpmentalhealth.com/FiveYearImpactReport/
- Annual Reviews: www.slpmentalhealth.com
- Recent national recognition
  - HSJ Patient Safety Awards: Police Advice and Guidance Line shortlisted in Best Use of Partnership Working and Integrated Care in Patient Safety, and Seni Lewis Award categories
  - HSJ Awards: Complex Care Programme and Adult Eating Disorders' Community Enhanced Treatment Team both shortlisted in Mental Health Innovation of the Year category; SLP shortlisted in overall Provider Collaboration of the Year category

NHS South West London
Integrated Care Board

Amendments to South West London Integrated Care Board's Constitution

Agenda item: 6

Report by: Ben Luscombe, Director of Corporate Affairs

Paper type: Decision

Date of meeting: Wednesday 18 September 2024

Date Published: Wednesday, 11 September 2024

Content

Purpose

The paper seeks approval for a number of amendments that need to be made to the South West London Integrated Care Board (ICB) Constitution as a result of updates to the national model constitution and accompanying guidance from NHS England. We have also taken the opportunity to tidy up a few, non-substantial, elements of the Constitution such as Committee name changes and formatting.

Executive summary

In 2022, NHS England issued a model constitution and accompanying guidance that all ICBs were obliged to adopt, with some flexibility for local adaption. NHS England periodically issue updates to both of these documents which ICBs are asked to adopt. Approval of any constitutional changes is reserved to the Board under the Scheme of Reservation and Delegation.

We have attached two documents with these papers, a PowerPoint 'at a glance' summary of all the changes and the full updated constitution.

Key Issues for the Board to be aware of

- The main requested amendments to note are:
    - Making one of the non-executive Board members, but not the Audit Committee chair, also the Deputy Chair of the Board.

    - ICBs should make one of their non-executive Board members the Senior Non-executive Member to support the NHS England Regional Director in the appraisal of the Chair and their compliance with the Fit and Proper Person Test.
    - Ensuring that the Chair's period of office is expressed clearly as a maximum rather than a fixed term.
    - Confirming that a proposal for the Chair or a non-executive to serve on the Board for longer than six years will be subject to rigorous review, and they will not serve as a Board member for longer than nine years in total.
    - Updating the reference to procurement rules to take account of the introduction of the Provider Selection Regime.
    - Removing the clauses related to the establishment of ICBs.
    - A small number of cross-references to other legislation.
- References to 'Remuneration and Nomination Committee' have been updated to 'Remuneration Committee' aligned with the Board's approval of the update Terms of Reference of this Committee.
- Reference to meeting of the Board and its Committees meeting virtually by default has been amended to meeting virtually by discretion.

Recommendation

The Board is asked to:

- Approve the revised South West London ICB Constitution incorporating the requested changes from NHS England.
- Note, once approved by the Board, the revised constitution will be submitted to NHS England for final approval.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
Not applicable

Corporate objectives
Not applicable

Risks
Not applicable

Mitigations
Not applicable

Financial/resource implications
Not applicable

Green/Sustainability Implications
Not applicable

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

Patient and public engagement and communication
Not applicable

Previous committees/groups

Committee name	Date	Outcome
Senior Management Team	1 August 2024	Noted

Final date for approval
Not applicable

Supporting documents
- SWL ICB Constitution Review – Schedule of Amendments
- NHS South West London ICB Constitution V3.0 DRAFT

Lead director
Ben Luscombe, Director of Corporate Affairs

Author
Ryan Stangroom, Lead Corporate Governance Manager

NHS
South West London

SWL ICB Constitution Review

Schedule of Amendments

September 2024

Changes to ICB Constitutions Requested by NHSE

NHS South West London

Where an ICB has not already made the following amendments to their constitution they are asked to do so at their next opportunity, which will be approved by NHS England in accordance with the Act:

- Making **one of the non-executive board members**, but not the Audit Committee chair**, also the deputy chair of the board** (this is not intended to be a new appointment but rather to ensure that if the Chair is unavailable, for a short or sustained period, it is clear who will chair meetings; they would not become the Chair as that is an appointment of the Secretary of State, but local quoracy rules should allow the board to meet without the Chair)
- In accordance with governance requirements of NHS trusts regarding Senior Independent Directors, one of the non-executive members must be appointed the Senior Non-executive Member. They may be the Deputy Chair or the Chair of the Audit Committee. The Regional Director, to whom the Chair is accountable, should agree the role of the Senior Non-executive Member in the appraisal of the Chair and in ensuring the Chair's compliance with the Fit and Proper Person Test. The Senior Non-executive Member is also expected to act as a sounding board for the Chair and if necessary mediate between the Chair and other board members.
- Ensuring that the **Chair's period of office is expressed clearly as a maximum rather than a fixed term**, recognising that interim Chair appointments (approved by the Secretary of State) may be necessary
- Confirming that a proposal for the Chair or a non-executive to serve on the board **for longer than six years will be subject to rigorous review to ensure their ongoing independence**, and **they will not serve as a board member for longer than nine years in total**, consistent with the Code of Governance for NHS provider trusts
- Updating the reference to procurement rules to take account of the introduction of the **Provider Selection Regime**
- **Removing the clauses related to the establishment** of ICBs
- A small number of **cross-references to other legislation**

Further Revisions

NHS
South West London

- References to ‘Remuneration and Nomination Committee’ have been updated to ‘Remuneration Committee’ aligned with the Board’s approval of the update Terms of Reference of this committee.
- Amended reference to meeting of the Board and its committees meeting virtually by default to meeting virtually by discretion.
- In addition to the amendments referred to minor revisions including updates to formatting and cross-references within the Constitution.

Summary of Changes - Page 1

Page Ref	Section/ Paragraph	Original text	Amended Text	Rationale
	Various		*Formatting changes and changes to cross-references within SWL Constitution*	
7	1.4 Statutory Framework	1.4.7 f) section 14Z44 (public involvement and consultation)	Section 14Z45 (public involvement and consultation)	Change in cross-references to other legislation in line with revised NHS Model Constitution
8	1.5 Status of this Constitution	1.5.2 This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.	*Paragraph deleted*	Removal of any clauses related to establishment in line with revised NHS Model Constitution
11	2.2 Board Membership	2.2.3 f) Four Non-Executive Members	Four Non-Executive Members; (one of which, but not the Audit and Risk Committee Chair, will be appointed Deputy Chair and one of which, who may be the Deputy Chair or the Audit Committee Chair, will be appointed the Senior Non-executive Member)	Align with new requirement re Deputy Chair and Senior Non Executive Member in line with revised NHS Model Constitution
13	3.1 Eligibility Criteria for Board Membership	b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles)	Be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles)	Align with requirements in line with revised NHS Model Constitution
13	3.2 Disqualification Criteria for Board Membership	3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, sections 56A to 56K of the Bankruptcy (Scotland) Act 1985 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).	A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).	Change in cross-references to other legislation in line with revised NHS Model Constitution
14	3.2 Disqualification Criteria for Board Membership	3.2.7 A Health and Care Professional (within the meaning of section 14N of the 2006 Act) …	A Health and Care Professional, meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, …	Change in cross-references to other legislation in line with revised NHS Model Constitution

Summary of Changes – Page 2

Page Ref	Section/ Paragraph	Original text	Amended Text	Rationale
15	3.3 Chair	3.3.4 The term of office for the Chair will be three years and the total number of terms a Chair may serve is three terms.	The term of office for the Chair will be a maximum of three years and the total number of terms a Chair may serve is three terms.	To ensure that the Chair's period of office is expressed clearly as a maximum rather than a fixed term in line with revised NHS Model Constitution
15	3.4 Deputy Chair and Senior Non-Executive Member	*Additional paragraph*	**3.4 Deputy Chair and Senior Non-executive Member** 3.4.1 The Deputy Chair is to be appointed from amongst the Non-executive members by the board subject to the approval of the Chair. 3.4.2 No individual shall hold the position of Chair of the Audit Committee and Deputy Chair at the same time. 3.4.3 The Senior Non-Executive Member is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair.	A non-executive member other than the Audit Committee chair must be appointed Deputy Chair in order to chair the ICB board if the Chair is not available in line with revised NHS Model Constitution. Consistent with governance requirements of NHS trusts, a non-executive member must be appointed Senior Non-executive Member in line with revised NHS Model Constitution.
16	3.6 Chief Executive	3.5.4 b) Subject to clause 3.3.3(a), they hold any other employment or executive role	Subject to clause 3.5.3(a), they hold any other employment or executive role	Clarifies eligibility for Chief Executive holding other employment excludes ICB in line with revised NHS Model Constitution
21	3.13 Non-Executive Members	3.13.3 d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration and Nominations Committee	3.13.3 d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee	Reflecting change to the Remuneration Committee
21	3.13 Non-Executive Members	3.13.5 The term of office for a Non-Executive Member will be three years and the total number of terms an individual may serve is three terms, after which, they will no longer be eligible for re-appointment.	The term of office for a Non-Executive Member will be a maximum of three years and the total number of terms an individual may serve is three terms, after which, they will no longer be eligible for re-appointment.	To ensure that the NEM's period of office is expressed clearly as a maximum rather than a fixed term in line with revised NHS Model Constitution

Summary of Changes – Page 3

Page Ref	Section/ Paragraph	Original text	Amended Text	Rationale
21	3.13 Non-Executive Members	3.13.8 The Chair may appoint one Non-Executive Member to be the ICB Board Vice Chair. The Vice Chair will be appointed by the Board following consideration by the Remuneration and Nominations Committee, based on the recommendation from the Chair.	3.13.8 The Chair may appoint one Non-Executive Member to be the ICB Board Deputy Chair. The Deputy Chair will be appointed by the Board following consideration by the Remuneration Committee, based on the recommendation from the Chair.	Change from Vice to Deputy for consistency and reflecting change to the Remuneration Committee
24	3.16 Specific arrangements for the appointment of Ordinary Members made at establishment	**3.16 Specific arrangements for appointment of Ordinary Members made at establishment** 3.16.1 Individuals may be identified as “designate Ordinary Members” prior to the ICB being established. 3.16.2 Relevant nomination procedures for Partner Members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5-3.7. 3.16.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate Ordinary Members should follow, as far as possible, the processes set out in section 3.5-3.13 of this Constitution. However, a modified process, agreed by the Chair, will be considered valid. 3.16.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and the Senior HR Advisor will appoint the Ordinary Members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments. 3.16.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial Ordinary Members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.13	*Paragraph deleted*	Removing the clauses related to the establishment of ICBs in line with revised NHS Model Constitution

Summary of Changes – Page 4

Page Ref	Section/ Paragraph	Original text	Amended Text	Rationale
27	4.6 Committees and Sub-Committees – 4.6.8	The Audit and Risk Committee will be chaired by a Non- Executive Member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.	The Audit Committee will be chaired by a Non-executive Member (other than the Chair and Deputy Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.	To clarify role and responsibilities of the Deputy Chair in line with revised NHS Model Constitution
32	7. Arrangements for ensuring Accountability and Transparency	7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 11(2) of Schedule 1B to the 2006 Act.	7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.	Change in cross-references to other legislation in line with revised NHS Model Constitution
33	7.2 Meetings and publications – 7.2.8	7.2.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under: • sections 14Z34 to 14Z45 (general duties of integrated care Boards), and • Sections 223GB and 223N (financial duties). and • Proposed steps to implement the South West London joint local Health and Wellbeing Strategy.	7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years (the “Joint Forward Plan”). The plan will in particular: a) Describe the health services for which the ICB proposes to make arrangements in the exercise of its functions b) Explain how the ICB proposes to discharge its duties under sections 14Z34 to 14Z45 (general duties of integrated care Boards), and Sections 223GB and 223N (financial duties). c) Set out any steps that the ICB proposes to take to implement the South West London joint local Health and Wellbeing Strategy d) Set out any steps that ICB proposes to take to address the particular needs of children and young persons under the age of 25 e) Set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).	To clarify expected content for ICB’s Joint Forward Plan in line with revised NHS Model Constitution

Summary of Changes – Page 5

Page Ref	Section/ Paragraph	Original text	Amended Text	Rationale
34	7.3 Scrutiny and decision-making	7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including complying with existing procurement rules until the provider selection regime comes into effect	7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime, including: a) Establishing decision-making structures within the ICB that are aligned with the NHS Provider Selection Regime for arranging healthcare services. b) Ensuring appropriate governance structures are in place to address challenges arising from provider selection decisions. c) Ensuring that there are processes in place for the ICB to demonstrate the proper execution of their responsibilities under the NHS Provider Selection Regime. d) Ensuring contracts awarded by the ICB are published and records of decision making kept, in accordance with good governance data processing principles. e) Ensuring organisational compliance with the SWL ICB Contracting and Procurement policy and processes. f) Ensuring that local internal audit arrangements are in place to review decisions made under the NHS Provider Selection Regime. 7.3.4 The ICB will ensure adherence to the requirements of the Public Contracts Regulations (PCR) for non-healthcare services and the Procurement Act once in place.	Provide surety that there are decision-making structures that will allow for decisions to be made in line with the NHS Provider Selection Regime as per NHSE guidance

Summary of Changes – Page 6

Page Ref	Section/ Paragraph	Original text	Amended Text	Rationale
35	8. Arrangements for Determining the Terms and Conditions of Employees	8.1.6 The duties of the Remuneration Committee include: a) Oversight of the nominations and appointments to Board Member roles; b) Set remuneration, allowances, terms and conditions for ICB Board members; …	*Deleted reference* 8.1.6 The duties of the Remuneration Committee include: a) Set remuneration, allowances, terms and conditions for ICB Board members; …	Reflect changes to Remuneration Committee Terms of Reference
41	Appendix 1: Definitions of Terms Used in this Constitution	Area: The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution.	**Area**: The geographical area that the ICB has responsibility for, as defined in clause 1.3 of this Constitution. **Forward Plan Condition**: The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance. **Level of Services Provided Condition**: The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.	Addition of new terms in line with revised NHS Model Constitution

Summary of Changes – Page 7

Page Ref	Section/ Paragraph	Original text	Amended Text	Rationale
44	Appendix 2 Standing Orders 4.2 Chair of a meeting	4.2.2 If the Chair is absent, or is disqualified from participating by a conflict of interest, the Vice Chair, if present, shall preside	4.2.2 If the Chair is absent, or is disqualified from participating by a conflict of interest, the Deputy Chair shall preside over meetings in the Chair's stead. 4.2.3. If both the Chair and Deputy Chair are absent or disqualified from participating by a Conflict of interest a) The assembled voting members of the Board may appoint one of their number to act as a temporary Deputy for the purpose of chairing the meeting	Change from Vice to Deputy for consistency. Aligned wording with NHS Model Constitution. Addition of situation where Chair and Deputy Chair may be excluded in line with revised NHS Model Constitution
45	Appendix 2 Standing Orders 4.6 Virtual attendance at meetings	4.5.3. The ICB Board and its committees may choose to meet physically (for example, for the purpose of an AGM), at its discretion. However, by default, the ICB Board and its committees will be held virtually.	4.5.3. The ICB Board and its committees may choose to meet virtually at its discretion. However, by default, the ICB Board and its committees will be held in person.	Meetings by default are now in person/hybrid this should change to reflect that
46	Appendix 2 Standing Orders 4.7 Quorum	4.7.1.The quorum for meetings of the Board will be 50% members, including: a) The Chair; … 4.7.2. For the sake of clarity: a) No person can act in more than one capacity when determining the quorum; b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum;	4.7.1.The quorum for meetings of the Board will be 50% members, including: a) The Chair or Deputy Chair; …. 4.7.2. For the sake of clarity: a) No person can act in more than one capacity when determining the quorum; b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum; c) A nominated deputy permitted in accordance with standing order 4.5 will count towards quorum for meetings of the board.	Clarifying roles of deputies towards quorum as suggested by revised NHS Model Constitution

NHS South West London
Integrated Care Board

NHS South West London Integrated Care Board

CONSTITUTION

Document Management

Revision history

Version	Date	Summary of changes/Approvals
1.0	1 July 2022	Approved by NHS England
2.0	16 November 2022	Updated to reflect changes to the model ICB constitution requested by NHS England
2.0	23 November 2022	Approved by NHS England
2.1	19 July 2023	Updated to include reviewed Standing Orders Appendix 2
3.0	TBC	Updated to reflect changes to the model ICB constitution requested by NHS England

CONTENTS

1. Introduction

1.1 Background / Foreword

1.1.1 NHSE has set out the following as the four core purposes of ICSs:

a) Improve outcomes in population health and healthcare.
b) Tackle inequalities in outcomes, experience, and access.
c) Enhance productivity and value for money.
d) Help the NHS support broader social and economic development.

1.1.2 The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

a) Improving the health of children and young people.
b) Supporting people to stay well and independent.
c) Acting sooner to help those with preventable conditions.
d) Supporting those with long-term conditions or mental health issues.
e) Caring for those with multiple needs as populations age.
f) Getting the best from collective resources so people get care as quickly as possible.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS South West London Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is coterminous with the London Boroughs of Croydon, Kingston upon Thames, Merton, Richmond, Sutton, and Wandsworth.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This Constitution is published at www.southwestlondon.nhs.uk

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions.

These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act).
b) Exercising its functions effectively, efficiently, and economically (section 14Z33 of the 2006 Act).
c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014).
d) Adult safeguarding and carers (the Care Act 2014).
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35).
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000).
g) Provisions of the Civil Contingencies Act 2004.

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

a) section 14Z34 (improvement in quality of services).
b) section 14Z35 (reducing inequalities).
c) section 14Z38 (obtaining appropriate advice).
d) section 14Z40 (duty in respect of research).
e) section 14Z43 (duty to have regard to effect of decisions).
f) section 14Z45 (public involvement and consultation).
g) sections 223GB to 223N (financial duties).
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.

1.5.2 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) The Constitution will be reviewed as necessary by the CEO of the ICB. Following this review, the CEO will recommend necessary amendments to the Chair of the ICB, for agreement.
b) Proposed amendments will be put to the ICB Board for ratification.
c) Urgent amendments will be agreed by the ICB CEO and Chair.
d) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) **Standing orders** – which set out the arrangements and procedures to be used for meetings and the process to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published.

a) **The Scheme of Reservation and Delegation (SoRD)** – sets out those decisions that are reserved to the Board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) **Functions and Decision map** - a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions** – which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook** – This brings together all the ICB's governance documents, so it is easy for interested people to navigate. It includes:

a) The above documents a) – c).
b) Terms of reference for all committees and sub-committees of the Board that exercise ICB functions.
c) Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body, or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
d) Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority, or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
e) The up-to-date list of eligible providers of primary medical services under clause 3.7.2.

e) **Key policy documents** - which should also be included in the Governance Handbook or linked to it - including:

a) Standards of Business Conduct Policy.
b) Conflicts of interest policy and procedures.
c) Policy for public involvement and engagement.

2. Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section three.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website (www.southwestlondon.nhs.uk).

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the Board" and members of the ICB are referred to as "Board Members") consists of:

a) a Chair
b) a Chief Executive.
c) at least three Ordinary members.

2.1.4 The membership of the ICB (the Board) shall meet as a unitary Board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England policy, requires the ICB to appoint the following additional Ordinary Members:

a) three executive members, namely:
- Chief Financial Officer.
- Executive Medical Director.
- Chief Nursing Officer.

b) At least two non-executive members.

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

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

2.1.7 While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the Board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has six Partner Members:

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

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

a) Six Place Members.
b) Deputy CEO.

2.2.3 The Board is therefore composed of the following members:

a) Chair.
b) Chief Executive.
c) Four Partner Members - NHS and Foundation Trusts.
d) One Partner Member - Primary Medical Services.
e) One Partner Member - Local Authorities.
f) Four Non-Executive Members (one of which, but not the Audit and Risk Committee Chair, will be appointed Deputy Chair and one of which, who may be the Deputy Chair or the Audit Committee Chair, will be appointed the Senior Non-executive Member).
g) Chief Finance Officer.
h) Executive Medical Director.
i) Chief Nursing Officer.
j) Six Place Members.
k) Deputy CEO.

2.2.4 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis, and treatment of mental illness.

2.2.5 The Board will keep under review the skills, knowledge, and experience that it considers necessary for members of the Board to possess (when taken together) in order for the Board to effectively carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular Participants and Observers at Board Meetings

2.3.1 The Board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda, and papers for Board meetings. They will be invited to attend any or all of the Board meetings,

or part(s) of a meeting by the Chair. Participants will be able to address the meeting and ask questions but may not vote. This may include:

a) All Executive Directors of the ICB who are not appointed members of the Board; and
b) A Local Authority Representative (this may be either a Chief Executive or someone who holds a relevant Executive level role or be an elected member of one of the bodies listed at 3.6.1).

2.3.3 Observers will receive advanced copies of the notice, agenda, and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

2.3.4 Observers may be asked to leave the meeting by the Chair in the event that the Board passes a resolution to exclude the public as per the Standing Orders.

3. Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test".
b) Be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles).
c) Fulfil the requirements relating to relevant experience, knowledge, skills, and attributes set out in a role specification.

3.2 Disqualification Criteria for Board Membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a Board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

a) In the United Kingdom of any offence, or
b) Outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the chair, a member, a director, or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office.

b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings.
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest.
d) of misbehaviour, misconduct or failure to carry out the person's duties.

3.2.7 A Health and Care Professional, meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated.
b) the person's erasure from such a register, where the person has not been restored to the register.
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded.
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002; or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities); or

b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria:

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area; or
b) Any of the disqualification criteria set out in 3.2 apply.

3.3.4 The term of office for the Chair will be a maximum of three years and the total number of terms a Chair may serve is three terms.

3.4 Deputy Chair and Senior Non-executive Member

3.4.1 The Deputy Chair is to be appointed from amongst the Non-Executive members by the board subject to the approval of the Chair.

3.4.2 No individual shall hold the position of Chair of the Audit Committee and Deputy Chair at the same time.

3.4.3 The Senior Non-Executive Member is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair.

3.5 Chief Executive

3.5.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.5.3 The Chief Executive must fulfil the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.5.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; or
b) Subject to clause 3.5.3(a), they hold any other employment or executive role.

3.6 Four Partner Members - NHS Trusts and Foundation Trusts

3.6.1 These four Partner Members are jointly nominated by the NHS Trusts and/or Foundation Trusts which provide services for the purposes of the health service within the ICB's area and meet the Forward Plan Condition or (if the Forward Plan Condition is not met) the Level of Services Provided Condition:

a) Croydon Health Services NHS Trust.
b) Central London Community Healthcare NHS Trust.
c) Epsom and St Helier University Hospital NHS Trust.
d) Hounslow and Richmond community Healthcare NHS Trust.
e) Kingston Hospital NHS Foundation Trust.
f) London Ambulance Service NHS Trust.
g) St George's University Hospitals NHS Foundation Trust.
h) South London and Maudsley NHS Foundation Trust.
i) South West London and St George's Mental Health NHS Trust.
j) The Royal Marsden NHS Foundation Trust.

3.6.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be the CEO of one of the NHS Trusts or FTs within the ICB's area.
b) Of the four members: one member will bring a perspective of Acute Services; one member will bring a perspective of Mental Health Services (and meet the requirements set out in para 2.2.4); one member will bring a perspective of Community Services and one member will bring a perspective of Specialised Services.

3.6.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.6.4 These members will be appointed by a panel constituted by the Chief Executive and will be subject to the approval of the ICB Chair.

3.6.5 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation listed at 3.6.1. will be invited to make one nomination for each of the vacant roles outlined in 3.6.2.
- Eligible organisations may nominate individuals from their own organisation or another organisation and will, at the same time, confirm

that nominations have been jointly agreed.
- All eligible organisations will confirm that they approve the full list of nominees proposed.

b) Assessment, selection, and appointment, will be subject to approval of the Chair under c):

- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.2 and 3.6.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval:

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.6.6 The term of office for these Partner Members will be three years with no limit on the number of terms that can be served. At the end of each term, the eligible nominators will be asked if they jointly agree to the current members being re-nominated. If they agree and subject to members remaining eligible, the Chair will be asked to re-approve these members. If they do not agree, the nominations, selection and appointment process will be re-run.

3.7 One Partner Member - Providers of Primary Medical Services.

3.7.1 This Partner Member is jointly nominated by providers of Primary Medical Services for the purposes of the health service within the ICB's area, and that are Primary Medical Services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

3.7.2 The list of relevant providers of Primary Medical Services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.

3.7.3 This member must fulfil the eligibility criteria set out at 3.1 and also be a practising GP in the South West London ICB's geography.

3.7.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.7.5 This member will be appointed by a panel constituted by the Chief Executive and be subject to the approval of the ICB Chair.

3.7.6 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation listed at 3.7.1 will be invited to make one nomination.
- The nomination of an individual must be seconded by five other eligible organisations.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals with a failure to confirm within five working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment will be subject to approval of the Chair under c):

- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.3 and 3.7.4.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.7 The term of office for this Partner Member will be for three years. The total number of terms they may serve is three terms. At the end of each term, the eligible nominators will be asked if they jointly agree to the current member being re-nominated. If they agree and subject to the member remaining eligible, the Chair will be asked to re-approve this member. If they do not agree, the nominations, selection and appointment process will be re-run.

3.8 One Partner Member - Local Authorities

3.8.1 This Partner Member is jointly nominated by the Local Authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) London Borough of Croydon.

b) The Royal Borough of Kingston upon Thames.
c) London Borough of Merton.
d) London Borough of Richmond upon Thames.
e) London Borough of Sutton.
f) London Borough of Wandsworth.

3.8.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be the Chief Executive or hold a relevant Executive level role or be an elected member of one of the bodies listed at 3.8.1.

3.8.3 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply.

3.8.4 This member will be appointed by a panel constituted by the Chief Executive and be subject to the approval of the ICB Chair.

3.8.5 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation listed at 3.8.1. will be invited to make one nomination.
- Eligible organisations may nominate individuals from their own organisation or another organisation and will, at the same time, confirm that nominations have been jointly agreed.
- All eligible organisations will confirm that they approve the full list of nominees proposed.

b) Assessment, selection, and appointment will be subject to approval of the Chair under c):

- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.8.2 and 3.8.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval:

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.8.6 The term of office for this Partner Member will be three years with no limit on the number of terms that can be served. At the end of each term, the eligible nominators will be asked if they jointly agree to the current member being re-nominated. If they agree and subject to the member remaining eligible, the

Chair will be asked to re-approve this member. If they do not agree, the nominations, selection and appointment process will be re-run.

3.9 Executive Medical Director

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act; and
b) Be a registered Medical Practitioner.

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.9.3 This member will be appointed by the Chief Executive Officer of the ICB subject to the approval of the ICB Chair.

3.10 Chief Nursing Officer

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act; and
b) Be a registered Nurse.

3.10.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.10.3 This member will be appointed by the Chief Executive Officer of the ICB subject to the approval of the ICB Chair.

3.11 Chief Finance Officer

3.11.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.11.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.11.3 This member will be appointed by the Chief Executive Officer of the ICB subject to the approval of the ICB Chair.

3.12 Deputy Chief Executive

3.12.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.12.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.12.3 This member will be appointed by the Chief Executive Officer of the ICB subject to the approval of the ICB Chair.

3.13 Non-Executive Members

3.13.1 The ICB will appoint four Non-Executive Members.

3.13.2 These members will be appointed by a panel constituted by the Chair and be subject to the approval of the Chair.

3.13.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Not be an employee of the ICB or a person seconded to the ICB.
b) Not hold a role in another health and care organisation in the ICS area.
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit and Risk Committee.
d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration, Committee.

3.13.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) They hold a role in another health and care organisation within the ICB area.

3.13.5 The term of office for a Non-Executive Member will be a maximum of three years and the total number of terms an individual may serve is three terms, after which, they will no longer be eligible for re-appointment.

3.13.6 Initial appointments may be for a shorter period in order to avoid all Non-Executive Members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

3.13.7 Subject to satisfactory appraisal, the Chair may approve the re-appointment of an independent Non-Executive Member up to the maximum number of terms permitted for their role.

3.13.8 The Chair may appoint one Non-Executive Member to be the ICB Board Deputy Chair. The Deputy Chair will be appointed by the Board following consideration by the Remuneration Committee, based on the recommendation from the Chair.

3.14 Other Board Members

3.14.1 The ICB will appoint six members to bring perspective and expertise on how the place arrangements operate in each of the ICB's places. While the Place Members will bring knowledge and experience from their place and will contribute the perspective of their place to the decisions of the Board, they are not to act as delegates of their place.

3.14.2 These members will fulfil the eligibility criteria set out at 3.1.

3.14.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.14.4 These members will be appointed by a panel constituted by the Chief Executive and be subject to the approval of the ICB Chair.

3.14.5 The term of office for this Partner Member is three years. There is no limit to the number of terms that can be served by this member. Subject to satisfactory appraisal, the Chair may approve the re-appointment of this Board Member.

3.15 Board Members: Removal from Office

3.15.1 Arrangements for the removal from office of Board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

3.15.2 With the exception of the Chair, Board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations, or guidance.
b) If they fail to attend a minimum of 75% of the meetings to which they are invited unless agreed with the Chair, in extenuating circumstances.

c) If they are deemed to not meet the expected standards of performance at their annual appraisal.
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the reputation and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently).
e) Defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.
f) Are deemed to have failed to uphold the Nolan Principles of Public Life.
g) Are subject to disciplinary proceedings by a regulator or professional body.
h) They materially fail to comply with the terms of the ICB's Constitution.
i) The person has refused without reasonable cause to undertake any training which the ICB requires all staff and Board members to undertake.
j) The person, where the Chair reasonably considers (having sought appropriate clinical advice) lacks capacity, for the purposes of the Mental Capacity Act 2005, to manage and administer his/her property and/or affairs.
k) The person is an active member of a body or organisation with policies or objectives such that his/her membership would be likely to cause the ICB to be in breach of its statutory obligations or to bring the ICB into disrepute.

3.15.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.15.2 apply.

3.15.4 If a Board member, other than an employee of the ICB, meets any of the criteria in 3.15.2, the following process will apply:

a) The Chair will convene a meeting of the Board, in private.
b) The approval of three quarters of the Board's membership is required to remove that individual from the Board, with the agreement of the Chair.

3.15.5 Executive Directors (including the Chief Executive) will cease to be Board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.15.6 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State for Health and Social Care.

3.15.7 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:
a) Terminate the appointment of the ICB's Chief Executive; and
b) Direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.16 Terms of Appointment of Board Members

3.16.1 With the exception of the Chair, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published on the ICB's website, and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-Executive Members will be set by a specially constituted Remuneration Committee which will not include Non-Executive Members of the ICB.

3.16.2 Other terms of appointment will be determined by the Remuneration Committee.

3.16.3 Terms of appointment of the Chair will be determined by NHS England.

4. Arrangements for the Exercise of our Functions

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

4.1.2 The ICB has agreed a Code of Conduct and Behaviours which sets out the expected behaviours that members of the Board and its Committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB code of conduct and behaviours is published in the Governance Handbook.

4.2 General

4.2.1 The ICB will:

a) Comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations.
b) Comply with directions issued by the Secretary of State for Health and Social Care.
c) Comply with directions issued by NHS England.
d) Have regard to statutory guidance including that issued by NHS England.
e) Take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England.
f) Respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this Constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) Any of its members or employees.
b) A committee or sub-committee of the ICB.

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority, or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other

body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the Board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a Scheme of Reservation and Delegation (SoRD) which is published in full on the ICB's website (www.southwestlondon.nhs.uk).

4.4.2 Only the Board may agree the SoRD and amendments to the SoRD may only be approved by the Board.

4.4.3 The SoRD sets out:

a) Those functions that are reserved to the Board.
b) Those functions that have been delegated to an individual or to committees and sub committees.
c) Those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the Board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published on the ICB's website (www.southwestlondon.nhs.uk).

4.5.3 The map includes:

a) Key functions reserved to the Board of the ICB.
b) Commissioning functions delegated to committees and individuals.
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority, or any other prescribed body.

d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees

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

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee, sub-committee, or Task and Finish Group established by the ICB operates under terms of reference agreed by the Board. All Terms of Reference are published in the Governance Handbook.

4.6.4 The Board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to:

a) Abide by the Terms of Reference for that committee or sub- committee, which will document the appropriate reporting and assurance arrangements.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not ICB Members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the Standing Orders as well as the Standing Financial Instructions and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

a) **Audit and Risk Committee**: This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit and Risk Committee will be chaired by a Non-Executive

Member (other than the Chair and Deputy Chair of the ICB) who has the qualifications, expertise, or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration Committee**: This committee is accountable to the Board for matters relating to remuneration, fees, and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by a non-executive member other than the Chair or the Chair of Audit and Risk Committee.

4.6.9 The Terms of Reference for each of the above committees are published in the Governance Handbook.

4.6.10 The Board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including Terms of Reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2, the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority, or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the Board.

4.7.4 The Board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the ICB's Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5. Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of Standing Orders which describe the processes that are employed to undertake its business. They include procedures for:

a) Conducting the business of the ICB.
b) The procedures to be followed during meetings.
c) The process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in Terms of Reference which have been agreed by the Board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFI's is published on the ICB's website (www.southwestlondon.nhs.uk).

6. Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the ICB's website (www.southwestlondon.nhs.uk).

6.1.3 All Board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Managing Conflicts of Interests (including Gifts and Hospitality) Policy and the Standards of Business Conduct Policy.

6.1.6 The ICB has appointed the Audit and Risk Committee Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's senior governance advisor, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest.
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest.
c) Support the rigorous application of conflict of interest principles and policies.

d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation.
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the following principles as they relate to its arrangements for managing conflicts of interest:

a) The Nolan Principles.
b) Ensuring clear policy guidance is provided to all those performing a role on behalf of the ICB.
c) Monitoring compliance in accordance with published guidance.
d) Ensuring all interests are proactively declared.
e) Keeping an audit trail of actions taken.
f) Such other principles as contained in the ICB's Managing Conflicts of Interests (including Gifts and Hospitality) Policy and procedures.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB.
b) Members of the Board's committees and sub-committees.
c) Its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB's website (www.southwestlondon.nhs.uk).

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1.

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the

specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee, and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) Act in good faith and in the interests of the ICB.
b) Follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles).
c) Comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7. Arrangements for ensuring Accountability and Transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders, and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Meetings and publications

7.2.1 Board meetings, and committees composed entirely of Board members, or which include all Board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.2.2 Papers and minutes of all meetings held in public will be published.

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

7.2.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.2.6 Information will be provided to NHS England as required.

7.2.7 The Constitution and Governance Handbook will be published as well as other key documents including but not limited to:

a) Managing Conflicts of Interests (including Gifts and Hospitality) Policy and procedures.
b) Registers of interests.
c) Those listed in 1.7.3.

7.2.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years (the “Joint Forward Plan”). The plan will in particular:

d) Describe the health services for which the ICB proposes to make arrangements in the exercise of its functions.
e) Explain how the ICB proposes to discharge its duties under sections 14Z34 to 14Z45 (general duties of integrated care Boards), and Sections 223GB and 223N (financial duties).
f) Set out any steps that the ICB proposes to take to implement the South West London joint local Health and Wellbeing Strategy.
g) Set out any steps that ICB proposes to take to address the particular

needs of children and young persons under the age of 25.

h) Set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

7.3 Scrutiny and Decision Making

7.3.1 The ICB will have five Non-Executive Members who will be appointed to the Board, including the Chair; and all the Board and Committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.3.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers, and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

a) Establishing decision-making structures within the ICB that are aligned with the NHS Provider Selection Regime for arranging healthcare services.
b) Ensuring appropriate governance structures are in place to address challenges arising from provider selection decisions.
c) Ensuring that there are processes in place for the ICB to demonstrate the proper execution of their responsibilities under the NHS Provider Selection Regime.
d) Ensuring contracts awarded by the ICB are published and records of decision making kept, in accordance with good governance data processing principles.
e) Ensuring organisational compliance with the SWL ICB Contracting and Procurement policy and processes.
f) Ensuring that local internal audit arrangements are in place to review decisions made under the NHS Provider Selection Regime.

7.3.4 The ICB will ensure adherence to the requirements of the Public Contracts Regulations (PCR) for non-healthcare services and the Procurement Act once in place.

7.3.5 The ICB will comply with local authority health overview and scrutiny requirements.

7.4 Annual Report

7.4.1 The ICB will publish an Annual Report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report

must in particular:

a) Explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care Boards).
b) Review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan).
c) Review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised).
d) Review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

2. Arrangements for Determining the Terms and Conditions of Employees

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The Board has established a Remuneration Committee which is chaired by a Non-Executive Member other than the Chair or Audit and Risk Committee Chair.

8.1.3 The membership of the Remuneration Committee is determined by the Board. No employees may be a member of the Remuneration Committee but the Board ensures that the Remuneration Committee has access to appropriate advice by:

a) Members of the HR team (including the Executive Director with responsibility for the HR function) being available to attend and advise the committee as needed; and
b) The ICB's senior governance advisor, providing support, advice and attending the committee as required.

8.1.4 The Board may appoint independent members or advisers to the Remuneration Committee who are not members of the Board.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the Board are published as part of the Governance Handbook on the ICB's website (www.southwestlondon.nhs.uk).

8.1.6 The duties of the Remuneration Committee include:

a) Approve the terms and conditions of employment for all individuals directly appointed by the ICB as workers, clinical leads, office holders, including pensions, remuneration, fees and travelling or other allowances payable.
b) Set remuneration, allowances, terms and conditions for ICB Board members.
c) Agree any discretionary payments or terms and conditions for staff employed by the ICB.
d) Approve any termination or redundancy payments.
e) Approve the transfers of staff into or out of the ICB.
f) Ensuring the ICB follows national pay and terms and condition frameworks.
g) Setting remuneration, allowances and terms and conditions for the Chief Executive and Very Senior Managers (VSMs) in line with national guidance.

h) Any other relevant duties.

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

3. Arrangements for Public Involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) The planning of the commissioning arrangements by the Integrated Care Board.
b) The development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them.
c) Decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

a) We have six local Health and Care Plans, one for each of our Local Authority Boroughs. We will ensure these are co-developed and inform our overall system plan.
b) To ensure the local Health and Care Plans are right for our communities we co-develop them through Partner and stakeholder engagement, health and care organisations at place level, as well as key stakeholders in the borough.
c) Broad engagement – using our current community/patient group networks, and wider engagement tools such as Citizens Panels and other 'representative sample' surveys or group work.
d) Targeted engagement with communities that experience health inequalities within each borough.
e) Targeted engagement with patients and communities that have Long Term Conditions – those that are prioritised in the local health and care plans and /or are prevalent in each borough.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities.

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.

b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.
c) Understand your community's needs, their relevant social histories, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
d) Build relationships with excluded groups – especially those affected by inequalities.
e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.
f) Provide clear and accessible public information about vision, plans, and progress to build understanding and trust.
g) Use community development approaches that empower people and communities, making connections to social action.
h) Use co-production, insight, and engagement to achieve accountable health and care services.
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.
j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.5 These arrangements, include:

a) Each borough or Place has a local communications and engagement group, comprising communication and engagement professionals from all partner organisations, the NHS, Local Authorities, Healthwatch and the voluntary sector, to drive forward and deliver our priority work. These groups ensure that work and insight is coordinated across the system and that we maximise channels and reach by working in partnership.
b) These local borough groups report regularly to each place-based partnership committee about past, current and planned engagement activities to contribute towards patient voice being central to influencing local decision making.
c) Informed by EHIAs, JSNAs and local insight, each borough has developed a map of key areas/communities to prioritise engagement work with. Indices of Multiple Deprivation data was overlaid with information about health inequalities. These maps will continue to be refreshed to ensure we are reaching our diverse populations working closely with the population health management team.
d) Assurance of good practice engagement happens at two levels: firstly, each borough or Place has a mechanism for assuring local work.
e) Secondly, we have a South West London group (including Healthwatch and the voluntary sector) to provide assurance to the ICB that the duty to involve has been met and to provide advice on engagement plans and activities to ensure they meet best practice and are inclusive of those that are seldom heard, experience health inequalities and or/have protected characteristics.
f) Listening to local people and communities is recognised as everyone's responsibility within the ICB. Training, development, and toolkits to

support good practice engagement to be delivered across teams/functions. Teams are encouraged to factor in communications and engagement requirements at an early stage of their planning so that they can be appropriately resourced and meaningfully delivered.

g) The Board will receive reports which provide an overview of the engagement activities across the ICB – noting the communities it has reached, impact that it has made, decisions it has influenced, and any lessons learned.
h) To support transparent decision making, ICB papers will be published in advance of meetings, including the engagement reports, and meetings will be held in public. Our 'involving people and communities' section of our website will include opportunities for people to be involved and provide information about past, current and planned engagement activities.
i) We will use the following methodologies to reach our local people and communities.
j) Broad community engagement - working with the voluntary and community sector to host 'community conversations', to hear and respond to feedback, answer questions, and gather insight. We also widen our reach through organic social media via NHS and partner channels, and paid digital adverts on platforms such as Facebook, Nextdoor and Instagram.
k) We champion 'every contact counts' supporting staff to have 'confident conversations' with local people and patients.
l) Community champions and influencers - working with key local influencers (faith leaders, community champions, health care professionals, GPs, and their practices) to lead and host conversations for us building trust and confidence within our diverse communities.
m) Grassroots support programme – to improve our reach into health inclusion communities facilitating and intensifying meaningful, respectful, and culturally appropriate activity in our local boroughs.
n) Surveys and questionnaires – for example working with our 'People's Panel' (a virtual group of local people who broadly reflect the population of South West London). These surveys have led to deeper dives into specific areas.
o) Targeted focus groups and one-to-one interviews - particularly for those who are digitally excluded to help inform and shape our work.

Appendices

Appendix 1: Definitions of Terms Used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB Board	Members of the ICB.
Area	The geographical area that the ICB has responsibility for, as defined in clause 1.3 of this Constitution.
Committee	A committee created and appointed by the ICB Board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Forward Plan Condition	The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Level of Services Provided Condition	The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people, and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the Board are referred to as Ordinary Members.

Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description; • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description; and • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

Appendix 2: Standing Orders

1. Introduction

1.1 These Standing Orders have been drawn up to regulate the proceedings of South West London Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

2.1 The Standing Orders are effective from 1 July 2022.

2.2 Standing Orders will be reviewed on an annual basis or sooner if required.

2.3 Amendments to these Standing Orders will be made as per paragraph 1.6.2 of the SWL ICB Constitution.

2.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application, and compliance

3.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2 These Standing Orders apply to all meetings of the Board, including its committees and sub-committees unless otherwise stated. All references to Board are inclusive of committees and sub-committees unless otherwise stated.

3.3 All members of the Board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the ICB's senior governance advisor, will provide a settled view which shall be final.

3.5 All members of the Board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6 If, for any reason, these Standing Orders are not complied with, full details of

the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification and the Audit and Risk Committee for review.

4. Meetings of the Integrated Care Board

4.1 Calling Board Meetings

4.1.1 Meetings of the Board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the Board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.
b) One third of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Board specifying the matters to be considered at the meeting.
c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3 A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the Board.

4.2.2 If the Chair is absent or is disqualified from participating by a conflict of interest the Deputy Chair shall preside over meetings in the Chair's stead.

4.2.3 If both the Chair and Deputy Chair are absent or disqualified from participating by a Conflict of interest the assembled voting members of the Board may appoint one of their number to act as a temporary Deputy for the purpose of chairing the meeting.

4.2.4 The Board shall appoint a Chair to all committees and sub- committees that it has established. The appointed committee or sub- committee Chair will preside over the relevant meeting. Terms of Reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the Board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times, and venues, will be published on the ICB's website (www.southwestlondon.nhs.uk).

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board.

4.5 Nominated Deputies

4.5.1 With the permission of the person presiding over the meeting, the Partner Members of the Board may nominate a deputy to attend a meeting of the Board that they are unable to attend. The deputy must be of an equivalent position to the Board member they are deputising for. The deputy may speak and vote on their behalf.

4.5.2 The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6 Virtual attendance at meetings

4.6.1 The ICB Board and its committees may choose to meet virtually at its discretion. However, by default, the ICB Board and its committees will be held in person.

4.7 Quorum

4.7.1 The quorum for meetings of the Board will be 50% members, including:

a) The Chair or Deputy Chair.
b) Either the Chief Executive or the Chief Finance Officer.
c) Either the Executive Medical Director or the Chief Nursing Officer.
d) At least one other Non-Executive Member.
e) At least two Partner Members.

f) At least two Place Members.

4.7.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.
c) A nominated deputy permitted in accordance with standing order 4.5 will count towards quorum for meetings of the board.

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8 Vacancies and defects in appointments

4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

a) The quorum will remain at 50% of total Board members (i.e. no reduction in the quoracy outlined in 4.7.1 of these standing orders).

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally, it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below (except where clause 3.14.4 of the main Constitution applies):

a) All members of the Board who are present at the meeting will be eligible to cast one vote each.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional Participants and Observers (under 2.3 of the Constitution) will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution

than against it.

e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3 Where helpful, the Board may draw on third party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent decisions

4.9.4 In the case urgent decisions and extraordinary circumstances, every attempt will be made for the Board to meet virtually. Where this is not possible the following will apply:

4.9.5 The powers which are reserved or delegated to the Board may, for an urgent decision, be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having been made to consult with as many members as possible in the given circumstances.

4.9.6 The exercise of such powers shall be reported to the next formal meeting of the Board for formal ratification and the Audit and Risk Committee for oversight.

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 Admission of public and the press

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960, all meetings of the Board and all meetings of committees which are comprised of entirely Board members or all Board members, at which public functions are exercised will be open to the public.

4.11.2 The Board may resolve to exclude the public from a meeting or part of a

meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Board.

5. Suspension of Standing Orders

5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least 50% of those members present.

5.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit and Risk Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents

6.1 The ICB shall have a Seal. All deeds executed by the ICB shall, unless otherwise so determined, be signed by two duly authorised members of the ICB. The Chief Executive Officer shall keep a register in which s/he, or another manager of the ICB authorised by him/her, shall enter a record of the sealing of every document.

6.2 In land transactions, the signing of certain supporting documents will be delegated to managers and set out clearly in the Scheme of Reservation and Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

NHS South West London
Integrated Care Board

SWL NHS Green Plan: progress update 2024/25

Agenda item: 7

Report by: Helen Jameson, CFO

Paper type: information

Date of meeting: Wednesday, 18 September 2024

Date Published: Wednesday, 11 September 2024

Content

Purpose

To provide a mid-year update on progress against the SWL NHS Green Plan to the ICB Board.

Executive summary

SWL NHS partners recognise that climate change is a health emergency that is already impacting our healthcare provision and our communities across the patch. Therefore, as a health system we have made a commitment to reduce our carbon emissions via the 2023-25 SWL NHS Green Plan.

The attached report provides the ICB Board with a mid-year update of our 2024/25 NHS Green Plan activities. It was agreed that six monthly updates would be presented to the ICB Board, aligned to reporting required by NHSE. The key highlights set out in the attached paper will be reported to NHSE.

This year, we have made significant steps to increased communications and training to reach a wider audience, with a view to win hearts and minds of staff and patients to support the agenda. We have continued to make progress across our target areas. This has included:

- Organised expert talks for the system (biodiversity, procurement and the circular economy)
- reduced the carbon footprint from nitrous oxide use and carbon-intensive inhalers
- Invested in heat decarbonisation and energy efficiency at Croydon Health Services (CHS) and Kingston Hospital (KH) (replacement of a heat and power system, installing solar panels, LED lighting and heat pumps)

- Developed air quality communications materials with local authorities and public health
- Increased our engagement across all local authorities which has led to broader representation at SWL NHS forums
- Started the journey towards measuring our carbon footprint, having identified Key Performance Indicators (KPIs) and measured the impact of particular actions.

Achievement against 2024/25 targets is work-in-progress, but we can measure that we have set into motion a reduction of 3,641tCO2e savings in the first part of 2024/25. We recognise that we remain on the journey with regards to how we can measure success and show that we are making a difference.

We are confident that we can push further by year end. In particular, we will be:

- Reviewing trust progress in more detail across the green surgery checklist, other initiatives supporting sustainable care and food waste initiatives to share best practice and increase actions taken in these areas.
- Working closely with GLA and NHSE to develop guidance on risk assessing long term climate resilience and development of adaptation plans, starting with a roundtable discussion on risk assessment in September 2024 (key actions were published in the London Climate Resilience Review in July 2024 – the attached paper includes a presentation from NHSE/GLA on the potential next steps for our health system).
- Continue to work with NHSE to demonstrate scale of investment required to decarbonise the estate and to explore alternative financing models
- Working closely with local authorities and public health to finalise and rollout air quality communications to health partners
- Measuring the impact of our completed actions, for example the carbon saving achieved for switching to reusable kit.

We will also be developing our NHS Green Plan for the next three years, which we expect to return to the Board for its approval in March 2025. We will develop the plan in partnership with system organisations. We welcome the Board's thoughts on taking this agenda its next stages.

Recommendation

The Board is asked to:

- Note the progress made to date and the continued momentum in activities in the first part of 2024/25 to support the SWL NHS Green Plan 2023-25.
- Discuss the outputs of the London Climate Resilience Review.
- Provide any feedback ahead of the development of the 2025-28 SWL NHS Green Plan.

Governance and Supporting Documentation

Conflicts of interest
n/a.

Corporate objectives
Tackling the Green agenda in line with the NHS's commitment to continue to reduce carbon emissions:

- By 2040 for the emissions it controls directly (e.g. use of fossil fuels) with an ambition of 80% reduction by 2028-32
- By 2045 for those it can influence (e.g. within supply chains) with an ambition of 80% reduction by 2036-39.

Risks
- Lack of engagement and ownership by partners across the organisations.
- Loss of momentum to drive forward change.

Mitigations
- Positioning the SWL NHS Green Plan as an umbrella strategy to capture and support the excellent work happening within organisations as well as providing a framework for shared practice and learning.
- Establish mechanisms and increase resource within the ICB to facilitate networking and sharing of best practice between our partners and reach out to a wider network of enthusiastic staff.
- Build sustainability considerations into normal systems and processes.

Financial/resource implications
- In the context of limited capital and revenue resources, we should be pursuing supplementary sources of funding where available (e.g. Public Sector Decarbonisation Grants).

Green/Sustainability Implications
This paper reports progress against priority areas within the SWL NHS Green Plan and our NHS carbon reduction targets.

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

Patient and public engagement and communication
Local engagement reports were analysed and key feedback was incorporated into the 2023-25 Green Plan. Consideration will be given to how to bring in feedback to the refresh of the Green Plan.

Previous committees/groups

Committee name	Date	Outcome
Green Plan Delivery Group	6 August 2024	Supported

Final date for approval

n/a

Supporting documents

- Progress update

Lead director

Helen Jameson, CFO

Author

Piya Patel, Director of ICS Investment and Projects

NHS
South West London

South West London NHS Green Plan 2023-25: Mid-year progress update 2024/25

ICB Board

September 2024

Summary

NHS South West London

- SWL NHS partners recognise that climate change is a health emergency that is already impacting our healthcare provision and our communities across the patch. Therefore, as a health system we have made a commitment to reduce our carbon emissions via the 2023-25 SWL NHS Green Plan.
- This report provides the ICB Board with a mid-year update of our 2024/25 NHS Green Plan activities ahead of updating NHSE.
- This year, we have made significant steps to increased communications and training to reach a wider audience, with a view to win hearts and minds of staff and patients to support the agenda, and have continued to make progress across our target areas. For instance, we have:
    - organised expert talks for the system (biodiversity, procurement and the circular economy)
    - reduced the carbon footprint from nitrous oxide use and carbon-intensive inhalers
    - invested in heat decarbonisation and energy efficiency at CHS and KH (replacement of a heat and power system, installing solar panels, LED lighting and heat pumps)
    - developed air quality communications materials with local authorities and public health
    - increased our engagement across all local authorities which has led to broader representation at SWL NHS forums
    - started the journey towards measuring our carbon footprint, having identified KPIs and measured the impact of particular actions.
- We also continued to feed into the Mayor of London's Climate Resilience Review, which was finalised and published in July. We include a summary of the findings and next steps for Health in this paper. We are working closely with GLA and NHSE to develop and provide guidance for the NHS system on how we risk assess our services and infrastructure and develop adaptation plans to cope with the frequency of more extreme climate in the future.
- **The Board is asked to note the delivery update against the 2023-25 plan.**

Key highlights so far in 2024/25…

NHS South West London

We have made good progress to date and can measure that **we have set into motion a reduction of 3,641tCO2e savings**, the equivalent of driving c.8.5 million miles in a petrol car.

Workforce and Leadership

- Successful system-wide sustainability forum on **Bio-Net Gain** and the **health co-benefits of nature**
- Successful system-wide sustainability forum on **Procurement and the Circular Economy**
- **Green Champions Groups** establishing at KH and SWLSTG (all trusts to have active champions by year end)
- Planned first cohort of **Carbon Literacy Training** ('Train the trainer' model) aligned with timing of COP29
- **Clean Air Day** marked at KH and HRCH; SWL-wide working group including all local authorities developing **Air Quality comms materials**
- **Clinical leadership strengthened**, including recruitment of three GP sustainability fellows in primary care and KH sustainability clinical leads funded by its charity

Food

- SWLStG's new **food waste monitoring system** has recorded reduced carbon emissions of 48kgCO2e across Springfield and Tolworth sites

Estates and Facilities

- The **investment cost of Trust Heat Decarbonisation plans** has been shared with NHSE to support national planning discussions
- **Heat Decarbonisation** project commenced by KHT to replace its combined heat and power (CHP) system and install heat pumps (30% carbon expected on completion in 2025/26, 2,500 tCO2e)
- Bid for funding submitted by SGH to New Hospitals Programme to deploy **SMART Building technology** (decision awaited)
- £1.1m grant funding awarded to KHT to install **LED lighting** and save c.115tCO2e and £200k annually

Travel and Transport

- Specification drafted for SWL patient transport service including requirements to **increase the electric fleet**
- Active promotion of **bike sheds** at KH and HRCH and **cycle to work scheme** at SWLStG; replacement of diesel intra-site vehicle at RMH with **electric vehicle**
- Funding secured from Croydon Council for **EV chargers** on CHS site for its electric ambulance

Sustainable Models

- Projects in development to introduce **reusable single use items** (theatre hats at KH, single use ports in laparoscopic surgery at CHS)
- **SMART Theatres rollout** at SGH near complete, with carbon savings in Q1 of 72tCO2e
- ESHT introduced a **Walking Aid Re-Use scheme**

Medicines

- **Nitrous oxide cylinder trial** in CHS underway to assess if it could replace piped gas and reduce waste
- **Inhalers projects** in primary care underway to audit use and increase use of lower carbon emission inhalers via training and clinical reviews
- Progress continues on our **medicines targets**, with the last 6 reported months demonstrating a 903tCO2e saving.

Data

- RMH procured a **Smart Carbon Calculator dashboard** and will share lessons with the SWL Data working group

Mid year progress against 2024/25 targets (1/2)

Workstream	Focus for 2024/25	Targets	Delivery at M5	Summary
Workforce and Leadership	Strengthen leadership and engagement by via increased communication and awareness campaigns and access to training	• Deliver at least two training, education, practical learning events per organisation • Deliver at least three SWL-wide communications campaigns • Establish an active Green Champions forum in each organisation	G	• Expert talks held (Biodiversity, Circular economy and procurement) • Progress made to develop materials SWL-wide Air Quality comms. • SWL participation in London's Greener NHS Week. • Training opportunities in development. • Green champions developing in KHT and SWLStG • SWL infrastructure strategy agreed, of which the green agenda is a significant part. **Next steps:** Adaptation session planned in Q3 linked to the London Climate Resilience Review; work with GLA and NHSE to seek and develop guidance on adaptation planning for system; finalise air quality materials and roll-out comms; deliver carbon literacy training for trainers.
Sustainable Models of Care	Refocus on the Green Surgery Checklist 2023/24 target	• Implement 'Green Surgery Checklist' principles across our clinical activities in all relevant organisations	A	• Implementation started at all acute trusts, but further work needed. • Sustainable practices being adopted - theatre hats at KH, single use ports in laparoscopic surgery at CHS, walking aids at ESHT **Next steps:** Progress review across checklist planned to share best practice between trusts and to identify areas of development for next six months.

Travel and Transport	Increased focus on air quality and meeting regional targets, incentivising where we can modality shift via encouraging Active Travel and Green Modes of Transport	• Go electric for patient, inter-site and courier transport by 2027, supported by:
		  • Completion of Travel Surveys by end of Q1
		  • Travel Strategies finalised by end of March 2025
		  • No. of modality shift initiatives implemented per organisation (minimum 3 per organisation)
		  • Delivery of common patient transport specification supported by participating trusts with specific KPIs for the electrification of the fleet; successful procurement
			A/G	• Not all travel surveys were completed by end of Q1 but all organisations on track to deliver travel surveys and strategies this year.
				• GESH, KHT, CHS reporting on track with NHSE-specified modality shift initiatives. Additional activities include replacing vehicles with electric vehicles, promoting cycling
				• SWL Patient transport specification drafted including electric vehicle targets
				Next steps: stocktake of travel strategy development with trusts and progress tracking in next six months, review of actions to increase adoption of NHSE-specified modality shift initiatives,

Medicines	Focusing on work relating to MDI inhalers and Nitrous Oxide and refresh workstream leads and governance structure	• Reduce nitrous oxide waste and emissions from MDI inhalers
		  • 23% reduction in tCO2e from nitrous oxide from both manifold, cylinders and mixed sources (against a 2019/20 baseline)
		  • 35% Reduction in in tCO2e from inhalers (against a 2019/20 baseline)
			G	• Latest data shows 50% reduction in emissions from nitrous oxide manifolds and portable cylinders against 19/20 baseline; 11% reduction from mixed nitrous oxide and air sources.
				• Nitrous oxide cylinder trial in CHS to assess if it could replace piped gas and reduce waste.
				• 39% reduction against the 19/20 baseline relating to MDI inhalers.
				Next steps: Develop funding bids for revenue support for nitrous oxide reduction activity; CHS to provide outcome of nitrous oxide cylinder pilot; others to provide benefits review of decommissioning activities across trusts, complete primary care inhalers projects.

Mid year progress against 2024/25 targets (2/2)

NHS South West London

Workstream	Focus for 2024/25	Targets	Delivery at M5	Summary
Food and Nutrition	Expand ambition, with a focus on reducing the carbon impact of our food waste	• Delivery of food waste by each organisation with measurable outputs • Increase number of other initiatives across reusables and reduced carbon footprint menus	A/G	• Continuing to develop monitoring of food waste, SWLStG has a new food waste system, SGH targeting 8% food waste reduction by March. • Percentage of staff and patient menus including plant-based options has increased from 43% to 75% **Next steps:** all trusts to take steps to measure food waste and increase number of initiatives to target waste reduction before year end, trusts to share initiatives with one another to share best practice, assess impact from further menu changes on the carbon footprint.
Estates and Facilities	Review decarbonisation plans for reductions in the carbon footprint of our estate	• Target reductions in carbon emissions from decarbonisation and other plans are identified and begin to deliver for 2024/25 and beyond. • Identify waste management plans	A/G	• KH commenced replacement of its Combined Heat and Power (CHP) system and installation of heat pumps (completes in 2025/26) and LED lighting installation underway. • CHS unsuccessful in securing Public Sector Decarbonisation Scheme funding for wider decarbonisation programme, however has progressed installing solar panels (due end of September). Directing solar power into CHS plant directly under consideration. • SWL trusts are preparing for next PSDS bidding round. Funding continues to be a barrier to the scale of decarbonisation activities. Trust decarbonisation plans reviewed and investment requirement shared with NHSE to support national discussions. SWL attended regional roundtable to discuss alternative financing model options. **Next steps:** continue to engage in regional/national discussions re: funding models, complete solar panel installation at CHS, progress KH project to replace CHP, collate and share waste management plans.
Data	Increased focus how we measure and track our carbon footprint and the impact of our efforts	• Identified SWL common methodologies for measuring scope 1,2, and 3 emissions • Identified KPIs for workstreams and embedded reporting into the Green Plan Delivery Group	A	• Working group set up and a set of draft KPIs agreed. Data refinement underway. • Challenges re: measurement of carbon savings identified • RMH trialling an approach to create a carbon dashboard. **Next steps:** finalise KPIs, continue to develop methods to calculate carbon reduction across key actions and projects, RMH to share trial dashboard with wider system, continue to seek learnings from national/regional teams and external to NHS to refine approach.

Next steps and 2025-28 Green Plan

NHS South West London

- In summary, we have continued to make progress across our key areas of focus and raising the profile of the green agenda and know where we need to continue to push forward delivery in the second half of the year, which includes:
  - Reviewing trust progress in more detail across the green surgery checklist, other initiatives supporting sustainable care and food waste initiatives to share best practice and increase actions taken in these areas.
  - Working closely with GLA and NHSE to develop guidance on risk assessing long term climate resilience and development of adaptation plans, starting with a roundtable discussion on risk assessment in September 2024 (see following slides for key actions from the London Climate Resilience Review).
  - Working closely with local authorities and public health to finalise and rollout air quality communications to health partners
  - Continue to work with NHSE to demonstrate scale of investment required to decarbonise the estate and to explore alternative financing models
  - Measuring the impact of our completed actions, for example the carbon saving achieved for switching to reusable kit.

- We will also be developing our NHS Green Plan for the next three years, which we expect to return to the Board for its approval in March 2025. We will develop the plan in partnership with system organisations. We welcome the Board's thoughts on taking this agenda its next stages.

THE LONDON CLIMATE RESILIENCE REVIEW

July 2024

NHS

MAYOR OF LONDON

Independent London Climate Change Resilience Review

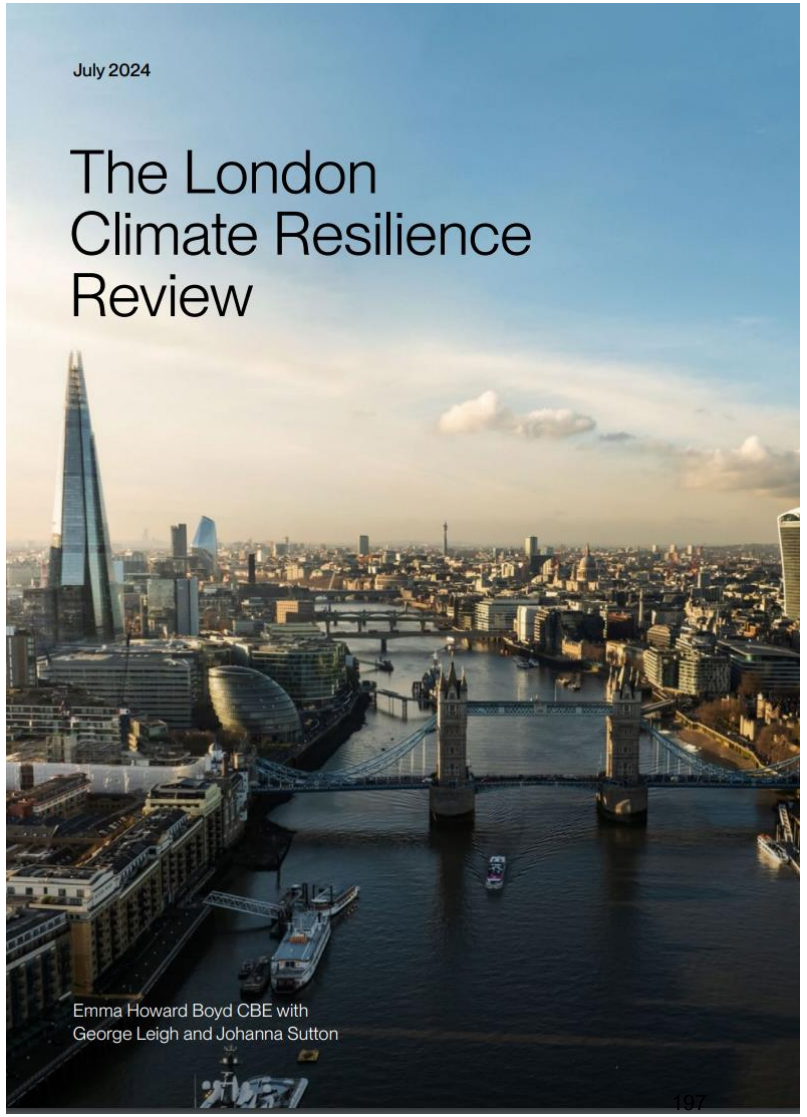
Climate resilience is about successfully coping with and managing the impacts of climate change while preventing those impacts from growing worse. A climate resilient society would be low-carbon and equipped to deal with the realities of a warmer world.

- cut the heat-trapping emissions that drive climate change
- adapt to the changes that are unavoidable
- do so in ways that makes London more equitable and just, not less.

Adaptation policies can lead to greater resilience of communities and ecosystems to climate change.

The Mayor commissioned a review in 2023 following 2021 floods and 2022 heatwaves to:

- Assess the actions needed at national, regional and local level to help reduce impacts on people, infrastructure, environment and economy in London.
- Provide a clear set of recommendations to the Mayor of London to guide London's preparation for climate hazards and develop a strategic direction for London's adaptation planning, identifying main areas of concern and possible responses.



Overall Findings: summary

- All organisations across London must advance their climate resilience and adaptation action- we are locking in significant risk.
- Heat and water scarcity require significant action
- Lack of financial and human resources are a significant barrier to adaptation action by public sector organisations.
- There is a need for central leadership to provide strategic direction to accelerate place-based adaptation
- Adapting London will require a step change in investment from public and private sources of finance
- Investment in place-based adaptation, developed with communities to meet their needs can create good, local jobs.
- Organisational and public awareness of climate impacts and adaptation options are a systemic barrier to action.
- Despite some understanding of the severity of climate change impacts and their costs there is a lack of will and drive to take action.

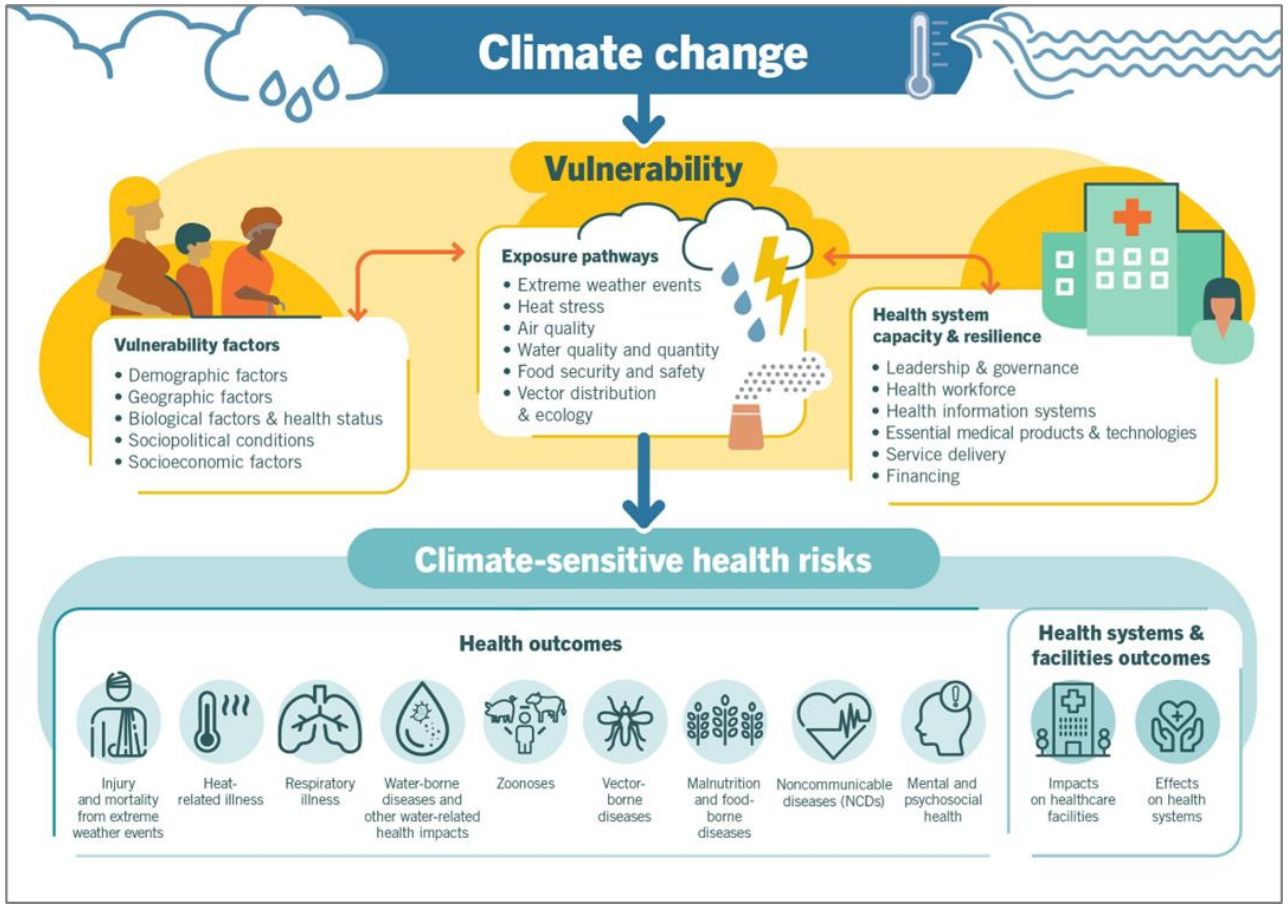
"There is no version of the evidence where we can argue the public are healthier now than they were 10 years ago". ...
"Public Health has been slow to get to climate change- we're starting now. We don't have a big position on this- but it is an emerging threat"
Royal Society for Public Health

"Shared leadership and effective partnership across transport, planning, health and education are required to reduce current and future climate change mortality and morbidity. Climate change policies must also consider interrelated issues of health inequalities..." ...
London Association of Directors of Public Health (ADPHL)

Key Findings: equity and vulnerability

Low income households, elderly people, marginalised and minority communities, children and youth and vulnerable health groups are consistently the most vulnerable to climate hazards

- Poorer Londoners are more likely to live in housing that is not well adapted to high temperatures, meaning they are more vulnerable to heat, and more likely to live in areas vulnerable to flooding and less likely to have flood insurance.
- The percentage of the population aged 65 and above is growing and “climate impacts pose a significant challenge to the health and wellbeing of older people, particularly those who live in vulnerable locations or lack the physical, mental, social, and financial resources needed to avoid or minimise the effects of extreme weather.”
- The Office for Health Improvement and Disparities told us: “Climate change will exacerbate and widen existing inequalities. This is because people who experience health inequalities have poorer health and are more likely than the general population to have health conditions that are made worse by, for example, extreme heat and cold.”



Overall recommendations for London

Enabling London to lead: Governance

- A co-designed vision for a London that is adapting well to climate impacts and an adaptation delivery plan to support that vision.
- Embed adaptation as a priority across all GLA and functional bodies work
- (UK Gov) ensure long-term, ringfenced adaptation funding w. straight forward reporting
- A strategic, regional approach to heat risk

Communities

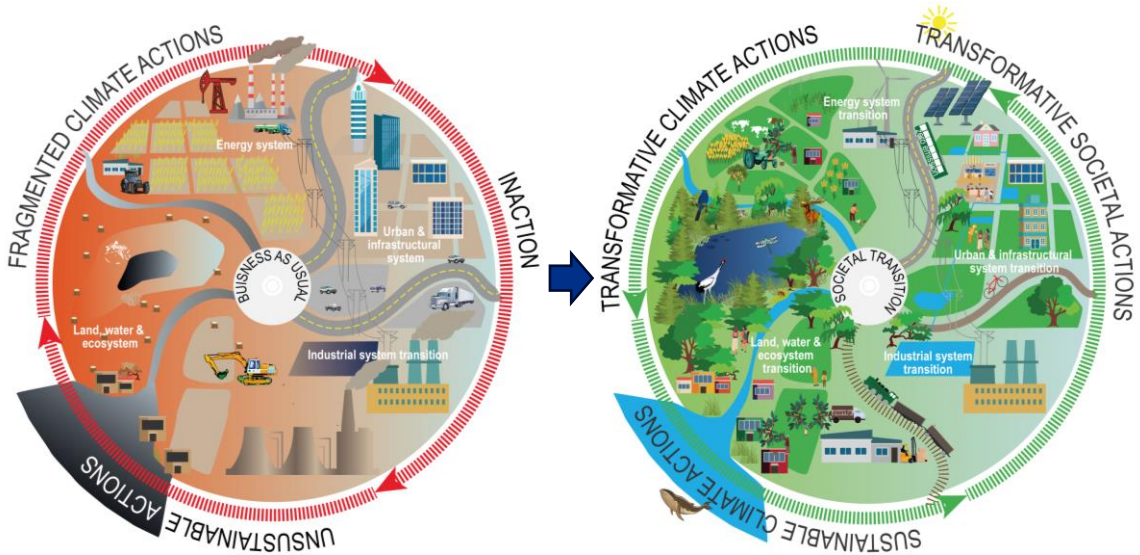
- Locally led work to identify climate risks
- Borough adaptation plans
- Funding for community engagement and capacity building
- engagement on climate risks, behaviour change & incentivising action
- Climate resilient health care system

Built Environment

- Climate resilient planning
- Infrastructure standards
- Nature based solutions and urban greening
- Integrated water management
- Retrofit for resilience
- Climate ready streets and buildings

Economy

- Adaptation finance (UK Gov)
- Mayor's green finance programme
- Technical assistance and a pipeline of projects
- Capturing costs of climate impacts and benefits of adapting
- Skills



- 50 Recommendations in total
- 25 directly to the Mayor of London
- 19 to UK Government
- 15 for local authorities
- Many require co-delivery and have multiple owners
- The Mayor of London and GLA will need to engage stakeholders (Anchors, wider public sector, businesses, communities, local authorities) to effectively advance London's climate resilience.

Health recommendations

For the health sector, key focus areas are: contributing to the vision for climate-resilient London; developing wider risk-based adaptation plans with a focus on strategic planning for heat

No	Short Title	Recommendation	Who
16.	Health Sector Adaptation Plans (1)	Provide strategic leadership and coordination to systems in London to allow them to develop and implement adaptation plans and risk assessments. Support identification of “once for London” opportunities.	NHS England in London
17.	Health Sector Adaptation plans (2)	Work with their organisations to collaboratively agree an approach to adaptation risk assessment and planning. Coordinating support required for providers and work with partners to set system level adaptation plans.	Integrated Care Boards
18.	Health Sector Adaptation plans (3)	Ensure they have completed a climate change/adaptation risk assessment to support development of an adaptation plan.	NHS Services
19.	Health Effects of Climate Change Priorities	Work with the London Health Board to mainstream adaptation action by ensuring that climate mitigation and adaptation are included in any future London Health and Care Vision or strategy, and by considering adaptation in its meetings in 2024/2025 (and beyond). The Mayor could act as a convenor to improve mutual understanding of what London’s priorities are for managing the health effects of climate change and preparing the health sector for acute and chronic impacts.	Mayor of London
20.	Climate Change and Health Systems Responsibilities	Ensure responsibility for regional aspects of climate change are clearly defined.	UK Government-UKHSA

NHS South West London
Integrated Care Board

Creating a SWL Missions Board and the development of a long-term Service and Organisational Transformation Strategy for the NHS in South West London.

Agenda item: 8

Report by: Sarah Blow

Paper type: Information

Date of meeting: Wednesday, 18 September 2024

Date Published: Wednesday, 11 September 2024

Content

Purpose

This paper proposes the creation of a SWL Missions Board, and the development of a long-term Service and Organisational Transformation Strategy for the NHS in South West London, to strengthen our governance arrangements and approach to driving system-wide transformation and delivering the ICB's financial plan.

Executive summary

- The ICB built a strong foundation to deliver our 2023/24 financial plan.
- To meet the ongoing financial challenge faced by the ICB, we propose creating five system missions and a new Missions Board to strengthen our governance arrangements and approach to driving system-wide transformation and delivering the ICB's financial plan.

Key Issues for the Board to be aware of

- It is proposed that:
    - The ICB Chairman chairs the new SWL Mission Board.
    - The SWL Mission Board has as part of its membership Non-Executive Directors and Non-Executive Members across the system to enhance scrutiny and assurance.
    - The new governance arrangements will take effect from 1 October 2024, with the Board meeting for the first time in October.
    - The new SWL Mission Board will replace the current Finance and Sustainability Board which would meet for the last time in September 2024.

Setting five system missions

We propose to bring together our transformation and financial recovery plans under 5 new missions. These are:

- We will transform elective care and reduce waiting lists
- We will redesign our non-elective pathway, reduce unnecessary stays in hospital and ensure seamless care
- We will redesign our workforce to support our changing services and meet the changing needs of patients
- We will deliver a Long-term Service and Organisational System Transformational Strategy for SWL
- We will develop and integrate out of hospital services so that patients are supported to stay well, ill health is prevented, and people are treated closer to home

Creating a new SWL Mission Board

Reporting to the ICB Board, the purpose of the SWL Mission Board will be to set and drive a long-term Service and Organisational Transformation Strategy for the NHS in South West London and ensure delivery of the 24/25 financial recovery plan. The Mission Board would have two parts:

Overseeing delivery (part one) - This part of the meeting will:

- Oversee delivery of the 24/25 financial plan and, if the forecast deteriorates at an organisation or system level, review and direct mitigations required.
- Ensure robust financial and workforce grip and controls are in place across the system.
- Seek expert clinical or other opinion to support effective decision making.
- Provide system oversight to SOF processes.
- Where appropriate, provide recommendations and actions to the Finance and Planning Committee and other Committees or Sub-Committees of the ICB Board.

Setting strategic priorities and plans (part two) - This part of the meeting will:

- Set a long-term Service and Organisational Transformation Strategy for the NHS in South West London.
- Agree the transformation portfolio and programmes to deliver the Service and Organisational Transformation Strategy.
- Set the portfolio and programmes to deliver the strategy. ensuring that project plans are in place, that progress is tracked and that the programmes deliver their agreed outcomes.
- Review and approve the quality and equality impact of any service or transformation change.
- Agree targets, metrics and trajectories for each programme.
- Ensure that there is appropriate resource and support for each programme.
- Ensure effective risk management of the programmes.

The SWL Mission Board will report to the ICB Board on progress twice a year or more frequently if required.

Recommendation

The Board is asked to **note:**

- The creation of a new SWL Mission Board to set and drive a long-term Service and Organisational Transformation Strategy for the NHS in South West London and ensure delivery of the 24/25 financial recovery plan.
- That the current Finance and Sustainability Board will be disbanded and would meet for the last time in September 2024.

Governance and Supporting Documentation

Conflicts of interest
n/a

Corporate objectives
This document will impact on the following Board objective:

- Overall delivery of the ICB's objectives.

Risks
There is a risk that without strong governance and control that the ICB does not meet its financial plan.

Mitigations
The creation of the SWL Missions board and development of a long-term Service and Organisational Transformation Strategy for the NHS in South West London.

Financial/resource implications
n/a

Green/Sustainability 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

Committee name	Date	Outcome
Senior Management Team	29 August 2024	Support
SWL Chief Executives Meeting	27 August 2024	Support

Final date for approval
N/A.

Supporting documents
N/A.

Lead director

Karen Broughton, Deputy Chief Executive Officer/Director of Transformation and People, SWL ICB.

Author

Karen Broughton, Deputy Chief Executive Officer/Director of Transformation and People, SWL ICB.

NHS South West London
Integrated Care Board

Board Assurance Framework

Agenda item: 9

Report by: Ben Luscombe, Director of Corporate Affairs

Paper type: discussion/information

Date of meeting: Wednesday, 18 September 2024

Date Published: Wednesday, 11 September 2024

Content

Purpose

This paper informs the Board of the current high-impact and significant risks on the Corporate Risk Register, which are considered part of the Board Assurance Framework (BAF).

The Board is asked to note the overall BAF position.

Executive summary

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

The BAF represents our highest-scoring risks across along with 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. Th risk cycle ensures that we are identifying and reviewing risks with all the teams and Executive Directors across the organisation.

The Corporate Risk Register and the BAF are regularly reviewed by our Committees and Senior Management Team and overseen by the Audit and Risk Committee.

The BAF is a living document and is continuously evolving and we are constantly working with our Committees to ensure we are capturing and accurately reflecting our ICB risk profile.

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).

Key Issues for the Board to be aware of

In total, the BAF report highlights a total of six risks. Among these, five have a score of 15 or above, while one risk holds a lower score.

RSK-037 - Urgent and Emergency Care

RSK-014 - Financial Sustainability

RSK-001 - Delivering Access to Care

RSK-149 - Interruption to clinical and operational systems as a result of Cyber Attack

RSK-025 - Workforce capacity well-being and availability

RSK-011 - Failure to modernise and fully utilise our estates

RSK-087 - System Quality Oversight

Since the last report in March 2024, the following changes have been made:

Risks added:

None

Score Changes:

RSK-011 – Failure to modernise and fully utilise our estates

Residual score has dropped to 12, from 16

The residual score has decreased, indicating that the current mitigation measures are effectively reducing the associated risks. This decrease reflects the success of the implemented strategies in managing potential issues.

RSK-014 – Financial Sustainability

Inherent score has risen to 25, from 20

Residual score has risen to 20, from 15

Although the overall target score remains the same, the balance of impact and likelihood has been adjusted.

Score updates are due to significant financial challenges requiring swift cost reductions amid operational demands and potential oversight impacts. Enhanced controls include increased NHSE assurance meetings and a new Recovery & Sustainability Board.

Key

- The BAF scoring under the Residual Risk Score reflects 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.

Recommendation

The Board is asked to:

- Note the overall BAF position.

Governance and Supporting Documentation

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.

Corporate objectives
Identifying risks is essential to delivering all the ICB's objectives.

Risks
A summary of ICB risks is listed on the risk register.

Mitigations
None

Financial/resource implications
None

Green/Sustainability Implications
None

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

Patient and public engagement and communication
N/A

Previous committees/groups

Committee name	Date	Outcome
Audit and Risk Committee	11/06/2024	
Quality & Performance Oversight Committee (QPOC)	14/08/2024	
Senior Management Team (SMT)	05/09/2024	

Final date for approval
N/A

NHS South West London
Integrated Care Board

Supporting documents

South West London Board Assurance Framework – Board – September 2024

Lead director

Ben Luscombe, Director of Corporate Affairs

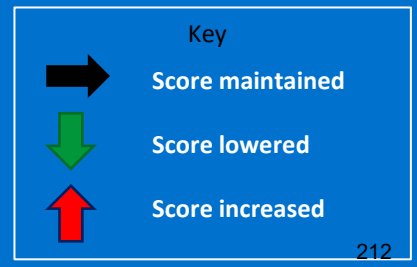
Author

Leigh Whitbread, Lead Corporate Affairs & Risk Manager

NHS
South West London

Board Assurance Framework South West London ICB Governing Body – September 2024

Ben Luscombe



Risk Scoring Definitions

Inherent Risk Score

Definition: Inherent Risk Score measures the level of risk in an activity or process in its natural, uncontrolled state. It's the potential for risk before any mitigating actions or controls are applied.

Example: An example the inherent risk score might include data breaches due to cyber threats, loss of patient confidentiality, or inefficiencies in patient record management. This score is assessed before any data protection or operational efficiency measures are in place.

Residual Risk Score

Definition: Residual Risk Score is the level of risk that remains after risk mitigation strategies and controls have been applied. It indicates the extent of risk that persists despite current management efforts.

Example: After the implementation of cybersecurity protocols, staff training on data privacy, and upgrades to its patient record systems, the risk of data breaches and inefficiencies reduces. The residual risk score represents this remaining level of risk after these measures are taken.

Target Risk Score

Definition: Target Risk Score is the level of risk a risk owner seeks to achieve in the future through the implementation of additional risk management strategies. It signifies the desired risk level following the execution of planned improvements.

Example: The risk owner may establish a target risk score aiming for enhanced data security and improved operational efficiency. Achieving this may require the adoption of advanced cybersecurity technologies, extensive staff training programmes, and sophisticated data management systems. The target risk score denotes the aspirational level of risk after these prospective enhancements are implemented.

RSK-037 ➡ Risk Title: Urgent and Emergency Care — Jonathan Bates

Inherent Impact	Inherent Likelihood	Inherent Risk Score
5	5	25

Residual Impact	Residual Likelihood	Residual Risk Score
4	5	20

Target Impact	Target Likelihood	Target Risk Score
3	3	9

Cause & Effect

There is a risk that the ICS is unable to deliver a consistently effective and high-quality urgent and emergency care service (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.

Causes for this risk are; 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. Consequently, it 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.

Impact of the risk:

- 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 and wellbeing 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.

Actions/Mitigations Implemented

- South West London has established a system-wide Urgent and Emergency Care (UEC) Board and four local Delivery Boards for each Hospital System with senior representation from all partners. Recognising the interdependencies across SWL boroughs and other work programmes (such as workforce and primary care) to ensure ongoing focus for patient pathways and performance improvement in this area.
- A programme of initiatives have been planned across the year by each local Delivery Board and approved by the UEC Board for greater productivity and efficiencies to be gained from services for our patients.
- Action plans are being monitored for implementation and effectiveness and reported to the UEC Delivery Boards.
- A high-level dashboard has been developed and implemented to enable the system to monitor whether there is an improvement in the length of stay whilst maintaining the national performance requirements. This is reported to the UEC Board on a regular basis.
- Performance metrics are reported to the UEC Board monthly, providing greater insight into the nature of the problem to be solved, including details of patients waiting in ED longer than 12 hours for physical and mental health.

Action Required

- A two-year UEC plan has recently been completed with the next steps currently being finalised with the revision of the UEC Board and Delivery Boards TOR and membership. 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.
- Implementation of the UEC National Recovery Strategy with a specific reference to recovering ambulance response, increasing senior clinical input into the 111 service and refocusing on the 4 hour wait in EDs alongside monitoring total time in ED. This includes a system ambition to meet the national target of at least 78% of patients admitted to a bed within 4 hours by March 2025.
- Implementation of a programme of work to reduce length of stay in acute beds by 1.5 days is recently underway to improve patient flow across the patient journey and reduce the risks in services as the flow out of ED and out of hospital; subsequently reducing the pressures and improving the experience for patients and staff. The boards of all organisations have been assured that the focus and oversight is being maintained.
- Re-establishment and expansion of the SWL UEC Transformation team following the SWL review of staffing has been undertaken. A newly created Director of UEC will oversee a team that will deliver transformation and oversight across the system from 2024/25.
- Implementation of the five-year plan: The team will use the UEC plan two-year plan as their programme delivery framework. 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.
- Ongoing implementation of the primary care and discharge programme improvement plans.

Person responsible: Jonathan Bates **To be implemented by:** March 2025

RSK-014 ⇧ Risk Title: Financial Sustainability — Helen Jameson

Inherent Impact	Inherent Likelihood	Inherent Risk Score
5	5 (4)	25 (20)

Cause & Effect

In line with other healthcare systems across England the SWL NHS system is currently spending more than it's base allocation to deliver the required healthcare services for the local population. Significant savings need to be identified to reduce the cost base back to the base allocation.

Further to this there is additional risk that the ongoing changes to the NHS financial frameworks, due to the creation of new population-based allocations (including specialised services), means the ICB/ICS will not deliver its strategy and the objectives of the Long-Term Plan due to the constraints of the financial envelope.

Healthcare services need to be delivered efficiently and effectively. So that investments can be made to support the local population's health and well-being. Over the last few years and in response to the pandemic additional investments have been made which have increased the cost base of the system. As well as costs are increasing through high levels of inflation and the impact of industrial action.

The system has identified opportunities to reduce costs but there is a risk it doesn't have the capacity to deliver them quick enough, alongside the operational demands and thus continues to spend more than it can afford and is unable to address the changing healthcare needs to the population.

Impact of the risk:

This has made medium-term financial sustainability a much more significant challenge. Consequently, the ICB and the system may have additional oversight and controls applied to it. These could reduce flexibility/ access to funding for investment in priority areas during the year and beyond, which could impact service delivery and performance.

In 2023/24 SWL ICS had additional funding support to cover the costs of Industrial action and the increased cost base. Part of which will need to be paid back in future years alongside the ongoing reduction of the allocation back to base levels. These reductions to available funding will put additional constraints on the system and increase the importance of reducing the system cost base as quickly as possible to ensure sustainability.

Residual Impact	Residual Likelihood	Residual Risk Score
5	4 (3)	20 (15)

Actions/Mitigations Implemented

- 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. SWL ICB Finance and Planning 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, quarterly 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.
- Recognising the ongoing financial challenges across NHS providers in SWL, a Recovery & Sustainability Board remains in place to oversee the development/delivery of a savings programme and a financial recovery plan. This reports to the ICB Finance and Planning Committee.
- In 2023/24 work was undertaken to analysis of the opportunities and their prioritisation to ensure the system is focussed on improving services for the population whilst reducing costs. These opportunities were consolidated into a high-level financial recovery plan. For 2024/25 we have reviewed the workstreams with in the plan and agreed the key focus should be on workforce, the systems infrastructure, elective services, improving the urgent and emergency care pathway. Whilst in parallel we are undertaking further modelling to further understand how we best deliver services to meet the future populations needs with in a financially sustainable envelope.
- NHSE now require all ICB and NHS partners to develop a Medium term financial strategy to bring the NHS back into balance. SWL ICB is working with partners to deliver this, which will build off the financial recovery plan.

Target Impact	Target Likelihood	Target Risk Score
3 (4)	4 (3)	12

Action Required

System Wide

- Ensure robust governance structures and reporting are in place for the delivery of the workstreams within the SWL recovery plan.
- Continue to strengthen and review financial governance across the system to ensure tight management of staffing, agency usage and non-pay spending. With NHSE overview and approval of spend as required.
- Focus on increasing productivity throughout the year to ensure patients receive timely treatment in a cost-effective manner.
- Continue to develop system reporting and dashboards to better understand our underlying financial position and real time performance

Person Responsible:, Joanna Watson
To be implemented by: 31 March 2025

ICB

- Continue to develop ICB reporting and dashboards to better understand our underlying financial position and real time performance
- Continue to strengthen and review financial governance within the ICB to ensure tight management of staffing, agency usage and non-pay spending. With NHSE overview and approval of spend as required.
- Ensure robust governance structures and reporting are in place for the delivery of the ICB savings programme

Person Responsible: Neil McDowell
To be implemented by: 31 March 2025

RSK-001 ➡ Risk Title: Delivering access to care (NHS Constitution Standards) Jonathan Bates

Inherent Impact	Inherent Likelihood	Inherent Risk Score
4	5	20

Cause & Effect

There is a risk of Backlog and waiting times on service delivery for patients creating a delay in patient treatment and an increase in waiting times. The providers may not meet national and local quality and performance standards. In that case, the ICB population does not have constitutional pledges honoured by providers, e.g., emergency departments (ED), Cancer waits for standards, referral to treatment (RTT) waiting times and list size, healthcare-associated infections (HCAI), improving access to Psychological Therapy (IAPT) and recovery rate.

Causes for this risk are; reduced capacity due to workforce issues (incl diagnostic); Patient Tracker List (total waiting list) growth since the Pandemic, increased two-week wait and urgent referrals taking precedence over routine; Compromised recording systems in the implementation phase; Complexities and challenges of system implementation; Inaccurate and untimely reporting output.

Prolonged waits in primary care, prioritising newer patients over stable long waiters. The underperformance of providers against quality and performance standards.

Impact of the risk:

- 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.
- This could affect SWL's financial provision.
- Poor performance and quality monitoring.
- Reduced activity.
- 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. SWL is consistently the highest-performing ICS in London across most constitutional standards.

Residual Impact	Residual Likelihood	Residual Risk Score
4	4	16

Actions/Mitigations Implemented

- Providers validate their patient tracker lists (PTL) quarterly, an activity led by the Acute Provider Collaborative.
- Clinical prioritisation is also taking place, following the recommendation by NHS England (NHSE) 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 P2s.
- Service changes have been implemented to enable adherence to infection prevention control 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 implementation of the locally agreed Elective recovery fund (ERF) 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 Constitutional standards. Regular reports are produced for both Performance and Quality and are reviewed at this meeting and also at the ICB Board and shared within the ICS.
- Quality and Service delivery are reviewed bi-monthly at SWL ICB Quality and Performance 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.

Target Impact	Target Likelihood	Target Risk Score
3	2	6

Action Required

- Monthly ICB triangulation meetings across key teams (Finance, Quality, Planning, Contracting, Workforce) to share intelligence and identify potential early warning signs of Trust issues, to inform coordinated mitigation actions.
- Fortnightly conversations between the provider recovery leads and the ICS Oversight and Assurance team to ensure the management of long-waiting patients.
- Data Quality improvement actions are reviewed via a monthly SWL-wide group meeting. The priority will be reducing data quality errors around long waiters, the completeness of priority coding and progressing waiting list validations down to 12 weeks.
- Monitoring of the SWL system-wide 2024/25 trajectories to ensure delivery of the national targets around elective recovery.

Person responsible: Suzanne Bates
To be implemented by: 30 November 2024

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

RSK-149 ➡ Risk Title: Interruption to Clinical & Operational Systems as a result of Cyber Attack — John Byrne

Inherent Impact	Inherent Likelihood	Inherent Risk Score
5	4	20

Residual Impact	Residual Likelihood	Residual Risk Score
4	4	16

Target Impact	Target Likelihood	Target Risk Score
3	2	6

Cause & Effect

There is a risk of persistent cyber threats targeting Southwest London Integrated Care System (ICS) services, including both provider and shared services. These threats could lead to data breaches, service disruptions, and significant impacts on patient care, financial stability, public trust, and the reputation of the system. While the Integrated Care Board (ICB) coordinates cyber security efforts across the ICS, each organisation remains accountable for its own security.

Key factors contributing to this risk include the need for a more defined cyber strategy to prioritise critical risks, improvements in asset and identity management practices, enhanced vulnerability management, better oversight of supplier risks, and the development of integrated response and recovery plans. Insufficient resources may also hinder effective risk management and security monitoring.

Ongoing initiatives are focused on developing a comprehensive ICS cyber strategy, improving compliance with security measures such as Multifactor Authentication, and enhancing asset and supplier management practices to strengthen security and efficiency.

Potential Impacts of the Risk:

- Risks to patient safety and public health
- Data breach and privacy concerns
- Financial impacts
- Reputational damage
- Legal and regulatory consequences
- Long-term effects on innovation

Actions/Mitigations Implemented

- Baseline Assessment: SWL ICB Digital Team has completed an ICS-wide cyber assessment to understand the overall security posture of the providers and ICB GP IT. This assessment informed the risk position.
- Collaborative Improvement: SWL ICS Digital team have put together some governance structures in partnership with the providers to maintain ongoing collaboration in the identification and mitigation of cyber risks. A draft cyber roadmap activities has been created following outputs from these structures.
- Cyber leadership: An ICS-wide cyber lead has been appointed to develop and manage the implementation of risk reduction strategies.
- Provider Controls: SWL ICS providers continue to have ownership and management responsibilities of their local risks and have implemented some risk reduction measures. The providers also undertake own assurance measures including annual IT Health Checks, and completion of NHS Data Security Protection Toolkit (DSPT). The ICS is supporting local measures while promoting a joined-up approach to risk reduction across the system with opportunities for cost savings and reduced service frictions.
- National Support: There are also national services from NHS England and the National Cyber Security Centre (NCSC) that are available to SWL providers. These include some cyber monitoring and incident response capabilities, particularly on devices in the shared NHS tenant, the Health and Social Care Network (HSCN). The centre is also supporting Trusts with security assessment/audits, and technical remediation services , as well as provide funding where available to address local security risks.
- Multi factor Authentication review has been completed for the participating organisations across the ICS.
- ICS wide Cyber Incident Simulation/Tabletop exercise has been completed.
- Key Cyber policies have been created and shared with the provider organisation for review and adoption.

Action Required

The goal is to simplify and harmonise security controls across the ICS while maintaining a safe healthcare system. Key areas of focus include:

- Development of a SWL ICS cyber strategy and implementation plan.
- Modernise the cyber-risk management, incident response and asset management practices.
- Standardise cyber training and promote awareness across the ICS.
- Support risk remediation and Monitor cyber compliance across the ICS.

Person Responsible: John Byrne
To be implemented by: 30 September 2025

RSK-025 ➡ Risk Title: Workforce capacity wellbeing and availability — Karen Broughton

Inherent Impact	Inherent Likelihood	Inherent Risk Score
4	5	20

Cause & Effect

With increased pressure on the NHS; the impact of staff turnover and sickness levels; the availability of trained staff; concern around cost-of-living increases; as well as the need to bring staffing numbers back in line with 2019/2020 workforce figures, there is a risk that South West London provider organisations will not have the right workforce capacity in place.

Impact of the risk:

The impact of this risk is that:

- There may be a reduction in the quality and timeliness of care.
- There could be increased pressure on existing staff which could have an adverse impact of their health and wellbeing which may lead to an increase in turnover or sickness levels.
- There is in an increase in agency use if substantive or bank staff are not available to temporarily fill vacant positions or shifts.

Residual Impact	Residual Likelihood	Residual Risk Score
4	4	16

Risk Controls

- The Mayors Skills Academy Programme successfully launched, embedded in the SWL system, working with social care equivalent where appropriate to improve domestic supply by attracting local people into the NHS.
- Recruitment and retention/workforce committees are in place in provider organisations to review staffing.
- Regular workforce reports reviewed by provider boards to highlight workforce pressures and suggested solutions to improve recruitment, retention and health and wellbeing concerns.
- Trusts and management focus on health and well-being support and facilities to ensure staff were cared for. (This includes financial well-being).
- Trusts have local, national and international recruitment campaigns in place.
- Providers have adopted fast-track recruitment processes.
- Following last year's operational planning round, Trust HR Directors worked together to determine priorities to support supply & retention & reviewed approaches to pay enhancements, bank/agency, & reward systems.
- SWL Health and Wellbeing Hub was created and put in place across SWL. Access to information and support is detailed on the SWL ICS website. Although funded through the ICP investment fund, ongoing funding threatens its continuation beyond March 2025, this will need to be reviewed. Trusts and ICB focus on health and well-being support and facilities to ensure staff were cared for. (This includes financial well-being).
- Regular meetings continue to be held with the staff counsellors who form the current SWL mental health and wellbeing hub and provider health and wellbeing leads. Whilst the mental health SDF funding to support the workforce is to cease, the remaining funding has been shared across the SWL system to positively support staff health and wellbeing.
- Occupational Health and specialist support in place across all SWL provider organisations to support staff.
- An SWL workforce report with input from the NHSE workforce team and SWL ICB Workforce team and includes both health and social care data is regularly presented at the People Board and ICB Board.
- A focus on staffing will continue through the SWL People Board.
- SWL ICB Chief Nurse is carrying out a skill mix review with three aims, to Strengthening safer nursing staffing across SWL, reducing high cost resourcing and to better understand the responsibilities and patient facing activities of professional nursing roles so they can spend more time with patients.
- There is partnership work across the system with full-time trade union officers.

Target Impact	Target Likelihood	Target Risk Score
3	4	12

Action Required

- Discussions continue with senior leaders in provider organisations to understand their operational plans, specifically focusing on the workforce, and seeking opportunities for further joint work on supply, health, and well-being across the system.
- SWL ICB has been working with the acute provider collaborative and NHSE colleagues on emerging workforce priorities, including emergency departments, the diagnostic workforce and Allied Health Professionals with a focus on frailty. The findings and outputs of this work is under review. This is to identify creative supply routes and future workforce design solutions to determine the future workforce requirements and right sizing of teams/professional groups.
- A continued focus on apprenticeships via the People Board, the Apprenticeship Networking Group/Hub and the Mayors Skills Academy Programme will seek to increase the uptake in apprenticeships, support the sharing of resources and levy usage.
- The Chief Nursing Officers will work together to review nursing staffing across SWL and set consistent nursing staffing ratios.
- Work with providers to deliver their agreed workforce plans and reduce reliance on temporary staffing.
- Delivery of the Integrated Care Partnership workforce plan to support local people into employment and reduce vacancies.
- ICB attendance at Regional NHS HR Director meetings continues where employers discuss how to support staff with the cost-of-living increases; suggested ideas/good practices will be reviewed and discussed within SWL and where appropriate, suggested for implementation after presentation to SMT/People Board.
- Partnership work across the system with full-time trade union officers will continue dates for the remaining financial year (2024/25) to be updated and invites issued.

Person Responsible: Karen Broughton, Lorissa Page
To be Implemented by: 30 November 2024

RSK-011 ⇩ Risk Title: Failure to modernise and fully utilise our estates — Helen Jameson

Inherent Impact	Inherent Likelihood	Inherent Risk Score
4	4	16

Cause & Effect

There is a risk that if we fail to modernise and utilise our estate fully, the capacity of services may not be fully optimised, ICB and provider cost bases may be adversely affected, backlog maintenance requirements may increase, estate may remain energy inefficient and the ICB could be liable for paying for void costs in return for no services being provided. There is a risk that the ICB and system partners fail to work together to get the most efficient and effective use of the collective estate, thus hindering ambitions within the Joint Forward Plan e.g. to facilitate integrated care in community settings. Funding may be too constrained to enable changes to services (capital budgets are required for new leases under IFRS 16), the conversion of existing estate and critical upgrades to improve utilisation and digital transformation to reduce the need to expand the estate (supporting our green agenda). National funding for primary care may remain limited to support primary care networks. Also, 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). 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.

Impact of the risk:

- An increase in the cost of voids passed onto the ICB and the wider system, contributing to the challenging financial environment.
- A lack of funding may hinder service transformation in primary care and community settings
- Lack of flexibility in PFI space may limit the ability to enable service change and reduce void costs.
- Significant impact on SWL ICS capital planning if system prioritisation processes don't align with population needs and minimise the backlog maintenance required.
- A lack of understanding of the estate and the system priorities may mean the system isn't able to successfully access national funding for specific projects and new hospital builds.
- Old estate that is impacted by infection control and ventilation guidance changes may lead to reduced patient activity or increased risk of infections.

Residual Impact	Residual Likelihood	Residual Risk Score
3	4	12 (16)

Actions/Mitigations Implemented

- Develop and deliver a SWL NHS estates and infrastructure strategy (including primary care) that is bought into by the health system, and which seeks to understand the SWL estate to identify opportunities maximise the use of it, minimise the carbon footprint and address local needs.
- Through the infrastructure strategy development and the Estates financial recovery workstream, review the collective estate with providers and Places for opportunities exit 'tail' estate and consolidate where appropriate.
- An effective data collation exercise is underway to better understand our primary care estates priorities and potential requirements, including opportunities to maximise use and limit vacant spaces make better use of digital technology and change ways of working in place of unaffordable large-scale developments.
- Review void space, vacant space and associated opportunities with NHS Property Services and Community Health Partnership.
- Establish a working group under the SWL financial recovery programme to maximise use of Queen Mary's Hospital, linking in closely with NHS Property Services and the PFI Provider to find solutions to void space within PFI contractual obligations and national policies that limit the conversion of space in PFI buildings.
- All capital prioritisation processes include critical infrastructure investment criteria to minimise the impact of old estate on patient care.
- Opportunities to address old estate, support transformation of services and to decarbonise the estate are being sought via the New Hospital Programme, the Public Sector Decarbonisation Scheme and other funds.

Target Impact	Target Likelihood	Target Risk Score
3	3	9

Action Required

- Work more 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.
- Continue to work with NHSE to develop the SWL NHS estates and infrastructure strategy (including primary care) which will seek to maximise the use of our estate, minimise the carbon footprint and address local needs.
- Work with regional and national teams to understand funding opportunities that will support the needs of the population and reduce costs for the system.
- Work with regional and national teams to provide visibility about funding requirements (including primary care).
- Ensure void spaces are minimised and work with NHS Property Services for the most effective use of the QMH site.
- Keep the capital investment prioritisation process under review to ensure it is fit for purpose and aligns with the ICS/P strategy
- Assess risks caused by adverse weather and longer-term impacts of climate change and make progress on developing adaptation plans across SWL organisations.
- Ensure regular updates are sought to ensure that RAAC issues are identified, and assurances provided with respect to their rectification.

Person Responsible: Piya Patel
To be implemented by: 31 March 2025

RSK-087 ➡ Risk Title: System Quality Oversight — Elaine Clancy

Inherent Impact	Inherent Likelihood	Inherent Risk Score
3	4	12

Cause & Effect

There is a risk that there could be an adverse impact on quality, positive experience, patient outcomes and threats to safety where factors may impact patient care.

This can be caused by the following:

- Increased workforce challenges and vacancies across our providers and ICB nursing directorate.
- Failure to meet adequate treatment times that lead to safer outcomes due to significant pressures especially on the urgent and emergency, mental health and children's and young people's pathways.
- Outbreaks of infections in the community and acute setting leading to potential bed closures.
- Failure to deliver safe services because of the disruption caused by continued industrial action.
- Failure to provide a positive experience of care for our patients.
- Failure to proactively manage and escalate quality risks and identify lessons learnt following adverse safety incidents.
- Inadequate rating of providers by regulators and media attention.
- Significant financial challenges across the system.

Impact of the risk:

- Patients experience a less-acceptable level of service delivery, which could result in patient harm, poor experience and less favourable outcomes.
- Patients lose confidence in quality of care and services, and this could impact their choice of accessing local services.
- Staff morale is low and psychological safety is impacted.
- Potential reputational damage for SWL if things go wrong for any of our providers.
- The ICB does not meet its statutory and oversight functions.

Residual Impact	Residual Likelihood	Residual Risk Score
3	3	9

Risk Controls

- All risks are identified, assessed, mitigated and monitored by the directorate that could have a potential adverse impact on the quality and safety of services that the ICB commissions from providers.
- The review of ICB's quality governance and assurance process will enable early identification and escalation of system risks and adequate systems and processes to mitigate them. The ICB's Quality Operational Management Group, the System Quality Council, the Place Quality Group meetings and the ICB Quality and Performance Oversight Committee are routes where escalations of quality risks are regularly monitored.
- Providers continue to report and provide assurance through their internal governance routes and via their quality committees on their quality risks and severe risks are escalated to their BAF.
- All SWL providers have successfully transitioned to the Patient Safety Incident Response Framework (PSIRF) and independent providers are on track.
- Regular SWL Chief Nurse meetings are held bi-weekly with the ICB Chief Nursing Officer, where 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, NHSE, and other regulators regarding provider concerns.
- Providers and Local Authorities are in a phase of readiness and preparation towards the new CQC single assessment regulatory framework. SWL LAs have all been peer reviewed for CQC inspections.
- Effective integration with contracts and commissioning teams to embed quality and safeguarding outcomes into provider contracts.

Target Impact	Target Likelihood	Target Risk Score
2	2	4

Action Required

- Recruitment is ongoing into ICB vacancies to ensure delivery of high-profile statutory quality functions.
- Commenced launch of collaborative offer of support to our Trusts to ensure the ICB provides peer support where appropriate as with the UEC and mental health pathways.
- Implementation of the System Learning Review process starting with provider/ Trust visits.
- Implementation of the place-based quality governance framework to standardise reporting and monitoring of statutory quality functions.
- Ongoing development of balance scorecard and triangulation of risks with Performance, Quality, Workforce and Finance for SMT to be sighted on system risks.
- Launch of the SWL Continuous Improvement Network and ongoing implementation of the NHS Impact Actions across the ICS.
- Ongoing implementation of the CNO governance framework
- Continue to complete quality impact assessments when there is significant change to commissioning, planning, care pathways or service redesign.
- Ongoing implementation of the Joint Forward Plan to improve patient safety, experience, effectiveness and outcomes.

Person responsible: June Okochi
To be implemented by: 31st December 2024

NHS South West London
Integrated Care Board

Finance and Planning Committee Update

Agenda item: 10a

Report by: Helen Jameson

Paper type: Information

Date of meeting: 18 September 2024

Date Published: 11 September 2024

Content

Purpose

To provide the Board with an overview of the key issues discussed at the Finance and Planning Committee at its July meeting.

Executive summary

The Finance and Planning Committee has met once since the last update to the ICB Board, on 19 July 2024. The meeting was quorate and chaired by Ruth Bailey. It discussed the following key items:

ICS business

ICS Financial Outturn and Recovery Plan updates

- The Committee received an update on the ICS M3 financial position.
- The Committee discussed the impact of industrial action and the NHSE cyber-attack in South East London which means that the SWL Month 3 year to date position is £5.9m adverse to plan.
- The Committee noted that the capital plan is being refreshed to reflect the reduction in the capital allocation as a result of agreeing a deficit control total.
- The Committee discussed the focus on finding recurrent savings and the peer review taking place on workforce controls.

Operational Plan Delivery

- The Committee noted the continued strong overall performance against the 2024/25 Operational Plan.
- The Committee discussed the continued operational pressures, in particular 12 hour waits in emergency departments and waits for diagnostics in some modalities.

Urgent and emergency winter funds

- The Committee received an update on the dispersal of winter funds for 2024/25 including the process undertaken and the detail of the successful schemes for each SWL Place and at ICS level.
- The Committee agreed the allocation of the non-recurrent funds for Urgent and Emergency Care Winter Schemes as outlined.

ICB Month 3 Finance update

- The ICB Month 3 finance position was presented to the Committee.
- The finance position at the end of June was £0.3m surplus, in line with plan to deliver £3.06m surplus for the full year.

Business cases and contract awards

- The Committee reviewed business cases and contract awards in line with the ICB governance arrangements and responsibilities of the Committee.

Recommendation

The Board is asked to:

- Note the committee report.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
N/A

Corporate objectives
- Delivering the financial plan
- Delivering the ICS operational plan

Risks
None as a result of this paper

Mitigations
None as a result of this paper

Financial/resource implications
None as a result of this paper

Green/Sustainability Implications
None as a result of this paper

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
None as a result of this paper

Patient and public engagement and communication
N/A

Previous committees/groups

Committee name	Date	Outcome
Finance and Planning Committee	19 July 2024	

Final date for approval
N/A

Supporting documents
None

Lead director
Helen Jameson, Chief Finance Officer, SWL ICB

Author
Kath Cawley, Director of Planning, SWL

NHS South West London
Integrated Care Board

SWL NHS Finance Report M4

Agenda item: 10b

Report by: Helen Jameson, CFO

Paper type: information

Date of meeting: Wednesday 18 September 2024

Date Published: Wednesday 11 September 2024

Content

Purpose

This report is brought to the Board to:

1. Provide an update as at month 4 on the ICB financial position against its internal budget.

2. Provide an update as at month 4 on the South West London (SWL) NHS system financial position.

Executive summary

As at month 4 the ICB financial position is a £0.5m surplus with Forecast Outturn (FOT) on plan to deliver a £3.1m surplus. The ICB has no unidentified efficiencies, although £9m of it is non recurrent which will need to be made recurrent for 2025/26.

The SWL NHS ICS year to date position is £7.3m adverse to plan, driven by industrial action impact on costs and lost elective income (£5.4m), additional costs and lost income at St George's Hospital (SGH) resulting from the cyber-attack in South East London (£0.9m) and shortfall in Royal Marsden Hospital (RMH) paediatrics income from NHSE (£1.0m). The FOT is reported in line with plan (£120m deficit) and NHSE reporting requirements, However, within this there are a number of significant risks, including:

- Delivery of the circa £250m efficiency plans, which equates to over circa 5.7% of costs, including a reduction in workforce. To date we are spending more than we have planned on pay costs.
- Impact of any further industrial action and/or critical incidents.
- Inflationary pressures in excess of those assumed in the plans.
- The system continues to face operational pressures in relation to demand for urgent care and mental health services which could lead to increased costs.

- To deliver the efficiency target organisations have committed to delivering a 5% increase in ERF activity.

As a consequence Trusts have been asked to develop plans to mitigate circa £84m of identified risks. These plans are currently worked up to differing levels of completion with varying risk levels across programmes, which includes some that are very high risk. We are currently working to strengthen all schemes to minimise the risk to increase the level of assurance.

To month 4 efficiency delivery was £61.4m, £0.6m adverse to plan. Within this, recurrent efficiency was £7.1m adverse and non-recurrent efficiency was £6.5m favourable. Total Whole Time Equivalents (WTEs) have reduced month on month due to the transfer of services from Hounslow & Richmond Community Healthcare (HRCH) to North West London, but are still above plan. The plan assumed a significant reduction in month 4 from efficiency schemes, which has not been achieved and this remains a significant risk.

Year to date capital spend at month 4 is behind plan by £29.6m overall, in part due to uncertainty in funding following a reduction to the system envelope by NHSE of circa £10m and other national funding sources in Q1. The in-year phasing of IFRS16 leases in the plan is also impacting the year to date position. Forecast spend for the year is expected to remain within allocation, and we are finalising updated plans in light of NHSE's review of capital programmes and the Government's announcement to review the New Hospitals Programme to ensure that the system remains within budget.

Key Issues for the Board to be aware of

- The SWL system is reporting year to date a £7.3m adverse position to plan, largely due to industrial action.
- WTEs are down month on month, due to a transfer of staff, but the plan assumed a greater reduction.
- The SWL system is under the agency cap trajectory.
- There remains significant risk to the delivery of the financial plan and the savings programme included within it
- Capital spend at month 4 is behind plan year to date by £29.6m overall, in part due to uncertainty in funding in the early months of 2024/25. We are finalising updated plans in light of NHSE and Government reviews.

Recommendation

The Board is asked to:

1. Note the ICB month 4 position.
2. Note the ICS revenue month 4 position.
3. Note the ICS capital month 4 position.

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Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
N/A

Corporate objectives
Achieving Financial Sustainability.

Risks
Achieving Financial Plan for 2024/25

Mitigations
- Enhanced grip and control actions have been implemented across SWL NHS organisations.
- Recovery and Sustainability Board management and oversight of financial position.
- Financial Recovery Plan developed.
- Finance and Planning Committee will scrutinise the ICB's financial performance.
- Each SWL NHSE organisation financial governance processes.
- NHS Trust and ICB Chief Executive scrutiny and leadership is focused on financial delivery.
- Measures taken by individual organisations and collectively to identify additional efficiency programmes.

Financial/resource implications
Within the report.

Green/Sustainability Implications
N/A

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

Patient and public engagement and communication
N/A

Previous committees/groups

Committee name	Date	Outcome
SMT	22/08/2024	Noted

Final date for approval
N/A

NHS South West London
Integrated Care Board

Supporting documents
SWL Finance Report M4 2024-25

Lead director
Helen Jameson

Author
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NHS
South West London

SWL NHS Finance Report M4

September 2024

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NHS South West London

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The ICB internal position

ICB financial overview month 4

NHS South West London

Key Messages:

- The ICB position year to date is a £0.5m surplus (in line with plan) with FOT on plan to deliver a £3.1m surplus.
- There are several cost pressures beginning to emerge at month 4 which we are currently forecasting will be mitigated by underspends in other budget lines.
- The efficiency plan is being met although £9m of it is non recurrent which will need to be made recurrent for 25/26. Work continues to identify further recurrent opportunities.
- For mental health we are reporting an adverse YTD position on mental health placements. These are all placements not covered by the risk share with SLP
- CHC and community services are reporting small underspends and we continue to enhance our forecasting processes.
- Primary care is showing a YTD and FOT underspend on prescribing which is mainly related to setting the budget based on the month 8 2023/24 position which was higher than outturn. This underspend is offsetting the delegated primary care overspend .

Targets:

- We are on target to meet our planned surplus of £3.1m.
- Early SLAM data has been used to estimate a system ERF position of 113% which is above the system target set by NHSE but below the average annual system plan to deliver 115%. In order to deliver the system plan for 2024/25 more activity will need to be delivered in future months, a risk compounded by industrial action at the end of June.
- Mental Health Investment Standard has been provided for in the plan and has been added into contract values where applicable.
- Running costs are within target.
- Better payments practice code of paying 95% of invoices within 30 days is being achieved
- At the end of the month cash in the bank was within the 1.25% draw down limit

ICB high level budget reporting month 4

NHS South West London

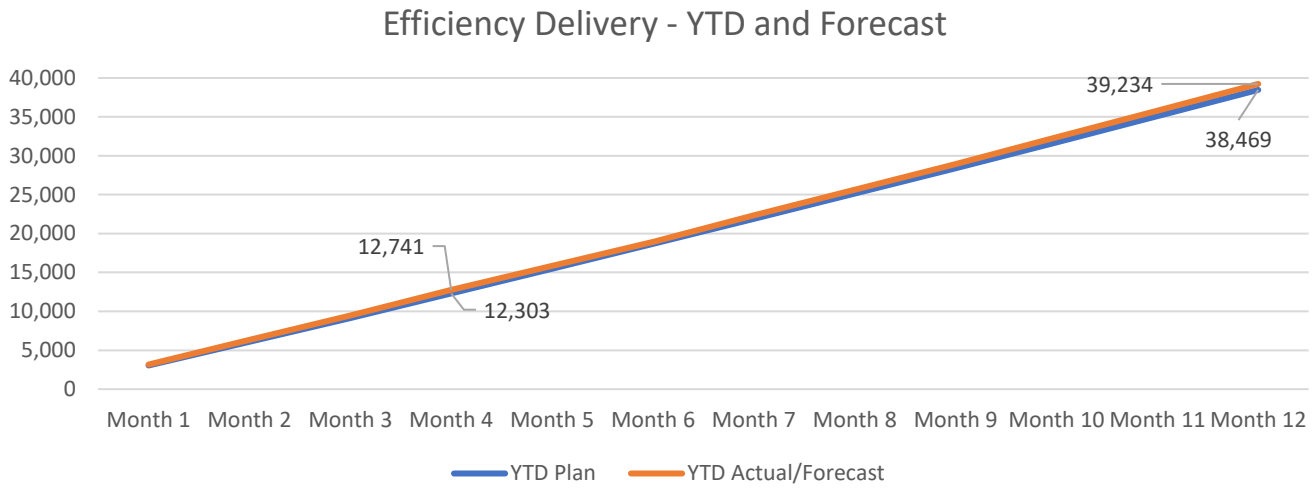
Allocation and Expenditure	Sum of YTD Budget £000s	Sum of YTD Actual £000s	Sum of YTD Variance £000s	Sum of Annual Budget £000s	Sum of Forecast Outturn £000s	Sum of Forecast Variance £000s
Total Allocation (Income)	**£1,108,301**			**£3,401,473**		
Expenditure:						
Acute Services (NHS & non NHS)	£579,362	£579,113	£249	£1,750,885	£1,750,885	£0
Community Health Services	£89,790	£89,401	£389	£269,822	£269,516	£306
All Age Continuing Healthcare	£55,327	£55,055	£273	£165,982	£166,056	-£75
Corporate & Other	£22,610	£21,594	£1,016	£137,776	£137,656	£120
Mental Health	£123,209	£123,813	-£604	£373,665	£374,017	-£352
Primary Care (Incl Prescribing & Delegated)	£237,511	£238,834	-£1,324	£700,284	£700,283	£0
Total Expenditure:	**£1,107,810**	**£1,107,810**	**-£0**	**£3,398,413**	**£3,398,413**	**£0**
Surplus/(Deficit)	**£491**			**£3,060**		

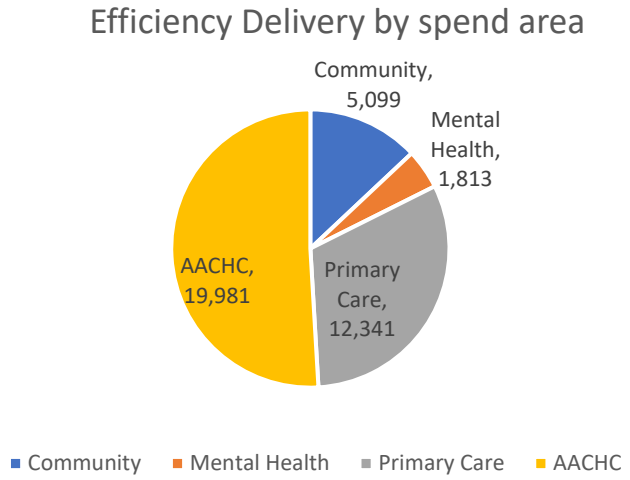
SWL Overview: (favourable/-adverse variance)

- Overall SWL ICB position is on plan to deliver projected surplus of £3.1m, with a YTD surplus of £0.5m.
- Primary care is showing a significant YTD and FOT underspend on prescribing which is mainly related to setting the budget based on the month 8 23/24 position which was higher than outturn. This underspend is offsetting the delegated primary care overspend
- Corporate budgets are YTD underspent by £1.0m generated from a number of vacant posts.
- For mental health we are reporting an adverse YTD position on mental health placements. These are all placements not covered by the risk share with SLP.

Overview of SWL ICB's efficiency plan

South West London





Narrative –

- The efficiency plan is forecast to be achieved.
- £9m of the forecast savings are non-recurrent in nature. Work continues to identify further recurrent opportunities..
- Risks
  - Teams still bedding into new structure and recruiting into vacancies which could impact on delivery and reporting
  - Early stage of the year and lag in receiving timely data means we may not take action as quickly as possible.
- Key priorities for the next month
  - Continue to develop and utilise enhanced reporting for CHC and prescribing.
  - Firm up the position on non-recurrent mitigations to offset recurrent savings that have slipped.

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The SWL NHS system revenue position

SWL NHS system revenue position month 4

NHS South West London

Month 4 Position:

- At M4 SWL system reported a year to date position of £75.6m deficit which is £7.3m adverse to the plan.
- The YTD adverse position driven by:
  - Industrial action impact on costs and lost elective income (£5.4m)
  - Additional costs and lost income at SGH resulting from the cyber-attack in South East London (£0.9m)
  - Shortfall in Royal Marsden paediatrics income from SpecComm (£1.0m)

Key Risks:

Whilst our forecast outturn remains on plan there remains significant risks which will have to be mitigated if we are to achieve our 2024/25 financial plan:

- Delivery of the c.£250m efficiency plans, which equates to over c.5.7% of costs, including a reduction in workforce. To date we are spending more than we have planned on pay costs.
- Impact of any further industrial action and/or critical incidents
- Inflationary pressures in excess of those assumed in our plans.
- The system continues to face operational pressures in relation to demand for urgent care and mental health services which could lead to increased costs.
- To deliver the efficiency target organisations have committed to delivering a 5% increase in ERF activity. At month 3 our acute organisations are behind this target

Month 4	Surplus / (deficit) YTD		
£m	YTD Plan	YTD Actual	YTD Variance
CHS	-7.0	-7.5	-0.4
ESHT	-22.5	-24.1	-1.5
KHT	-9.9	-10.9	-1.0
SGH	-25.4	-28.4	-3.0
HRCH	-1.0	-1.0	-0.0
SWL StG	-0.3	-0.3	0.0
RMH	-2.6	-4.0	-1.4
Trusts Total	**-68.7**	**-76.1**	**-7.3**
SWL ICB	0.5	0.5	-0.0
SWL System	**-68.2**	**-75.6**	**-7.3**

SWL NHS system mitigation plan

NHS South West London

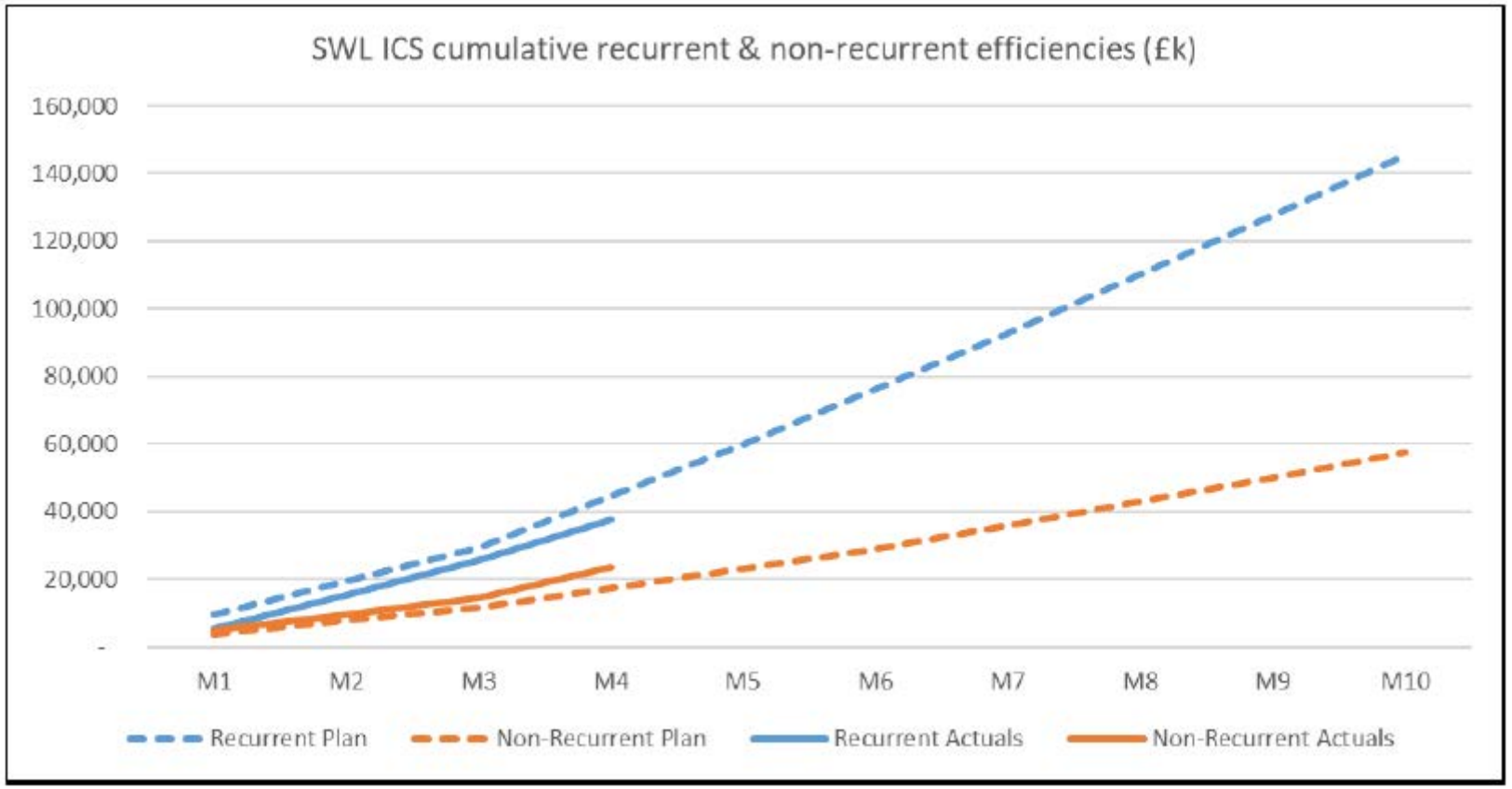
M4 mitigation of risk and run-rate pressures

- At month 4 NHSE have requested that ICSs develop actions to mitigate risk and any run-rate pressures that exist. In SWL we have worked across the system to produce in-year mitigation action plans to submit to NHSE and help us to minimise the risks we face.
- The M4 mitigation plans have been developed at an organisational level and shared across SWL to ensure all opportunities have been exhausted at each organisation as well as to ensure consistency of approach.
- The actions will be reviewed and monitored alongside on a monthly basis.
- The mitigations fall into four categories.
    1. **Stopping future spend**
    2. **Reducing pay spend**
    3. **Reducing non-pay spend**
    4. **Operational performance mitigations – increases in ERF, productivity and going further faster**
    5. **Income and technical**
- **Currently to meet our 2024/25 financial plan we have:**
    - **£84m identified mitigation actions**.
        - The mitigation plans are worked up to differing levels of completion with varying risk levels across programmes; this includes some that are very high risk. We are currently working to strengthen all schemes to minimise the risk to increase the level of assurance.
        - **£9.4m unidentified mitigations** (driven by, Industrial Action, cyber and paediatric income at RMH.)

SWL NHS system efficiency

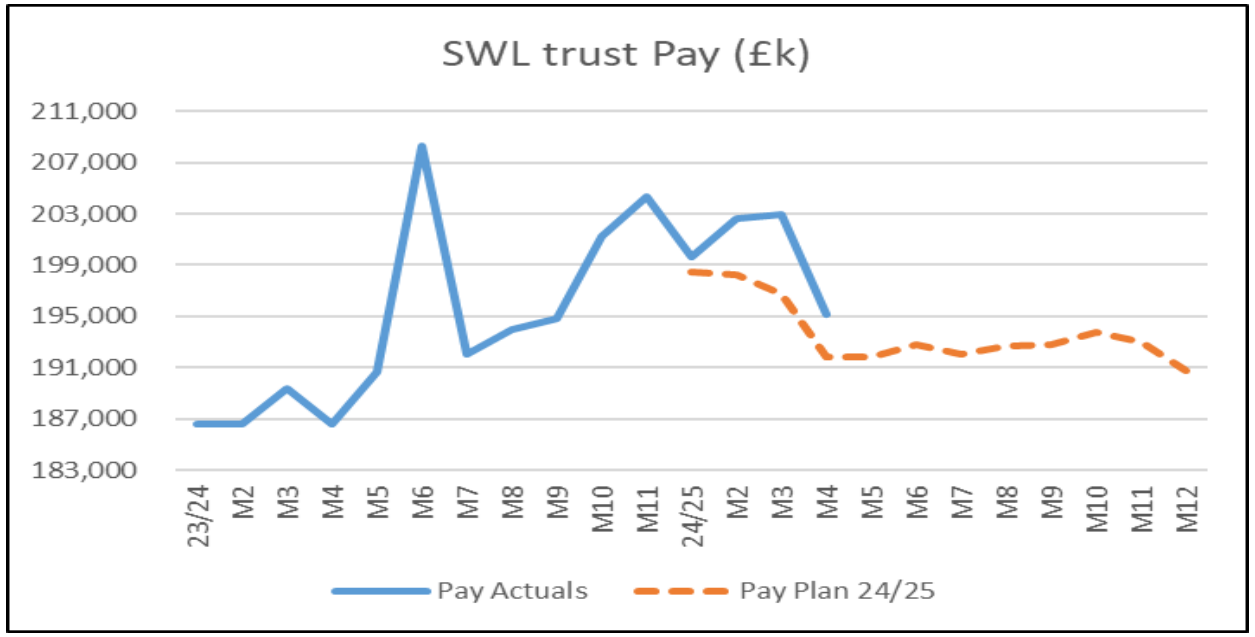
NHS South West London

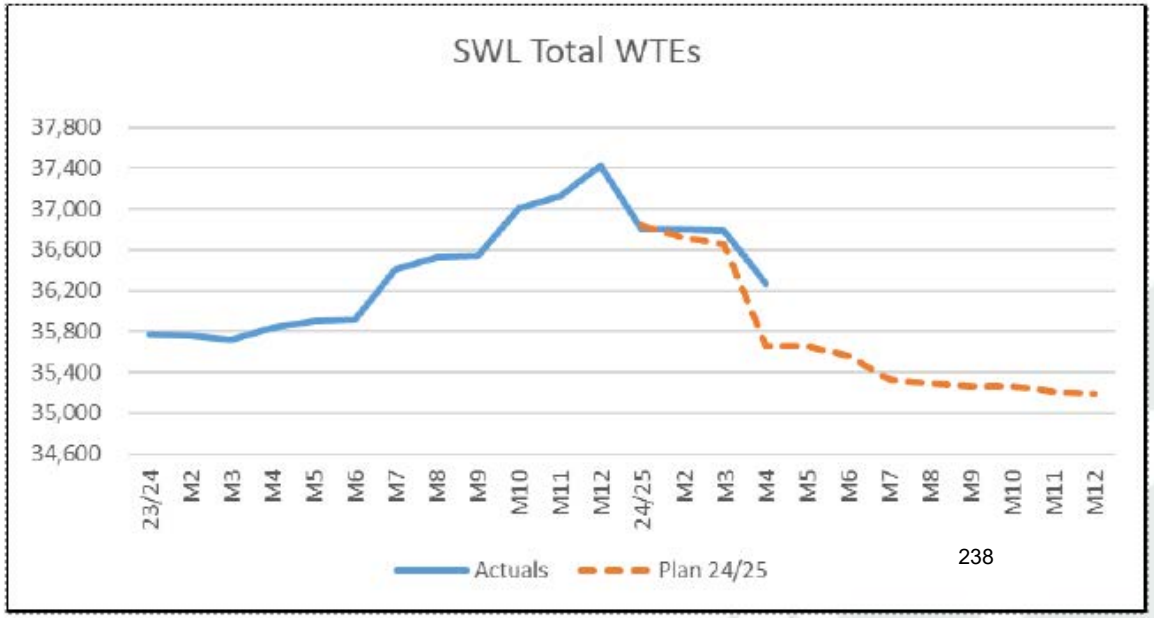
- The total system efficiency plan for the year is £256.4m, of which £77.4m (30%) is anticipated to be non-recurrent.
- To M4 efficiency delivery was £61.4m, £0.6m adverse to plan. Within this, recurrent efficiency was £7.1m adverse and non-recurrent efficiency was £6.5m favourable.



SWL NHS system workforce

- The charts shows cost and whole time equivalent (WTE) actual trajectories against plan for total trust staff (substantive, bank and agency).
- Overall system pay costs are year to date £10.6m adverse to plan, predominantly due to bank costs. A significant part of the agency reduction plan this year was moving shifts to bank. In addition, there were sizeable bank overspends due to medical cover during the junior doctor strike in months 3 and 4.
- Total WTEs have reduced month on month due to the transfer of services from HRCH to North West London, but are still above plan. The plan assumed a significant reduction in month 4 from efficiency schemes, which have not been met. This is a driver of the recurrent efficiency variance outlined on the prior slide.

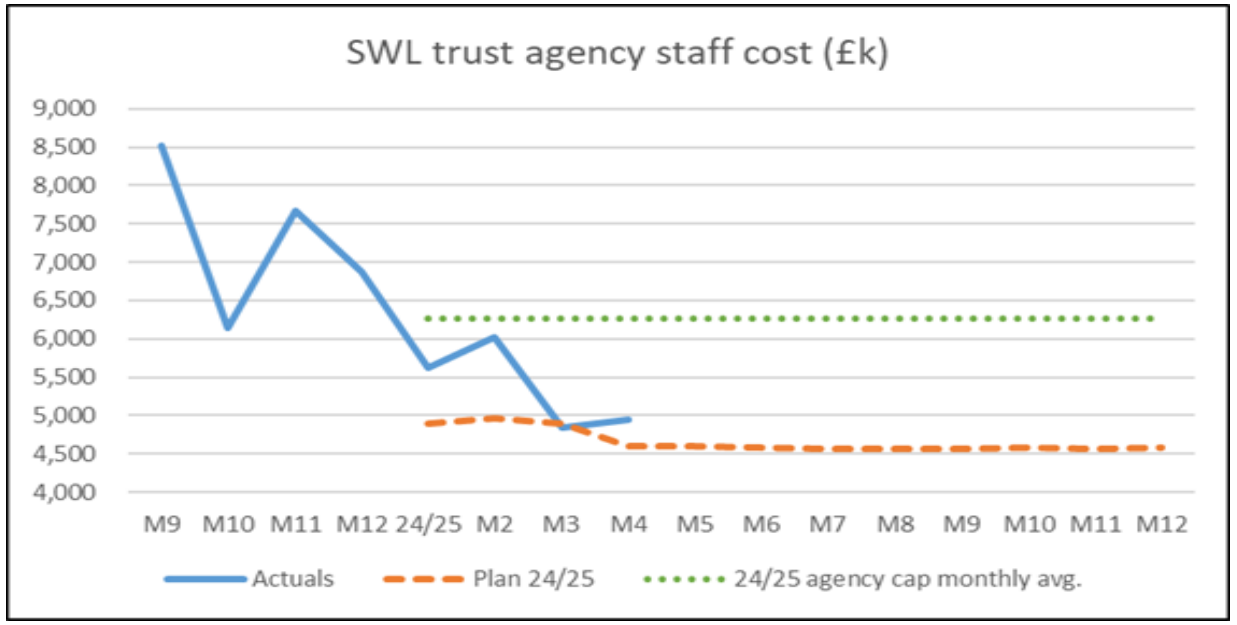


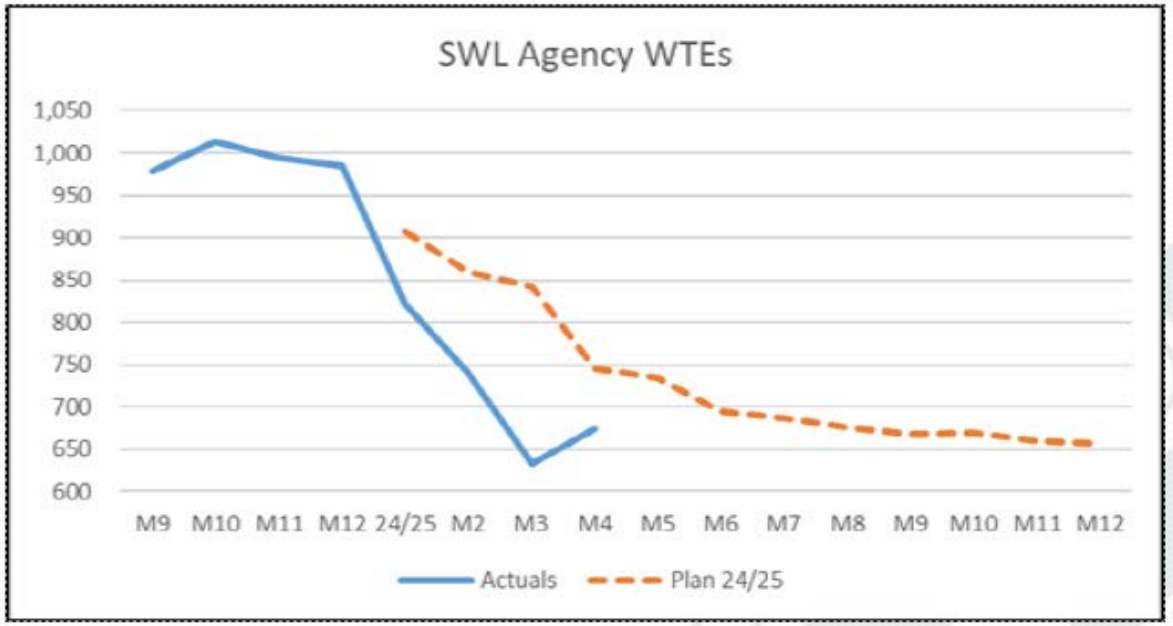


SWL NHS system workforce - agency

NHS South West London

- Agency costs are higher than plan year to date by £2.1m (11%) but within the agency cap set by NHSE. Costs increased slightly month on month, after a sharp fall in Q1.
- The plan spend has been set below the system agency cap. Although costs are currently above the plan, they remain below the cap and have fallen markedly since 2023/24.
- Agency costs are adverse at all Trusts except SGH and RMH YTD, however, are close to the challenging plan trajectory set.
- Agency WTEs are up month on month after a sharp fall. Review of cost per WTE indicates that there remains some low volume, high cost non-clinical agency.





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The SWL system capital position at month 4

SWL NHS System draft Capital Position

NHS South West London

- Year to date spend at M4 is behind plan by £29.6m overall, in part due to uncertainty in funding following a reduction to the system envelope by NHSE of c.£10m and other national funding sources in Q1. The in-year phasing of IFRS16 leases in the plan is also impacting the YTD position.
- We are finalising updated plans in light of NHSE's review of capital programmes and the Government's announcement to review the New Hospitals Programme.
- Trust forecast outturn reported to NHSE is a £23.5m overspend, however the position is in line with envelope as the SWLSG plan includes asset sales that generate CDEL credits to offset expenditure and these cannot be recognised in the forecast until transacted. A £23.5m overspend in SWLSG will be reported until the sales are transacted in the autumn.

	SWL CDEL			IFRS16 CDEL			National CDEL			Total CDEL		
Month 4	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance
CHS	1.1	2.0	0.8	0.0	0.0	0.0	1.3	0.2	-1.1	2.5	2.2	-0.3
ESHT	6.0	1.8	-4.2	0.0	0.0	0.0	5.3	3.8	-1.6	11.3	5.5	-5.7
KHT	4.4	3.6	-0.8	0.0	0.0	0.0	3.2	0.0	-3.2	7.6	3.6	-4.0
SGH	6.2	3.6	-2.6	2.9	0.6	-2.3	5.5	0.7	-4.8	14.6	4.9	-9.7
HRCH	0.6	0.2	-0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.2	-0.4
SWL StG	9.4	8.8	-0.6	4.3	0.0	-4.3	2.6	2.6	0.0	16.3	11.4	-4.9
RMH	4.6	4.4	-0.2	3.3	0.0	-3.3	1.1	0.0	-1.1	9.1	4.4	-4.6
Trust total	**32.3**	**24.4**	**-7.9**	**10.5**	**0.6**	**-9.9**	**19.0**	**7.3**	**-11.8**	**61.8**	**32.2**	**-29.6**
ICB	0.3	0.2	-0.1	0.0	4.5	4.5	0.0	0.0	0.0	0.3	4.7	4.4
SWL System	**32.6**	**24.6**	**-8.0**	**10.5**	**5.1**	**-5.4**	**19.0**	**7.3**	**-11.8**	**62.1**	**36.9**	**-25.2**

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Summary

Summary of financial position

NHS South West London

- The Board is asked to:
  - Note the ICB financial position for M4 2024/25
  - Note the ICS revenue position for M4 2024/25
  - Note the ICS unaudited capital position for M4 2024/25

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

NHS South West London
Integrated Care Board

Quality & Performance Oversight Committee Update

Agenda item: 10c

Report presented by: Mercy Jeyasingham, Non-Executive Member & Chair of the Quality & Performance Oversight Committee

Paper type: For information

Date of meeting: Wednesday, 18 September 2024

Date Published: Wednesday,11 September 2024

Purpose

To provide the Board with an overview from the Non Executive Member Chair of the Committee regarding the key quality matters discussed at the South West London (SWL) ICB Quality and Performance Oversight Committee meeting on 14 August 2024.

Executive Summary

The Quality and Performance Oversight Committee has met once since the last update to the ICB Board, on 17 July 2024.

The updates below are following consideration and discussion of key items at the meeting:

Quality and Performance Risk Register

The Committee reviewed the Quality and Performance risk register noting a new risk which has been added to the risk register (Risk 196 'Failure to identify children and young people's needs in a timely way and subsequent impact on access to appropriate intervention'). It was also agreed that the Cyber Security Risk and Estates Risk would be reviewed and updated to ensure the risk to patient safety in the event of cyber-attack and the impact on waiting times relates to estates was reflected.

South West London (SWL) ICB Performance Report

The Committee noted the SWL ICB Performance report. The following key areas of challenged performance were discussed:

- **Long waiting patients** - SWL continues to have the fewest long waiting patients in London, however, the ICB is above its trajectory for May with 216 patients waiting over 65 weeks against a trajectory of 108 in May and 21 patients waiting over 78 weeks against a zero target.
- **12-hour A&E breaches** in June saw a reduction of 458 from the previous month yet remain the highest in London and third highest nationally.
- SWL report 142 **mental health 12-hour breaches** in June a significant increase from the previous month.

The following areas were identified as areas of improvement:

- **A&E 4-hour performance** improved significantly to 77.2% in June, exceeding the NHSE target of 76%.

- **Discharges of people not meeting the Criteria to Reside (CTR)** for SWL improved to 48% in June an improvement on the 44% in May, putting the system third of five in London.
- **111 calls** abandoned reduced to 2.6% in June, achieving the 3% target for the first time in more than 2 years.
- Less than **6 week waits for diagnostics** improved by 2% on the previous month in May reaching 87.3%, SWL performance being second highest out of the five ICBs in London.

Urgent and Emergency Care
An early overview of South West London performance was presented to the Committee, noting that this was following an ask from NHS England asking NHS Boards to assure themselves that they are working with system partners to deliver the ambition of the national Urgent and Emergency Care (UEC) Recovery Plan with specific questions around leadership, quality, 7 day services, delivering the UEC Recovery Plan and flow. There was no requirement to report back to NHSE. In response to the ask the SWL UEC Board created a template which was sent to each Trust for completion. In addition, the Trusts were asked to respond to the UEC Recovery Plan Operating Guidance. All acute Trusts and SWL and St George's (SWLSTG) responded within the given timeline.

Following discussion, the Committee agreed that the report in its current format did not provide the evidence to assure the Committee that the draft report comprehensively described the assurances in place, the ongoing pressure on UEC pathways and the system working to support the recovery of UEC. It was agreed that the report would be reviewed and updated for presentation to the ICB Board on 18 September. The Committee noted the report and next steps.

Gynaecology elective recovery
The Committee noted an update of the progress made in reducing the gynaecology waiting list size this past year, noting the following key points:

- Nationally, two-week waits have increased from 16% pre-pandemic to 44% by 2023.
- Growth in SWL has been driven by Epsom & St Helier University Hospitals NHS Trust (ESHT), who report that inappropriate 2 week wait referrals was one of their biggest issues.
- All Trusts used additional capacity to tackle demand, successfully driving down their collective Patient Tracking Lists (PTLs) by 10% in the past year.
- ESHT reduced their PTL size by 16%, however, their 52 week waits have grown to circa 360 patients which illustrates clinical prioritisation with 2 week waits and urgent demand taking priority over routine patients, whose wait times increase.
- The increased capacity is only a short-term solution, given the financial challenge while the SWL gynaecology clinical network works with primary and secondary care and the ICB on the longer-term strategy to ensure the sustainability of high-quality gynaecology services.
- SWL are developing and progressing some pilots for women's health hubs and expect to have one in place by the end of December.

SWL ICB Quality Report

The Committee received the SWL ICB quality report noting the following key updates:

- Continued pressures across all Emergency Departments (EDs) and UEC services.
- 72 hours waits in the ED for children and adults awaiting a mental health bed is increasing month on month.
- Ambulance hours lost to delayed hospital handover delays over 15 minutes in May, was 2717 hours, compared to 2635 in April.

- SWL Quality Team Review Visit commissioned by the ICB Chief Nursing Officer (CNO)/St George's, Epsom and St Helier Hospital (GESH) Group CNO following an incident in ED at St Georges, was undertaken in July. Report findings will be provided at the next Quality & Performance Oversight Committee meeting.
- Never Events: Recent increase in Never Events at Kingston Hospital NHS Foundation Trust (KHFT).
- Kingston Hospital's paediatric audiology service has successfully retained its Improving Quality in Physiological Services (IQIPS) accreditation, Kingston Hospital and Hounslow and Richmond Community Healthcare (HRCH) are the only paediatric audiology services with this accreditation in SWL.
- A Joint Targeted Review in Richmond was undertaken in July, once finalised the report will come back to a future Quality & Performance Oversight Committee meeting.

Continuing Healthcare (CHC)
A detailed report on CHC was presented to the Committee noting the following key points:

- A significant improvement in finance and performance measures over the last 18 months and a continued focus on workforce as the service transitions to new ways of working.
- For 28-day performance, both Kingston and Richmond are responsible for the largest number of delays and for over 12–week performance in SWL, Wandsworth has the greatest opportunity for improvement.
- The need to continue engagement of interim clinical staff as a substantive team builds steadily.

The Committee noted the report and supported the engagement of interim clinical staff.

South West London ICB Prevention of Future Deaths (PFD) briefing
The paper was presented to provide the Committee with:

- A summary of PfD's that have been issued to the ICB and progress of actions.
- High level summary of most recent PfDs issued to SWL organisations.
- Proposed next steps for ICB to support increase in PfD and establishment of process to support consistent management of PfD's in the ICB, across SWL and share learning.

South West London Mortality Deep dive (insights, themes and learning)
A deep dive on SWL's mortality data was presented noting the following areas of good progress and improvement:

<u>Areas of good progress</u>

- Mortality review process, identification of themes, learning and improvement across SWL organisations.
- Establishment of an effective process and governance for statutory requirements.
- End of Life Care (EOLC) patient care.
- This report will be presented to NHSE in September – as the work had already started in SWL the ICB will report first.
- Medical examiner process with bereaved families has been positive with recognition that families have reassurance that an independent medical professional has reviewed the death.

Areas for Improvement

- Croydon has an elevated number of deaths compared to other boroughs in SWL to the significant level of deprivation and CORE20PLUS in Croydon Place.
- Across SWL population there is a noticeable number of deaths at 0 years old, representing neonatal and infant deaths, this correlates with the top themes from the child deaths review.
- ESTH has had an elevated level of mortality for two years and the Trusts reports this is due to coding issues. This remains an area of risk.
- Data and reporting variation to be resolved to enable consistent and effective benchmarking

As a next step it is proposed to establish a SWL System Mortality Insights, Learning and Improvement Group reporting to the Quality Operation Management Group (QOMG) and the Quality & Performance Oversight Committee. The Committee agreed.

Quality and Performance Workplan 2024/25
The Committee reviewed the workplan for 2024/25.

Recommendation

The Board is asked to:

- Note the Quality and Performance Oversight Committee report.

Governance and Supporting Documentation

Conflicts of interest
None.

Corporate objectives
Quality is underpinned by everything we do in SWL ICB. Quality supports the ICB's objectives to tackle health inequalities, improve population health outcomes and improve productivity.

Risks
Quality risks are included in the SWL ICB Corporate risk register and escalated to the Board Assurance Framework where appropriate.

Mitigations
The mitigations of the quality risk are included in the corporate risk register.

Financial/resource implications
Balancing system efficiency across SWL without compromising patient safety and quality.

Green/Sustainability Implications
Not Applicable.

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
An EIA has been considered and is not needed for this report. However, EIAs are being completed as part of the process in identifying system efficiency.

Patient and public engagement and communication
We work closely with Quality and Safety Patient Partners, patients and public including specific impacted communities linking with our Voluntary Care Sector the voices of our population and using this insight to improve organisations to ensure we are listening to quality.

Previous committees/groups

Committee name	Date	Outcome
SWL Quality & Performance Committee (QPOC)	14 August 2024	Noted

Final date for approval
Not applicable

Supporting documents
None

NHS South West London
Integrated Care Board

Lead Director
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NHS South West London
Integrated Care Board

Quality Report

Agenda item: Item 10d

Report by: Elaine Clancy, SWL ICB Chief Nursing Officer

Paper type: For information

Date of meeting: 18 September 2024

Date Published: 11 September 2024

Content

Purpose

The purpose of the report is to:

- To provide the Board with an overview of the system quality picture across South West London (SWL), highlighting key risks identified at the SWL ICB's Quality and Performance Oversight Committee held in August 2024.
- To provide the Board with assurance that mitigations are in place to manage risks that impact patient care, and that the system continues to make improvements to improve safety and quality through an increased learning culture.

Executive summary

The report provides an overview of the quality of services within the SWL Integrated Care System. The focus of the report is to provide the ICB Board with an update of emerging risks and mitigations, provide an outline of where continuous improvements have been made and provide assurance that quality risks and challenges are being addressed appropriately. The report covers the period of April - June 2024 (unless stated otherwise).

Key Issues for the ICB board to be aware of

- **Urgent and Emergency Care:** Continued pressures across all Emergency Departments (EDs) and Urgent and Emergency Care (UEC) services. Impact of patient safety and poor patient experience remains a risk for the system.
- **Mental Health in Emergency Department:** Length of stay (LoS), and 72-hour breaches in the ED for children and adults awaiting a mental health bed is increasing month per month.

- **ED Handover Delays:** Ambulance hours lost to delayed hospital handover delays over 15 minutes in May, was 2717 hours, vs 2635 in April.
- **St George's Hospital (SGH) ED quality review visit:** SGH ED quality review visit: A Quality Review Visit jointly commissioned by the ICB Chief Nursing Officer (CNO) and St Georges, Epsom & St Helier (GESH) Group CNO following an incident in ED at St George's Hospital, was undertaken in July. Report findings will be provided at the next Quality and Performance Oversight Committee meeting.
- **Prevention of Future Deaths (PfD)/Regulation 28:** Increased PfD actions being issued across SWL and London region following Coroners Inquests.
- **Friends and Family Test (FFT) performance low:** Decrease in rates of patients recommending SWL ED and inpatient services to family and friends as a result of pressures and long waits on ED.
- **Never events:** Recent spike in Never Events at Kingston Hospital. The Trust has commissioned some external support to undertake a review for improvement.

Recommendations

The Board is asked to:

- Note the content of the quality report and be assured that risks are being managed through the appropriate governance and escalation arrangements between providers and the ICB.
- Safety and quality in EDs across SWL remain a focus following the letter issued in June by NHS England re safety in pressurised services.
- Be assured that the exceptions highlighted within the report have been presented and discussed at the Quality and Performance Oversight Committee in August and a deep dive into Mortality, Prevention of future deaths and All Age Continuing Health Care were also provided to assure the committee of the ICB's collaborative work with providers to make improvements.
- Be assured that system risks continue to be identified, mitigated and monitored as part of the ICB's risk management process and risks are escalated to the Board Assurance Framework where appropriate.

Governance and Supporting Documentation

Conflicts of interest
None

Corporate objectives
Quality is underpinned by everything we do in SWL ICB. Quality supports the ICB's objectives to tackle health inequalities, improve population health outcomes and improve productivity.

Risks
Quality risks are included in the SWL ICB Corporate risk register and escalated to the Board Assurance Framework where appropriate.

Mitigations
The mitigations of the quality risk are included in the corporate risk register.

Financial/resource implications

- Balancing system efficiency across SWL without compromising patient safety and quality.

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
An EIA has been considered and is not needed for this report. However, EIAs are being completed as part of the process in identifying system efficiencies and where significant change is service delivery or care pathways impact patients and staff.

Patient and public engagement and communication
We work closely with Quality and Safety 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

Committee name	Date	Outcome
SWL ICB System Quality Council	9 July 2024	Providers escalation report presented and noted.
SWL ICB Quality Operational Management Group (QOMG)	15 July 2024	Internal directorate review and assurance
SWL ICB Quality and Performance Oversight Committee (QPOC)	15 August 2024	Quality Oversight

SWL ICB Senior Management Team (SMT)	15August 2024	Internal ICB review

Supporting documents
Quality Report

Lead director
Elaine Clancy, Chief Nursing Officer

Authors
June Okochi, Director of Quality
Charity Mutiti, Deputy Director of Quality

SWL System Quality Report
SWL ICB Board Meeting, September 2024

Introduction

This exception report provides an overview of the quality of services within the South West London's (SWL) Integrated Care System (ICS). The purpose of the report is to provide the Board with an update of emerging quality risks impacting the delivery of high-quality care with a specific focus on safety in emergency departments (ED), an outline of where continuous improvements has been made and assurance that risks and challenges are being mitigated. The report covers the period of April to June 2024 (unless stated otherwise).

Executive Summary

Key quality focus areas include:

- **Urgent and Emergency Care:** Continued pressures across all EDs and Urgent and Emergency Care (UEC) services. Impact of patient safety and poor patient experience remains a risk for the system.
- **Mental Health in Emergency Department:** Length of stay (LoS), and 72-hour breaches in the ED for children and adults awaiting a mental health bed is increasing month per month.
- **ED Handover Delays:** Ambulance hours lost to delayed hospital handover delays over 15 minutes in May, was 2717 hours, vs 2635 in April.
- **St George's Hospital (SGH) ED quality review visit:** A Quality Review Visit commissioned by the ICB Chief Nursing Officer (CNO)/St Georges and Epsom & St Helier (GESH) Group CNO following an incident in ED at St George's Hospital, was undertaken in July. Report findings will be provided at the next Quality and Performance Oversight Committee (QPOC) meeting.
- **Prevention of Future Deaths (PfD)/ Regulation 28:** Increased PfD actions being issued across SWL and London region following Coroners Inquests.
- **Friends and Family Test (FFT) performance low:** Decrease in rates of patients recommending SWL ED and inpatient services to family and friends because of department pressures and long waits in ED.
- **Never events:** Recent spike in Never Events at Kingston Hospital. The Trust has commissioned external support to undertake review for improvement.

Key quality improvement areas:

- **Martha's Rule**: Royal Marsden Hospital and Kingston Hospital are SWL's national pilot sites for Martha's Rule.
- **Children's audiology service maintains quality accreditation** Kingston Hospital's paediatric audiology service has successfully retained its Improving Quality in Physiological Services (IQIPS) accreditation.
- **Infections:** No Methicillin-resistant Staphylococcus aureus (MRSA) infections in 2023/24 across SWL
- **Cancer:** Croydon Health Services (CHS) remains compliant with the 31-day Cancer standards and have significantly improved in the Referral to Treatment (RTT) long waiters with less than 5 patients waiting over 78+ weeks.
- **Right Care Right Person (RCRP):** Incidents of violence and aggression linked to right care right person are reported by Trusts to have reduced.
- **Workforce:** Staff turnover rates across Trusts generally improved.
- **Same Day Emergency Care (SDEC)**: 296 conveyances across the SWL hospitals between March – May 2024. The 'Trusted assessor' model (TAM) is operating at all SW ED SDEC's; and SW is the only LAS sector / ICB in London to have TAM in place

across all sites. St Georges, St Helier and Kingston have all seen improvements in numbers since moving to TAM. 111 SDEC conveyances in May, which is the highest recorded; with referrals / conveyances having more than doubled over the last 12 months, reflecting the ongoing work to raise and maintain awareness. SW sector / ICB is seen as an exemplar across London.

The report outlines the key focus areas of the quality domains below:

1. Safety

1.1. First Phase of Martha's Rule

In response to the case of Martha Mills and other cases related to the management of patient deterioration, the Secretary of State for Health and Social Care and NHS England committed to implement Martha's Rule to ensure concerns of patients and those who know them best are listened to and acted upon.

Kingston University Hospital and the Royal Marsden Hospitals were successful and selected to be one of the first sites implementing Martha's Rule this year.

Being part of this first phase will support NHS England to devise and agree a standardised approach to all three elements of Martha's Rule, ahead of scaling up to further sites in England in the following years.

In Kingston, this supports the work of the Critical Care Outreach team to relaunch Kingston Hospital's Call 4 Concern (C4C) service which is in place for all adult inpatient wards within the hospital and is now being extended to maternity and paediatric services.

1.2. Safety in Emergency Department

Following the Channel 4 Dispatches documentary, filmed in the Emergency Department at Royal Shrewsbury Hospital highlighting the significant pressures in the department and the impact on safety and quality, a letter was sent on 26 June to CEOs, CNOs, Chief Medical Officers (CMOs) of provider, ICB and ICP Boards regarding **maintaining focus and oversight on quality of care and experience in pressurised services.**

The letter asks Boards across the NHS to assure themselves that they are working with system partners on six actions:

1) their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter
2) basic standards of care, based on the Care Quality Commission's (CQC's) fundamental standards, are in place in all care settings
3) services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund
4) executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance
5) there is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both Trust and system level
6) regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time, and these are relayed back to the Board
7) in addition, wherever a patient is receiving care, there are fundamental standards of quality which must be adhered to. Corridor care, or care outside of a normal cubical environment, must not be considered the norm – it should only be in periods of escalation and with Board level oversight at Trust and system level, based on an assessment of and joined up approach to managing risk to patients across the system

(through the Operational Pressures Escalation Levels (OPEL) framework). Where it is deemed a necessity – whether in ED, acute wards or other care environments - it must be provided in the safest and most effective manner possible, for the shortest period of time possible, with patient dignity and respect being maintained throughout and clarity for all staff on how to escalate concerns on patient and staff wellbeing.

Our Trusts are working to provide assurance to the UEC Board with response to these actions and a submission is required to the ICB on 10 August and will be presented on 17 August at the SWL UEC Board.

The ICB CNO and her directorate are providing support to the Trusts in several ways. One of which was a planned quality review visit jointly commissioned by the ICB CNO and the Group CNO of St George's and Epsom and St Helier Hospitals to the ED at SGH in July to identify safety standards, review quality of care with a focus on mental health, flow, Infection, Prevention and Control (IPC) and deterioration. The review team met with staff across the department, walked the pathway and collated patient feedback. The outputs of this report will be provided to the next QPOC meeting.

1.3. Mental Health Length of Stay (LoS) in the Emergency Department

LoS for children and adults awaiting a mental health bed across our EDs are increasing month per month. The longest stay in the emergency department in June was reported to be an average of 12 days and was a paediatric case, this patient was admitted to a SWLStG inpatient bed.

These long stays in ED cause delays to treatment and are negatively impacting on patients' recovery journey. The EDs are crowded, loud and busy with no access to safe outdoor space and natural light, providing a non-therapeutic environment for those in mental health crisis. This perpetuates the incidents of violence and aggression towards staff and others. The current waits for mental health beds are a continued challenge to safely managing these very unwell patients on acute inpatient wards. At SGH, the longest patient awaiting an inpatient mental health bed has been waiting for three months.

Due to the increase in LoS across medical wards, patients detained under the Mental Health Act Section 2 awaiting transfer are seeing their Sections lapse before they have been assessed and treated. Tribunals and detentions under Section 3 while in an acute hospital setting are increasing while resource to actively treat patients with mental health needs are not increasing.

Provider safety mitigations in ED

1.4. **SGH ED** - A working group has been set up to help improve patient safety and quality within the ED after the two serious falls occurred in February 2024 resulting in patient deaths. An action plan has been devised and is regularly reviewed. This is monitored by the Site Chief Nurse and feeds into the Urgent Emergency Recovery meeting chaired by the Trust Managing Director.

1.5. **SGH Mental Health champions in paediatrics' ED:** Champions have been recruited and trained and are embedded into the Children and Young People (CYP) ED and Frederick Hewitt Ward. These champions are working well with patients and staff to support children and young people who have the greatest needs.

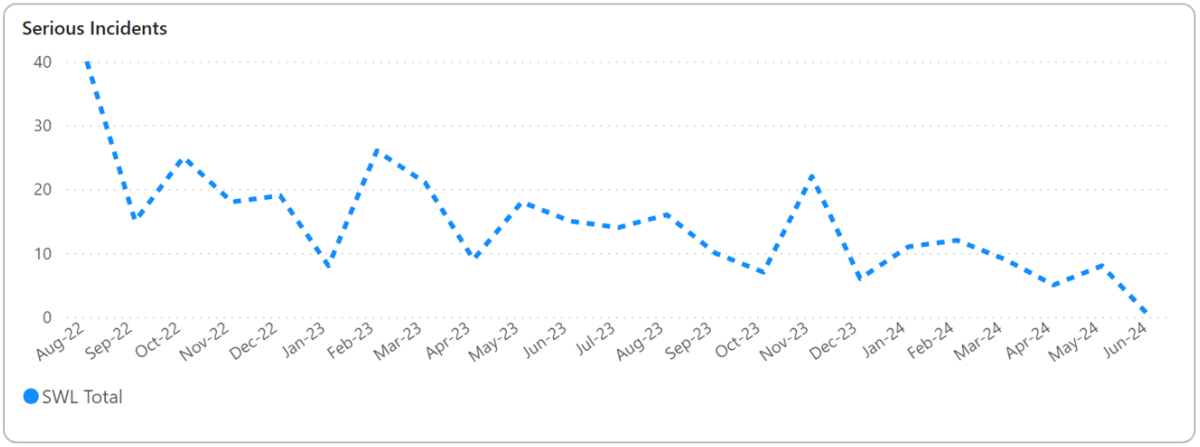
1.6. **Mental Health team in the ED at SGH:** Psychiatric Liaison Team (PLT) have feedback that there has been an improvement in information sharing. They have been able to discharge patients sooner due to support from the new team who have provided information to them regarding patient's presentation. The team has also been able to engage patients in discharge planning, by building relationships and discussing safety planning. This has been done in collaboration with PLT and is a marked quality improvement.

1.7. **Incidents of violence and aggression in EDs:** In July, some SWL providers reported that incidents in ED, linked to Right Care Right Person, are reducing since the commencement of joint meetings with the Metropolitan Police and the Mental Health teams. Sharing information between services has allowed for collaborative working and has reduced risk towards staff. The meetings will continue monthly.

1.8. **Croydon's External Review in ED:** CHS commissioned an external review into the nursing standards of care at the ED. The focus was on the CQC ED fundamental standards of care to ensure the Trust is complaint with minimum care standards. The report is currently going through the Trust governance and recommendations for improvement are being agreed.

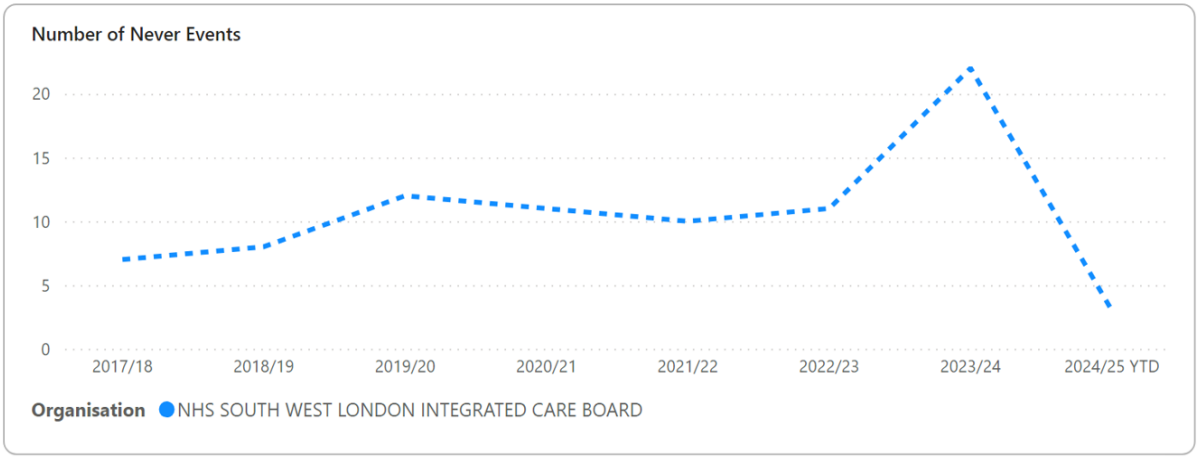
1.9. **Safety Incidents:** As all providers have fully transitioned into (patient Safety Incident response framework (PSIRF), the numbers of Serious Incidents will drop after June 2024 and will no longer be reported. St George's Hospital (SGH) and Epsom and St Helier Hospital (ESTH) were late in transitioning but are fully transitioned now. The ICB will start reporting relevant detail on the various learning responses such as Patient Safety Incident Investigations (PSII's).

A full picture of PSII's will be provided at the QPOC meeting in October.



Graph 1: SWL Serious incidents

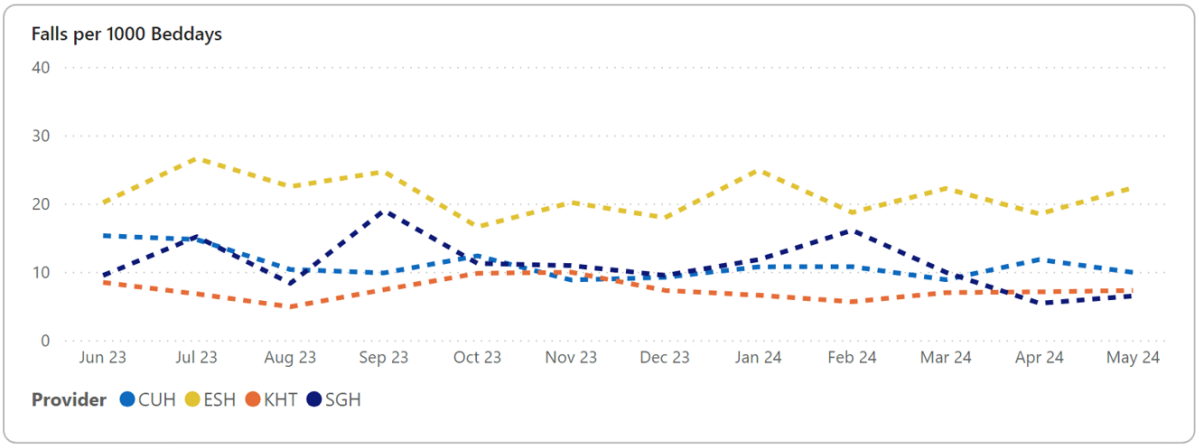
1.10. **Never events (NEs):** SWL providers have reported four never events in May and none in June. This brings the total for SWL for 2024/ 25 to five never events. The NE reported in May were 2x wrong site surgery, 1x retained foreign object and 1x wrong implant/ prosthesis. The table below shows the current NE trend for SWL over the last eight years.



Graph 2: SWL Never Events

Following six never events reported in the eye unit service over the last 11 months, the Trust has also commissioned an independent review to support the learning and improvement actions. The ICB quality team is supporting the Trust in the review process and the PSIIs.

1.11. **Hospital Falls:** ESTH has seen an increase in falls in hospital. There were a total of 91 falls reported within the Acute Services in May 2024, this equates to 4.4 falls per 1,000 Occupied Bed Days (OBDs). Unwitnessed falls for the Acute Services in May was 70% - however, this remains lower than June 2023 data which is in keeping with the longest period of decline.



Graph 3: SWL Falls per 1000 bed days

1.12. Infection and Prevention Control

Norovirus: Outbreaks and clusters of norovirus and acute respiratory infections including Covid-19 and para influenza in acute and social care settings continue to be reported. Norovirus and Covid have caused outbreaks and bed/ bay closures in acute hospitals. A variant of Covid-19 is once again on the rise with the expectation of a summer surge.

Invasive Group A *Streptococcus* (IGAS): In July, an increase in cases of Group A streptococcus was being reported in patients admitted to Kingston Hospital. In addition, there had been a cluster of cases reported at a Kingston nursing home. An IMT group was set up and swabbing and chemoprophylaxis for staff and residents has occurred.

Measles: High levels of measles continue to be seen in London. Wandsworth continues to report the highest number of confirmed cases in London with 26 cases between June and July. The whole of London has now been moved into a category 3 response which means follow up of contacts is restricted to the vulnerable i.e. <1 years, pregnant people, immune-suppressed and healthcare workers.

Pertussis (whooping cough) London has experienced a rise whooping cough cases since January 2024, with a very large increase in March, April and May. Richmond has seen the highest number of cases in London since 1 January, but Kingston now has the highest number of confirmed cases since June. The ICB is currently seeing cases in all of SW London boroughs. UK Health Security Agency (UKHSA) declared a National Standard Incident for Pertussis on 13 May 2024 and convened a national IMT to coordinate the national system response.

2. Quality

2.1. **Prevention of Future deaths** (PFD): The ICB has received a Prevention of Future Deaths notification (PFD) in June with concerns related to shortage of mental health

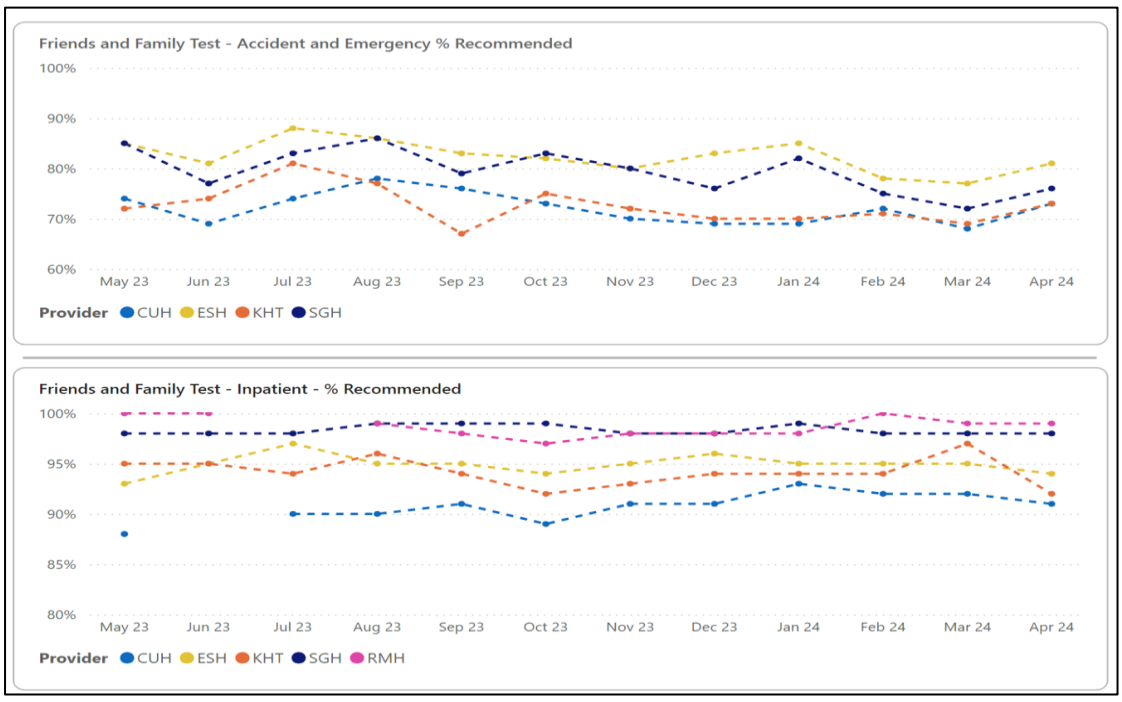
bed spaces. Themes from PfDs in SWL are predominantly around mental health access, bed capacity and discharge. The ICB is working with system partners to provide a response on learning and actions to improve to the coroner. All open PFDs have been presented as part of the mortality deep dive report to Quality and Performance Oversight Committee in August to provide assurance that the system is taking actions to prevent the risk of occurrence.

3. Caring

3.1. **Friends and Family Tests (FFTs) in Emergency Department (ED) and Inpatient:** Throughout 2023/24, FFT recommendations for EDs in SWL have remained below the required target 95%. The consistent themes for all Trusts have been because of the pressures, long waits and delays in treatment in ED. SWL average is around 75%. This is triangulated to the challenges across our EDs outlined earlier in this report.

FFT for inpatient areas fluctuated throughout the year and rates have generally decreased below 80% as of April for CHS and KHFT.

These decreases in rates provide a picture that patients are not happy with their care in both ED and inpatients and therefore do not feel they can recommend the services to friends or family. Trusts across SWL are working with their patient experience teams to ensure areas of feedback from patients and carers are being progressed as part of their quality priorities for 24/25 and that targeted actions are in place to improve patient experience.



Graph 5: A&E and Inpatient FFT % recommended

4. Children and Young People (CYP) Update

4.1. **Children's audiology service maintains quality accreditation**: Kingston Hospital's paediatric audiology service has successfully retained its Improving Quality in Physiological Services (IQIPS) accreditation, following a recent assessment by national accreditation body United Kingdon Accreditation Services (UKAS), making

Kingston Hospital and Hounslow and Richmond Community Healthcare (HRCH) the only paediatric audiology services with this accreditation in South West London.

Childhood deafness is a significant health and developmental risk, and the Care Quality Commission (CQC) are working closely with NHS England to understand the quality of hearing services for children across the country. IQIPS accreditation ensures that patients receive consistently high-quality care and brings national recognition to the service with a badge of quality. Some minor recommendations for improvement were made following the inspection at Kingston Hospital, and we have submitted evidence to UKAS of action taken to address these. In the last 12 months, Kingston Hospital has had no incidents reported of children suffering detriment due to delayed or missed diagnosis or treatment, or not receiving timely follow up care and support in this area.

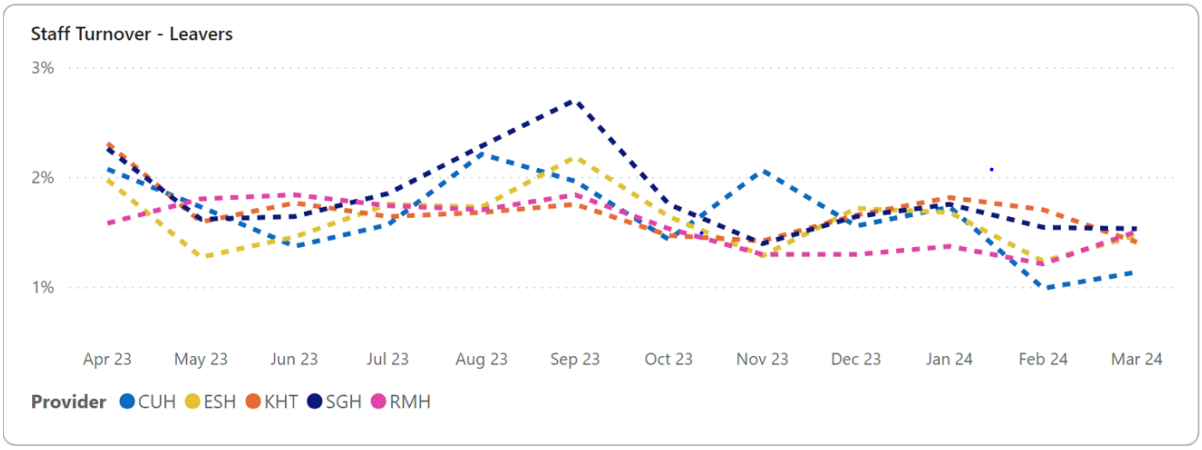
4.2. **Richmond CQC Inspection –** The CQC have announced to the ICB a planned joint thematic area inspection (JTAI) in Richmond of "front door services". The CQC visited sites on Monday 15 July until Friday 19 July. This is an inspection of the partnership. https://www.gov.uk/government/publications/joint-targeted-area-inspection-of-the-multi-agency-response-to-identification-of-initial-need-and-risk--2/joint-targeted-area-inspection-of-the-multi-agency-response-to-identification-of-initial-need-and-risk

Inspectors evaluated:

- how effectively the front doors of individual agencies identify and respond to initial need and risk. It will include an evaluation of services out-of-hours.
- the effectiveness of the multi-agency safeguarding hub (MASH) - the early help and safeguarding hub.
- how effectively each agency contributes to the multi-agency response, including early decision-making across early help, child in need and child protection.
- how effectively the local partnership, through its multi-agency safeguarding arrangements (MASA), monitors, promotes, coordinates and evaluates the work of the statutory partners. The lead representatives of the safeguarding partners are the Local Authority Chief Executive, the Accountable Officer of the Integrated Care Board and a Chief Officer of police.
- the impact of leaders and managers on practice with children and families in relation to the front door
- the timeliness of this work and the impact of the local area's actions to improve the multi-agency response to children in need of help and protection.

The scope does not include longer-term interventions with children and families. The inspection will focus on recent practice. This is practice within the last 6 months. The inspection will evaluate how well current practice takes account of relevant history in children's cases.

5. Workforce



Graph 6: SWL Staff Turnover Rates

Trusts across SWL are reporting lower rates of turnover of staff. There was a peak in turnover between September 23 and November 23. However, the rates have stabilised across the system.

5.1. **Staff Vacancy Rates:** The table below outlines the vacancy position for Trusts in May. Generally, Trusts are reporting lower vacancies across SWL. Specialist roles remain a challenge to recruit, especially within the community.

Royal Marsden Hospital	The Trust vacancy rate has decreased to 7.9% to 7.0% and is on target for the lowest in the last 12 months. The top three staff groups with the highest vacancy rates are as follows: 1) Additional Clinical Services (12.4%), 2) Estates and Ancillary (11.1%) 3) Allied Health Professionals (10.1%) There are currently 211 Whole Time Equivalents (wte) candidates in the recruitment pipeline of which 80.7 wte candidates have a confirmed start date. All patient facing admin and clerical roles bands 2-4 going via the apprentice route. The Trust is committed to providing a comprehensive range of apprenticeships, as they recognise the multitude of benefits this approach provides. The Trust's nurse vacancy rate **reduced to 2.8% the** lowest over the last 36 months. There are 56.4 wte nurses within the domestic recruitment pipeline an additional 17 newly qualified nurses and 16 international nurses in the pipeline.
CHS	• CHS's vacancy rates remains well below target and turnover remains on a downward trajectory. • **Vacancy rate**: Remains below 14% target and **has fallen further to 12.0% in May.** • Turnover (12 month): Continued steady downward trajectory, at 12.0% in May • Stability/retention rate: Steady improvement, currently at the 88% target at 88.0% in May

SGH	The registered nurse (RN) vacancy rate **has remained low at 5.6% in May (5.8% in April) 2024**. An extensive RN recruitment campaign has been continuously maintained over the last year period in addition to 214 WTE (total) internationally educated nurses starting their Objective Structured Clinical Examination (OSCE) training in the Trust since January 2023. RN turnover rate has reduced again slightly from 16.9% in April 2024 to 16.5% in May (compared to 20% at this time last year). The Health Care Support Worker (HCSW) vacancy rate has improved from 14% in April 2024 to 13% in May 2024 and the turnover rate has also reduced slightly from 20% in April 2024 to 19.6% in May (21% in December 2023 and January 2024).
ESH	For the month of May, the vacancy rate is at 12%, against a target of 10% and turnover position is a bit better at 12.5% against a target of 13%.
Kingston	For the month of June 2024, the vacancy rate is at 6.7% which is slightly below target of 7%. Turnover is also below target at 12.5% against a 14% target.

6. Recommendations

The Board is asked to:

- Note the content of the quality report and be assured that risks are being managed through the appropriate governance and escalation arrangements between providers and the ICB.
- Safety and quality in EDs across SWL remain a focus following the letter issued in June by NHS England re safety in pressurised services.
- Be assured that the exceptions highlighted within the report have been presented and discussed at the Quality and Performance Oversight Committee in August and a deep dive into Mortality, Prevention of future deaths and All Age Continuing Health Care were also provided to assure the committee of the ICB's collaborative work with providers to make improvements.
- Be assured that system risks continue to be identified, mitigated and monitored as part of the ICB's risk management process and risks are escalated to the Board Assurance Framework where appropriate.

NHS South West London
Integrated Care Board

ICB Performance report – July 2024

Agenda item: 10e

Report by: Jonathan Bates, Chief Operating Officer

Paper type: For information

Date of meeting: 18 September 2024

Date Published: 11 September 2024

Content

Purpose

The purpose of this report is to provide Board Members with oversight and assurance in relation to the overall performance and quality of services and health care provided to the population of South West London. The report highlights the current operational and strategic areas for consideration.

Executive summary

The ICB Performance Report provides an overview of performance against constitutional standards at an ICS level and, in some cases at the Provider level. This report focuses on performance for May 2024 and June 2024 using nationally published and local data.

Key Issues for the Board to be aware of

Key areas where SWL has seen improvements in performance:

- **Despite higher than usual activity this summer, A&E 4-hour performance improved** to 77.2% in June, exceeding the NHSE target of 76%. Trust level performance ranged from 81.9% at St George's hospital to 74.1% at Croydon hospital and is mainly driven by non-admitted non-elective performance.
- **111 calls abandoned** reduced to 2.6% in June, achieving the 3% target for the first time in more than 2 years.
- **Less than 6 week waits for diagnostics** improved by 2% on the previous month in May reaching 87.3%, SWL performance being second highest out of the five ICBs in London.
- **Long waiting patients -** SWL continues to have the fewest long waiting patients in London, however, the ICB is above its trajectory for May with:
    - 216 patients waiting over 65 weeks against a trajectory of 108 in May.
    - 21 patients waiting over 78 weeks against a zero target.

- The ICB and Acute Provider Collaborative (APC) are working closely with providers to have very few patients waiting over 65 weeks by September 2024, mainly through increased capacity and improved productivity.
- **12-hour A&E breaches** in June saw a reduction of 458 from the previous month yet remain the highest in London and fifth highest nationally. Continuous flow and integrated care programmes continue to target improved inpatient flow and discharge, focusing on hospital discharge processes, improved coordination with system partners around complex discharges, and use of virtual wards for expedited discharge as well as admission avoidance. Intensive work is also taking place to reduce the length of stay of patients across the system.
- **Mental health 12-hour A&E breaches** saw a significant increase in June to 142. South West London's focus is on improving the mental health crisis pathway for patients, reducing the need to stay in an A&E and improving transfers of care to more appropriate mental health services. There is particular focus on the coordination between partner NHS organisations, both within and outside the ICS, looking at the effectiveness of multi-agency decision-making

Recommendation

The Board is asked to:

- ICB Board is asked to note the contents of this report

Governance and Supporting Documentation

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

Corporate objectives
This document will impact on the following Board objectives:

- Meeting performance objectives across the SWL ICS

Risks
Poor performance against constitutional standards is a risk to the delivery of timely patient care.

This document links to the following Board risks:

- RSK-001 Delivering access to care (NHS Constitution Standards)
- RSK-024 Delivery against the NHS 2023/24 Elective Recovery Plans.

Mitigations
Action plans are in place within each Programme workstream to mitigate poor performance and achieve compliance with the constitutional standards, which will support overall patient care improvement.

Actions taken to reduce any risks identified:

- For long waiting patients: Increased capacity, focus on productivity by APC-led elective care programmes, mutual aid, transformation led by clinical networks.
- For 12-hour A&E breaches: Continuous flow programmes within each of the Trusts and continuation of Winter focus and bed capacity, further processes by South West London and St Georges for mental health patients to reduce Delayed Transfers of Care and prevent admissions
- For 12-hour mental health A&E breaches: Alternative pathways to A&E are in place such as the section 136 hub, step-down hotel capacity and the 111 ‘press 2’ pathway. Further actions are being taken to reduce delays to discharge from secondary care mental health beds.

Financial/resource implications
- Compliance with constitutional standards, will have financial and resource implications

Green/Sustainability Implications
- N/A

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

Patient and public engagement and communication
N/A

Previous committees/groups

Committee name	Date	Outcome
Quality, Performance & Oversight Committee	14 August 2024	Noted
SMT	15 August 2024	Noted

Final date for approval
N/A

Supporting documents
ICB Performance Report – July 2024

Lead director
Jonathan Bates

Author
Suzanne Bates

South West London Integrated Board Report

July 2024

DATE REFRESHED : 17-07-2024

SRO: Jonathan Bates

NHS South West London

Commentary on Data

- The South West London (South West London) Integrated Board 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 NHS England, 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.
- This is the current iteration of the Integrated Care Board Performance Report and the number of indicators will continue to be reviewed and refined as work progresses to develop reporting within the Integrated Care Board (ICB).
- Data Quality Issues: There are data quality issues across South West London, mostly affecting Royal Marsden reporting due to the new Patient Administration System implementation.
- Data on 45-minute handovers is from London Ambulance Service and has not been validated by South West London Trusts.

Key Findings

NHS South West London
Integrated Care Board

- **Urgent and emergency care:** Unusually, South West London (SWL) has seen more A&E demand this spring-summer than during last winter, reflecting London and national trends. Despite the increased demand, SWL continued to improve its A&E 4-hour performance to 77.2% in June. Performance ranged from 81.9% at St George's to 74.1% at Croydon Hospital, driven by non-admitted non-elective performance. The volume of 111 calls decreased by 4,252 in June, and there was a decrease in the percentage of abandoned 111 calls to 2.6% in June, achieving the target of <3% for the first time in more than two years.
- **Inpatient flow – physical health 12-hour A&E breaches:** Emergency care pressures are on the admitted non-elective pathway; 2,071 patients waited over 12 hours from 'decision to admit' to admission in June. Although this is a decrease of 458 on last month, this was the highest number of 12-hour breaches in London and the fifth highest nationally. **To reduce the time to treatment and discharge, the system is focusing on its Continuous Flow programmes and the utilisation of virtual wards.** All Same Day Emergency Care services in SWL are now receiving patients directly from the London Ambulance Service (LAS) under the Trusted Assessor model, the only ICS in London to do so. Virtual Wards had an occupancy of 77% in June and an increased capacity of 415 beds. The system has invested in a range of initiatives to reduce front end pressures, including frailty at the front door and additional therapy and pharmacy services.
- **Admission prevention and 2-hour urgent community response (UCR):** Some of the virtual wards mentioned above are 'hospital at home' wards, which aim to prevent unnecessary admission. The latest urgent community response 2-hour performance is 90%, the second highest in London and well above the national standard of 70%. SWL continues to have the highest percentage of UCR referrals from care homes in London.
- **Mental health 12-hour A&E breaches:** Unvalidated figures show that in June, there were 142 x 12-hour breaches, an increase since May and the highest volumes since June 2023. Actions to support improvement include additional hostel beds and private sector beds, bed prioritisation scoring and focussed flow improvement work to address coordination within mental health providers and across partner organisations.
- **Cancer:** On the 28-Day faster diagnostic standard, SWL performance was 82.4%, above the 77% standard and the highest in London. Performance against the 62-day aggregated performance standard was 78.4% against a standard of 85%, the highest in London. Referrals continue to far exceed 2019/20 levels.
- **Planned care and long waits:** At SWL providers, the waiting list growth has slowed in the past year to 5.6%, below the London average of 9.5%. This is mainly due to increased capacity to see and treat patients, and digital solutions to make best use of capacity, such as text reminders and the ability to reschedule an outpatient appointment via the SWL patient portal. 20% of 52-week waits are Gynaecology patients, mainly at Epsom and Croydon. However, the two trusts have increased capacity, and the longer-term trend has been a reduction of this patient cohort. Orthopaedic patients make up the next largest cohort of 52-week waits at 13%; this cohort has grown by nearly 50% since March. Half of this growth is at Epsom's South West London Elective Orthopaedic Centre (SWLEOC), a specialist centre that does large volumes of mutual aid, mainly long waiters for other SWL providers and other ICSs nationally.
- **Severe Mental Illness Health checks:** In Quarter 4, 74% of Severe Mental Illness patients received all six annual health checks, exceeding the trajectory of 65%. Additional healthcare assistant resource has been made available to support primary care to reach patients not attending for their health checks.
- **Childhood Immunisations:** In Quarter 4, SWL continued to surpass London, with an outcome of 89% for the 12-month cohort of children. Highest uptake continues to be in Kingston and Sutton averaging 91%. There will be 2 MMR services delivered in Community Pharmacies, firstly MMR London Enhanced service (13 pharmacies in SWL to deliver MMR vaccinations) and secondly, MMR MECC Service (make every contact count, 100+ pharmacies) to have dedicated conversations with parents. Site assurance visits are taking place to ensure that sites are ready to deliver the service.

Domain: Urgent and Emergency Care

NHS South West London
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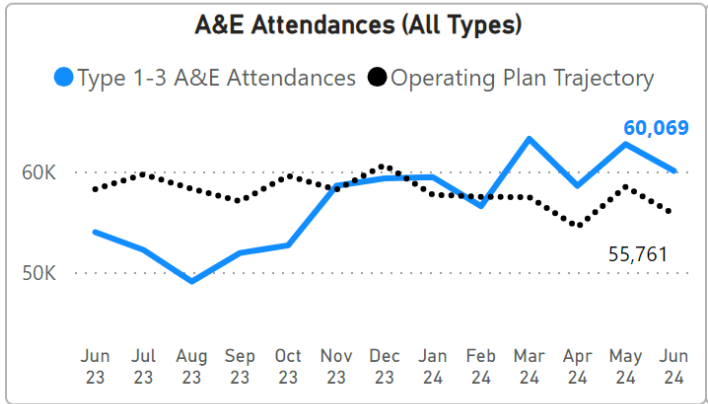

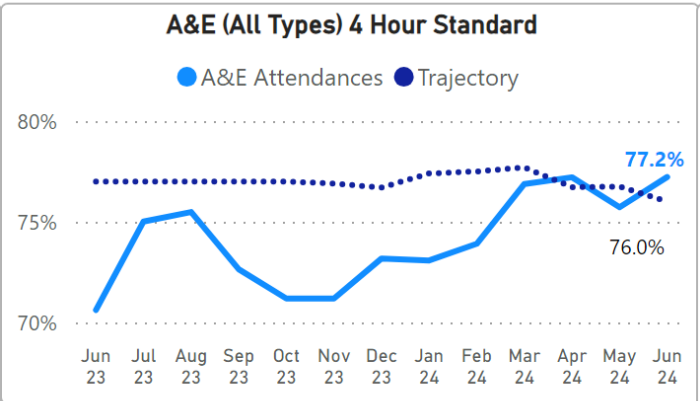

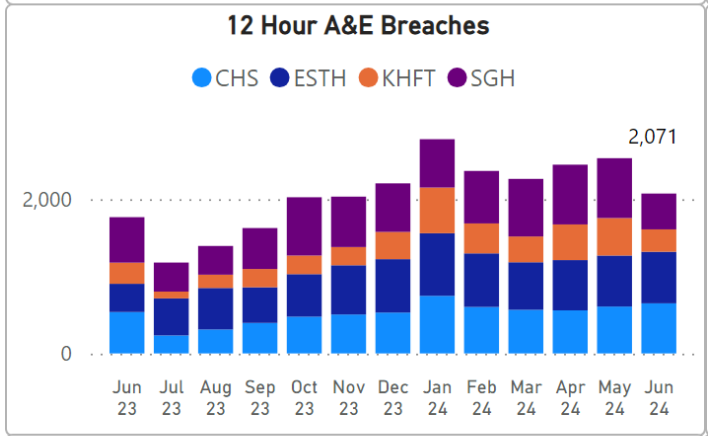

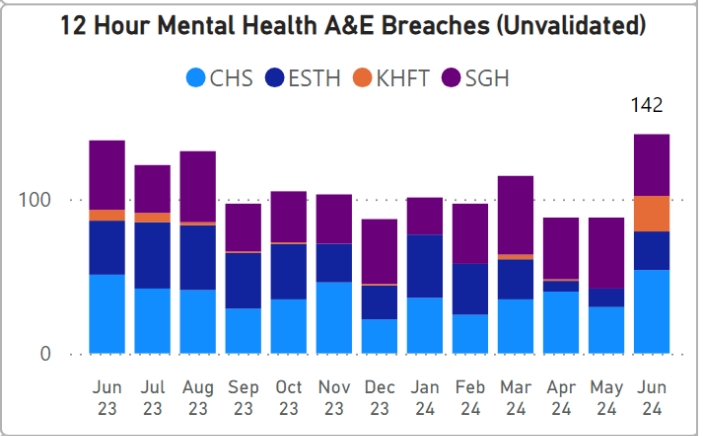

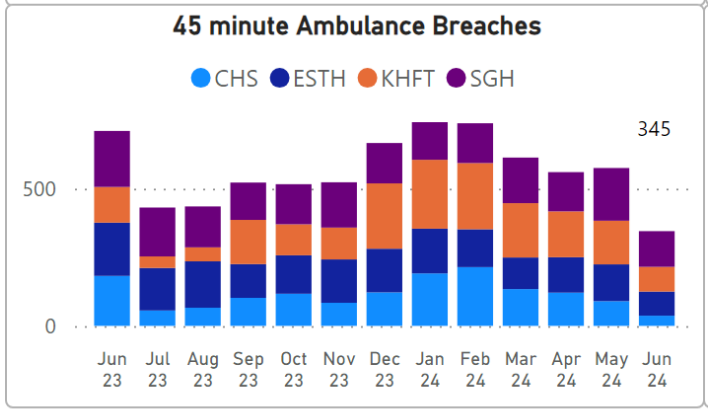

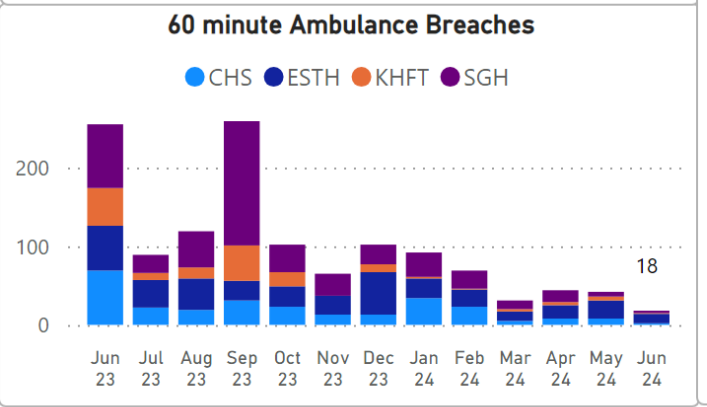

Accident & Emergency (A&E) Attendances and performance

A&E attendances saw the usual seasonal decline in June but was still well above levels seen this time last year, following a step change in March. Performance against the 4-hour A&E target improved from 75.7% to 77.2%. A significant piece of work is in progress to support a reduction in A&E waits and improve flow across the whole Urgent Emergency Care Pathway by focussing on patients waiting to be admitted and 12-hour breaches.

12 Hour breaches

The number of physical breaches decreased slightly in June, however, there was a marked increase in mental health (MH) breaches from 88 in May to 142 in June, reflecting increased pressures seen nationally. South West London's (SWL) focus is on improving the mental health crisis pathway for patients, reducing the need to stay in an A&E and improving transfers of care to more appropriate MH services. This is being achieved through pathway changes such as:

- the Section 136 hub, where staff can review service user history, crisis plans and ensure individuals are directed to a suitable place of safety, including;
- Step-down hostel capacity – a staff-supported 24 hr community environment
- Additionally, the '111 Press 2' pathway which helps patients to access secondary mental health professionals earlier or access local crisis resolution and home treatment teams for an urgent assessment.

There is ongoing work to improve how we communicate and coordinate between partners both within and outside the system, so that agreements are reached more quickly and there is improved visibility of information on different systems.

Ambulance handovers

45-minute breaches reduced significantly in June, along with a further decrease in 60-minute breaches. All providers continue to support 45-minute handover, noting the challenges this presents to acute trusts, often requiring ED nurses and additional space to support cohorting. Most local systems have allocated part of their Urgent and Emergency Care Winter funds to support this additional resource requirement. SWL now has all its Same Day Emergency Care services receiving patients directly from the London Ambulance Service (LAS) under the Trusted Assessor model, the only ICB in London to do so, which helps reduce handover delays at Emergency Department (ED).

Domain: Urgent and Emergency Care

NHS South West London
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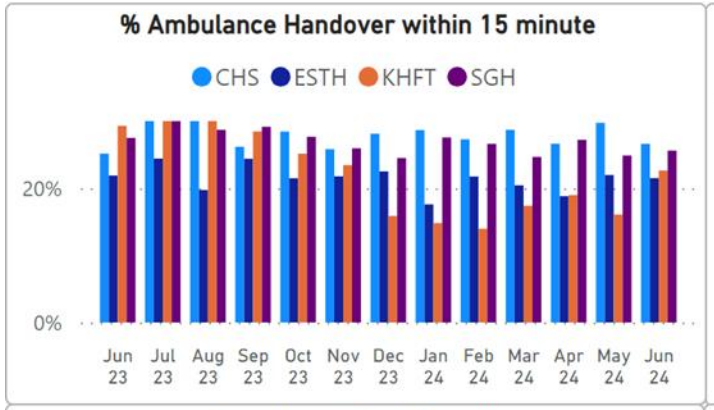
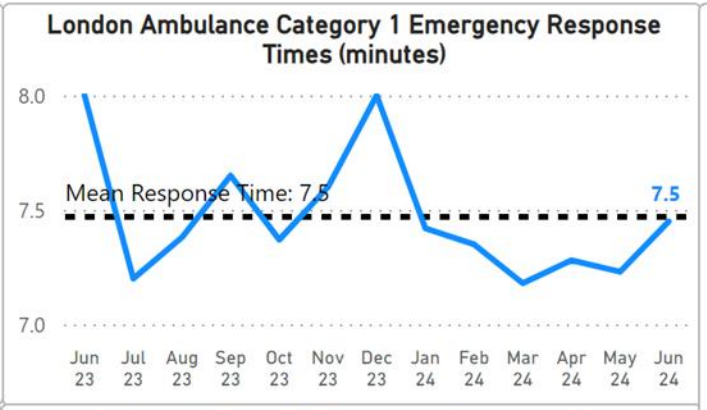
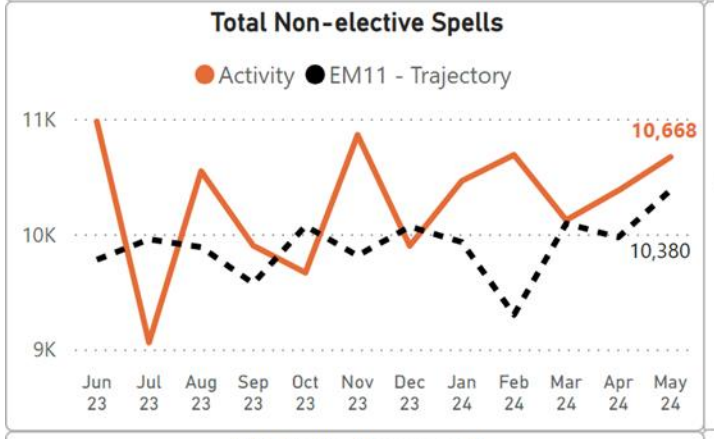
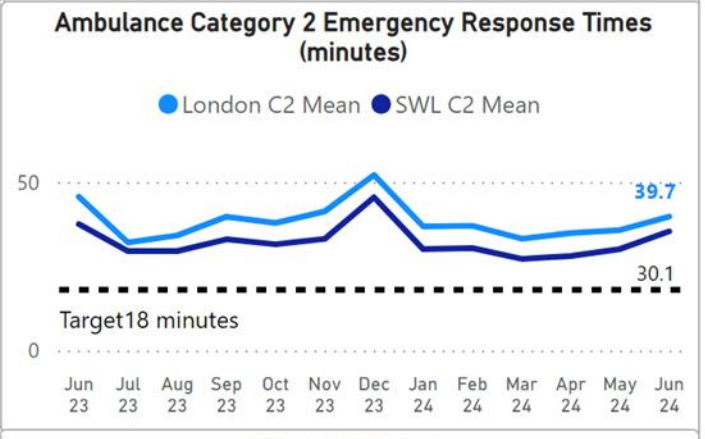
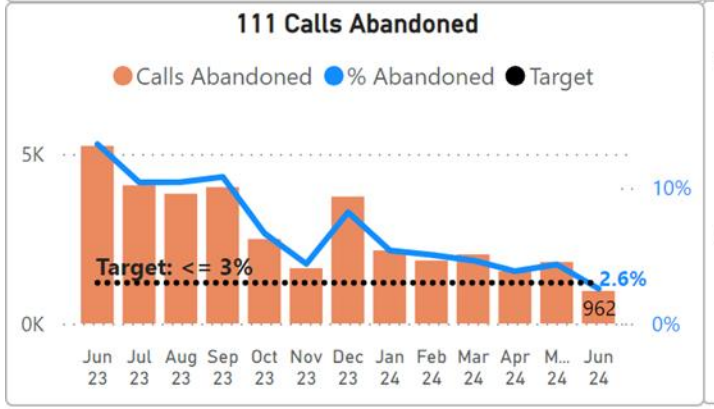
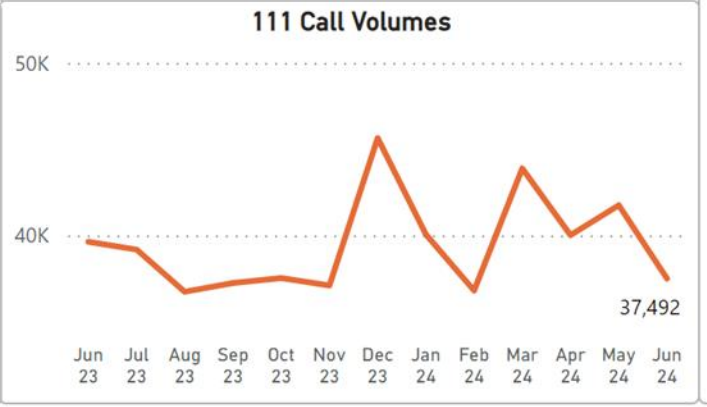












Ambulance Response Times
Mean response times for Category 1 at London level increased slightly in May to 7 minutes 30 seconds. SWL's performance was 7 minutes 35 seconds.

The mean Category 2 response for London deteriorated from 35.5 in May to 39.7 minutes in June. South West London's (SWL) performance, 30.1 minutes, continues to be better than the London position; the UEC Recovery Plan target is 30 minutes. The system is committed to reducing waits for all patients and getting crews back on the road via the 45-minute Ambulance Handover protocol.

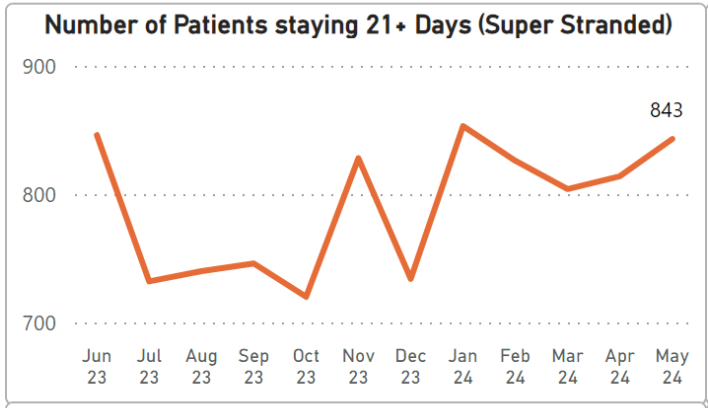
Non-elective spells
The number of non-elective spells has continued to increase between March and May; there would normally be a seasonal decrease in April, and volumes remain above planned levels. This will be one of the metrics closely monitored through the length-of-stay reduction work.

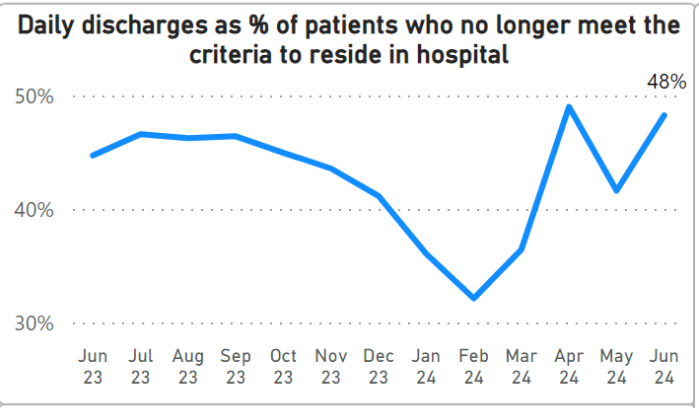
111 Calls
Call volumes decreased from 41,744 in May to 37,492 in June and the rate of calls abandoned decreased to 2.6%, achieving the 3% target for the first time in more than two years. The average speed of answer dropped from 89 seconds in May to 59 in June which is the lowest it has been in at least a year.

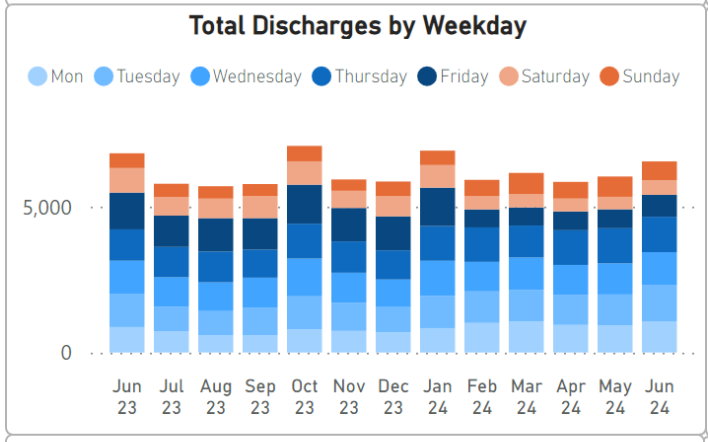
Both providers are implementing internal action plans for improvement for their clinical response rate. PPG, the 111 service provider, is focussing on recruitment, more alignment in terms of rota fill, continued focus on handling times and adherence to scheduling. In addition, PPG are also dedicating time to reducing clinical advisor call lengths and case-handling times to improve productivity. The London Ambulance Service (LAS) has been working on improving clinical call-back performance with skillset mapping, performance management of teams, and improved queue management.

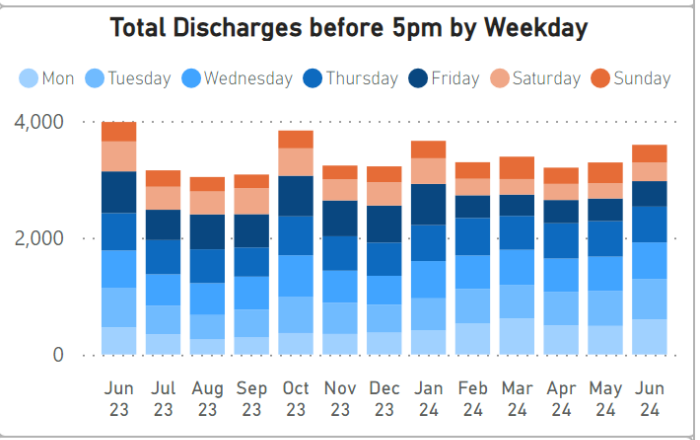
Domain: Integrated Care

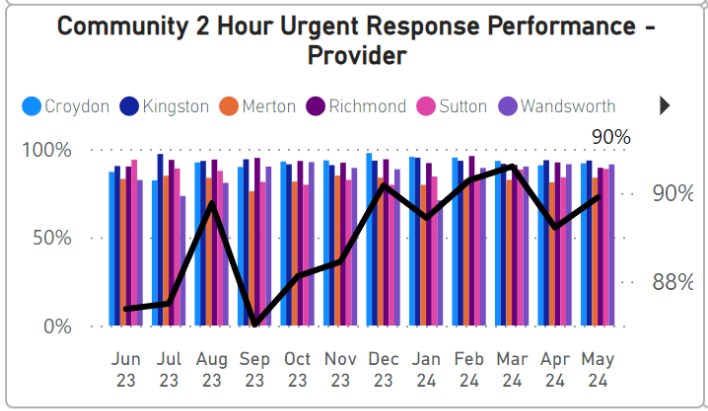
NHS South West London
Integrated Care Board

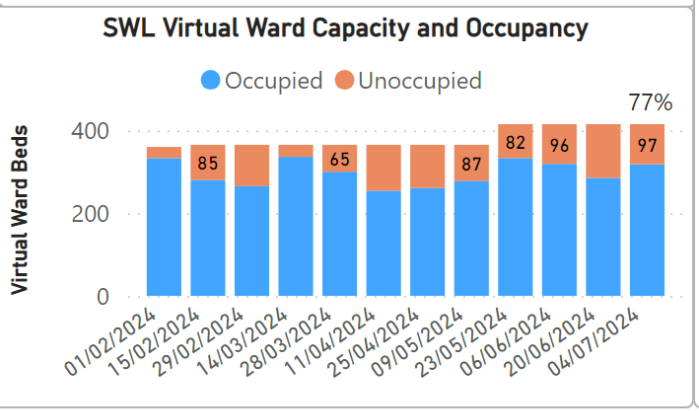












Patients with a length of stay over 21 days

As the number of non-elective admissions has remained higher than expected, the number of patients in acute inpatient beds over 21 days also remains high, despite measures to improve the pathway and increase capacity in the community. Data deep dives are planned and scoping to better understand barriers continues. The proportion of patients discharged who no longer met the criteria to reside (CTR) improved in April and June to 48%, the best performance in at least a year.

Total discharges by weekday and before 5.00pm

All providers have improvement plans to increase hospital discharges before 5pm each day. These plans include optimal use of care transfer hubs, discharge lounges, partnership working, and ensuring that discharge teams include social worker availability at the weekend. In 2024/25, the ambition of the ICS is to reduce hospital length of stay (LoS) by 1.5 days; discharging patients before 5pm to access the assistance of system partners is a key factor in reducing LoS.

2 Hour Urgent Community Response (UCR)

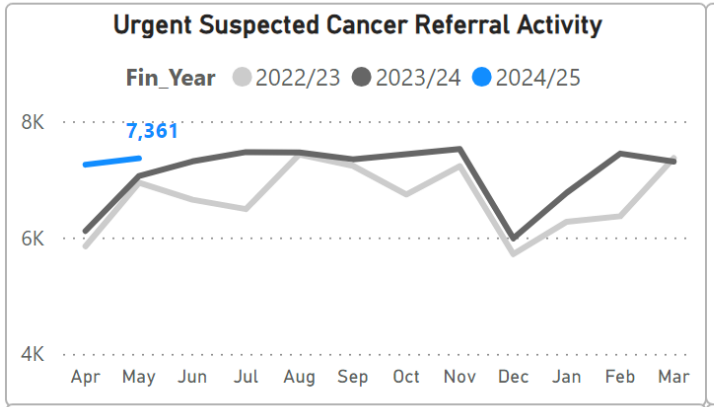
In May, South West London's (SWL) performance of 90% against the 70% standard was the second highest of the London ICSs. SWL 2-hour UCR services are fully operational in all six boroughs, running from 8 am to 8 pm, seven days a week, with Sutton providing a 24-hour service. Currently, efforts are underway to enhance the integration between UCR and Virtual Ward (VW) patients, while increasing referrals from 111 and the London Ambulance Service (LAS). SWL continues to achieve the highest number of referrals from Care Homes, in London. Preparation is underway to support the system over the winter months with extended UCR services, including with extended opening hours and upskilling of the workforce.

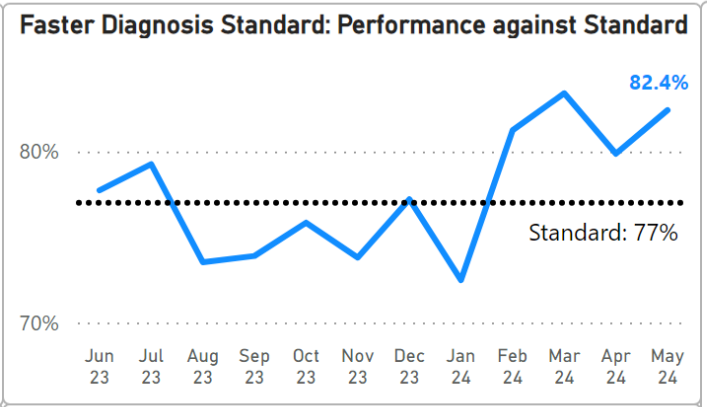
Virtual Wards (VW)

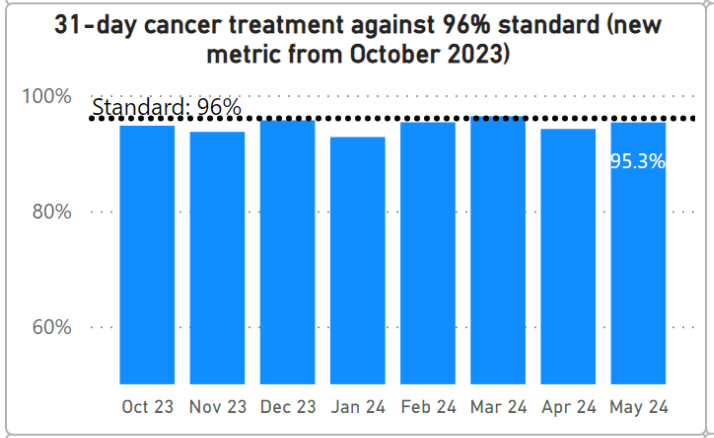
SWL Virtual Wards increased their capacity to 415 beds in May achieving 77% occupancy, just short of the 80% national target. Occupancy fluctuates during the week, and there is particular attention on where VWs can make the greatest impact. Local Virtual Wards have capacity to take on additional patients on admission avoidance or step-down pathways. Paediatric and neuro pathways are being piloted. Work to strengthen admission avoidance pathways continues and is currently focusing on UCR and other pathways to support hospitals further.

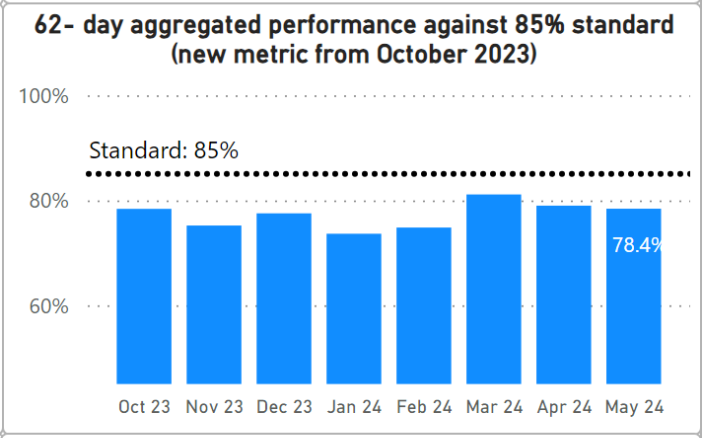
Domain: Cancer

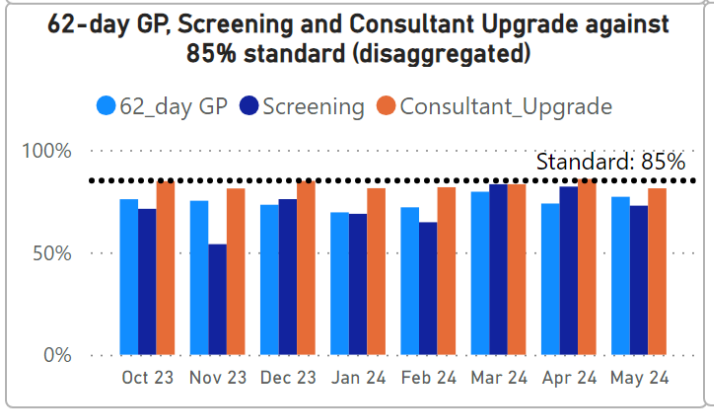
NHS South West London
Integrated Care Board

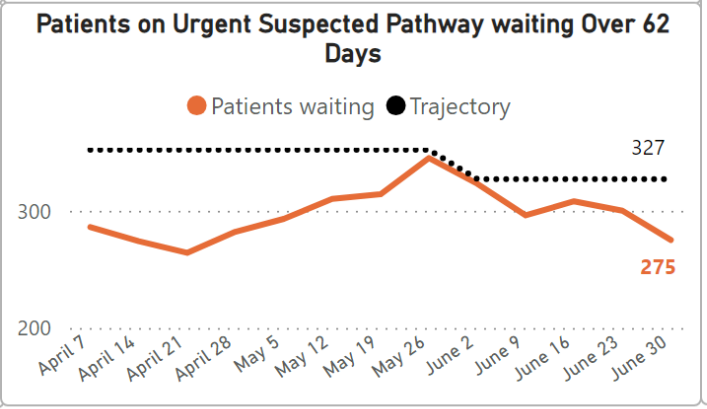












Urgent Suspected Cancer Referral Activity
Referral activity continues to exceed 2019/20 as well as 2023/24 levels and is following seasonal trends. Although no longer a constitutional standard from October 2023, South West London (SWL) achieved 76.5% in May for patients seen within 2 weeks on an urgent suspected cancer pathway.

Faster Diagnosis Standard
SWL ICB was the highest performing system in London with 82.4% against the Faster Diagnosis Standard (FDS) of 77% (the standard increased from 75% to 77% in April 2024). All SWL providers reported a compliant position, with the exception of St George's Hospital at 74.4%.

31-day cancer treatment against 96% standard (new combined metric from October 2023)

The May performance was 95.3%, just below the new combined 31-day treatment standard of 96%.

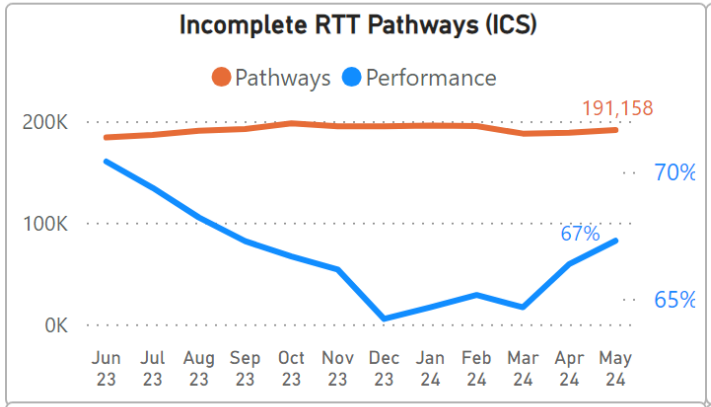
62-day aggregated performance against 85% standard (new combined metric from October 2023)
SWL providers were the highest performing in London, reporting 78.4% in May, however performance remains below the constitutional standard of 85%. Performance in May was most challenged at Royal Marsden Hospital with an outcome of 66.7%, driven by a high number of breaches in the Lung pathway.

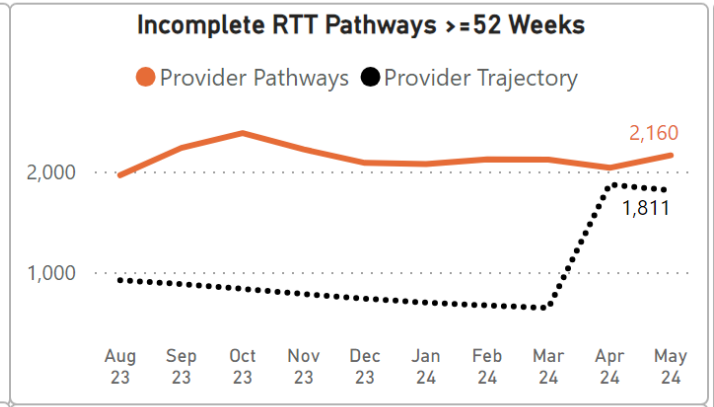
62-day GP, Screening and Consultant Upgrade against 85% standard (disaggregated)
SWL providers disaggregated 62-day performance demonstrates a consultant upgrade performance of 81.2% and a screening performance of 72.7%.

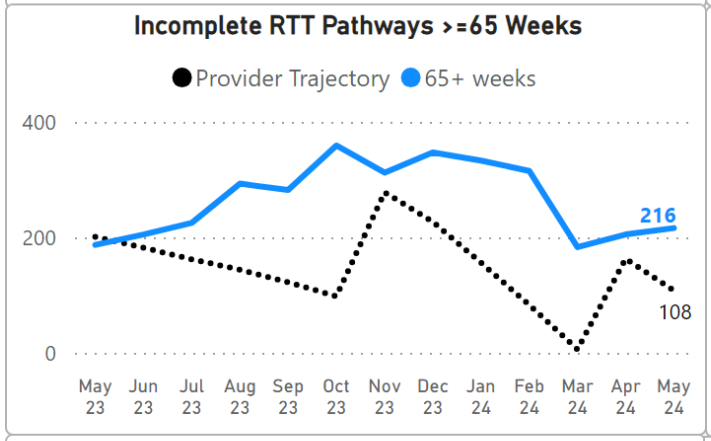
Patients on an Urgent Suspected Pathway waiting over 62 days
At the end of June there were 275 patients on an urgent suspected pathway. For the 2024/25 operating plan, there is no trajectory for patients waiting over 62-days, however there are continued reviews of this cohort of patients. The graph includes the trajectory of 327 which is the established baseline for 2024/25.

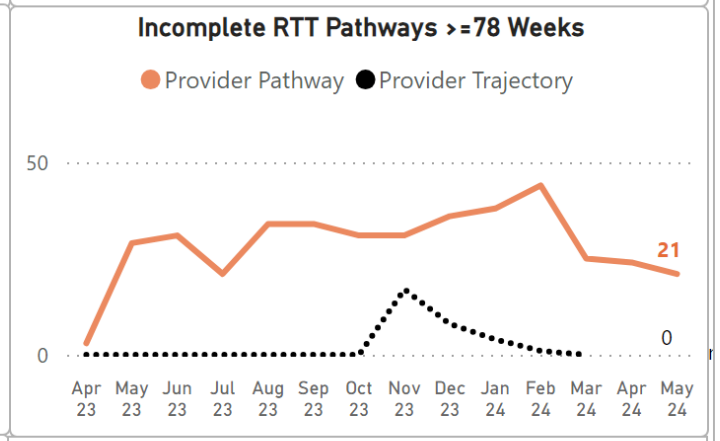
Domain: Planned Care

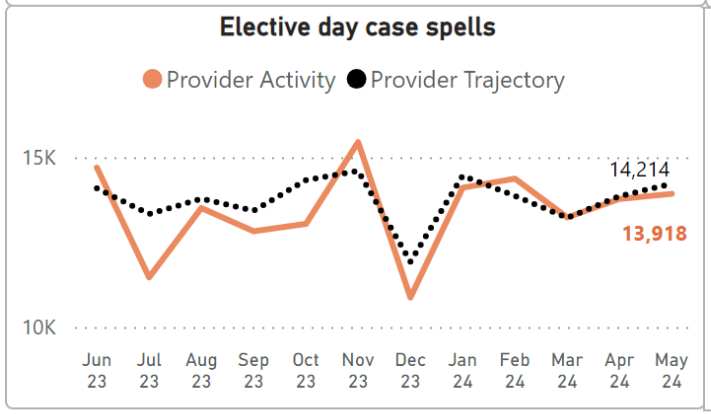
NHS South West London
Integrated Care Board

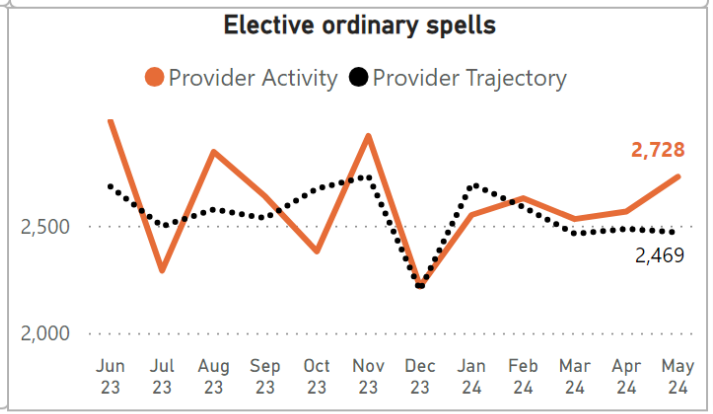












Incomplete waiting list pathways
At South West London (SWL) level there were 191,158 patients on an incomplete pathway in May awaiting treatment at a provider in or outside SWL. 67.3% of patients were waiting under 18 weeks. The number of SWL patients waiting has increased by 5% in the last year, lower than the London-wide increase of 9.5%.

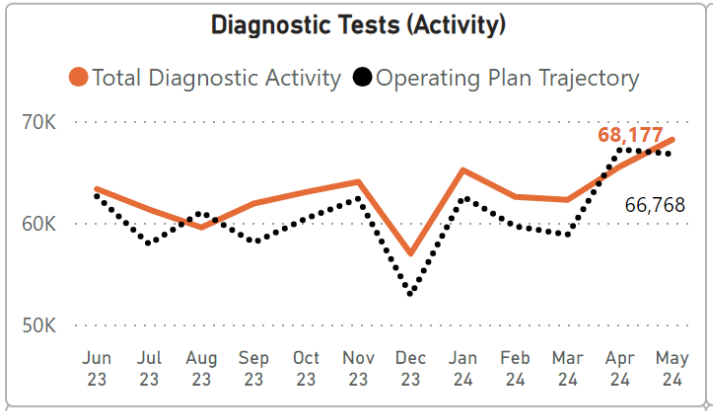
Long waiters – patients waiting over 52 weeks for treatment
SWL continues to have the fewest patients waiting over 18 and 52 weeks in London, with 2,160 patients waiting over 52 weeks for treatment at SWL providers in May. In the past 12 months, 52-week waiters have grown by 29.6%; most of that growth is at Epsom and St Helier, Kingston and Croydon hospitals. Mitigations include a Community Paediatrics Quality Improvement Plan led by Epsom and St Helier and St George's, extra Gynaecology capacity at Croydon and Epsom and St Helier and mutual aid from St George's hospital to the latter.
20% of SWL providers' 52-week waits are Gynaecology patients, mainly at Epsom and Croydon. However, the two trusts have driven down these long waits since October 2023 by increasing capacity, and the longer term trend is a reduction of this patient cohort. Orthopaedic patients make up the next largest cohort of 52-week waits at 13%, and this cohort has grown by nearly 50% since March. Half of this growth is at Epsom's South West London Elective Orthopaedic Centre (SWLEOC), a specialist centre that does large volumes of mutual aid for other SWL providers and long waiters for other ICSs nationally.

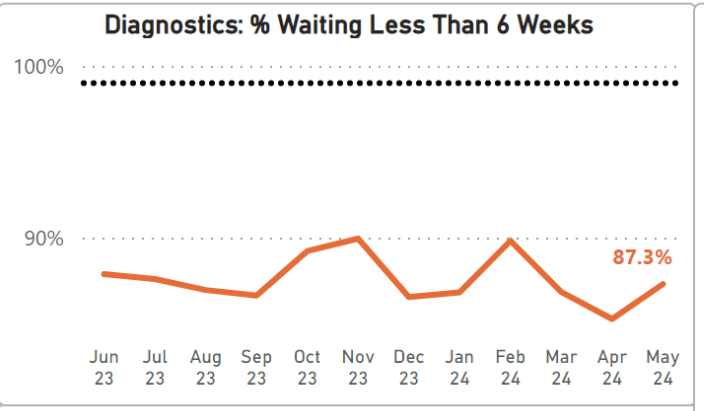
Long waiters – patients waiting over 65 weeks for treatment
There were 216 patients waiting over 65 weeks at SWL providers for treatment at the end of May. The month end trajectory was 108. Epsom and St Helier had 140 of the breaches, of which 83 were in Gynaecology.

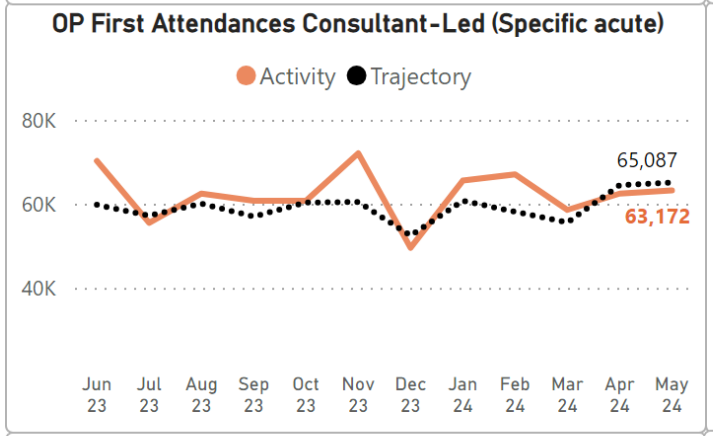
Elective day case spells & Elective ordinary spells
Day cases have an over-performance both in-month and YTD by 1% and 2% respectively. For Ordinary Electives over-performance is 13% against in-month plan and 11% against YTD plan. The percentage split of activity between day cases and Ordinary electives continues to remain marginally off the recommended level of 85%, a trend seen throughout 23/24 (83%-day case and 17% elective). This is in part due to the number of long waiters, who tend to have a higher level of complexity than the routine patients treated quickly.

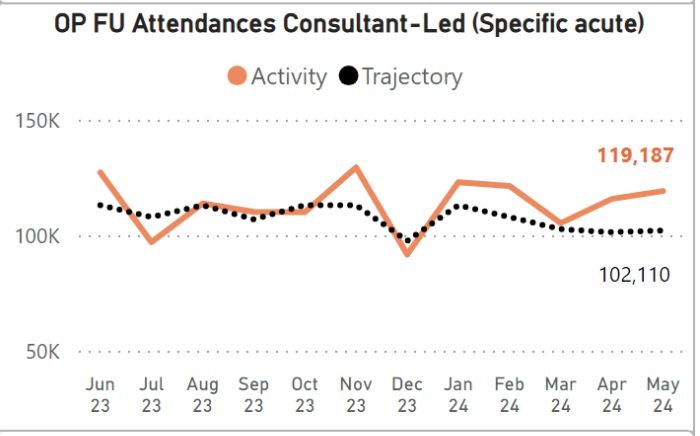
Domain: Outpatients and Diagnostics

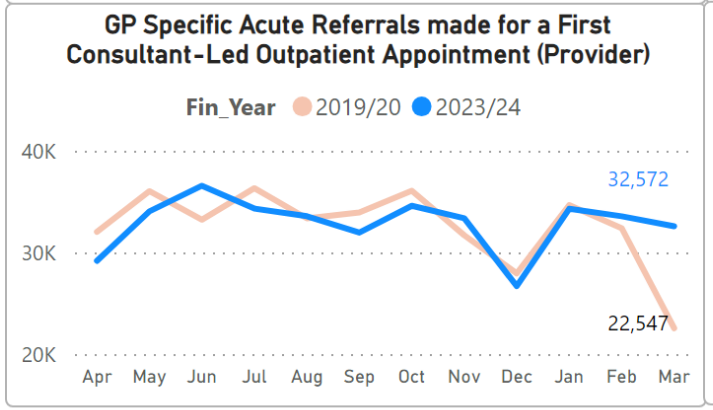
NHS South West London
Integrated Care Board

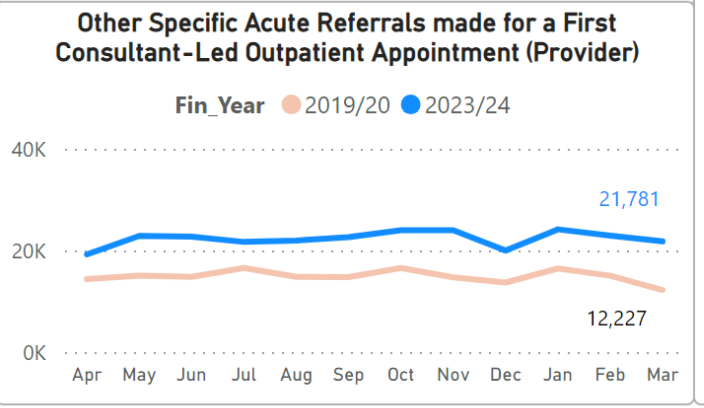












Diagnostic Activity (9 tests)
Diagnostic total activity was 68,177 in May, which was above the operating plan trajectory of 66,768.

% waiting less than 6 weeks (All tests)
The system achieved 87.3% in May, an improvement on the 85.3% in April. Across SWL overall there are a total of 5,871 patients waiting over 6 weeks, an improvement since April. Both Kingston and Croydon continue to be challenged with non-obstetric ultrasound (NOUS), which represents 52% of the SWL backlog. Echocardiography is a challenge for Kingston and audiology assessments for Croydon. These continue to remain South West London's (SWL) priority, with recovery plans underway to improve trajectories.

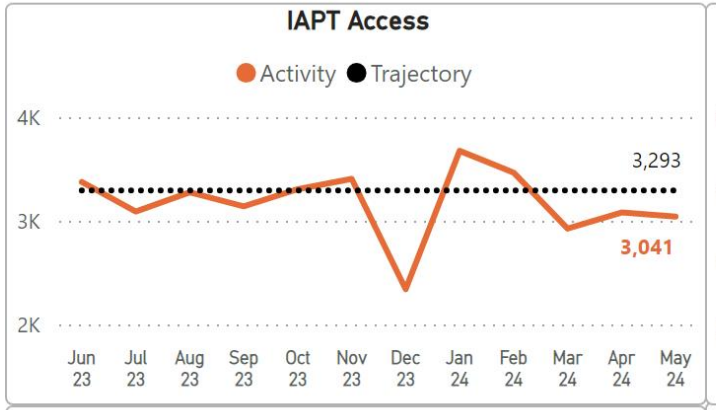
Consultant-led first outpatient attendances (Specific Acute)
Outpatients First Appointment performance was under plan by 6% in-month and year-to-date (YTD). Croydon and Royal Marsden are the only providers reporting activity levels over the in-month plan in May. The percentage of outpatient attendances as a first or procedure was 44% against national target of 49%. Under-performance was mainly driven by RMH (10% performance); which is due to the nature of Cancer pathways, which require a sequence of follow ups. NHS England has recognised the SWL level of performance excluding Royal Marsden and are satisfied with our performance levels.

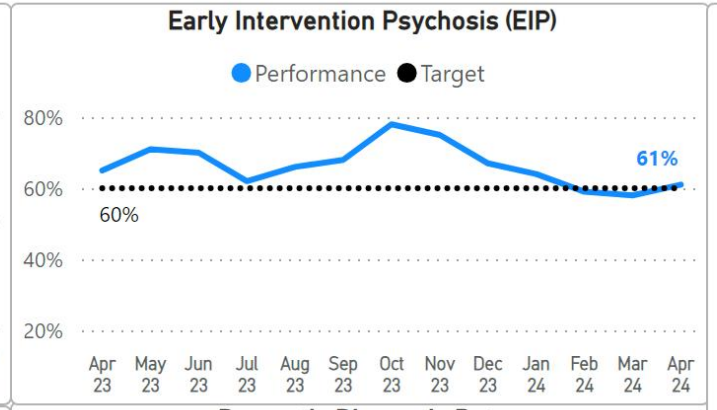
Consultant-led follow-up outpatient attendances (Specific Acute)
Outpatient follow-up volumes are nearly 20% higher than planned. The performance for outpatient follow-ups without procedure was off plan by 9% in-month and YTD, and significantly over the national target of 75% of 2019/20 baseline.

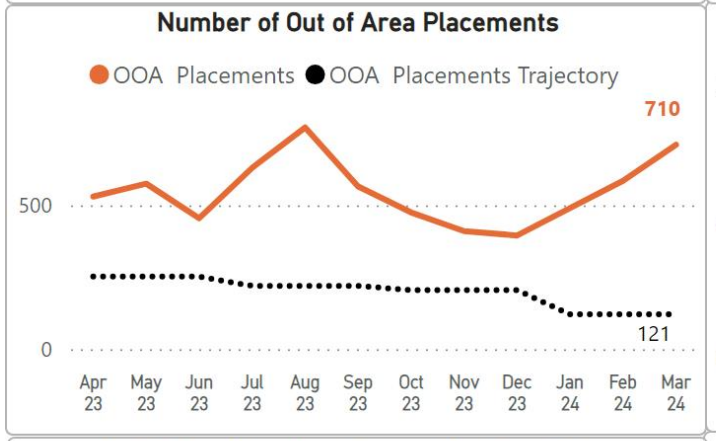
GP and Other Specific referrals for first consultant-led outpatient appointment
NHS England has suspended the collection and publication of the Monthly Referral Return (MRR) data until further notice. These charts will be replaced in the August Report.

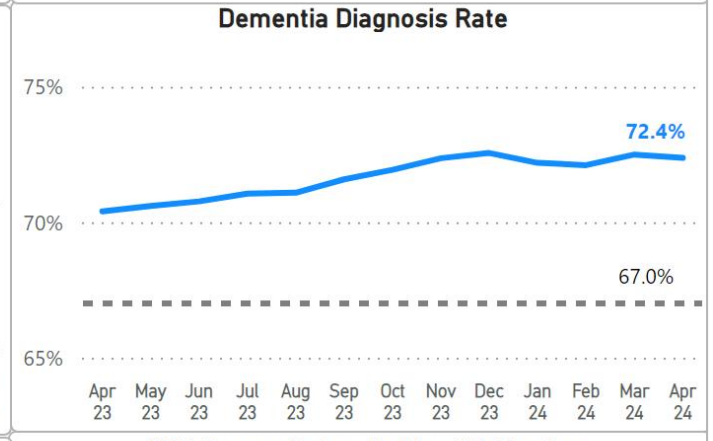
Domain: Mental Health Services

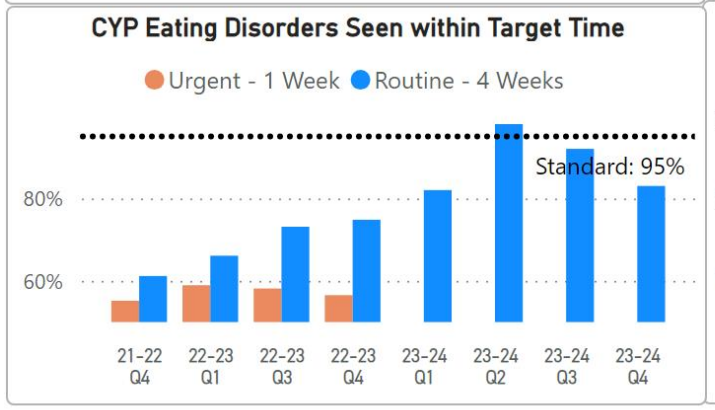
NHS South West London
Integrated Care Board

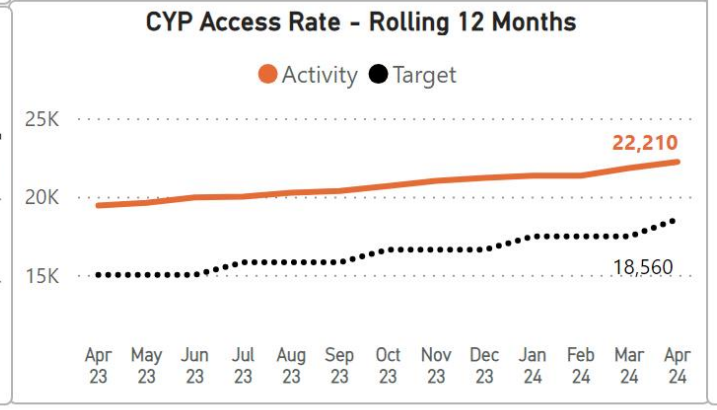












Improving Access to Psychological Therapies Access (IAPT)
Performance in April and May was marginally below trajectory. Text messaging has been used to promote IAPT services, and providers are seeking to make full use of all assessment capacity.

Early Intervention in Psychosis
Performance was above target in April. Vacancies continue to impact on delivery, along with the speed of referral into the Early Intervention in Psychosis service. South West London & St George's (SWLSTG) are reviewing their referral process and are exploring digital solutions.

Out of Area Placements (OAP)
OAPs remain above plan. Mental health providers and Local Authorities continue to work on admission prevention, length of stay, timely discharge and the ten key interventions set out in the 'Discharge Challenge' guidance. Monthly multi-agency meetings are in place, and a series of actions is being implemented to improve patient flow and reduce delayed transfers of care. SWLSTG are carrying out an Intensive Support Intervention programme on acute inpatient wards to identify and address barriers to discharge. This work will also support reduction in 12-hour mental health breaches in A&E. From April, the OAP measure changed nationally to count the number of patients rather than bed days. In April, South West London had 10 out of area patients which is comparable to other London ICBs.

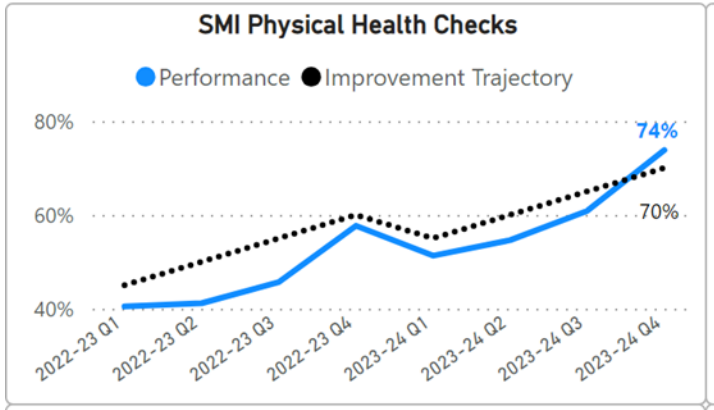
Dementia Diagnosis rate
SWL continues to maintain good performance levels (72.4%) exceeding both the national target of 66.7% and the London ambition of 70%.

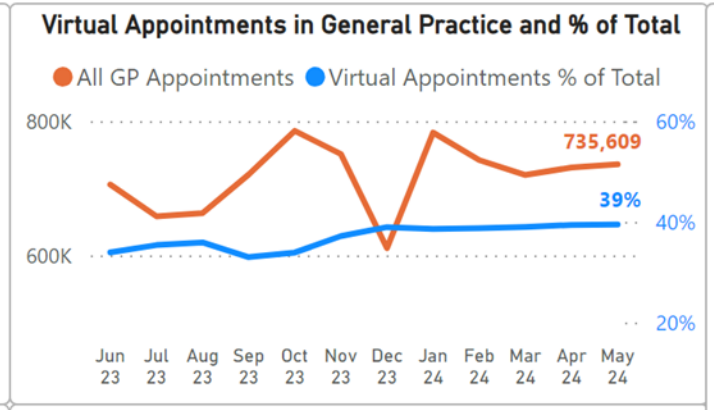
Children and Young People's Eating disorders
Performance for quarter 3 and 4 dropped below the 95% target. The reduction in performance is related to increased referrals and reduced staffing. Recruitment is underway to address the capacity issue.

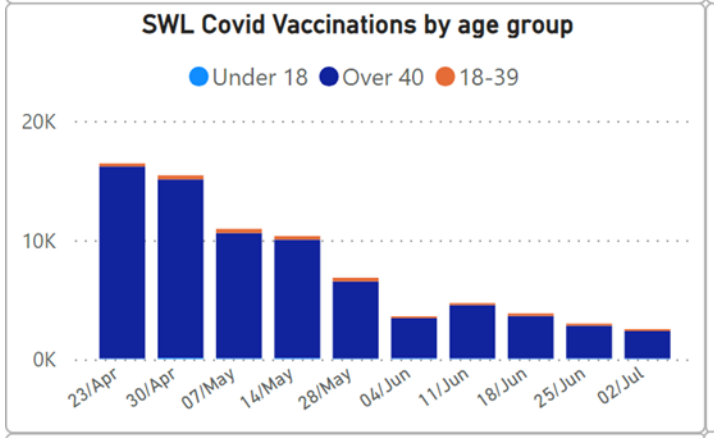
Children and Young People's Access rate
Performance levels have consistently improved month on month at a steady rate.

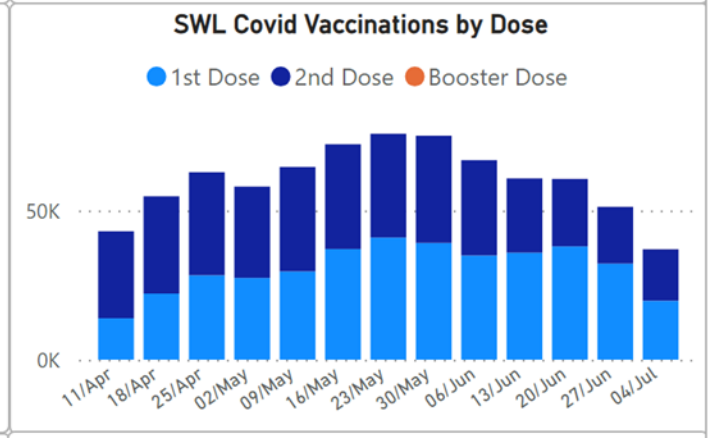
Domain: Primary Care

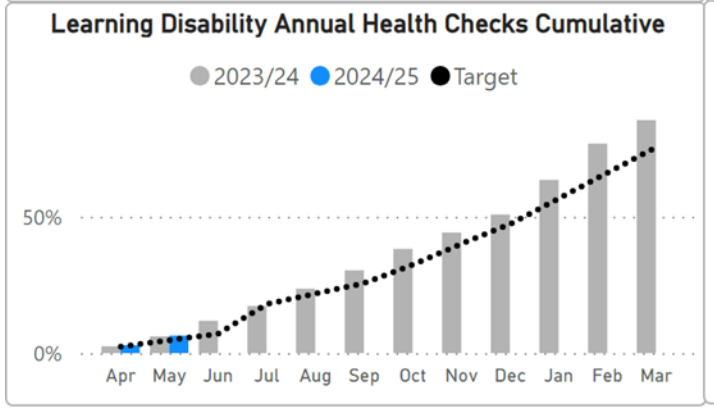
NHS South West London
Integrated Care Board

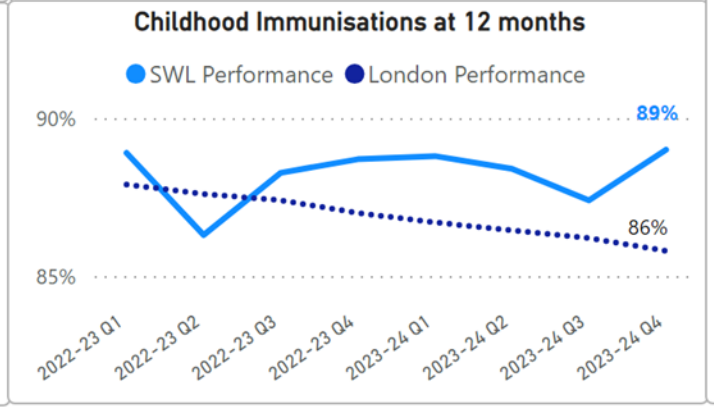












Severe Mental Illness Physical Health Checks
In Quarter 4, 74% of Severe Mental Illness patients received all six physical health checks, exceeding the national target. Additional healthcare assistant resource has been made available to support Primary Care reaching out to patients that are due for their annual health check.

GP Appointments
735,609 appointments were delivered in May 2024, an increase of 5,000 since April. Of these, 59% were face-to-face consultations, 47% were delivered the same day and 88% were delivered within 14 days (including same day).

COVID Vaccinations
The Spring Campaign for Covid began in April for care homes, housebound patients, the over 75s and immunosuppressed patients. Over the ten-week period South West London (SWL) vaccinated nearly 63k patients, achieving a 45% uptake, the highest in London (London average was 38%) and exceeded the national forecast of 41%. The team is now vaccinating newly immunosuppressed during the inter-seasonal period and preparations are underway for the Autumn campaign.

Learning Disability Health Checks
Performance was ahead of the May target with 6.4% of Annual Health Checks delivered. SWL is launching a secure, web-based resource for professionals to share learning and good practice across the system. This is on track to be rolled out in Q2 2024-25.

Childhood Immunisations
The Q4 12-month immunisation uptake has improved since the previous quarter with SWL continuing to surpass London, averaging 89%. Highest uptake continues to be in Kingston and Sutton averaging 91%. Coverage at 24 months has remained the same since Q3, averaging 84%. There will be 2 MMR services delivered in Community Pharmacies, firstly MMR London Enhanced service (13 pharmacies in SWL to deliver MMR vaccinations) and secondly, MMR MECC Service (making every contact count, 100+ pharmacies) to have dedicated conversations with parents. Site assurance visits are taking place to ensure that sites are ready to deliver the service.

NHS South West London
Integrated Care Board

Remuneration Committee Update

Agenda item: 10f

Report by: Mercy Jeyasingham, Non Executive Member, SWL ICB

Paper type: Information

Date of meeting: Wednesday, 18 September 2024

Date Published: Wednesday, 11 September 2024

Content

Purpose

To provide the Board with an update from the Remuneration Committee, as a Committee of the Board.

Executive summary

The update reflects the discussion, agreement and actions at the meeting on 22 August 2024 and is brought to the Board to provide an update on the work of the Committee.

Key Issues for the Board to be aware of

The Remuneration Committee has met once since the last update to the ICB Board, on 22 August 2024. The meeting was quorate and discussed the following items:

Fixed Term Contracts – Potential Compulsory Redundancy Case Approval

The Committee approved the redundancy cases and potential costs in relation to staff on fixed term contracts ending on 31 March 2025 to enable these to be presented to NHS England for their approval at either regional or national level.

Annual Pay Award Agenda for Change 2024/25

The Committee approved the 2024/25 pay award for staff on Agenda for Change terms and conditions, subject to agreement being reached on Band 8A-9 additional spine points *[Addendum: The NHS Staff Council has now ratified these plans*].

Non Executive Members and Associate Non Executive Members posts

The Committee noted the appointments to Non Executive Members and Associate Non Executive Members posts and approved the proposal to appoint one additional Associate Non Executive Member.

Management Cost Reduction Update

The committee noted an update on the Management Cost Reduction programme.

Clinical Leadership

An update was provided on the implementation of new Clinical Leadership Model.

Recommendation

The Board is asked to:

- Note the update from the Committee.

Governance and Supporting Documentation

Conflicts of interest
N/A

Corporate objectives
This document will impact on the following Board objective:

- Overall delivery of the ICB's objectives.

Risks
N/A.

Mitigations
N/A.

Financial/resource implications
N/A.

Green/Sustainability Implications
N/A.

Is an Equality Impact Assessment (EIA) necessary and has it been completed?
An EIA has been completed for the management cost reduction programme.

What are the implications of the EIA and what, if any are the mitigations?
The EIA for the management cost reduction programme outlines actions to support staff to find suitable alternative employment and reduce redundancies.

Patient and public engagement and communication
N/A.

Previous committees/groups

Committee name	Date	Outcome

Final date for approval
N/A.

Supporting documents
N/A.

NHS South West London
Integrated Care Board

Lead director

Karen Broughton, Deputy Chief Executive Officer/Director of Transformation and People, SWL ICB.

Author

Maureen Glover, Corporate Governance Manager

NHS South West London
Integrated Care Board

Chief Executive Officer's Report

Agenda item: 11

Report by: Sarah Blow, Chief Executive Officer

Paper type: Information

Date of meeting: Wednesday, 18 September 2024

Date Published: Wednesday, 11 September 2024

Content

Purpose

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

Executive summary

At each Board meeting in public the Chief Executive Officer provides a brief verbal and/or written update regarding matters of interest to members of the Board and members of the Public.

Key Issues for the Board to be aware of

Response to Riots

The riots that took place across the country at the beginning of August following the tragic events in Stockport shocked the nation. At the time, I wrote to all of our staff condemning the actions of a minority and re-iterating our steadfast support and work to be an anti-racist organisation. I will continue to prioritise this work within not only SWL ICB, but our system and the country. Our thoughts and support continue to go to all those, and particularly our NHS colleagues, who have been affected not only by the events in Stockport but also the subsequent civil unrest.

Staff Conference

NHS South West London will hold its first all staff conference on Friday 13 September at the AFC Football Stadium in Wimbledon. It will be a fantastic opportunity to bring the organisation together and look towards the future with a renewed focus by designing our new ways of working and launching our organisational values of respect, integrity, collaboration, and excellence. We will also be establishing the ICB Staff Awards to recognise and celebrate the hard work and dedication of NHS staff across the ICB with the inaugural ceremony to be held September 2025.

General Practitioner Collective Action

From 1 August some General Practitioners (GPs) have been taking collective action as part of a dispute between the British Medical Association (BMA) and NHS England. Collective action is not strike action and GP practices will remain open, but some practices may, for example, choose to introduce measures which could limit the number of available appointments. For more information on the potential action taken by GP Practices please visit the BMA website.

NHS South West London is working with primary care networks and individual general practices to understand and mitigate any impact on patients.

GP Patient Survey Results 2024

The GP Patient Survey (GPPS) is an England-wide survey, providing data about patients' experiences of their GP practices. The results of the 2024 GP Patient Survey were published in July with more than 80,000 questionnaires issued in South West London with 18,000 responses.

Four out of five people in South West London rate their local general practice as good, according to the findings of the Survey. This figure is above the national average and the highest in London. When asked about their most recent appointment, more than 90% of respondents had confidence in the person providing their care and felt their needs were met. The survey also revealed that people in South West London find it easier to contact their GP by phone or online, than the England and London averages.

Thank you to all of our GP practices, their teams and our South West London and borough primary care teams for the work they do every day to provide excellent patient care. NHS South West London's primary care team, primary care networks, and individual general practices will use these results to share best practice and help improve services further for local people.

Childhood Immunisations Campaign 2024

The second wave of the childhood immunisation vaccine campaign went live nationally on the 26th of August and runs until the 4th of October 2024. The campaign aims to encourage parents whose children (0-5 years old) have missed, or may miss, a vaccine to get their children vaccinated. The childhood vaccination programme prevents around 5,000 deaths, and more than 100,000 hospital admissions, each year in England. For information on NHS vaccinations, please visit the NHS website.

Kingston Hospital and Hounslow and Richmond Community Healthcare Merger

Kingston Hospital NHS Foundation Trust and Hounslow and Richmond Community Healthcare NHS Trust are planning to merge in October 2024 subject to NHS England and Secretary of State approval. The merger aims to provide seamless care to local people and jointly deliver on strategic priorities.

Recommendation

The Board is asked to:

- Note the contents of the report.

NHS South West London
Integrated Care Board

Governance and Supporting Documentation

Conflicts of interest
Not applicable

Corporate objectives
This document will impact on the following Board objectives:

- Overall delivery of the ICB's objectives.

Risks
Not applicable

Mitigations
Not applicable

Financial/resource implications
Not applicable

Green/Sustainability Implications
Not applicable

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

Patient and public engagement and communication
Not applicable

Previous committees/groups
Not applicable

Final date for approval
Not applicable

Supporting documents
Not applicable

Lead director
Ben Luscombe, Director of Corporate Affairs

Author
Ryan Stangroom, Lead Corporate Governance Manager