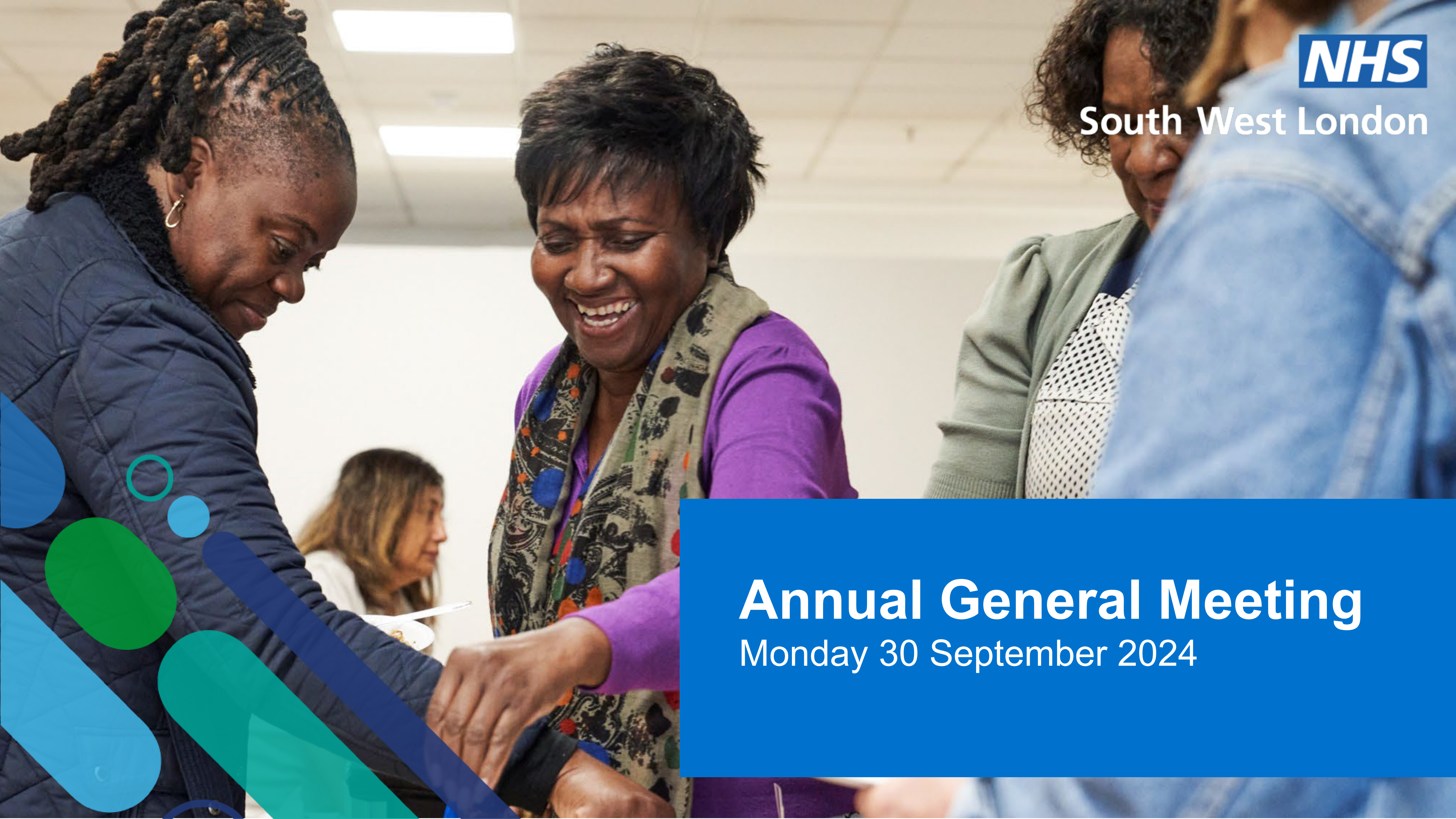

NHS
South West London
Annual General Meeting
Monday 30 September 2024

Housekeeping…

Read our annual report

Read our full annual report and more about our work on our website southwestlondon.icb.nhs.uk

Agenda

Time	Item	Presenter
2pm	Welcome and housekeeping	Mike Bell, Chair
2.05pm	Looking back to 2023/24	Sarah Blow, Chief Executive Officer
2.25pm	Annual Accounts	Helen Jameson, Chief Financial Officer
2.35pm	Introduction to our case studies…	Mike Bell, Chair
2.40pm	Case study: Pro-active care	Dr Annette Pautz, Kingston ICS Clinical Director Shaheena Khan, Kingston PAC Care Co-ordinator
2.50pm	Case study: Virtual Wards	Aisling Vaugh, Operational Manager Anna Ryan, Lead Matron for the Virtual Ward Inreach Team
3.00pm	Case study: From Brazil to Battersea	Dr Jenni Ellingham, GP Battersea Primary Care Network Habeebah Green, Community Health and Wellbeing Worker
3.10pm	Looking ahead to 2024/25	Sarah Blow, Chief Executive Officer
3.30pm	Questions and Answers	Facilitated by Mike Bell, Chair
4pm	Close	Mike Bell, Chair

NHS
South West London
Looking back to 2023/2024
Sarah Blow, Chief Executive Officer

We are an integrated care system

South West London Integrated Care System launched on 1 July 2022 bringing together all the local health and care partners.

The ICS replaced the South West London Health and Care Partnership, taking on new statutory roles and responsibilities.

- Our acute and community providers
- Our two mental health providers
- Our 39 primary care networks
- GP Federations in each of our six boroughs
- The London Ambulance Service
- Our six local authorities
- Our six local Healthwatches
- Our South West London voluntary and community and social enterprise (VCSE) sector
- Our NHS provider collaboratives

What is an Integrated Care System?

The Health and Care Act 2022 established 42 ICSs across England on a statutory basis.

Integrated Care Systems are made up of two parts, in South West London:

- **NHS South West London Integrated Care Board** decides how the NHS budget of £3.4 billion is spent and we work together to improve people's health, deliver higher quality care, and better value for money

- **South West London Integrated Care Partnership** brings the NHS together with our six local authorities, the voluntary sector, Healthwatch and our other key partners, to develop a strategy to enable the Integrated Care System to improve health and wellbeing across South West London

Our aims

We are committed to four key aims:

1. **Improving outcomes in population health and healthcare**
2. **Tackling inequalities in outcomes, experience and access**
3. **Enhancing productivity and value for money**
4. **Helping the NHS to support broader social and economic development**

The ICB's role

- NHS South West London Integrated Care Board is part of the integrated care system.
- The ICB is a statutory organisation bringing together the NHS to improve population health and establish shared priorities for local people, as well as being responsible for deciding how the NHS budget for South West London is spent.

We serve around 1.5 million people across our six diverse boroughs:

- Croydon
- Kingston
- Merton
- Richmond
- Sutton
- Wandsworth

Looking back at 2023/24

- Our collaborative approach helped us **continue as a high performing system**, with strong delivery of NHS constitutional standards.
- In 2023/24 we performed well against NHS targets and priorities, including **waiting times, cancer treatment standards and access to primary care**.
- Each part of our NHS system has worked together to **deliver a financial position that has been agreed with NHSE**.

Rapid community response

More than 25,000 people kept safe and well at home, avoiding trips to A&E, thanks to the two-hour urgent community response service.

Artificial intelligence

Introducing AI in care homes to monitor residents, helping to reduce falls and hospital stays

Creating local opportunities

Helping hundreds of local people into employment in the NHS, to reduce health inequalities and better reflect the communities that we serve.

Increasing use of the NHS App

Monthly logins to the NHS App from south west Londoners went up by 48% this year - giving more people better access to local NHS services

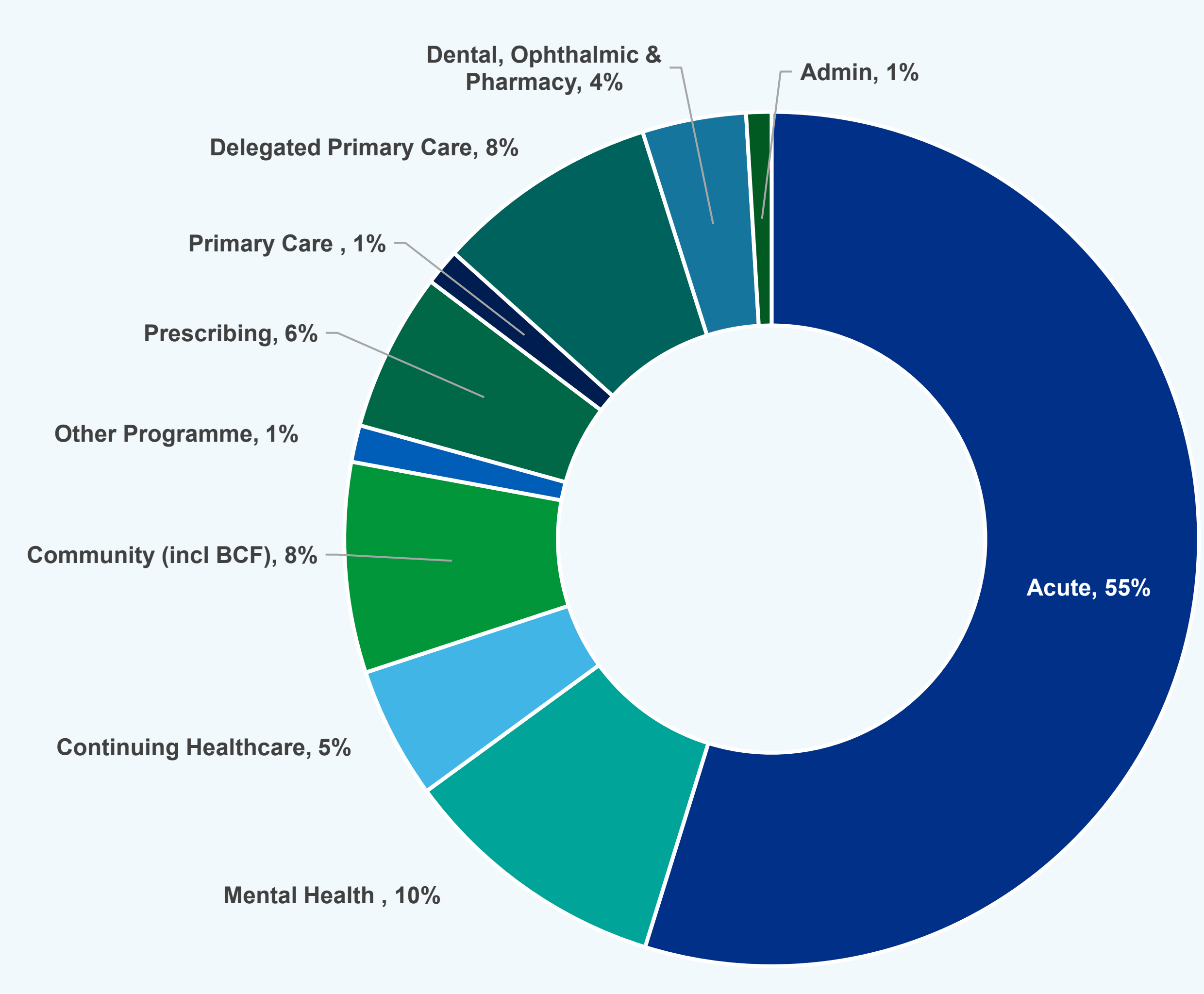
NHS
South West London
Finances 2023/24
Helen Jameson, Chief Financial Officer

2023/24 ICB Financial Overview

- The financial statements:
  - give a true and fair view of the financial position of the ICB for the year ending 31 March 2024 and of its expenditure and income for the period then ended,
  - have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023/24; and
  - have been prepared in accordance with the requirement of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

- Maintain financial stability
- Fair and effective use of resources
- Investment made in mental health in line with our growth allocation
- Stay within running costs target

Where Did We Spend Our Money?



- In 2023/24 **£3.489bn of funding** was received to deliver healthcare services for the population of SW London
- Funding was calculated to the ICB based off the number of patients registered with a SW London GP (**1.73m patients).** This equates to **£2,017/head**
- We delivered a £2.5m surplus against this funding which was in line with our agreed system plan.
- Around **76% of the funding for planned care** was spent with Providers within SWL.
- Whereas **80% of funding related to urgent and emergency care** was spent within SW London.

What did our funding buy?

Our healthcare spend with Acute NHS Providers delivered the following activity:

Patient Care	Activity 2022/23	Activity 2023/24
Planned Care Patient Spell	186,180	214,390
Urgent Care Patient Spell	152,111	152,012
Outpatient Attendances	2,964,963	3,409,727
A&E Attendances	589,713	615,109

In addition:

- In 2023/24 our GPs carried out **8.36 million appointments** (an average of 696k per month) this included **5.16m face-to-face**, **2.52m telephone** and **472k online/video**
- We had on average **3,393 continuing healthcare packages in place per month**.

We **received £13.1m of winter funding** that enabled us to:

- To maintain and expand bedded capacity for unplanned admissions by supporting the "front door" particularly on services around our Emergency Departments (ED) to reduce handover delay and facilitate patient flow.
- Enhance the Mental Health Psychiatric Liaison services in ED, **support Homelessness work at St George's** and Neuro-Rehab beds.
- We continued to invest in establishing **virtual wards** to support patients earlier discharge from hospital
- During winter 2023/24 we have **run a range of priority campaigns – promoting 111 online, mental health crisis prevention, using pharmacies, NHS app and promoting vaccines and immunisations**.

What did our funding buy?...continued

We continued to invest in **reducing health inequalities**.

A total of **39 projects** were funded with a focus on supporting mental health but also included prevention, children & young people and homelessness. A third of projects **supported community empowerment and increasing equity of access to services**. **We are grateful for the voluntary sector delivering a large number of these projects.**

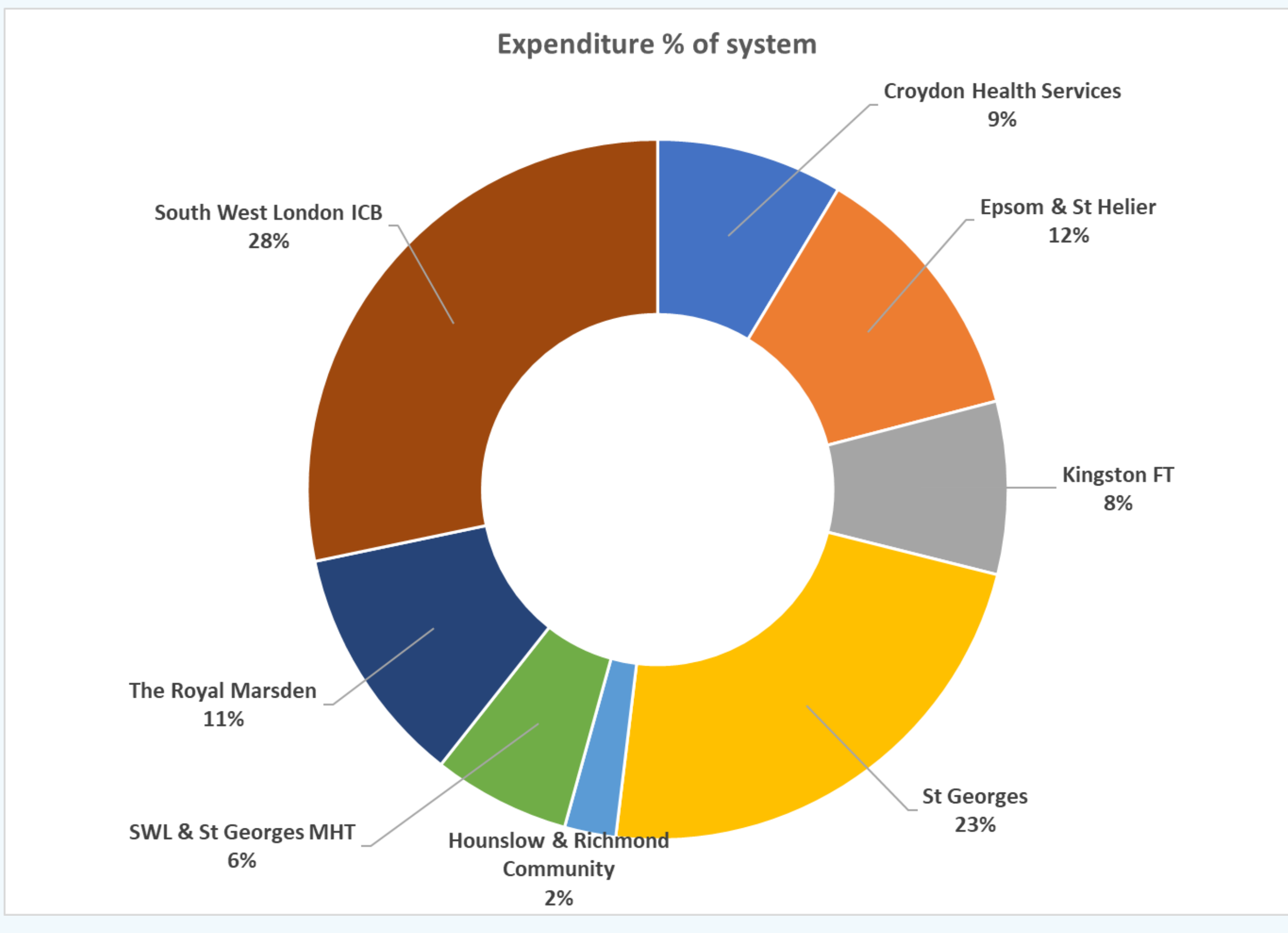
Three ongoing projects were scaled up to South West London level: SPEAR's work on homelessness (to be delivered across all 6 boroughs), setting up of social prescribing for children and young people and implementation of the 'Brazil Model' from Battersea, in all boroughs. **The Brazil to Battersea Model is a scheme which transformed the health of people in Brazil's poorest neighbourhoods.**

In addition, we continued to **invest in mental health services**. With an additional £25.1m (9.18%) allocated through the mental health investment standard. This enabled the NHS to:

- Work to improve recovery rates and quality of life for serious mental illness and mild to moderate mental health conditions
- Improve levels of access to services across different communities
- Work towards reducing suicide and self-harm rates
- Work to reduce rates of detention for men from black ethnic backgrounds
- Increasing understanding of mental health issues and wellbeing amongst communities

NHS SWL system finances 2023/24

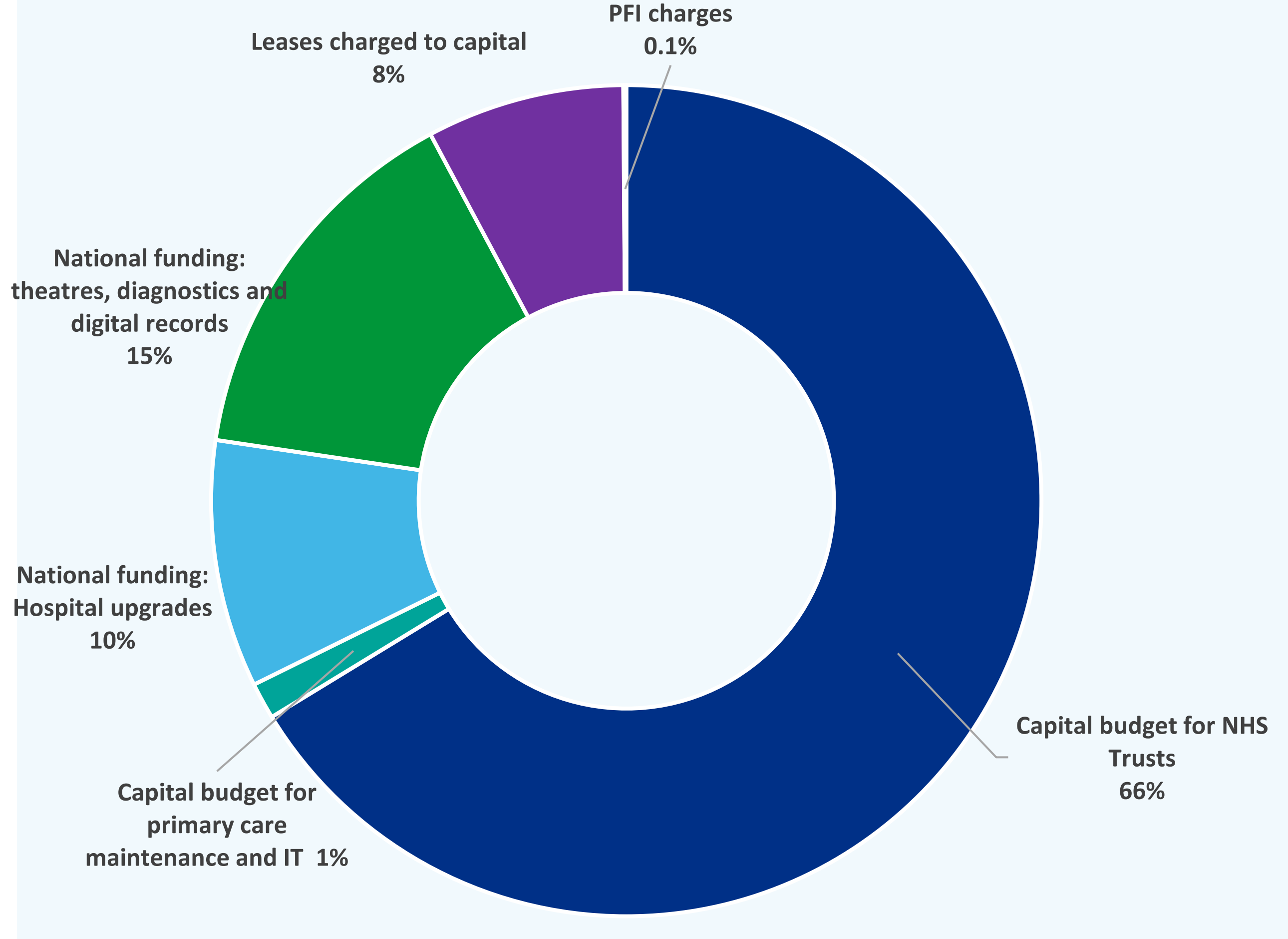
NHS SW London 2023/24 Draft Integrated Care System (ICS) Spend



- In 2023/24 the SWL providers and ICB combined funding was **£5.73bn** (excluding ICB funds spent with SWL providers).
- These funds were spent on healthcare for SWL population and any patients that travelled from outside the geography for treatment at our providers.
- In-year the SWL NHS system **spent £5.8m less than it received,** but this included £81m of additional funding that will have to be repaid in future years.

NHS SW London 2023/24 draft system capital spend

The NHS SW London system spent £185.9m of capital funding in 2023/24 on the following key investments:



- Over 65% of the funds were spent on maintenance and other critical replacement investment in estates, IT and medical equipment to support day to day operations in our providers
- Other key investments included:
  - Completing the **new Intensive Treatment Unit** at Croydon University Hospital
  - Progress towards implementing a **new electronic patient record** at Epsom and St Helier Hospitals
  - Enabling works and further **development of proposals to redevelop the Tolworth Hospital site**
  - Building **community diagnostics capacity** in Kingston and Croydon
  - **SMART theatre technology** to support our net zero targets.
  - **Primary care** funding was allocated to reconfigure and refurbish practices in areas of deprivation, and where patient list sizes had increased.

Looking forward to 2024/25

Financial Plan 2024/25

- As we look forward the ICB has developed a financial plan for 2024/25 which reports a **planned surplus of £3.06m against the expected funding allocation**. This forms part of the wider NHS ICS financial plan (£120m overspend), which is under significant pressure to deliver additional planned care with a decreasing budget.
- This makes delivering current services within the current funding available very difficult and the requirements for **efficiencies and improved productivity increasingly important**.
- As a consequence, **the system is collaborating to deliver a financial sustainability plan** to ensure all organisations are able to deliver improve access, reduce waiting times and provide high quality services to the population within their financial envelopes.
- With a further ambition to **invest additional funding in the community to continue to address health inequalities and preventing illness.**

NHS
South West London
Introducing our case studies
Mike Bell, Chair

Proactive Anticipatory Care

Dr Annette Pautz, Kingston ICS Clinical Director
Shaheena Khan, Kingston PAC Care Co-ordinator

Proactive Care – An Overview

Overall Objective

"Proactive Care aims to optimise use of the health and care system for the Proactive Care population, by intervening **earlier**, **proactively**, and more **holistically**, whilst the patient is at home."

Inclusion Criteria

- Adults living with **2 or more LTCs** and frailty – moderate or severe
- Those experiencing health inequalities as defined by **Core20PLUS**
- Those individuals **reliant on unplanned care** - individuals who have attended A&E or urgent care services five or more times in the last 12 months and/or have been admitted as an emergency for a chronic ambulatory care sensitive condition (ACSC).

Operating Model

- Case identification
- Holistic Assessment
- Personalised Care and Support Planning
- Multidisciplinary working
- Coordinated care
- Interventions and support

Proactive Care in SWL (in numbers)

- Approx **1.7 million people** registered with a SWL GP Practice
- Over **170,000 people** living with 2 or more long term conditions
- Approximately **6,000 individuals** are included on the Proactive Care priority cohorts (all individuals have 2 or more long term conditions and have had 2 or more emergency admissions in the last 12 months)
- Highest number of individuals on the priority cohorts in SWL live in Croydon. Smallest number live in Wandsworth.
- There are **1,800 people** who experience health inequalities (defined by Core20PLUS) who live in Kingston and Richmond.
- There are over **44,000 people** living with 2 or more LTCs in Kingston and Richmond. Of these, over **16,000** have been diagnosed with moderate or severe frailty.

Data from Health Insights BI dashboard

Key Aims

- Reduce use of avoidable unplanned care
- Reduce avoidable exacerbation of ill health
- Reduce health inequalities
- Deliver a better patient experience
- Further develop the evidence base for proactive, integrated care in community setting
- Improve staff retention and satisfaction through opportunities for development, multidisciplinary working and effective coordination.

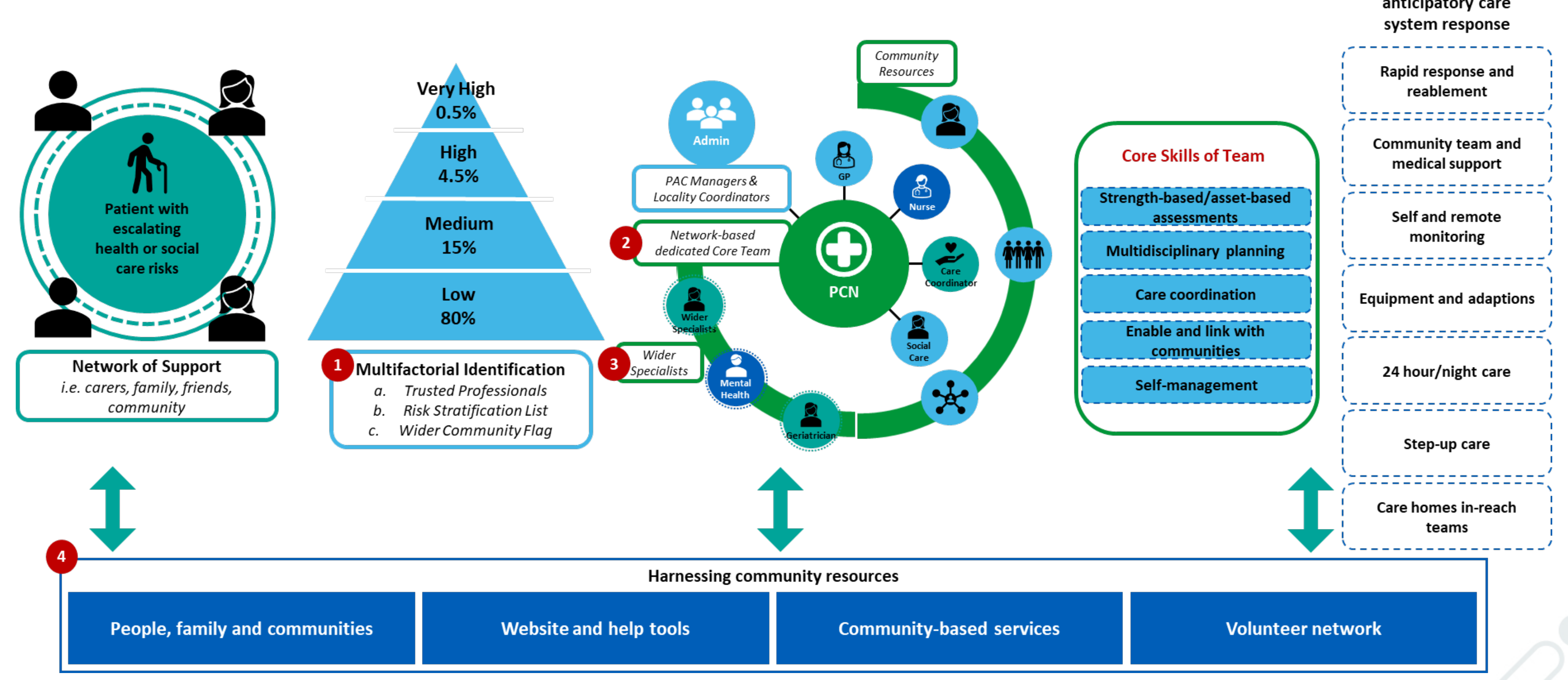
Workstreams within SWL Proactive Care Programme

1. BI (Analytics) – outcome dashboard development on Health Insights
2. Comms and engagement
3. Health Inequalities
4. Data and IG (bringing relevant ASC data into Health Insights)
5. Universal Care Plan

Programme Funding

- Ageing Well funding
- Some funding available at Place level

PAC Model of Care



1. **Multifactorial identification of escalating risks –** Identification of people done by trusted professionals using joint health and care risk stratification and professional judgement. Ability for wider community to flag concerns.
2. **Network based dedicated core team –** Dedicated core team of multi-agency professionals with time and capacity to focus on people with escalating risks in that network. Team to include medical, therapy, social and care-coordinators.
3. **Wider specialist and MDT –** Direct availability and support from wider MDT including geriatricians and mental health.
4. **Harnessing community resources –** Model to adopt a strength-based approach utilising opportunities with the person and family complemented by a range of community-based resources.
5. **Integrated and timely anticipatory system response –** Range of services that will require timely mobilisation beyond direct care and co-ordination from network-based core team.

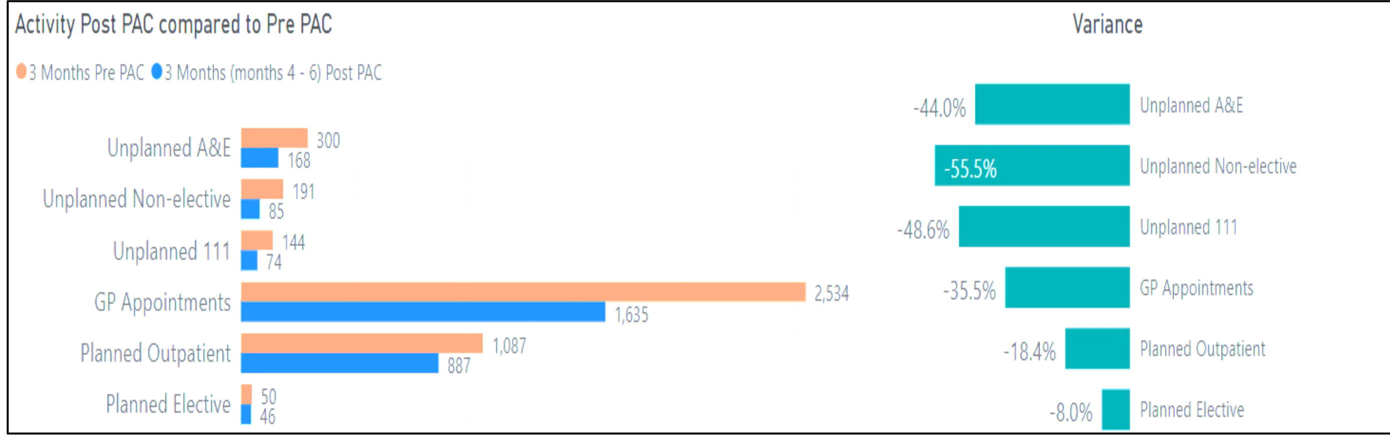
PAC Proof of Concept: Activity & Outcomes

Kingston (NM&WP PCN)	
Number of new patients discussed	**461**
Number of patient reviews undertaken	494
Total patient discussions	957
Patients accepted on PAC caseload	235
Average age of patients discussed	69
% patient sex (male)	44%
% referrals from GP	69%
% Care Lead assigned	99%
% Care Coordinator assigned	100%

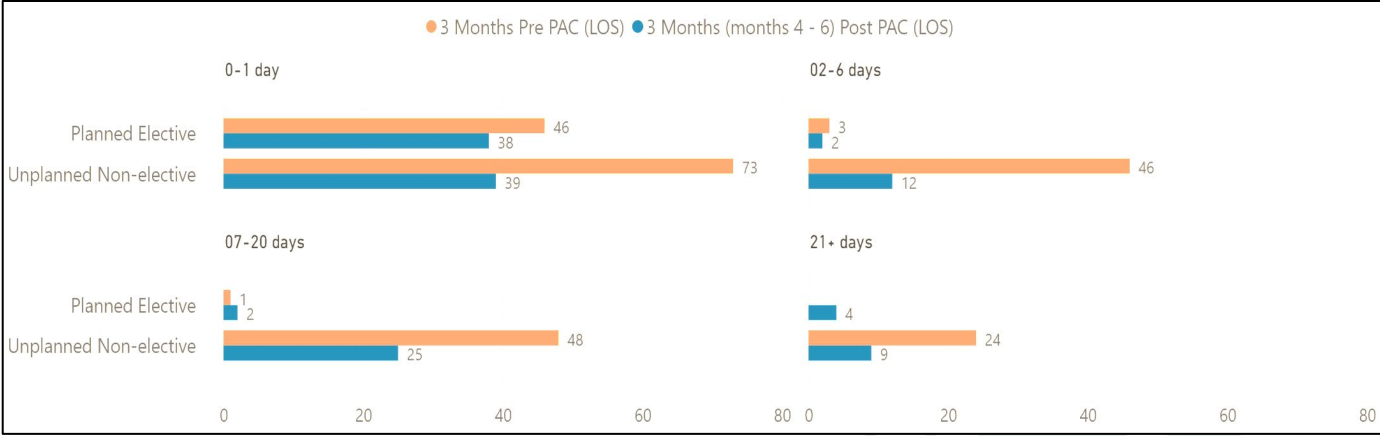
Richmond (Teddington PCN)	
Number of new patients discussed	**263**
Number of patient reviews undertaken	964
Total patient discussions	1233
Patients accepted on PAC caseload	234
Average age of patients discussed	74
% patient sex (male)	44%
% referrals from GP	48%
% Care Lead assigned	93%
% Care Coordinator assigned	80%

Data period: 10/05/21 to 31/08/23

Where patients have been on the PAC programme for 4 months or longer, **unplanned care has reduced by 49% overall.**



Where patients have been on the PAC programme for 4 months or longer length of stay for unplanned non-elective reasons **has reduced by 55% overall.**



PAC Roll Out: Activity & Outcomes

Kingston	
Number of New Patients Discussed	**468**
Patients Accepted onto the PAC Caseload	199
Patients Not Accepted onto the PAC Caseload	269
Acceptance Rate	43%
Average Age of Patients Discussed	66
% Referrals from GP	86%

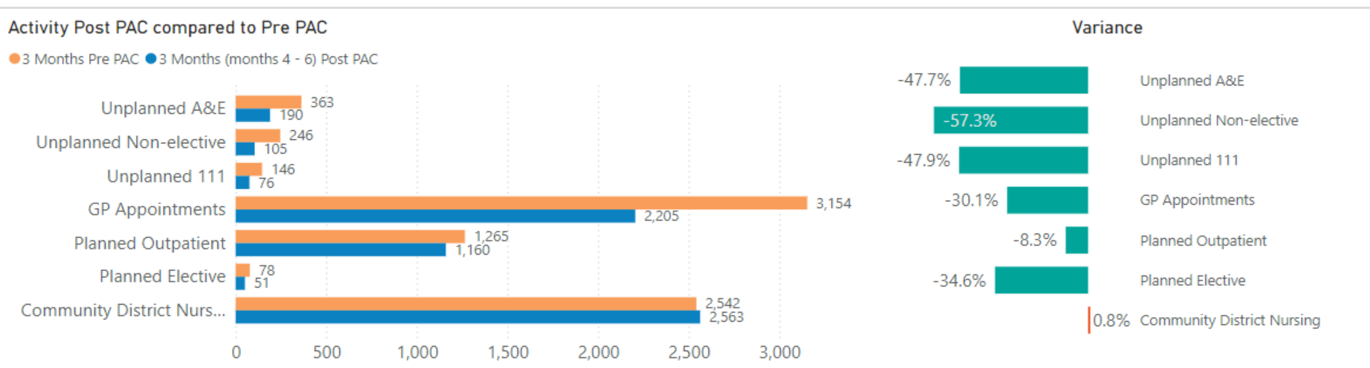
Richmond	
Number of New Patients Discussed	**472**
Patients Accepted onto the PAC Caseload	353
Patients Not Accepted onto the PAC Caseload	119
Acceptance Rate	75%
Average Age of Patients Discussed	74
% Referrals from GP	63%

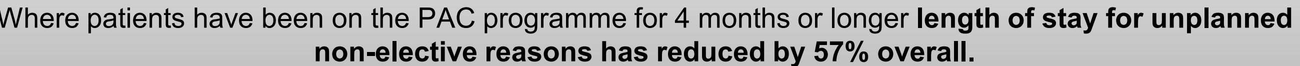
The Kingston acceptance rate is lower than that in Richmond due to later onboarding of some Kingston Care Coordinator posts during the phased roll out period (referrals were kept on a waitlist rather than 'accepted onto caseload' during this time). In line with data from the proof of concept, we expect acceptance rates to increase during the remainder of the year.

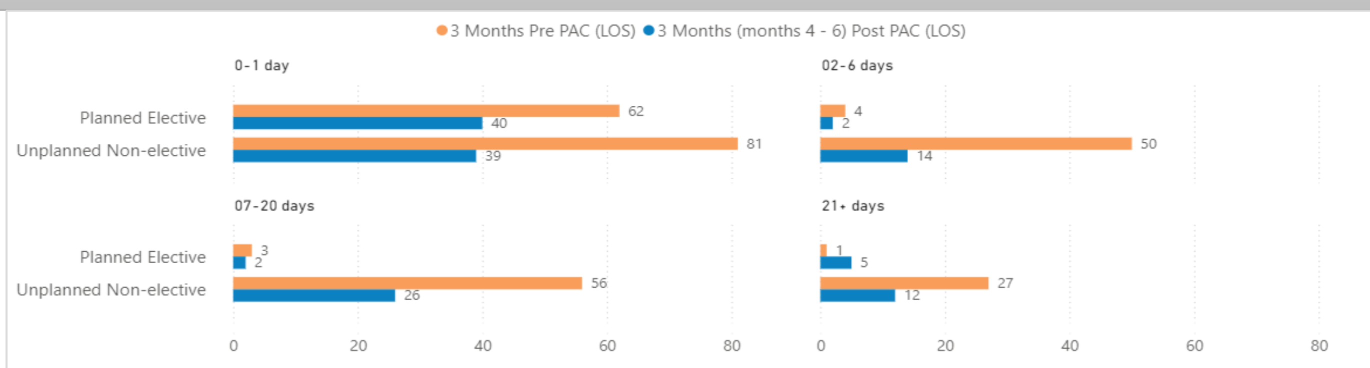
The service utilisation and LOS data does not currently include data from all Practices so should be treated as indicative – we are working with the Analytics team to improve this data quality.

Data period: 1st September 2023 – 2nd August 2024

Where patients have been on the PAC programme for 4 months or longer, **unplanned care has reduced by 51% overall.**







PAC Roll Out: Outcomes

NHS
South West London

Patient Feedback

Invaluable!

I value that my [Care Coordinator] takes my problems to heart. I would have not got this far without [their] help. It has been invaluable.

[Being on the PAC Programme] has helped point me in the right direction, helped me with contacts for support and helped to motivate me to reach out for help.

Just grateful, you've all shown the real spirit of looking after people. Grateful to the Community Matron and Care Coordinator. I'm lucky.

I realise I am more capable than I thought [and] that I am a nice person. I know what support is available. I have learned to look after me. I was lost before [my Care Coordinator] came into my life, she supports me with understanding my health condition which can be hard due to my dyslexia. [My Care Coordinator] has been a calming influence when I am not mentally coping.

Staff Feedback

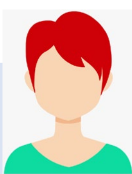
Patients referred to the PAC team have benefitted tremendously…[PAC] has made patients more independent in their own home, not afraid to seek help, have someone to contact when in need and take advice from the MDT team without delay.

PAC has encouraged more communication between professionals meaning more positive outcomes for patients.

PAC has helped so much in communication with patients and to educate families to manage their interactions. It would be great if this was more widely known in the UK.

It has worked extremely well and has enabled access to clear communication with professionals that we would not otherwise interact with. Having a care coordinator…has saved valuable time.

Excellent, it means that patients are managed effectively and kept out of hospital as much as possible.

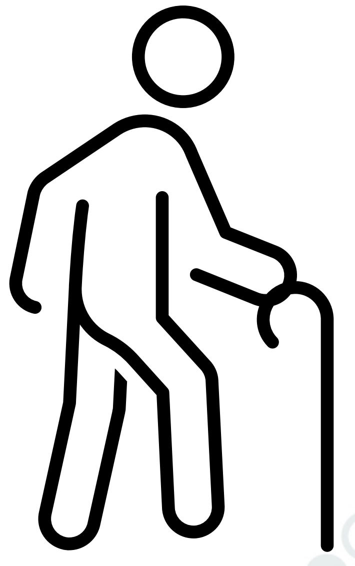


PAC Patient Case Study

Shaheena Khan, Kingston PAC Care Co-ordinator

Background

- 42 years old, female
- Multiple health problems
- Emotionally unstable personality disorder
- User of analgesia drugs, cannabis
- History of trauma



Additional Information

Reasons for GP referral:

- Lack of motivation and confidence
- Poor mobility
- Relationship breakdown
- Mental health concerns

Patient Goals:

- Adaptations to home
- help with personal care
- Assistance to manage debt.
- Support with mental health
- Support to consider reducing drug taking
- Bereavement support
- Reduce social isolation.

The PAC Journey

Shaheena (Care Coordinator) provided support to the patient in the following areas:

- ✓ Referral to Adult Social Care for personal care support
- ✓ Referral for an urgent OT assessment
- ✓ Support with mental health
- ✓ Debt assistance
- ✓ Support to combat social isolation

Patient Outcomes

Significant improvement in wellbeing (due to support with housework/personal care)	Feels more in control of her finances	Improved mental wellbeing (attending community groups with new partner)
Improved independence and confidence	Reduced drug use (as she feels calmer and more content)	Feels ready to be 'stepped down' (but knows who to contact if needed)

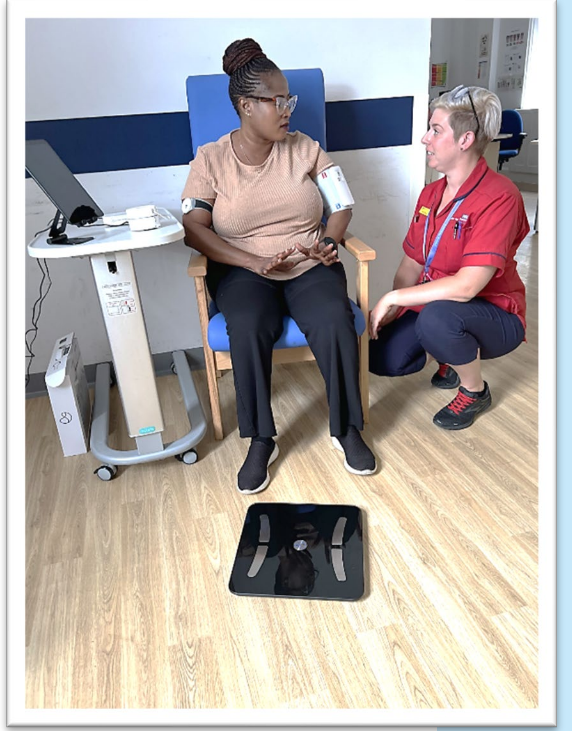
"I now have a support network for which I am very grateful to PAC"

Virtual wards

Aisling Vaugh, Operational Manager
Anna Ryan, Lead Matron for the Virtual Ward Inreach Team

Virtual wards caring for patients across South West London

- **9,013 patients** supported by virtual wards between April 2023 and March 2024
- **4,963 admissions avoided** and **3,926 early supported discharges**
- **56,657 bed days** for patients cared for by virtual wards during 2023/2024
- **Between 751 and 1,044** new patients cared for each month
- On average, people stay on a virtual ward for **6.6 days**
- **34,000 days** that **patients** have been cared for in South West London's virtual wards in 2024 alone



Caring for thousands of Croydon's patients

Between 450-650 referrals into the service every month

Approx 250 patients monitored remotely since 2022

3,320 patients cared for in 2024 so far

Over 20,000 days that patients have been cared for in Croydon's virtual ward in 2024 alone

Hospital standard care, in your own home

Suitable patients include those who can safely be cared for at home, such as those with:

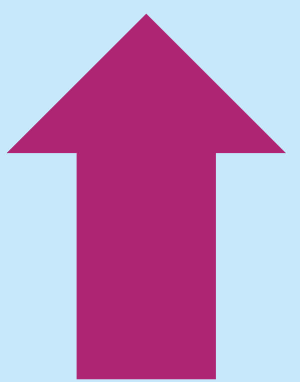
- fluid overload
- exacerbation of COPD/Asthma
- infections (UTI/ chest/ diverticulitis)
- viral infections
- gastroenteritis
- post-op monitoring and more

We are also piloting new pathways, such as ‘oxygen weaning’ for respiratory patients, allowing us to look at what further support we can offer patients and the Trust.

Adapted model to meet the needs of local people

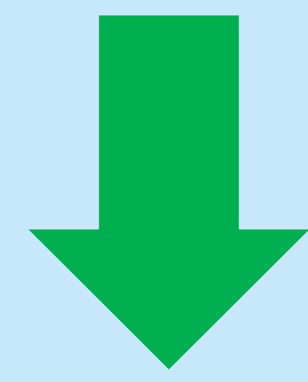
Croydon has high levels of deprivation, low levels of digital literacy and ageing patients with multiple complex conditions; so we adapt our offer dependent on who we are caring for.- fully ‘digital’ is not right for everyone!

Supporting our local health and care system



Able to ‘step up’ care, taking referrals from primary care, nursing homes and direct from London Ambulance Service…

…as well as stepping down hospital inpatients, who can be cared for safely at home, with the help of our virtual ward in-reach team



From Brazil to Battersea

Dr Jenni Ellingham, Battersea Primary Care Network
Habeebah Green, Community Health and Wellbeing Worker

Community Health and Well-being Workers

From Brazil to Battersea

Dr Jenni Ellingham, GP Battersea Primary Care Network
Habeebah Green , Community Health and Wellbeing Worker

Partners

From Brazil to Battersea

Brazil

- About 275K Community health workers in Brazil
- Employed Non- clinical workers, from the local community
- 150 households/ FT worker
- Proactive, looks at the household as a whole
- Integrates health and social care
- Vital part of the Primary Health care team
- Long term building trust
- 34% reduction in CVD mortality

Pimlico SW1V

- Started in 2021
- 600 households – 4 community workers
- After 1 year

  47% in crease in imms uptake

  Screening uptake 82% more likely

  3x more likely Health checks

Battersea – Doddington Estate SW11

- Battersea Fields Practice as host practice
- 64% Core 20. 12% +5
- 75 different first languages
- The changing face of North Battersea
- Started August 23
- 1FTE CHWW – initially visiting 120 households,

The team

1 Year on…

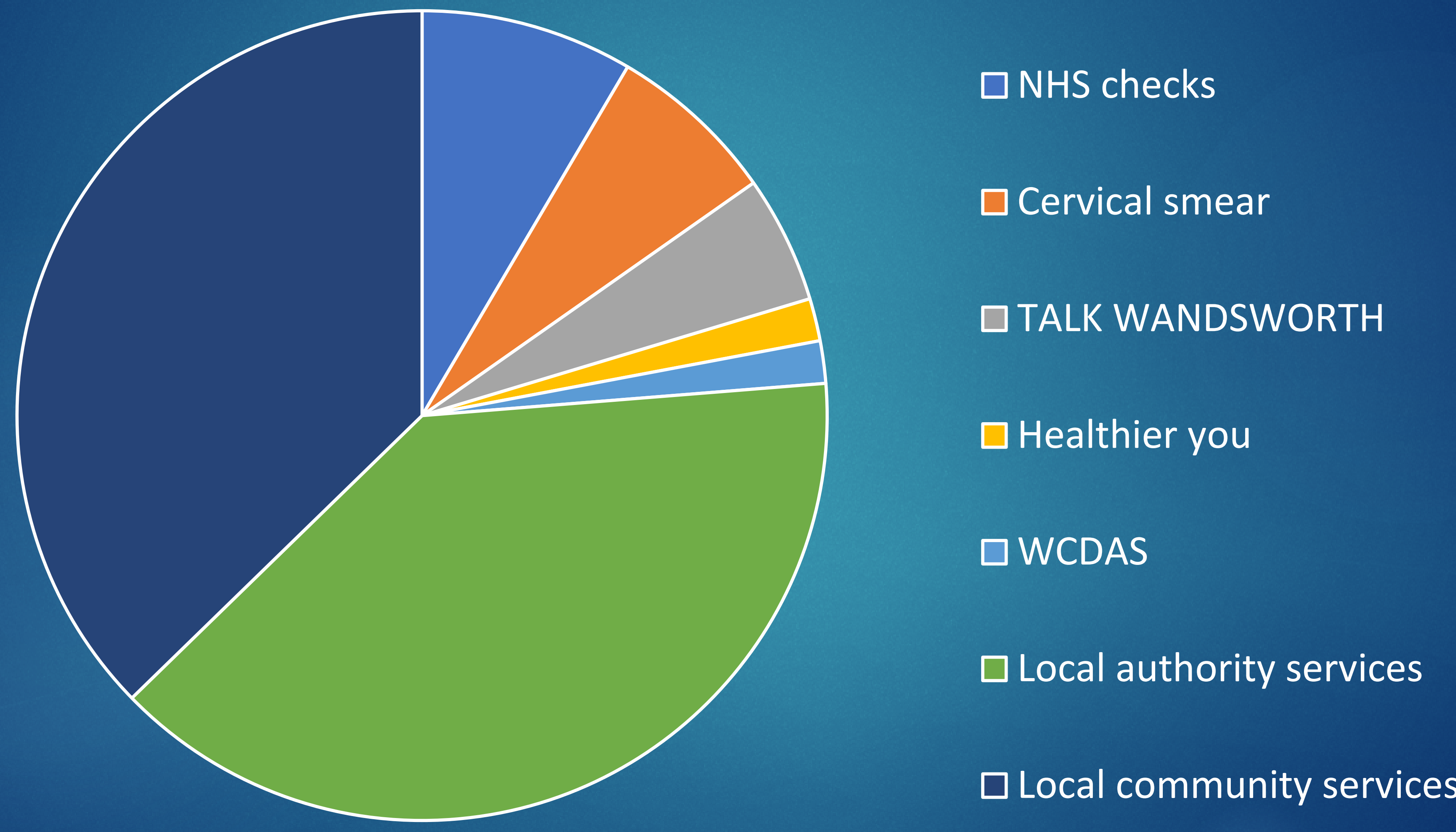
- The sweet spot !
- Recruited service manager
- Recruiting new CHWW
- Additional household – aiming to be reaching 240 households in next few months
- 846 door knocks- since Oct 23
- Currently 408 residents, 487 "meaningful contacts"
- 5 Health and well being breakfasts - …. Up to 15 attendees

1 year on….

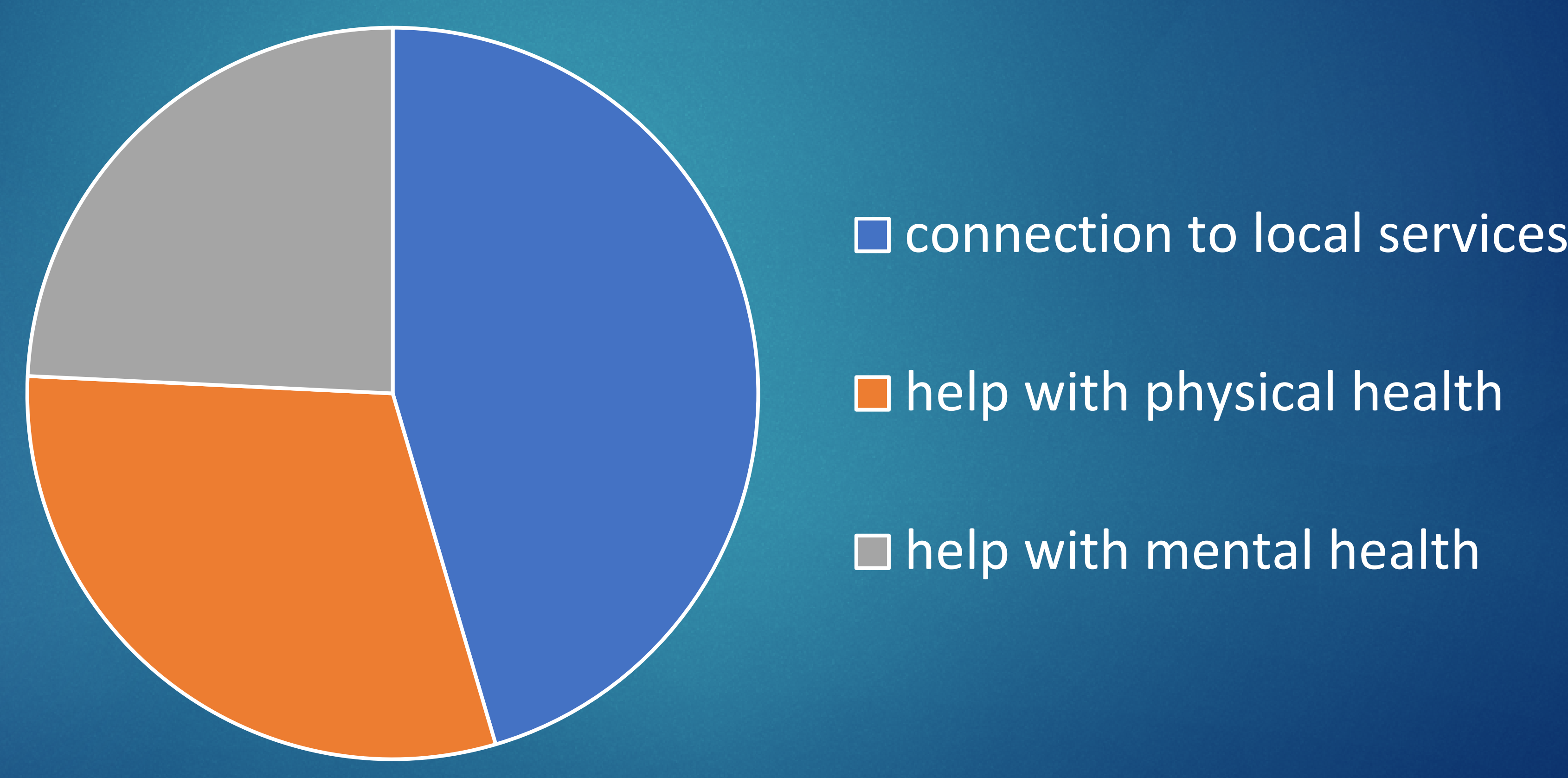
- Ambassadors within the ICB and nationally
- NHS England Health Inequalities Lead –

  Prof Bola Owolabi visit March 24
- Habeebah and Rhianna are NAPC champions
- The opportunity to champion other initiatives within the community eg Connected Lives Parenting Course
- The opportunity to be a central part of Integrated Neighbourhood Teams

Onward referrals-



Resident survey – What has been most helpful?



Stories from the team

"I really appreciate the help from Rihanna as a community worker. She helped a lot, she is the best person I ever met"

Doddington Resident

Challenges ahead

- Building a resilient team
- Reaching the Sweet Spot
- Building and maintaining the trust of the local community

NHS
South West London
Looking ahead to 2024/2025
Sarah Blow, Chief Executive Officer

Looking ahead

- New government and new direction for the NHS going forward
- Ensuring safe and sustainable services for South West London
- Working in partnership

Independent investigation of the NHS in England

Lord Darzi's report

The Government commissioned an eminent surgeon, Lord Ara Darzi, to undertake a rapid investigation of the state of the NHS

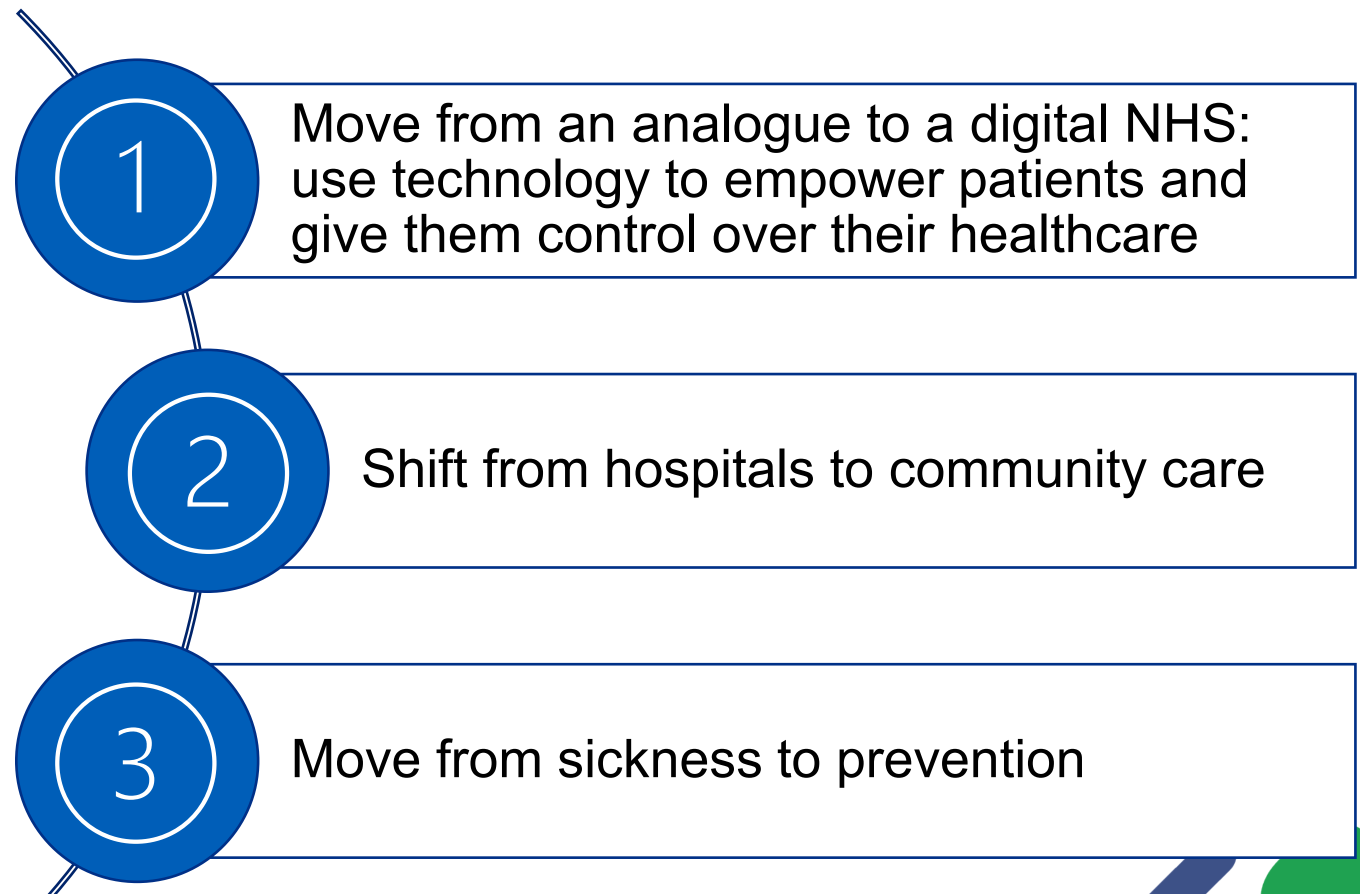
There are multiple and interlinked challenges facing the NHS

The Prime Minister has said that NHS reform will be set out in the 10-year plan, which is due to be published in the Spring – with a period of engagement beforehand

- **Austerity** - most austere period in NHS history - lacking capital investment
- **The legacy of the Covid pandemic** - the state of the NHS is not due entirely to what has happened within the health service. The health of the nation has deteriorated and that impacts its performance
- **The NHS budget should be spent differently** – more in community and primary care services, less in hospitals and we need to improve productivity
- **Waiting times and access need to improve**– for primary care, community care, mental health and hospital care
- **Staff and patient voice** – needs be a driver of change

The 10-year plan for the NHS and the 3 shifts

- The Prime Minister has suggested the 10-year plan will be framed around three key themes.
- We anticipate October-December as a consultation period on the new 10-year Plan
- The NHS will be talking to front line staff, communities and partners



Our plan and strategy

NHS Joint Forward Plan

Our five-year plan for the NHS in South West London

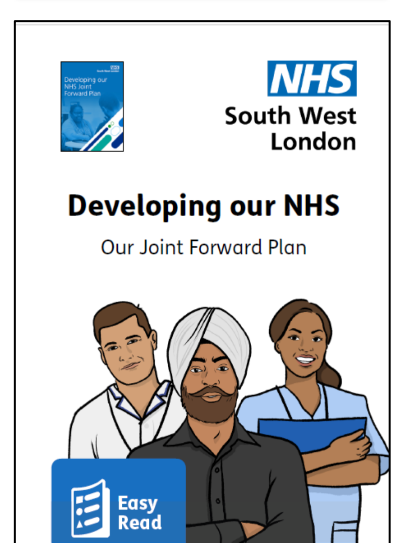
Integrated Care Partnership Strategy

A shared strategy for health and care across South West London

NHS Joint Forward Plan: 2023-2028

The eight priorities of the Joint Forward Plan are:

1. Prevent ill health and support people to self-care
2. Reduce health inequalities
3. Keep people well and out of hospital
4. Provide the best care wherever patients are accessing our services
5. Use technology to improve care
6. Manage our money
7. Make South West London a great place to work
8. Deliver the NHS requirements of the Integrated Care Partnership strategy



Integrated Care Partnership Strategy

A shared strategy for health and care across South West London

Our shared ICP priorities:

Reducing **Health Inequalities**	**Preventing ill-health**, promoting self-care and supporting people to manage long term conditions	Supporting the health and care needs of **children and young people**
Positive focus on **mental well-being**	Community-based support for **older and frail people**	Tackling our system-wide **workforce challenges**

South West London
Integrated Care Partnership
Strategy
2023-2028

Five missions for a financially sustainable system for South West London

MISSION ONE: We will transform elective care and reduce waiting lists

MISSION TWO: We will redesign our non-elective pathway, reduce unnecessary stays in hospital and ensure seamless care

MISSION THREE: We will redesign our NHS workforce to support our changing services and meet the changing needs of patients

MISSION FOUR: We will deliver a long-term financial strategy for each Trust and NHS organisations across SWL

MISSION FIVE: 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

Your questions

Mike Bell, Chair

Thank you for joining us

A copy of the recording and presentation will be made available on our website:

www.southwestlondon.icb.nhs.uk