NHS
South East London

NHS South East London Integrated Care Board
Population Health Equity Executive
Terms of Reference

FINAL – 23 May 2022

1. Introduction

1.1. We have an ever-intensifying perfect storm of stalled improvements in life expectancy, growing inequalities, immediate and medium-term impact of the pandemic, growing demand with a tired and stretched workforce, along with cost-of-living increases and an economic outlook that will disproportionately affect the most vulnerable in our communities. If this is our context, we cannot continue to do more of the same. A new approach is needed.

1.2. It is in and because of this context that we have established the Population Health Equity Executive (PHEE). The PHEE will develop shared ambitions and priorities to ensure that inequalities and public health are actively targeted, implemented, and spread at scale throughout the ICS. It will do this through embedding a population health approach throughout all activities.

1.3. The PHEE will oversee a joint programme of work between SEL ICS and King's Health Partners. The programme has three areas of work; as they are interrelated we refer to them as 'cogs' of work. They are:

1. Population Health Management (PHM) and Data;
2. Prevention and Inequalities; including The Vital 5 and Core20Plus5
3. Making the most of our Assets.

1.4. The PHEE is supported by a Population Health Equity Partnership Advisory (PHEPAG). This PHEPAG has a wide membership of partners from across health, social care, public health and wider within the ICS. It provides both strategic and operational input into our priorities (linked to the ICP strategy) to ensure collective alignment.

2. Purpose

2.1. The purpose of the PHEE is to provide executive oversight of the programme of work and hold coherence on all activities (of the programme and of the wider work within our organisations) related to population health and equalities.

2.2. The PHEE oversees SEL population health equity activities that take place at the system level across SEL. It identifies gaps in delivery which the ICS can collectively target.

2.3. In support of these, the PHEPAG has an important complimentary role as a representative group of stakeholders from across the ICS that tests thinking and provide input into strategic development

3. Scope

3.1. The PHEE is concerned with all activities across the ICS relating to population health, population health management, and inequalities in our population of south east London.

a. **Population health** includes any activity aimed at improving the health and well-being of a defined population health, whilst simultaneously reducing inequalities. This includes steps that address wider determinants of health.

b. **Population health management (PHM**) is a specific tactic within population health approaches. It involves **data driven planning and delivery of care**, to achieve maximum impact at improving the health of a specific population.

c. **Inequalities** within PHEE scope are the systematic, avoidable and unfair differences in health outcomes between different groups of people, driven by the four key policy factors of socio-economic factors (e.g., income), geography (e.g., urban/rural), specific characteristics (e.g., sex, ethnicity, disability), and socially excluded groups (e.g., people experiencing homelessness).

3.2. PHEE provides a coordinating and promoting role across the ICS, to ensure coherence. This will ensure that SEL collective action is greater than the sum of its parts, and hence that inequalities will be reduced and population health improved.

3.3. The focus is on population health and inequalities, e.g., across pathways/settings with particular emphasis on reducing inequities in access, experience, and outcomes.

4. Duties

4.1. The PHEE will oversee and coordinate SEL's efforts to improve population health and reduce inequalities. It will test new ideas, sharing learning and celebrating best practice.

4.2. PHEE will ensure national best practice is incorporated, with onwards representation at regional and national population health equity bodies, including the London Health Equity Delivery Group.

4.3. Within the ICB committee and other sub-committees, PHEE will ensure that inequalities are embedded in all discussions.

4.4. PHEE's main remit is to coordinate activity across the ICS. Coordination across the Population Health Equity Programme will ensure maximal benefit is realised from simultaneous development of each "cog":

4.5. **Cog 1: Population Health Management**

a. PHEE will focus on restoring NHS services inclusively and ensuring that datasets are complete and timely.

b. It will enable SEL ICS to establish PHM as the way of working in SEL, using data and local insights to improve population health and delivery of care and health equity.

4.6. **Cog 2: Prevention and inequalities**

a. PHEE will focus on Core20PLUS5 & the Vital 5, focusing on accelerative preventative programmes.

b. This 'cog' will relentlessly focus on identifying and tackling the small number of things that disproportionately impact health and health inequalities.

c. Working with the Directors of Public Health across SEL, we will target the key drivers of poor outcomes and inequalities in SEL through enhanced health promotion and prevention, starting with Core20Plus5 and The Vital 5 (hypertension, smoking, obesity, mental health, alcohol misuse). Additional priorities include ensuring that more people with cancer are diagnosed at an earlier stage, and inequalities in Covid vaccine uptake are addressed. Focus on health checks for people with a learning disability (LD) or severe mental illness will continue.

4.7. **Cog 3: Make the most of our assets/ Health in All Policies (HiAP)**

a. In this cog, PHEE will focus on identifying potential partners, with whom to explore collaboration on specific workstreams aligned to the goals of the SEL Population Health Equity Programme.

b. We will continue to establish an 'Anchor system' which recognises our assets of population, staff, organisations and communities.

5. Accountabilities, authority and delegation

5.1. The Population Health Equity Programme is a joint programme between SEL ICS and King's Health Partners. The Population Health Equity Executive is the ICS sub-committee supporting and overseeing the programme of work.

5.2. PHEE reports to the South East London ICB and ICP.

5.3. Reporting into PHEE is the 'Prevention & Equalities Working Group'. This is chaired by Catherine Mbema (Director of Public Health, Lewisham). It has a broad range of members from different disciplines and boroughs within SEL.

5.4. Reporting into PHEE is the Population Health Equity Partnership Advisory (PHEPAG). which tests thinking and provides strategic input. This is chaired by the PHEE Co-chairs.

5.5. Individual members and advisory/task and finish group leads are responsible for reporting back on activities.

5.6. The PHEE may establish a working group or task and finish group to lead work under a defined term of reference / engagement. It must agree by majority on the establishment of any of the groups and formally agree their terms of reference.

5.7. The PHEE will consider reports from place-based meetings, provider collaboratives, clinical senates, safeguarding partnership and adult boards, thematic work (e.g. advisory/task and finish group), national policy work and other sources.

5.8. Key points from meetings will be formally recorded and made available.

6. Membership and attendance

6.1. The PHEE will be constituted of members from ICS partner organisations, non-ICS partners and the wider system. PHEE members will include:

- ICS CE (Joint Chair)
- KHP Managing Director (Joint Chair)
- ICS CMO(s)
- DPH (representing 6 SEL DPH)
- ICS Executive Director of Planning

- Director of Population Health and Inequalities
- A place-based executive with local authority background
- KHP Director Partnerships and Programmes
- Inequalities Lead, Planning Directorate
- Prevention Lead, Planning Directorate
- Director of System Development

6.2. The PHEE is permitted with agreement of the chair and a majority of members, to formally co-opt additional members and/or other subject matter specialists to broaden the range of input should this be deemed necessary. The Executive may additionally request subject matter experts attend on a one-off or *ad hoc* basis as required.

7. Chair of meeting

7.1. The meeting will be jointly chaired by the ICS CE & KHP Managing Director

7.2. At any meeting of the PHEE one of the co-chairs will chair (typically on a rotating basis). If they are both absent, ICB Executive Director of Planning shall preside.

7.3. If the presiding Chair is temporarily absent on the grounds of conflict of interest, ICB Executive Director of Planning shall preside, or, in the case that they also may not, then a person chosen by PHEE members shall preside.

8. Quorum and conflict of interest

8.1. The quorum of PHEE is at least 50% of members.

8.2. In the event of quorum not being achieved, matters deemed by the chair to be 'urgent' can be considered outside of the meeting via email communication.

8.3. PHEE agrees to enact its responsibilities as set out in these terms of reference in accordance with the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles).

8.4. Members will be required to declare any interests they may have in accordance with the ICB Conflict of Interest Policy. Members will follow the process and procedures outlined in the policy in instances where conflicts or perceived conflicts arise.

9. Decision-making

9.1. The PHEE does not have formal decision-making authority relating to budgets or other organisational resources.

9.2. Any proposals arising from the Executive (e.g. for use of resources) should be requested via the usual ICS governance process.

10. Frequency

10.1. PHEE will meet bimonthly, subject to annual review.

10.2. All members will be expected to attend all meetings or to provide their apologies in advance should they be unable to attend.

10.3. Members are responsible for identifying a suitable deputy should they be unable to attend a meeting. Arrangements for deputies' attendance should be notified in advance to the PHEE Chair and meeting secretariat.

10.4. Nominated deputies will count towards the meeting quorum as per the protocol specified in the ICS constitution, which means individuals formally acting-up into the post listed in the membership shall count towards quoracy and deputies not formally acting-up shall not.

10.5. Members and staff members from ICS partner organisations are expected to contribute to reasonable requests for information and input to the work undertaken by the PHEE.

11. Reporting

11.1. Papers will be made available five working days in advance to allow members to discuss issues with colleagues ahead of the meeting. Members are responsible for seeking appropriate feedback.

11.2. The PHEE will report on its activities to ICB and ICP. In addition, an accompanying report will summarise key points of discussion; items recommended for decisions; the key assurance and improvement activities undertaken or coordinated by the PHEE; and any actions agreed to be implemented.

11.3. The minutes of meetings shall be formally recorded and reported to the NHS ICB.

12. PHEE support

12.1. The KHP team will provide business support to the PHEE. The meeting secretariat will ensure that draft minutes are shared with the Chair for approval within three working days of the meeting. Draft minutes with the Chair's approval will be circulated to members together with a summary of activities and actions within five working days of the meeting.

13. Review of Arrangements

13.1. The PHEE shall undertake a self-assessment of its effectiveness on at least an annual basis. This may be facilitated by independent advisors if the PHEE considers this appropriate or necessary.