Integrated Care Board – Meeting in Public

12.30 to 15.45 on 31 January 2024

160 Tooley Street London SE1 2TZ

Chair: Richard Douglas, ICB Chair

Agenda

No.	Item	Paper	Presenter	Timing
-	**Public Open Space** *Opportunity for members of the public to meet the board ahead of the formal meeting*	-	-	12.30
	Opening Business and Introduction			
1.	**Welcome** Apologies for absence Declaration of Interest. Minutes of previous meeting actions and matters arising	 **A** **B**	 RD RD	12.45
	ICB corporate business			
2.	**Operating Plan** *To receive the operating plan for 2024-25, and a discussion of the Medium Term Financial Strategy being implemented by partners.*	**C**	SC/MF	12.50
	Report for Assurance and discussion of current issues			
3.	**Chief Executive Officer's report**	**D**	AB	13.10
4.	**Overall report of ICB committees and Provider Collaboratives** **Update from the Quality and Performance Committee** **Update from the Planning and Finance Committee**	**E**	TF/ABh SC/PL SC/MF	13.15
5.	**Board Assurance Framework** • **Assurance on key risks from committee chairs**	**F**	TF	13.35
	Delivering our Integrated Care Strategy			

6.	**Digital as an Enabler** *Presentation of progress of priority digital actions and future plans and seek input into a review of the digital strategy*	**G**	BB	13.55
7.	**Borough Focus – Southwark** *A presentation of local work taking place in Southwark*	**-**	MW	14.15
8.	**Strategic Priority: Ensuring a good start in life** *A discussion on the ICS priority*	**H**	MW/RD	14.40
Reducing Health Inequalities				
9.	**Update on Perinatal care** *To discuss the progress made by the Local Maternity and Neonatal system in addressing inequalities identified nationally in relation to perinatal care and support the work.*	**I**	PL/ GB	15.10
Closing Business and Public Questions				
10.	**Any other business**	**-**	RD	15.30
11.	**Public questions and answers** *An opportunity for members of the public to ask questions regarding agenda items discussed during the meeting.*	**-**	-	15.35
CLOSE 15:45				

Presenters

Richard Douglas (RD)	Chair
Andrew Bland (AB)	Chief Executive
Tosca Fairchild (TF)	Chief of Staff
Sarah Cottingham (SC)	Deputy Chief Executive and Executive Director of Planning
Paul Larrissey (PL)	Acting Chief Nurse
Angela Bhan (ABh)	Place Executive Lead Bromley
Mike Fox (MF)	Chief Financial Officer
Beverley Bryant (BB)	Chief Digital and Information Officer KCH and GSTT
Sam Hepplewhite (SH)	ICB Director of Partnerships & Prevention
Prof Clive Kay (CK)	Partners Member
Fiona Howgego (FH)	Managing Director - NHS SE London Acute Provider Collaborative
Gina Brockwell (GB)	Chief Midwife Evelina London and Chair Local Neonatal and Maternity Service

NHS South East London

NHS South East London Integrated Care Board
Register of Interests declared by Board members and attendees
Date: 31/01/2024

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Richard Douglas, CB	Chair	1. Senior Counsel for Evoke Incisive, a healthcare policy and communications consultancy 2. Trustee, Place2Be, an organisation providing mental health support in schools 3. Trustee, Demelza Hospice Care for Children, non-remunerated role.	Financial interest Non-financial professional interest Non-financial professional interest	March 2016 June 2022 August 2022	Current Current Current
Andrew Bland	Chief Executive	1. Partner is an NHS Head of Primary Care for Ealing (a part of North West London ICB)	Indirect interest	1 April 2022	Current
Sarah Cottingham	Deputy Chief Executive and Director of Planning	None	-	-	-
Peter Matthew	Non executive director	None	n/a	n/a	n/a
Paul Najsarek	Non executive director	1. Non-executive director for Richmond Fellowship mental health charity 2. Advisor to Care Quality Commission on their approach to local authority assurance 3. Non-executive director for What Works Centre for Wellbeing 4. Policy spokesperson for health and care for the Society of Local Government Chief Executives 5. Local Government and Social Care Ombudsman 6. Board member, The Health Foundation	Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	April 2022 April 2022 2017 2017 April 2023 April 2023	Current Current Current Current Current Current
Anu Singh	Non executive director	1. Non-executive director on Camden and Islington FT Mental Health Board 2. Non-executive director for Barnet, Enfield and Haringey NHS Trust 3. Non-executive director on Board of Birmingham and Solihull ICS. 4. Independent Chair of Lambeth Adult Safeguarding Board. 5. Member of the advisory committee on Fuel Poverty. 6. Non-executive director on the Parliamentary and Health Ombudsman.	Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	2020 2020 March 2022 April 2021 2020 April 2020	Current Current Current Current Current Current
Dr. Angela Bhan	Director of Place, Bromley	1. Consultant in Public Health for London Borough of Bromley.	Non-financial professional interest	1 April 2020	Current Current Current
David Bradley	Partner member, mental health	1. Unpaid advisor to Mindful Healthcare, a small start up providing digital therapy 2. Wife is an employee of NHS South West London ICS in a senior commissioning role 3. Chief Executive (employee) of South London and Maudsley NHS Foundation Trust	Non-financial profession interest Indirect interest Financial interest	April 2019 July 2019	Current Current Current

Date last saved: 29/01/2024 09:39

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Andrew Eyres	Director of Place, Lambeth	1. Director of Lambeth, Southwark and Lewisham LIFTco, representing the class B shares on behalf of Community Health Partnerships Ltd for several LIFT companies in the boroughs. 2. Married to Managing Director, Kings Health Partners AHSC 3. Strategic Director for Integrated Health and Care – role spans ICB and Lambeth Council.	Financial interest Indirect interest Non-financial professional interest	1 April 2013 1 April 2021 1 October 2019	Current Current Current
Tosca Fairchild	Chief of Staff	1. Partner is a Consultant in Emergency Medicine. Potential to undertake locum work. 2. Bale Crocker Associates Consultancy – Client Executive 3. Non-Executive Director, Bolton NHS Foundation Trust	Non-Financial Professional Interest Financial Interest Financial Interest	01 May 2022 03 May 2022 01 Dec 2023	Current Current
Mike Fox	Chief Finance Officer	1. Director and Shareholder of Moorside Court Management Ltd 2. Spouse is employed by London Regional team of NHS England 3. Friends of Green Lane Primary School –Treasurer of the PTA	Financial interest Indirect interest	May 2007 June 2014 16 Jun 2023	Current Current Current
Dr. Toby Garrood	Medical Director	1. Shareholding in Serac Healthcare 2. Consultant rheumatologist at Guy's and St Thomas' NHS Foundation Trust (GSTT) 3. In my role at GSTT I have received research and service development grant funding from Versus Arthritis, Guy's and St Thomas' Charity, Pfizer, Gilead and NHSx 4. I undertake private practice at London Bridge Hospital 5. Honorary Treasurer for British Society for Rheumatology 6. Frensius-Kabi sponsorship for educational meeting	Financial interest Financial interest Financial interest Financial interest Non-financial professional interest Sponsorship	April 2020 2009 2018 2012 July 2020 30 March 2023	Current Current Current Current Current
Dr. Jonty Heaversedge	Medical Director	1. Sessional GP at Crowndale Medical Centre in Lambeth 2. Clinical director, Imperial College Health Partners 3. Director, Vitality Ltd – a wellbeing communication consultancy	Non-financial professional interest Non-financial professional interest Financial interest	1 March 2017 1 November 2019 1 March 2015	Current Current Current
Angela Helleur	Chief Nurse	1. Member of Kings Fund Council	Non-financial professional interest	May 2021	Current
Ceri Jacob	Director of Place, Lewisham	None	n/a	n/a	n/a
Prof. Clive Kay	Partner member, Acute	1. Fellow of the Royal College of Radiologists 2. Fellow of the Royal College of Physicians (Edinburgh) 3. Chief Executive (employee) of Kings College Hospital NHS Foundation Trust	Non-financial professional interest Non-financial professional interest Financial interest	1994 2000 April 2019	Current Current Current
Martin Wilkinson	Interim Director of Place, Southwark	None	-	-	-
Sarah McClinton	Director of Place, Greenwich	1. Director, Health & Adult Services, employed by Royal Borough of Greenwich 2. Deputy Chief Executive, Royal Borough of Greenwich 3. President and Trustee of Association of Directors of Adult Social Services (ADASS) 4. Co-Chair, Research in Practice Partnership Board	Financial interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	November 2019 May 2021 April 2022 2016	Current Current Current Current

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Dr. Ify Okocha	Partner member, Community	1. Chief Executive (employee) of Oxleas NHS Foundation Trust 2. Director, Dr C I Okocha Ltd, providing specialist psychiatric consultation and care 3. Director, Sard JV Software Development 4. Director, Oxleas Prison Services Ltd, providing pharmacy services to prisons and Kent and South East London 5. Holds admitting and practicing privileges for psychiatric cases to Nightingale Hospital 6. Fellow of the Royal College of Psychiatrists 7. Fellow of the Royal Society of Medicine 8. International Fellow of the American Psychiatric Association 9. Member of the British Association of Psychopharmacology 10. Member of the Faculty of Medical Leadership and Management 11. Advisor to several organisations including Care Quality Commission, Kings Fund, NHS Providers and NHS Confederation.	Financial interest Financial interest Financial interest Financial interest Financial interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	2021 1996 2011 27/09/16 1992 1985	Current Current Current Current Current Current Current Current Current Current Current
Stuart Rowbotham	Director of Place, Bexley	1. Director of Adult Social Care and Health, London Borough of Bexley	Financial interest	16 January 2017	Current
Meera Nair	Chief People Officer	1. Royal College of Psychiatrists Trustee (and Lead Trustee for safeguarding and EDI) 2. The Maya Centre, Chair since 28 November 2022, and Trustee before that. 3. Amnesty International Member Nominations Committee	Non-Financial Personal Non-Financial Personal Non-Financial Personal	2nd Aug 2021 26th Nov 2019 1st Jul 2023	Current Current Current
Debbie Warren	Partner member, local authority	1. Royal Borough of Greenwich salaried Chief Executive transacting financially with the SEL 2. Lead London Chief Executive on Finance, also contributing to the London Councils lobby on such matters including health.	Financial interest Non-financial professional interest	December 2018 (acting in role from July 2017) March 2020	Current Current
Dr. George Verghese	Partner member, primary care	1. GP partner Waterloo Health Centre 2. Lambeth Together training and development hub director 3. Lambeth Healthcare GP Federation shareholder practice	Financial interest Non-financial professional interest Non-financial professional interest	2010 2022 2019	Current Current Current
Ranjeet Kaile	Director of Communications and Engagement	None	-	-	-
Paul Larrisey	Acting ICB Chief Nurse	None	-	-	-
Beverley Bryant	CDIO	None	-	-	-

Integrated Care Board meeting in public

Minutes of the meeting on 15 November 2023

Bromley Civic Centre, Council Chamber, Stockwell Close, Bromley BR1 3UH

Present:

Name	Title and organisation
Richard Douglas [Chair]	ICB Chair
Anu Singh	Non-Executive Member
Paul Najsarek	Non-Executive Member
Prof Clive Kay	Partner Member Acute Care
Andrew Bland	ICB Chief Executive Officer
Dr Angela Bhan	Bromley Place Executive Lead
Ceri Jacob	Lewisham Place Executive Lead
David Bradley	Partner Member Mental Health Care
Dr George Verghese	Partner Member Primary Medical Services
Sarah McClinton	Greenwich Place Executive Lead
Stuart Rowbotham	Bexley Place Executive Lead
Mike Fox	Chief Finance Officer
Andrew Eyres	Lambeth Place Executive Lead
Martin Wilkinson	Interim Southwark Place Executive Lead
Dr Toby Garrood	ICB Joint Medical Director

In attendance:

Neil Kennett-Brown	COO Greenwich Place
Paul Larrisey	ICB Director of Quality
Sarah Cottingham	ICB Deputy CEO and Director of Planning
Tosca Fairchild	ICB Chief of Staff
Sam Hepplewhite	Director of Prevention and Partnerships
Ranjeet Kaile	ICB Director of Communications and Engagement
Julie Screaton	Chief People Officer Guys and St Thomas Trust
Meera Nair	Chief People Officer Lewisham and Greenwich NHS Trust
Sam Hepplewhite(item 8)	Director of Prevention and Partnerships
Hayley Ormandy (item 8)	Programme Director Prevention and Vital Five Kings Health Partners
Fiona Howgego (item 9)	APC Managing Director
Dr Elizabeth Aitken(item 9)	Clinical and Care Professional lead for Quality.

1.	**Welcome and Apologies**
1.01	Richard Douglas as Chair welcomed members, attendees and members of the public to the meeting. Apologies for absence were recorded from Dr Ify Okocha Beverley Bryant, Peter Matthews, Dr Toby Garrood, Debbie Warren and Sarah McClinton
	Receive Register of Interests
1.02	The Board received the register of interests. No additional interests were declared or conflicts of interest in relation to items on the agenda.

	Minutes of previous meeting actions and matters arising
1.03	The minutes of the meeting held on 19 July 2023 were **approved** as a record of the meeting.
1.04	Richard Douglas advised the board that the ICB had implemented required processes for the Fit and Proper Persons test. The national requirements for NHS organisations had been based on recommendations made by Tom Kark's 2019 review and needed to be fully implemented by 31 March 2024. Work was underway and no concerns had been identified.
1.05	The action log was reviewed.
2.	**Borough Focus - Bromley**
2.01	The Board received a presentation on how the One Bromley health and care partnership was working to attract its future workforce and retain current staff. The initiatives had been developed in response to high vacancy and turnover rates, an ageing workforce, and barriers to recruitment such as lack of understanding of job opportunities career pathways, complicated job searches and an association of health and care jobs with low pay and long hours.
2.02	The One Bromley recruitment campaign had focused on a website, videos and social media based on research. The materials aimed to promote the careers at One Bromley and Bromley itself as a great place to live. The impact of the ongoing programme would be monitored with a view to sharing learning across South east London.
2.03	The One Bromley Cadets Programme was aimed at attracting younger people to work in the health and care sector in Bromley. Based on best practice and consultation with local schools, the programme aimed to highlight the many career paths available in addition to medicine and nursing professions, and provide work experience opportunities in health and care settings and support with university and job applications. Every young person who had enrolled in the Connect programme of after-school sessions for 16-19 year olds had completed the programme, and had rated the programme 3.7 out of 4.
2.04	Anu Singh praised the work and highlighted the importance on work to improve retention of existing staff. Greater flexibility for people to move between the health sector and the care sector during their career would also be useful.
2.05	Dr Jonty Heaversedge noted that the wider socioeconomic opportunities created within south east London were important as anchor organisations within the system. Local care partnerships had a role to access local communities in support recruitment in the whole system, and not just out of hospital care but the hospital trusts as well.
2.06	Professor Clive Kay welcomed the work, whilst pointing out the need for co-ordination in the context of limited available staff to avoid a successful campaign un-intentionally attracting people away from other areas of need in south east London.
2.07	Stuart Rowbotham noted that links to the wider south east London people strategy was important. In Bexley care workers were being given opportunities to develop their career by becoming trusted partners who could complete care act

2.08	assessments and sometimes go on to social work training programmes. He agreed that further work was needed on moving between healthcare and social work. The Board **noted** the update.
3.	**Primary Care Access Recovery Plan**
3.01	Sam Hepplewhite presented the local actions being taken in response to the national plans for recovering access to primary care. South east London's Joint Forward Plan had previously set out a range of actions at Local care partnership and place level as well as across south east London, which contributed towards these goals. The plans and progress on actions had been set out in the paper with an update on each borough as well as progress on system-wide requirements such as digital and telephony tools, self-referrals, communications, and use of the Additional Roles Reimbursement Scheme ARRS and System Development fund.
3.02	The Board were asked to note challenges and risks including reliance on the outcome of community pharmacy contract negotiations and the national rollout of cloud telephony, current workforce challenges across primary care, the risk that changes and increased triage may cause confusion with patients and that there would be variation across practices. General practice in south east London had never before been so busy or delivered so many appointments, and there was likely to be additional pressures over winter.
3.03	Residents would understandably expect immediate improvements, but progress would require a combination of many actions. It would be important to engage both primary care colleagues and patients on the plans, and to provide the time and resources for the changes to be implemented.
3.04	Dr Toby Garrood was leading work to understand and improve the interface between primary and secondary care in recognition of the need to improve the flow of patients through to the specialist services they required. A significant amount of engagement was taking place with the aim of developing principles to support cultural change and improve patient experience as well as reduce workload.
3.05	Paul Najsarek asked about the risk identified of variation between practices, and whether this was based on varying needs, and how the system might encourage primary care needs to be prioritised in the planning of new housing developments.
3.06	Anu Singh asked how the priorities for the work might be measured, whether by patient experience or experiences of colleagues. In providing care navigation and making improvements to the existing system it was important to also embrace bold and new steps towards how primary care should work.
3.07	Dr George Verghese supported the proposition to build forums to improve the Primary care/Secondary care interface. It was important that this involved the full system with participation from acute medical colleagues and not just primary care. There were concerns from primary care that it was not yet clear how bureaucracy they faced would be reduced.
3.08	Dr Angela Bhan that there were sometimes constraints on access to central resources such as training. Inconsistency on interpretation of elements such as social prescribing or provision for falls, suggested a need for consistency across

	the system. The public would also need to be enabled to access the services they needed.
3.09	The Board **noted** the update.
4.	**WRES and WDES and WDS2022**
4.01	Tosca Fairchild thanked the Board for their support of Equality, Diversity and Inclusion and referred them to the detailed papers which set out action plans and indicators based on data provided by sources such as the NHS Staff survey. The organisation's aim was equality for everyone irrespective of their characteristics as they worked in, or applied for, jobs within the ICS. The current documents focused on staff directly employed by the ICB.
4.02	Anu Singh recalled the Board's previous discussions recognising the need to ensure deliverables were achievable, but asked if there were any areas where there was an opportunity for the ICB to accelerate the delivery of the actions and demonstrate excellence to lead by example.
4.03	Ceri Jacob suggested that more targeted interventions may be required to address specific issues - for example a relative lack of progression for black and minority ethnic staff from Agenda for Change Band 6 to Band 7 and from Band 7 to Bands 8a. The impact of hybrid working on accessibility for example for disabled colleagues may also need to be better understood.
4.04	Richard Douglas noted the Board's support for an increase in ambition in this area and suggested that the board would need to return to the issue in the context of the management cost reduction process to consider resetting ambitions in this area.
4.05	The Board **noted** the findings of the WRES and WDES reports, **endorsed** the action plans to address disparities and **approved** the WRES and WDES for publication.
5	**CEO report**
5.01	Andrew Bland referred to the report and highlighted items for the Boards particular attention. He thanked those involved in the successful implementation of the Epic system at Kings College NHS FT and Guys and St Thomas NHS FT. ICB employees were being consulted on changes as part of a management cost reduction exercise in which redundances were expected given the scale of the reduction. An update had been provided on the work of the SEL leadership academy. In personnel changes, the Board were advised that Dr Toby Garrood would increase the capacity available to the ICB after Dr Jonty Heaversedge left the ICB. Stuart Rowbotham had announced his retirement in 2024 and a process would begin to fill the role. The leadership role in relation to people and workforce pioneered for the ICS by Julie Screaton would now be taken on by Meera Nair.
5.02	The Board **noted** the Chief Executives report.
6	**Report of the ICBs Committees**
6.01	Richard Douglas asked the Board to note the report of the ICB committees and to consider the three decisions escalated to the Board: The Bromley Local Care Partnership had submitted its revised terms of reference for approval following a

change in membership. The Planning and Finance Committee had recommended to the board a Community Health Services contract be awarded to Bromley Healthcare for a further two years following the expiry of the current contract on 30 November 2024. The Healthier Greenwich Partnership had recommended a deed of extension related to the current Section 75 agreement in place with the Royal borough of Greenwich expiring 31 March 2024 for a further three year term.

6.02 The Board **approved** the revised terms of reference for the Bromley Local Care Partnership.

6.03 The Board **endorsed** the recommendation for the community health services contract to be awarded to Bromley Healthcare CIC for a further two years following expiry of the current contract.

6.04 The Board **approved** extension of the section 75 agreement between the Royal Borough of Greenwich and South East London ICB.

Committee reports.

6.05 Sarah Cottingham updated on the ICBs performance against key metrics. Following some improvement during Q1, there had been a deterioration in performance over the previous three months driven by demand and capacity, flow and workforce challenges across both mental and physical health. Actions aligned to best practice were in place aiming to improve flow and allow waiting times to reduce, and there had been some improvement in ambulance handover delays following the implementation of the 45-minute handover policy.

6.06 In relation to elective and cancer considerably more patients were waiting more than 65 weeks and 78 weeks than modelled at the start of the year. A planned reduction in elective activity to allow the Epic system to be implemented and industrial action (with significant associated cancellations) were key drivers. There had been positive performance in relation to the 28-day standard for faster diagnosis, but there remained a significant backlog of those waiting more than 62 days for treatment, with further deterioration expected to be unavoidable.

6.07 In relation to non-acute performance, more bed-days were spent by patients outside the south east London area than had been modelled in planning, indicative of very high demand. There were proposals to increase the NHS bed capacity in relation to mental health. Length of stay in hospital for people with learning disability and autism was reducing, but there was an increase in inpatient care placements, mostly due to newly diagnosed patients. Performance was better than planned in relation to dementia diagnosis rates, physical health checks for people with LD and Autism, two-hour rapid response and GP appointment access.

6.08 Paul Larrisey gave an overview of quality issues. As part of monitoring patient safety, serious incidents, never events and quality alerts were reviewed in order to identify themes. The key theme in serious incidents related to suspected or actual suicide, and a deep dive had been conducted, showing that numbers were consistent with previous years but a trend towards younger individuals completing suicide, and a shift towards more females than men. In addition to existing work in south east London and across the capital the system quality group would discuss the issue in more detail. Three ‘never events’ reported in the quarter related to wrong site surgery, retained objects and scalding. An independent investigation had been commissioned following the death of a young person in the Child and

	adolescent Psychiatric Intensive Care Unit at South London and Maudsley NHS FT.
6.09	The Board **noted** the reports of the committees.
7	**Board Assurance Framework**
7.01	Tosca Fairchild presented the Board Assurance Framework which had been reviewed by the relevant committees within the ICBs governance structure.
7.02	Mike Fox updated that the planning and finance committee on 2 November 2023 had increased the residual risk score for SEL risk 394 which relates to system financial balance, given the current financial environment. Since this discussion details of a financial settlement had been made available to systems who had been provided with a funding in relation to the cost impact of industrial action, and ability to utilise unspent funds in previously ringfenced budgets. This additional funding, whilst substantial did not fully meet the entire projected financial gap, and colleagues across the system were currently working to identify opportunities to close the residual gap and achieve a forecast of financial balance by the end of the financial year, but were at the point of needing to consider potentially unpalatable decisions about trade-offs necessary to achieve this balance.
7.03	Andrew Bland added that board members should be aware that a draft submission would be required from the system by 22nd November. Chief Executives and Chief Finance Officers were meeting regularly to ensure everything was being done to make effective use of all budgets before making choices that may have an operational and performance impact. The board could be assured that all involved were firm in their commitment not to make decisions that would compromise the safety of patients particularly those needing emergency care.
7.04	Professor Clive Kay reiterated that the board should be reassured that patient safety was a primary concern. In the acute trusts a meeting had been convened with chief nurse and chief medical officers to discuss the impact and no decisions to reprioritise services would be made without sign off by clinical executive leads as with any cost improvement programme.
7.05	Richard Douglas pointed out that the injection of funds was very significant, and the ICS would be expected to reach the required balance using the means allowed, moderated by the commitments stated on the impact on patients. Highlighting the deadline for submission within the following week, he proposed that the board be engaged by correspondence on the final changes agreed by Executives of the ICB and large trusts. If there were any concerns by members that physical or virtual meeting was needed this should be advised to the Chair for action.
7.06	Prof Clive Kay noted that provider organisations would also require to engage their boards and asked whether this should occur sequentially or in parallel. Richard Douglas suggested that in view of the very short timescale given this would need to happen in parallel.
7.07	Richard Douglas pointed out that where risks had very high scores the Board would need to have available a fuller explanation of the risk and actions being taken in response.

7.08	Paul Najsarek commented that risks seemed likely to remain high for some time they perhaps effectively becoming 'issue'. Given the current pressures the number of red rated risks was understandable, but it highlighted the vital importance of transformation programmes as mitigations for example in relation to primary care or inequalities, and suggested a more conscious linking between strategy and the mitigation of risk.
7.09	Richard Douglas suggested that risks should have a full explanation and perhaps a discussion with the audit committee about whether a full Board discussion was needed. Tosca Fairchild suggested that this discussion focus on whether the controls in place listed against each risk were viewed as satisfactory. Prof Clive Kay suggested that committees might be expected to review risks affecting the areas within their terms of reference, and provide detail as part of their updates on their committees. David Bradley suggested that where a risk had remained highly rated for some time it might merit a discussion in any case.
7.10	The Board **approved** the Board Assurance Framework.
8	**Strategy: Prevention**
8.02	Sam Hepplewhite highlighted the Board's commitment to reducing inequalities by focusing on prevention and wellbeing, which had been reflected in the ICS strategic priorities, the Joint Forward Plan and a number of corporate objectives in relation to prevention. There was also investment in prevention in the inequalities fund. The paper showed work to embed prevention as part of the core service rather than as a standalone agenda. Across south east London examples included the cardiometabolic project, work on cardio vascular disease and immunisations, and a summary some of the range of activities locally had been provided for each Place. The ICB was also working with Kings Health Partners on the Vital five.
8.03	Haley Ormandy important that we have a joint population health and equity across KHP and ICB. The vital five were a small number of items felt to have the biggest impact on health and equity, including high blood pressure, healthy weight, healthy mind and tobacco and alcohol dependency. Vital metrics were also being developed for children given the need to address the whole life course and families together. Partners had been considering how to add value, embed consideration of the vital five and support people to manage their health and wellbeing.
8.04	Examples included rolling out the Ottowa smoking cessation model across all trusts, as well as more consistent community-based provision smoking cessation services across all boroughs. There had been thought given on how to provide culturally tailored and appropriate eight management programmes focussed on particular areas of need, for example the Up! Up! programme in Lewisham. There had also been work to pilot a novel screening tool for the vital five in community pharmacies and outreach services aimed to support people to know their numbers reduce risk factors and think about preventative education. Over 7000 checks had been conducted through a mixture of face to face and kiosk interfaces.
8.05	Sam Hepplewhite noted that a round table discussion on prevention had led to some approaches on next steps in prevention, this including continuing to value prevention and to commit beyond individual projects. Developing trust and relationships with residents was viewed as key as well as sharing knowledge and

	information in the way that people wanted it. A place based and comprehensive approach was advocated, and patience to allow results to be delivered over the long term.
8.06	Anu Singh suggested that the benefit of health interventions was often short-lived where they were not connected who local people were, how they lived their lives and what was important to them. Greater links with housing, employment and community building may be necessary to create a positive change in the way south east London people experienced their lives and happiness.
8.07	Paul Najsarek asked how the performance of these initiatives might be measured, for example with a statement of ambition, associated metrics and consideration of risks and mitigations.
8.08	Dr Jonty Heaversedge agreed that interventions should avoid an overly medicalised approach, and pointed out that the 'vital five' was useful in that it used measures that people were likely to use to describe their own health. There was a good opportunity to facilitate people knowing their own 'numbers' including the vital five and a population health management approach in future would enable preventative services to be provided to those who needed them most.
8.09	Professor Clive Kay asked if in the context of the financial situation of the ICS it would be more appropriate to prioritise a smaller number of interventions that delivered the best impact relative to the resources invested, and to increase focus on secondary prevention, rather than the mostly primary prevention measures outlined.
8.10	Andrew Bland noted the strategy process led by the Integrated Care Partnership has called out five priority areas, the delivery of which would extend beyond the NHS. Local care partnerships as well as local health and wellbeing boards had a role to contribute to areas such as housing, and the ICB had identified funding to support the strategy which currently was NHS funding but should move to a blended model. The ICP had representation from local government as well as Kings Health Partners. Richard Douglas emphasised that coming together of health with other areas would be at Place. With ICB and ICP both having a relationship back to each Place.
8.11	Angela Bhan estimated that health services contributed only 2-5% to overall health of population and recognising the wider determinants of health was crucial. The current mixture of primary, secondary and some tertiary prevention, although there was opportunity to work with public health more, as well as working in acute trusts more such as knife-crime.
8.12	Andrew Eyres noted that although the ICB had focused on NHS, there were a great deal of initiatives ongoing way in place for example holiday support for children and energy support during winter.
8.13	Ceri Jacob agreed that support provided came together at place and worked with councils and VCSE services. Some of these preventative approaches had benefit for the whole system such as Atrial Fibrillation.
8.14	Neil Kennett-Brown added that for example in discussions locally about MSK had brought to light a need for people to have more information about how to access the health service in general. The role of place was significant in this area and

	continuing to integrate with local authorities was important given strain on their budgets.
8.15	Martin Wilkinson offered examples of where connecting different partners was working for example the community connect work with teachers, parents, students and the health services to improve child mental health, and the south London listens initiative of listening to communities and being held to account directly by the community on pledges made in relation to mental health.
8.16	Richard Douglas reflected that most of the integration must be done at a local level, working with democratically elected local representatives. At ICB level general themes could be encouraged including financial and other support to enable this work to happen in communities.
8.17	Tosca Fairchild highlighted the importance of the cost-of-living crisis which affected everything from affordability of healthy food to the ability of health and care staff to afford housing. There was a role of the larger organisations as anchor institutions to provide support.
8.18	Anu Singh stated that the opportunity to think about how better health interventions in the light of wider determinants of health, rather than just doing the old things better.
8.19	Dr George Verghese opportunity for the ICB to promote the vital five screening as a clear signal for all places to focus on.
8.20	The Board **approved** the decisions recommended by its committees listed in the report.
9	**Enabler: Workforce**
9.01	Julie Screaton and Meera Nair gave a presentation on workforce and the under the direction of the People Board chaired by Dr Ify Okocha with NHS and social care working together.
9.02	Julie Screaton noted that the workforce had grown by 14% over the past five years and continued to grow, although there was expected to be a 20,000 gap for the NHS and 10,000 gap for social care by 2030. Other factors included new technology, new and different roles, and the need to focus on education. Recent industrial action, challenges with morale and goodwill were also factors. The workforce strategy focused on the high-impact actions which would be additive across the system. This included strategic workforce planning, making it easy for local people to work in the system. Training and education was important and better use needed to be made of the university sector. Promoting south east London as a great place to work with a culture of inclusion and wellbeing was critical with the south east London having a comparatively poor record on negative experiences of staff from minority ethnic groups. The work to deliver the strategy was characterised by collaboration, particularly among NHS employers on these key items as well as on payroll and other services.
9.03	Meera Nair outlined some of the work in delivering the strategy. In relation to recruitment activities with schools and colleges aimed to set up a pipeline of new people working in health and care, and there was consideration of how to reach people who were neurodiverse or disadvantaged. With funding from the London Mayer a health and social care jobs hub aiming to bring 700 young

	people into health and care sector. Standardising practice and promoting apprenticeships were a key part of increasing domestic supply as well as return to practice. The long-term plan aimed to reduce reliance on international recruitment but international recruits remained critical to all organisations. Retention of existing staff was a pillar of the long-term workforce plan, and focusing on health and wellbeing as well as equality diversity and inclusion were priorities. Flexibility on working patterns, rosters, hybrid working as well as wellbeing conversations were important ways to keep people in posts longer. New ways of working was an area of growth with funding on additional roles reimbursement scheme particularly in primary care. The education and training collaborative would aim to develop the skills needed in the future. Challenges to meet the future workforce needs were real and longstanding nationally, the focus of the work was therefore to create spaces where core values were upheld consistently, staff were safe supported and included, and build on this to deliver efficiencies as well as encouraging people to join the workforce.
9.04	David Bradley asked if there was anything that could be prioritised across the whole of the system to make a big difference rather than multiple smaller interventions. Julie Screaton suggested that a focus on ensuring equity for staff was likely to have the greatest impact on retention and morale, as well as improving retention. Practically, simplifying and collaborating on back office functions was important.
9.05	Dr Jonty Heaversedge emphasised that innovation was enabled not primarily by technology or financial means but by giving people working in the system the skill, capabilities and time to innovate. This in turn often gave people more motivation and satisfaction with their work. Innovation may also be brought to bear to mitigate some of the gaps, for example automation of processes to free up the time of staff. Julie Screaton suggested existing innovation resource and expertise within south east London could be combined to think around longer term contribution of innovation.
9.06	Anu Singh suggested that the work was important even though the impact would take some time to be felt. However, it may be useful to consider which elements were timed such that they could address the more immediate problems such as safer staffing on wards and flow. A wider understanding of workforce beyond the NHS and into social care was also important. Consideration and checking in with how the workforce were feeling was important in many areas it seemed that staff had not recovered since the pandemic and the cost-of-living crisis had exacerbated this. Whilst apprenticeships were welcomed, other systems had prioritised certain groups such as care leavers which may be useful to consider.
9.07	Julie Screaton suggested that improving retention even by a small amount had a greater effect than education and recruitment, and sharing best practice was a key function of the workforce programme. Work to support social care was difficult but some initiatives such as the wellbeing hub set up with NHS funding had also benefitted domiciliary care workers. In relation to wellbeing, morale was challenge and goodwill was lower, a new psychological contract with staff was needed.
9.08	Andrew Bland asked if co-ordination of ARRS role recruitment and retention support might help smaller organisations attract the workforce they needed, either across south east London or the whole capital.
9.09	Ranjeet Kaile reflected on the need to link better with local communities, and make jobs more accessible and exciting. This might involve rewriting job

	descriptions and be brave in reviewing standard wording or removing rigid requirements which put off or prevented young people from applying. Julie Screaton noted that the job application process was currently difficult, and the guys and St Thomas charity had sponsored an end-to-end review of the process which could be shared across the system.
9.10	Meera Naira added that recent research indicated that a feeling of a lack of respect and fairness was a common reason given for burnout and often a greater factor than workload itself.
9.11	The Board **noted** the update.
10	**Update on Elective Care and Inequalities approach**
10.01	Fiona Howgego set out the south east London Acute Provider Collaboratives' work on health inequalities in relation to the unprecedented waiting lists which had been seen following the pandemic. The biggest inequality was inequalities in access with length of waits varying between the three trusts. Work to reduce inequality included work on a standard pathway and framework for referrals and tests and medication protocols ahead of referral into secondary care ENT and urology. A three-month difference in waiting time had been identified in oral surgery and a single point of access had reduced the differential to one week. A SEL Inequalities dashboard brought together waiting list data from sources across primary and secondary was being examined for inequalities that could be addressed. For example it had been noted that DNA (Did not attend) rates varied with ethnicity, age and deprivation, and that in admitted pathways Black and minority ethnic people tended to wait longer than average.
10.02	Dr Elizabeth Aitken described work at Lewisham and Greenwich NHS trust where it had been noted that patients whose surgery was cancelled tended to have multimorbidity, and using an integrated data set matched to the waiting list it was identified anaemia and blood glucose control were a key factor in delays to surgery. By using a multidisciplinary approach to help optimise patients at the time they were listed, it was possible to start to avoid delays. Expanding this approach on head and knee surgery to integrate with the population health database was now underway, as well as work with patients themselves to identify their needs. Robust multidisciplinary teams and recruitment of additional resources to address anaemia control, as well as to create appropriate pathways for patients, aimed to improve clinical outcomes and patient experience and reduce surgery cancellations, reduce length of stay and avoid inappropriate referrals.
10.03	Dr Jonty Heaversedge strongly welcomed the approach which exemplified the population health management approach which could help improve peoples health in a targeted way rather than generic interventions, and showed how it might be possible to even to predict the areas where people may need better support.
10.04	Paul Najsarek welcomed the work and the way it had helped to define the problem. He asked how the outcomes could benefit residents across south east London as well as in specific trusts.
10.05	Fiona Howgego noted that an inequalities subgroup helped to oversee bids for inequality funding by individual institutions, however there was a commitment that these approaches were developed into interventions which could eventually be implemented as a system.

10.06	Neil Kennett-Brown noted that people with learning disability and autism had poorer outcomes because of physical health and there was an opportunity for this work to start to address this inequality.
10.07	David Bradley noted that by using the resources available at KHP was a real opportunity to help address inequalities in the system.
10.08	Angela Bhan suggested that there were inequalities in referrals and suggested that an approach to the whole pathway may be useful using this approach. Dr Elizabeth Aitken noted that addressing referral was the subject of co-production with patients to work with patient groups who tended to refer late to identify issues that could be resolved.
10.09	Anu Singh asked how the balance between building approaches in south east London and learning from approaches elsewhere which could be tailored. Dr Elizabeth Aitken noted that there had been work to ensure that learning from across the country had been considered and promoted in the system.
10.10	Prof Clive Kay noted that as well as the technology a cultural shift was starting to happen, and that this health inequalities should become the key thing for which the south east London ICB was recognised.
11	**AOB**
11.01	There was no other business.
12	**Public Questions and Answers**
12.01	Richard Douglas noted the questions received in advance with answers published on the website. There were no further questions from the public.
	Close

NHS South East London Integrated Care Board

ACTION LOG

REFERENCE	DATE ACTION AROSE	ACTION DESCRIPTION	STATUS	ACTION OWNER	DATE FOR COMPLETION	UPDATE/NOTES
		(None outstanding)				

Integrated Care Board meeting

Item: 2
Enclosure: C

Title:	**2024/25 Operational Planning**
Meeting Date:	31 January 2024
Author:	Sarah Cottingham, Deputy CEO and Director of Planning
Executive Lead:	Sarah Cottingham, Deputy CEO and Director of Planning

Purpose of paper:	To summarise planning guidance received, update on the ICB's proposed approach to planning and set out next steps	Update / Information	X
		Discussion	X
		Decision	
Summary of main points:	This paper provides a summary of the guidance received, provides Board members with an update on the ICB's proposed approach to planning and sets out next steps. The planning round for 2024/25 takes place against the backdrop of an extremely challenging 2023/24. Systems will need to develop their plans for next year over Quarter four. The Board will be engaged with regular updates on planning for 2024/25, alongside opportunities for direct input to the planning process by Board members, noting the need for Board sign off of the ICB's Joint Forward Plan refresh, the Joint Capital Resource Use Plan, and the final operating plan prior to final submission.		
Potential Conflicts of Interest	None identified		

Relevant to the following Boroughs	**Bexley**	**X**	**Bromley**	
	Greenwich	**X**	**Lambeth**	
	Lewisham	**x**	**Southwark**	

	Equality Impact	Prevention and Health inequalities is a 2023/24 planning priority.
	Financial Impact	The interplay with finance is addressed in the paper.
Other Engagement	Public Engagement	This paper is being presented to a Board meeting held in public for the purposes of transparency.

	Other Committee Discussion/ Engagement	The executive committee have agreed an approach engagement as part of the planning process and the planning and finance committee are kept updated.
Recommendation:	The Board is asked to **note** the update	

2024/25 Operational Planning

1. Background

1.1. NHS England (NHSE) published a number of documents related to the 2024/25 planning round on 22 December 2023. These are outlined below, noting that further, more detailed guidance is expected in the New Year, including the detail of operational priorities for 2024/25.

- A cover letter from NHS England.
- The draft national standard contract for 2024/25, which is subject to consultation prior to be finalised.
- Details of the proposed amendments to the national payment system for 2024/25.
- Updated Joint Forward Plan guidance for 2024/25.
- Guidance on developing Joint Capital Resource Use Plans for 2024/25.

1.2. This paper provides a summary of the guidance received, provides Board members with an update on the ICB's proposed approach to planning and sets out next steps.

1.3. The guidance received is very much a continuation of 2023/24 priorities, with a focus on improving current performance to meet core performance standards alongside a break even financial position, with an associated emphasis on demand and capacity planning plus productivity and efficiency improvement.

1.4. The planning round for 2024/25 takes place against the backdrop of an extremely challenging 2023/24. Start year financial plans required the setting of ambitious productivity and efficiency and cost improvement targets alongside a range of challenging performance commitments. The NHS has struggled to meet these objectives, with in year challenges significantly increased as a result of the on-going industrial action that the NHS has experienced. In SEL and across most of the country our 2023/24 outturn position may well exacerbate the 2024/25 planning challenges, with an underlying deficit financial position and waiting times and backlogs that are in excess of our start year plans. As we look forward to 2024/25 these financial, workforce, performance and flow challenges will remain, noting that the 2024/25 financial settlement, whilst one of growth, represents a lower uplift than that received over previous years.

1.5. Systems will need to develop their plans for next year over Quarter four. We will need to work back from the national planning timetable, noting this has not yet been published. We know however that we will need to produce refreshed Joint Forward Plans – the ICB's medium term more strategically focussed plan - for end March 2024, plus a number of 2024/25 operational planning templates, narratives and other outputs. These are expected to include triangulated plans across activity, workforce and finance, signed off by ICB and partner trust/foundation trust boards.

1.6. Alongside the overarching planning to support the delivery of national and local priorities the ICB will also need to agree contracts with providers for 2024/25, inclusive of the application of the NHS payment scheme (the funding arrangements and tariffs that will apply) and an updated national standard contract. Importantly the new Provider Selection Regime comes in to force in January 2024 and the ICB will need to ensure it demonstrably fulfils the requirements of the PSR in its planning and agreement of contracts for the provision of services for 2024/25.

1.7. As we undertake our planning for 2024/25, we will work closely with the Board to ensure regular updates are provided, alongside opportunities for direct input to the planning process by Board members, noting the need for Board sign off of the ICB's Joint Forward Plan refresh, the Joint Capital Resource Use Plan, and the final operating plan prior to final submission.

2. Summary of guidance requirements and ICB plans

Delivery expectations

2.1. High level expectations have been set out for 2024/25 planning, although the detail of delivery expectations and associated targets has yet to be received. In the meantime we understand that:

- Core national priority areas will remain as set out for 2023/24, with recovery plans for urgent and emergency (UEC) care, primary care access, elective and cancer care called out in the national guidance received to date. The national objectives in these and other areas listed in the 2023/24 planning guidance are summarised in Appendix 1 for information and context. We expect a focus on recovering and further improving core service delivery, inclusive of a focus on ensuring that required capacity, core UEC capacity, elective and diagnostic investment to support delivery of system activity targets and primary care investment to improve access, is in place.
- Systems will be expected to submit break even plans for 2024/25 from a finance perspective. We expect a key focus on productivity with productivity metrics that systems will need to measure their performance against, alongside action to reduce reliance on temporary staffing.

2.2. We will need to review and model the implications of 2024/25 delivery requirements once received, including working through the challenges of securing them in the context of our 2023/24 outturn position and taking due account of demand, capacity, workforce, productivity and efficiency, overall and relative priorities.

2.3. We have well established mechanisms for undertaking demand, capacity, activity and performance modelling and will continue with these approaches for 2024/25, with further work to ensure approaches that enable effective alignment with workforce and financial plans.

2.4. It will also be important to collectively better understand the barriers to securing a sustainable improvement in delivery, particularly in terms of access and waiting times to ensure our start year plans seek to unblock barriers and issues and mitigate in year delivery risks as far as possible. This will require the agreement of core actions that will underpin our improvement plans for the year.

ICB funding

2.5. Two-year allocations were notified to systems in 2032/24. Our understanding is that:

- The 2024/25 allocation notified last year will be confirmed in the detail of the forthcoming planning guidance, updated for in year allocative changes, related particularly to pay awards.
- The detail of the 2024/25 planning guidance will confirm further details around other funding streams, such as targeted Service Development Funds, capacity and discharge funding, noting our expectation is that these will remain as notified in 2023/24, albeit with further clarity required to confirm which funding streams are recurrent and which non recurrent in nature.

2.6. We have already started work to update our medium-term allocative strategy to reflect expected 2024/25 funding. Our objective is to retain the key principes, priorities and commitments agreed as part of our 2023/24 Medium Term Finance Strategy (MTFS), inclusive of the continued development of ring-fenced funding to support targeted investment in inequalities, alongside funding in line with the Mental Health Investment Standard, community based care and children and young people, aligned to our strategic priorities.

2.7. We already know that after the application of the convergence factor adjustment, an adjustment made to ICB allocations to bring them closer to target funding levels, available growth for investment will be extremely limited. We will therefore need to ensure we are focused on ensuring value for money across the totality of our funding, that where we do invest we are clear about the expected return on investment and that we are maximising opportunities around improving productivity and efficiency and service/care pathway transformation.

2.8. In developing our operational plans we will also need to take due account of external income e.g. from other commissioners as these are a key factor in determining our overall ICB financial position and particularly that of a number of our provider partners. We expect external sources of funding to be similarly tight, thereby amplifying the need to ensure a collective focus on cost and run rate rather than income as we plan for 2024/25.

2.9. We have already started work on our financial recovery plans for 2024/25, with the planned agreement of a number of core system wide recovery workstreams that we will collectively progress over 2024/25 and beyond. This will build from identified system opportunities related to productivity and efficiency, workforce plus transactional, infrastructure and care pathway opportunities. System wide workshops are planned for early 2024 to enable us to rapidly progress our plans, inclusive of ensuring effective resourcing to enable us to drive them forward and measure progress. As we undertake this planning, we will be ensuring join up with our wider operational delivery planning, to ensure alignment alongside ensuring we play in a clear population, inequalities, quality and outcomes perspective too.

Draft national standard contract

2.10. The NHS Standard Contract is intended to set national terms and conditions applicable for the 2024/25 financial year and the guidance released on 22 December 2023 includes the draft national contract for the forthcoming year, which is subject to consultation until end January 2024, following which a final contract will be issued.

2.11. The consultation sets out a number of proposed changes to the 2024/25 standard contract, including:

- Updating the contract to reflect new core quality requirements, such as the CQC Quality Statements, the Fit and Proper Persons Test framework, updated NHS complaints standards.
- A planned update to reflect 2024/25 national performance standards and deliverables.
- Updates to reflect wider changes to national policy and service provision, including the provisions of the Provider Selection Regime.
- Updated provisions around information breaches, activity management, audit and invoicing.
- The removal of specific provisions for items that have now become business as usual.

2.12. We will review the proposed changes with system partners and determine whether an ICB response to the standard contract consultation is warranted. The guidance on the contract also highlights the scope for the agreement of contracts for more than one year and we will consider this flexibility further with regards our core providers and in the context of the Provider Selection Regime requirements.

Proposed changes to the national payment system

2.13. The planning guidance sets out proposed changes to the way providers will be funded through contracts. Proposed changes are relatively small noting the payments guidance that was issued in 2023/24 was two-year guidance. The key areas highlighted in the updated guidance for 2024/25 include:

- Confirmation that the payment approach to support elective recovery – the Elective Recovery Fund (ERF) - will continue for 2024/25. Commissioners (ICBs and NHS England) will be allocated fair shares of ERF funding and an associated activity target for the year. Provider payment will be based on activity with payment made at 100% of tariff. The activity targets and ERF thresholds, which will determine when additional payments will be made to providers, have yet to be set for 2024/25, noting our expectation is that these will represent an improvement from 2023/24 targets.
- Some changes to payment arrangements in anticipation of the start of delegation of some specialised services to ICBS in 2024/25, including a number of new tariffs and a guaranteed minimum provider top up payment for specialised services.
- Pausing of the national CQUIN scheme for the year pending a further review of approaches to incentivising quality improvement going forward. This means CQUIN funding will be guaranteed to providers in 2024/25.
- Further guidance on payment for Evidence Based Interventions with a prior approval requirement for four procedures.
- Income protection around the implementation of GIRFT (Right Procedure, Right Place guidance).
- Some wider updating of tariffs, guidelines and values, including a revised weighting for the pay element of the cost uplift factor to align it to education and training tariffs.

2.14. The national guidance states that proposed changes when considered together are considered to have a relatively minor impact when applied at a provider level, but we will need to work through and understand impact for SEL and its providers.

2.15. As part of our planning for 2024/25 we will reflect the reviewed tariffs and payment arrangements in our assessment of underlying income against proposed funding envelopes at a provider level, noting there is no longer a direct correlation between price x activity and overall contractual income. Overall payment arrangements remain as for 2023/24 with providers of NHS services will be paid as follows:

- Aligned payment and incentive (API) contracts - fixed element for most services plus a variable element, with the variable element applying to elective activity which will be paid on a cost per case basis. This will be the default contract arrangement with NHS trusts.
- Low volume activity (LVA) – block payments nationally set for smaller value ICB to provider flows to reduce transaction costs.
- Activity based payments – cost and volume.
- Local payment arrangements – locally determined.

Joint Forward Plan guidance

2.16. The suite of national planning guidance documents includes updated guidance to Integrated Care Boards (ICBs) in relation to the Joint Forward Plans (JFP) that were first published by ICBs on 1 July 2023. In overall terms guidance remains as for 2023/24 with the following requirements:

- A requirement for the JFP to be refreshed annually, with an updated plan for 2024/25 onwards published at end March 2024. ICBs are expected to engage with partners on the plans, noting consultation is only required if the 2024/25 update represents a material change.
- The scope remains permissive with ICBs having flexibility to develop and structure the plans as determined locally. In doing so the guidance encourages ICBs to utilise the JFP to describe how it will deliver the system's integrated care strategy alongside a number of minimum requirements: how the ICB will arrange services to meet the needs of its population, the delivery of the national priorities and addressing the core purpose of integrated care systems and the statutory requirements of ICBs.

2.17. Three principles are reiterated in the 2024/25 guidance, namely that the JFP should be aligned to the wider partnership ambition in terms of both the integrated care strategy plus borough based Health and Well Being Plans, it should support sustainability by building on local strategies and plans plus NHS commitments and should be delivery focused, including where appropriate specific objectives, trajectories and milestones.

2.18. The ICB's 2023/24 JFP represented a bottom-up development process that met the national guidance recommendations, building from our Integrated Care Partnership strategic priorities, our six borough based Health and Well Being Plans and our core programme objectives across our key care pathways and our enabler functions.

2.19. For 2024/25 we will refresh our plans during Quarter 4, with a specific focus on:

- Assessing the delivery of the objectives we set out in 2023/24.
- Updating our JFP to reflect the progress made in further developing our integrated care strategic priority areas over 2023/24.
- Providing a more detailed view of our key priorities and objectives for 2024/25 and initial thinking around 2025/26, working back from the medium-term strategic objectives and vision articulated in our 2023/24 plan.
- Updating our plans to reflect national standards and requirements for 2024/25 and beyond.

2.20. We are not envisaging material changes to our plans, noting that we undertook significant engagement activity as part of our 2023/24 JFP development, which will be nine months old at the start of 2024/25. We intend therefore to make our update and refresh of the JFP for 2024/25 as light touch as possible, whilst ensuring we can demonstrate our 2023/24 progress and 2024/25 delivery priorities in the context of our medium-term vision and objectives.

Joint Capital Resource Use Plan

2.21. The planning guidance also sets out the need for ICBs to produce system plans around the utilisation of capital funding. The ask is that the plans:

- Set out how the ICB and partner trusts will use their planned capacity resource for the year, whilst ensuring that plans do not exceed the system Capital Delegated Expenditure Limit (CDEL).
- Plans should be aligned to integrated care system and Joint Forward Plan infrastructure strategies.
- Plans should further set out the vision, aims, objectives and strategic priorities to be addressed via capital investment.

2.22. The ICB has undertaken work over the last year to develop an agreed capital plan which has prioritised capital requirements and proposals against available resource. We have developed an agreed set of principles and priorities that will govern our forward approach. We will build from this in finalising our 2024/25 capital expenditure plans, ensuring a read across to our wider system strategies and plans.

3. Next steps

3.1. We will need to take stock of the planning requirements for 2024/25 and collectively consider our response to them and the overlay of our own priorities in the context of population need, current operational and sustainability challenges and care pathway improvement opportunities when the full suite of national planning guidance has been released. In the meantime we have sufficient information from which to progress our planning for the year ahead with immediate effective. On the operational planning aspects of the guidance:

- We had already started work on financial planning in terms of updating our allocative strategy to reflect 2024/25 allocations and the application of the

approach and commitments made in our 2023/24 medium term financial strategy. This will enable us to confirm a set of indicative financial envelopes to give certainty to our planning. We have also initiated work to ensure we have clear plans focussed on cost and productivity improvement for 2024/25 and beyond to enable us to develop plans that work back from the national break-even expectation. This will be challenging to achieve in the context of our underlying outturn position plus on-going operational delivery pressures that we will need to manage over the year ahead.

- We will also be undertaking work to need to work through the national delivery expectations and targets to ensure we understand what will be needed in terms of resourcing, be it physical capacity, workforce, wider infrastructure or agreed pathways to secure delivery. The Half Two (H2 - for Quarters 3 and 4) planning refresh that ICBs have recently completed, plus our regular monitoring and forecasting our expected year end positions across the key areas of performance, will be helpful in providing the baseline information from which to plan for 2024/25.

3.2. To support the above process we will be re-establishing our SEL planning groups, which involve ICB multi-disciplinary leads as well as provider planning leads to ensure a coordinated and joined up approach to the planning process. The outputs of this work will also be fed through provider and ICB governance to secure the appropriate approvals prior to our various planning submissions being made.

3.3. Our work will ensure that we put national priorities alongside our local priorities and objectives, noting these align in many areas to the national ambition but with a clear need to ensure that we are focussed on targeting our work and actions to meet the needs of the south east London population specifically. Our Joint Forward Plan refresh will enable us to draw out and update our local priorities thereby ensuring we cover these appropriately in our planning outputs.

3.4. We also need to agree contracts between the ICB and providers for 2024/25 which will require rapid and pragmatic work to agree baselines, associated activity plans and delivery objectives, noting we have existing mechanisms in place to support timely discussions and agreement with our major SEL providers.

3.5. As we progress our planning, we will be working to ensure we are able to give regular updates and seek the views and inputs of the Integrated Care Board and that we are geared up to produce the draft planning submissions that will be required as we make progress.

Appendix A

2023/24 Planning Priorities – from which 2024/25 priorities will be built

	Area	Objective
Recovering our core services and improving productivity	**Urgent and emergency care***	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise

	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

Integrated Care Board meeting

Item 3
Enclosure D

Title:	**Chief Executive Officer's Report**
Meeting Date:	31 January 2024
Author:	Andrew Bland, ICB Chief Executive Officer
Executive Lead:	Andrew Bland, ICB Chief Executive Officer

Purpose of paper:	**To receive the report from the Chief Executive Officer**	Update / Information	*X*
		Discussion	
		Decision	
Summary of main points:	This report updates the Board on matters of interest across NHS South East London since the last Board meeting on 15 November 2023		
Potential Conflicts of Interest	**None**		

Relevant to the following Boroughs	**Bexley**	**X**	**Bromley**	**X**
	Greenwich	**X**	**Lambeth**	**X**
	Lewisham	**X**	**Southwark**	**X**

	Equality Impact	Equality Impact Assessments are considered where applicable
	Financial Impact	N/A
Other Engagement	Public Engagement	Public engagement takes place where appropriate and this report is presented to the Board meeting in public and published on the ICS website
	Other Committee Discussion/ Engagement	N/A
Recommendation:	**The Board receive the Chief Executive Officer's Report**	

Chief Executive Officer's Report

The report that follows provides an overview of the activities of the ICB and its partners across the Integrated Care System seeking to highlight those issues that the Executive Directors and their teams have been addressing over the last period and to record those developments of note in our system.

Over the months of November to January our system has managed significant operational pressures combined with industrial action, whilst seeking to progress those priorities the Board has set to improve the health and wellbeing of our population. As with each of these reports it remains clear that the challenges we face are system wide and impact all our partners. Likewise, that the solutions will only be found in our combined and co-ordinated efforts.

Everything the ICB and its teams have undertaken and achieved over this most recent period has been conducted against the background of our Management Cost Reduction (MCR) programme, which has created additional uncertainty for our staff as they received proposals for new structures that include a reduction in staff numbers going in forward. I want to place on record my gratitude to our staff who have exhibited a professional approach throughout.

The report sits alongside our wider Board meeting agenda that will deal with the performance of the system and the actions we are taking to improve it. Of particular note is the process of re-planning that the NHS – and our ICB are a part of it – has undertaken since we last met in November ('Half 2' planning). The details of that process and their planning outcomes are recorded here and were acknowledged to carry significant risk. Our agenda items today will highlight our immediate performance against those recent commitments and in particular the operational pressures the system is experiencing now; the emergent or expected impact of industrial action; and recent reporting of variance against our planned financial position within our partnership.

1. Industrial Action Overview

BMA Junior Doctors

1.1. Since the November meeting of this Board in public, Junior Doctors took full walkout action from the morning of 20 December to the morning of the 23 December and again between 7am on Wednesday 3 January to 7am on Tuesday 9 January 2024. All south east London providers were affected in this round of industrial action, which occurred at the most pressured period for services following the public holidays, during winter and at a time of prolonged system pressure prior to Christmas.

1.2. Board members can be assured that all providers undertook daily assessments to prioritise the safety of our patients and submitted Patient Safety Mitigation (PSM) requests if the risk profile changed, and safety became a concern as peer national arrangements.

1.3. Where PSMs were requested, they were signed off by the respective Chief Medical Officer and Chief Executive Officer at the Trust, as well by the ICB Medical Director and regional Chief Medical Officers/ deputy Chief Medical Officers and submitted to the national team as per arrangements agreed nationally with the BMA.

1.4. The south east London system ended the period of industrial action in a stable position, with no overnight escalations in relation to the urgent care system. Over the industrial action period, the ICS position was well managed, albeit highly pressured. This was a testament to hard work of staff across the system and importantly the patient focus that remained at the forefront of all decision making and the dedication to maintaining this.

1.5. The level of disruption was, however, high with cancellation of elective/ planned care right across our providers. Industrial action will have come at a significant financial cost to our system; and most importantly our Medical Director and our Chief Medical Officers will undertake work to understand the impact of patient care that has resulted.

2. 'Half 2' 2023/24 - Replanning exercise

2.1. The ICB worked with provider partners to undertake the national 'Half 2' or H2 replanning exercise (a 2023/24 planning refresh covering the second half of the year) during Quarter three. The ask was as follows:

- To review financial forecasts for the year, after taking account of increased national funding made available to the NHS for the cost of Industrial Action over the first half of the year
- To review performance trajectories for Accident and Emergency performance, Referral to Treatment Time (Elective) performance, with a specific focus on long wait patients, and Cancer performance (focussed on backlog numbers and Faster Diagnosis Standard performance)
- To confirm planned capacity for the latter part of the year, in line with winter plan submissions for general and acute and virtual ward capacity

2.2. The ICB's H2 submission reflected the following position, agreed across the ICB and its provider partners and was subject to NHS England regional and national review:

- A financial year end break even forecast at ICB level, aligned to our start year break even financial plans
- A confirmed commitment to meeting our start year plans around Accident and Emergency performance, cancer performance and planned winter capacity
- A re-forecast Referral to Treatment Time position, reflective of the significant impact that industrial action has had on system performance over the first part of the year, exacerbated by the ICB's planned activity reductions over October and November due to the implementation of the EPIC system at Guy's and St Thomas's Hospital NHS FT (GSTT) and King's College Hospital NHS FT (KCH). Our forecast represents a departure from our start year plan with a forecast of just over 400 over 78-week waiters at year end (compared to a plan of 0) and approximately 2,600 over 65-week waiters (compared to a plan of 50)

2.3. The ICB's H2 forecasts were recognised to be extremely challenging to achieve, with delivery of the confirmed year end positions requiring a step improvement in run rate

and performance across each of finance, urgent and emergency care, planned care and cancer. Whilst the ICB has agreed action plans in place to underpin the commitments made there are key risks that will need to be mitigated, including demand, capacity, flow, workforce, cost pressures and operational bandwidth.

2.4. Crucially the H2 plans assumed no further impact of industrial action on performance and delivery. The Junior Doctors strikes that were subsequently announced and have now taken place will have a material impact on planned care and cancer appointments and treatments over the period of industrial action, putting into jeopardy the ICB's ability to secure the H2 forecast positions, noting a financial impact of industrial action to manage as well. The ICB is working through the impact of the end December and early January industrial action, and this will enable an assessment of the impact on the year end position.

3. Outcome of Management Cost Reductions (MCR)

3.1. All ICBs are required to deliver a 30% reduction in running costs by April 2025, with 20% of this delivered by April 2024.

3.2. The ICB carried out a 3-step process to identify how the 30% reduction could be achieved. This process included a line-by-line review of all non-pay running costs and significant engagement with staff to design new staffing structures to secure delivery of the ICB core functions within a reduced financial envelope.

3.3. A staff consultation was carried out between 16 October 2023 and 29 November 2023 with final staff structures and a full management response issued on the 14 December 2023. In total, 298 responses to the consultation were received and responded to, either through responses to individuals or at one of the regular staff briefings and through publication of FAQs. Staff responses were constructive and helpful and were used to help inform our final proposals and structures that were provided to all staff and stakeholders ahead of Christmas.

3.4. Between January and April 2024, posts in the new structure will be filled through a fair and transparent process as set out in the Staff Consultation Management Response document and our ICB Management of Change Policy.

3.5. The ICB will reduce the number of posts in the structure by approximately 217.12 WTE posts to meet its management cost target. The impact from this reduction is significant and will require new ways of working across the ICB and its teams plus the wider integrated care system. A programme of work is being developed to support ICB staff and system partners to develop and embed these new ways of working and to secure the benefits of integrated planning and delivery for the population of south east London.

4. The work of the Integrated Care Partnership

4.1. The Integrated Care Partnership (ICP) last met in October 2023, at which point three substantive items were taken: an update on elective care; the proposed Voluntary, Community and Social Enterprise (VCSE) Charter for comment and approval; and an

update on the Integrated Care Strategy.

4.2. Following the update on elective care, the ICP urged the ICB to continue work to improve performance and patient experience, recognising the challenges faced and the need for collaboration in addressing them, including with primary care and social care services.

4.3. The ICP continues to provide strategic direction to the work of the ICB, including through the development of the Integrated Care Strategy and its five system priorities first published in February 2023. The Partnership last met in October 2023 to consider proposals related to the development and implementation of the priorities. Since this discussion, and the ICP's continued support for the priorities, further implementation planning is underway, led by the ICB with engagement with partners from across the system. A progress update will be provided at the February 2024 ICP meeting.

4.4. The VCSE Charter was approved by the ICP, subject to additional comments made in the meeting. Work is now underway to map out cross-system implementation, working with our partner organisations.

5. South London Listens and Anchor Programmes

South East London Citizens Community Health Assembly

5.1. Over 400 people, NHS South East London senior leaders, local councillors and representatives from community organisations, came together at the South East London Citizens Community Health Assembly on 15 November, to address health inequalities impacting local residents. Through South London Listens we listened to over 2,500 local people as part of workshops, small groups, 1:1 listening sessions, virtual listening events and surveys, to ask, 'What puts pressure on you and your community's ability to thrive?'

5.2. NHS South East London plays a key role in this programme and will be central to its future success. The Assembly focused on public pledges made by NHS South East London and anchor programme partners to collaborate with local communities to develop solutions over the coming year to mitigate the impact of housing, racial disparities, low wages and language barriers on health and well-being for local residents.

5.3. This powerful Assembly concluded with a celebration of progress made and a pledge to support ongoing efforts in building stronger relationships, sharing power, listening to communities, co-producing solutions, and taking continued action to address health inequalities.

5.4. We had the opportunity to share our learning from this work nationally at the annual NHS Confederation Integrated Care System Network Conference on 28 November. This short film highlights the work taking place: South London Listens (youtube.com)

6. Estates Strategy Endorsement

6.1. The importance that healthcare infrastructure has in the future delivery of health services has long been recognised. As a major enabler for change, having a coordinated and shared understanding of what priorities and developments look like

is vital at all levels of the system. To respond to this challenge NHS England (NHSE) will look to produce a national strategy for estates infrastructure which will be the culmination of the 42 ICS estates infrastructure plans.

6.2. South east London stepped forward to be part of the national pilot for ICB estates infrastructure plans and the South East London Integrated Care System estates infrastructure strategy envisions a modern, adaptable healthcare estate, underpinned by three key ambitions:

- Stronger, safer, greener buildings – Buildings that are safe, adaptable and ones that support the NHS to achieve net-zero emissions by 2040
- Better and smarter use of estate infrastructure – Supporting multi-disciplinary collaboration, enabled by technology
- Fairer and more efficient use of resources – Provide a levelled-up estates investment plan that tackles health inequalities

6.3. Finalising this strategy has been a huge partnership effort that has required significant input and support from estates leads across the whole NHS system to ensure the information contained within it is accurate. This strategy highlights some estates achievements in south east London (SEL) and sets out where SEL is now, where it wants to be and how it is going to get there.

6.4. The key objectives are:

- To maintain an estate that is fit for purpose
- Create a net zero estate by 2040
- Work as a system to maximise value from the SEL estate
- Support modern clinical care
- Support the delivery of place-based care
- Making smart use of SEL estate
- Enabling the wider ICS partner strategies
- Ensuring value for money and affordability of health and care facilities

6.5. South East London is one of a few ICBs who have completed this strategy so far and this was endorsed at the ICB Board meeting on 1 December 2023.

7. Bexley Borough Update

Bexley Winter Campaign

7.1. The Bexley Wellbeing Partnership continued to promote the *National Get Winter Strong* messaging throughout December 2023. The focus for December 2023 was to encourage residents to order prescriptions ahead of the Bank Holidays and ask neighbours and loved ones to help vulnerable residents during the winter months.

7.2. There was also a focused push on asking residents to alleviate the pressure on A&E Departments by *Using the Right Service* and considering other support that is available to residents from *NHS 111* to visiting local pharmacies.

7.3. The Bexley Wellbeing Partnership designed their annual 4-page *Winter Wellbeing Pull-out* was included in the Bexley magazine that is produced by the London Borough of Bexley Council. The magazine is delivered to 100,000 homes across the borough.

7.4. *Winter Wellbeing Pull-out* provided information and support to residents on self-care and using their local pharmacy for common ailments such as colds, coughs, cuts and grazes. It also encouraged residents to get their COVID and flu vaccinations and promoted access to GP Services available on mornings, evenings, on Saturdays, the NHS App and *Use the Right Service.*

7.5. *The Be*xley Wellbeing Partnership's *Self-Care* campaign *#BeattheSneeze* was updated for winter during *Self Care* week, which ran from 13-19 November 2023. Messaging was shared on multiple platforms across all six boroughs that make up south east London.

Bexley Wellbeing Partnership Microsite

7.6. The Bexley Wellbeing Partnership Microsite will be launched in January 2024. The site provides:

- A hub of information for residents and the local care and health ecosystems on what support is available to them through partners and how it enables healthy lives
- Signposts users to health and social care services on their doorstep
- Highlights partnership achievements and successes through case studies
- Promotes the important work of the partnership to support residents of Bexley in tackling health inequalities
- Showcases and thanks the 550 strong network of Bexley Community Champions and promote joining the network

Bexley Voluntary Service Council Directory

7.7. On 22 November 2023, the Bexley Voluntary Service Council (BVSC) launched a new website: www.connectedbexley.co.uk, which provides a 'one-stop shop' directory of services and support available to Bexley residents. The partnership supported with co-design of the Directory.

Community Champion Network

7.8. Vicky Kelly started in post as the Bexley Community Champions Network Co-ordinator in December 2023.This full-time post is initially funded by the Bexley Wellbeing

Partnership for one year and is hosted by BVSC, with integrated partnership co-management.

7.9. Since the inception of the Community Champions Network led by the London Borough of Bexley Council in July 2020, over 550 Champions have joined to share, support and feedback on health and wellbeing information and campaigns to the Bexley populations. The next steps for the network will begin with three celebratory events in February 2024 where Champions will come together to co-produce their future programme.

7.10. In addition, there will be a learning and training programme to support developing knowledge and insight into health and wellbeing. The first of these is a workshop on Long COVID and will take place in January 2024.

8. Bromley Borough Update

GP Access

8.1. GP access represents both a local and a national priority, forming part of the One Bromley strategy. The Bromley primary care team, working with primary care networks (PCNs) and practices, is modernising the way patients contact their GP surgery and introducing new technology to improve the patient experience of contact and better manage demand for primary care services.

8.2. The workstreams include:

- **Implementing digital telephony** – switching every GP practice onto a digital telephony system, offering call queuing, call backs and more sophisticated call management through integration with clinical systems
- **Improving patient experience** – collection, analysis and service improvement through locally collected survey data in addition to expanding the coverage of Friends and Family Test surveys
- **Remote consultations** – expanding use of this as a core digital access channel and utilising at-scale hub models to manage queries efficiently and in a timely manner
- **Empowering patients through modern technology** – revamped practice websites compliant with national digital accessibility standards; increasing NHS App registrations and maximising use of this functionality for repeat prescriptions, appointment booking, viewing patient records, and more; extending use of messaging systems for call/recall, reminders and health questionnaires; self referrals via online tools and establishing remote monitoring hubs for hypertensive patients
- **Improved navigation** – triaging patients' needs effectively at the first point of contact, so patients are better signposted where appropriate or booked an appointment in a timely manner with the right clinician or other professional based on their clinical need
- **Pharmacy First** – enabling community pharmacy to complete episodes of care for common infections through self-care, safety-netting advice and supply of certain medicines, avoiding the need to visit the GP practice

- **Primary/secondary care interface** - making the best use of clinical time and NHS resources in both settings through improved organisation of care and as a result better patient experience of care

8.3. It should be noted that a major change to the remote consultations tool will be taking place during Spring 2023 as a result of a south east London wide procurement of a new provider. This will coincide with the roll-out of digital telephony for a number of practices, and the expansion of triaging initial contacts in line with national expectations.

Update on the Covid autumn booster campaign

8.4. Covid vaccine delivery partners and estate for the Autumn 2023 campaign comprised of:

- one borough-wide service: One Bromley Health Hub at The Glades
- three GP-led services: Orpington (Chelsfield), Penge (Oaks Park) and London Lane
- twenty Community Pharmacies across the borough
- four pop-up clinic events
- twelve outreach clinics at Orpington Health and Wellbeing Centre

8.5. This provision involved some changes to previous campaigns. This included additional community pharmacy services, a new GP-led service at Chelsfield, and a transfer of clinical provider at the One Bromley Health Hub, which was run by a clinical team from the Bromley GP Alliance.

8.6. The main public Covid Autumn booster campaign ended on 15 December 2023, with an extended period for outreach activity for under-served groups until 31 January 2024. Despite a challenging campaign, with the support of One Bromley partners, over 55,000 eligible patients received their Covid booster by the 15 December public campaign deadline. The indicative figures (which continue to be subject to change) are below:

Covid 2023 Booster Uptake:

Patient cohort	Uptake
Over 75	75%
65-74	63%
Immunosuppressed/ At-risk	26%
Housebound	69%
Care Homes	84%

Source: *Bromley Primary Care Data 18.12.2023*

8.7. The One Bromley vaccination taskforce met regularly throughout the campaign to enable service providers, the ICB and Public Health to collaborate, assist each other with delivery issues and identify actions to improve uptake and address obstacles. Taskforce members are contributing to a lessons learned exercise so that the experiences and learnings can be shared at ICS level and beyond to help understand the issues and improve future campaigns.

8

Seasonal Flu 2023/24 campaign

8.8. To date, One Bromley partners have administered over 73,000 Flu vaccines, with the Bromley team supporting practices, community pharmacies and partners with a 'final push' before the campaign ends on 31 March 2024. This includes offering reminders to patients and promoting partner services at community pharmacies and catch-up clinics for school age children.

8.9. The current uptake figures (which are subject to change ahead of the end of the campaign) are below:

Winter 2023/24 Flu uptake:

Patient cohort	Uptake
Over 65	75%
18-64 at risk)	44%
2-3	48%
>18 months	48%

Source: Bromley Primary Care Data 01.01.2024

Bromley Health and Wellbeing Centre Revenue Business Case

8.10. The Bromley Health and Wellbeing Centre project is progressing well with significant achievements made over the last few months. The key highlights are:

- The RIBA Stage 4 design is now complete, and all documents are being prepared to go out to tender for the construction contractor shortly.
- Expressions of interest for contractors have been issued and 5 out of 7 suppliers were interested
- Both the Revenue and Capital NHS Business cases have been drafted. The Revenue Business case went to the Primary Care Group on the 11 January 2024 and was given approval. The Capital Business Case draft has been shared with NHS England for initial comment
- The District Valuer's value for money report has been completed and received. It has recommended this project as representing value for money
- Building Control approved the application of the 1st floor fit out to a Health and Wellbeing Centre on the 8 January 2024
- The Travel plan is being drafted
- The NHS facilities management services procurement for the Health Centre is underway
- A public webinar was held on the 14 December 2023. Positive feedback was received from attendees and the various comments and suggestions have been taken forward. The slides and further information can be found here [The Bromley Health and Wellbeing Centre - South East London ICS (selondonics.org)]

- Further engagement events are being arranged

8.11. Finally, although there has been some programme slippage, it is not predicted to impact on the end date and the centre is still due to open at the end of 2024 as planned, subject to final approvals.

Bromley All-Age Continuing Care Partnership Service

8.12. Over the last two years, Bromley has been transforming its All-Age Continuing Care service to better meet the needs of Bromley's growing population. One element of this work has been the successful procurement of a new partner agency to support an improved service. The ICB team in Bromley is pleased to announce that NHS Midlands and Lancashire Commissioning Support Unit (CSU) has been awarded this contract and will start running Bromley's continuing healthcare (CHC) nursing function from 1 April 2024. The CSU already delivers these services in Liverpool, Derbyshire and other parts of England, as well as working with NHS England on national CHC guidance.

9. Greenwich Borough Update

Encouraging children and young people to start well

9.1. Greenwich continues to focus on reducing cardiovascular disease and is sponsoring work for frontline practitioners and residents to develop and test new solutions over 100 days. Teams are encouraged to develop and test small, measurable changes that could be scaled if they work well. The purpose is to work together differently with communities to rapidly create real tangible change.

9.2. Wave 1 was focused on high blood pressure identification and concluded in August 2023. Wave 2 started on 3 November and is focused on physical activity in children and young people with three main priorities:

- Early years: improving physical activity within early years / children's centres settings. This project is aiming to build confidence and improve attitudes of parents and staff of children under 5s to physical activity, which is maintained throughout the lifecycle. The team are working with parents to develop a programme which will be tested at Waterways Children's Centre, which is in an area of high childhood poverty
- Teenage girls: increasing physical activity in young teenage girls and understanding what they feel their barriers are. This project aims to increase the amount of planned physical activity in teenage girls in Year 8, focusing on outside the school day. The team is working with teenage girls to develop alternative physical activity sessions that are more appealing than traditional sport activities. They are also exploring using local girls and women as role models to inspire others
- Special Educational Needs (SEND): developing physical activity programmes within SEND schools and organisations. This project aims to see more children and young people with SEND accessing 20 minutes of activity each day to improve their cardiovascular health, mental health and mood. The team are looking at developing resources to better signpost families and carers to opportunities for physical activity; creating opportunities for young people in special educational settings; and creating opportunities for children with SEND in mainstream settings

Digital front door at Queen Elizabeth Hospital

9.3. At the Urgent Treatment Centre at Queen Elizabeth Hospital patients are now using an innovative self-service kiosk to record their symptoms before being directed to the most appropriate service. This means that they can be seen more quickly and in the correct setting, as they use the digital triage tool to assess their symptoms before they see a clinician. The kiosk is expected to improve both the patient experience and the care provided. This is one of a number of improvements put in place by Greenwich Health Ltd (GP Federation) since they took over as provider of the service in June last year.

Breast cancer screening campaign

9.4. Uptake of breast screening in Greenwich has dropped significantly in recent years and there are health inequalities with lower uptake amongst some ethnic groups and in areas of higher deprivation. A successful application was submitted to South East London Cancer Alliance and £50,000 has been allocated to run a behavioural science informed campaign to increase uptake. The campaign is being developed as a partnership between the Greenwich ICB team, public health and primary care. Behavioural science is being used to better understand the diverse audiences, analyse behavioural barriers, refine decision-making journeys, and create persuasive, creative communications so residents can easily move from intent to action and access their breast screening. The campaign is planned to launch in March 2024. Learnings and resources will be shared with other boroughs.

Developing and scaling a shared identity for our local care partnership

9.5. Healthier Greenwich Partnership members have been working together to develop and scale the identity of the partnership. This is necessary to improve awareness and bring the partnership to life amongst front-line staff, encouraging them to think and act differently for the benefit of patients and residents. A visual identity has been developed and agreed and an event has been organised for staff in March 2024 as part of this work.

10. Lambeth Borough Update

Our Health, Our Lambeth

10.1. The Our Health, Our Lambeth - Lambeth Together Health and Care plan 2023-28 was launched in May 2023 and sets out how health and care services will work together, with residents and communities, to improve health and wellbeing over the next five years.

10.2. The Plan outlines the shared aspirations and activities partners will undertake to achieve these aspirations and the impact measures to understand the difference being made. It sets out the ambitions by incorporating over 200 activities to be delivered through the three Delivery Alliances and five Programme Areas. A requirement has been set out within the Plan for annual review and the production of an action plan for the following year. This is a process that has commenced, and the team look forward to the opportunity to celebrate elements of the plan which have been achieved, but equally, seek to understand learnings, evaluate and importantly, to respond to

emerging issues and change. The aim is to have the review and action plan finalised in the first quarter of 2024/25 as part of wider business planning timescales.

10.3. In December, the Lambeth Together Care Partnership Board had its third organisational development programme away time. Held in one of the community sites in the heart of Brixton, the session was designed to deepen connections within the Lambeth Together Partnership, and to consolidate work on anti-racism and equity, keeping it front and centre. It also gave members an opportunity to identify emerging issues, next steps and apply learning in the delivery of the Plan.

Living Well Network Delivery Alliance

10.4. The Alliance supported the Lambeth Collaborative to hold an Open Space event on 23 November with over 80 people attending, the majority of whom had experience of, or cared for those with experience of, using mental health services in Lambeth. The recommendations, which include greater acknowledgement and information of community networks, increasing use of paid peers and a longer-term talking therapy offer, are now being turned into an action plan by the Collaborative and Alliance.

10.5. An extension to the Alliance business contract has also been up for review and Certitude and Thames Reach have agreed the extension. The Council has agreed this in principle, the ICB have reviewed the papers informally and the South London and Maudsley NHS trust (SLaM) executive leadership team have agreed to support the extension in principle, all of which should be signed off at the relevant meetings in March. The Alliance continues to manage high demand and various spells of industrial action whilst maintaining services and managing the number waiting to be assessed by the Single Point of Access.

Children and Young People Delivery Alliance

10.6. The past year saw significant developments across the Alliance's key focus areas - the Alliance successfully enhanced their communications and engagement, ensuring that the voices of Lambeth's children, young people, and expectant mothers are heard and considered in-shaping services. A milestone was achieved with the publishing of the agreed Alliance Work Plan, with a commitment to ongoing structured and impactful service delivery.

Neighbourhood and Wellbeing Delivery Alliance

10.7. Since April 2023, the Alliance has been able to increase the available virtual ward bed capacity by 45% to 201 beds and expect to provide 240 beds, an increase of 65%, by the end of March 2024. They are also working on new opportunities to develop a coordinated approach across Lambeth and Southwark, primary care, acute hospital and community services, to care for more patients outside of hospital in an environment familiar to them such as their own home.

Work in the Community

10.8. Equality, Diversity and Inclusion - the EDI group reviewed the projects funded through the SEL ICB Health Inequalities Funding, including the work of nurses who were funded to provide emotional and mental health support for vulnerable children who are not in

education or are educated other than at school and the project aimed at supporting the emotional health and well-being of unaccompanied asylum-seeking children.

10.9. Lambeth Community Diabetes Service – in October 2023, Guy's and St Thomas's NHS Foundation Trust were established as the new provider of the Community Diabetes Service. The new service is building on the established integrated model of care with existing Lambeth Together partners and continues to support the ambition of the Neighbourhood and Wellbeing Delivery Alliance on improving outcomes and personalised care for people living with diabetes.

10.10. Estates - the NHS and Council teams have worked in partnership and agreed use of the former library site on Lower Marsh for the temporary relocation of Waterloo Health Centre. Planning permission has been granted and works are close to completion to install and fit out a modular building, which will open to patients in January 2024.

Carer's Strategy

10.11. Shortly before Carer's Rights Day in November, the Lambeth Carer's Strategy was signed off at the Lambeth Together Care Partnership Board. The strategy is the result of close collaboration with unpaid carers and stakeholders and partners are working closely together to mobilise the workstreams that will respond to the feedback carers provided. The strategy is being finalised, following sign off and final comments from stakeholders, and the communications team are now progressing production of the final, public-facing strategy document.

11. Lewisham Borough Update

CYP (Children & Young People)

11.1. In order to increase access to emotional wellbeing support for young people aged 13-25, Lewisham place has initiated foundational work to develop a second GP-led youth clinic in the south of the borough. This expansion follows the success of the pilot programme in the north of the borough, conducted in collaboration with North Lewisham Primary Care Network (PCN), South London & the Maudsley NHS Foundation Trust (SLAM) and Metro Charity. The clinic aims to provide a dedicated space where young people can receive comprehensive primary care and mental health support tailored to their specific needs in a youth-friendly and non-clinical setting. It is anticipated that the second site will be operational by the end of 2024-25.

11.2. By extending the reach of youth-focused primary care services, the initiative aims to address health concerns (primarily mental health concerns), promote well-being, and foster a proactive approach to health management amongst the adolescent population. The establishment of the second clinic signifies a strategic effort to create a borough-wide network of accessible and youth-friendly healthcare, ultimately contributing to the overall health and well-being of Lewisham residents.

Hypertension

11.3. A holistic and ambitious programme to tackle the high rates of poorly controlled Hypertension within Lewisham has been designed with clinical input and is going through final sign off for early 2024 implementation. The programme includes

incentivising Primary Care participation in best practice training and action planning, patient co-production to develop a peer-led support model for hypertensive patients and harnessing the input of the voluntary sector to promote improved adherence to blood pressure medications.

11.4. The programme will run in Lewisham up to March 2025, as a minimum, pending evaluation and longer term investment, and will work closely with colleagues with Clinical Effectiveness South East London (CESEL) and from across Lewisham Local Care Partnership (LCP).

11.5. The Hypertension programme aims to increase the proportion of people with high blood pressure who are managed to NICE standards from the current 55% up to the national target of 77% or better, thereby preventing 50 people from experiencing Heart Failure and 63 people from suffering a stroke.

Waldron Stakeholder Group

11.6. The Waldron Health Centre in New Cross forms part of Lewisham's wider vision to improve the delivery and integration of community-based care at a neighbourhood level. Plans to redevelop the Waldron to be a thriving community hub that supports health and wellbeing have moved forward and work will now start on site early in 2024.

11.7. The Community Engagement Group has been re-formed and will focus on creating opportunities for stakeholder engagement to ensure that the Waldron can be an asset for the local community, developing a future operating model to build a vibrant community space on the ground floor and supporting anchor organisation responsibilities by providing facilities for local community groups to enhance population health and wellbeing, for instance through signposting and delivery of local services. The team have also been working with North Lewisham PCN to maximise the use of the Additional Roles Reimbursement Scheme (ARRS) for roles that will help animate the space and to support the coordination of activity within the building. Free space has also been made available for community groups and prioritised where this supports local health priorities.

Lewisham Home First Programme

11.8. The Home First team was pleased to be invited to an event at 10 Downing Street in December to discuss hospital discharge. This followed a presentation at the national Better Care Fund conference. The improvement programme is currently focussed on changes to the enablement and therapies interface, with a view to optimising the use of these constrained resources.

11.9. The programme also hopes to appoint a hospital care homes liaison post this quarter. This pilot post will provide better communication and trust between the hospital and care homes locally, to improve patient and staff experience and speed up the discharge process. More recently the team have identified a significantly increased need for housing options to support hospital discharge, and for improvements in housing-related services, and are working with Council housing partners to explore options.

12. Southwark Borough Update

Local Green Plans and Commitments

12.1. In January, the Partnership Southwark Strategic Board received an update on its previous commitments and policy statement to environmental sustainability and the green agenda. These commitments seek to add value over and above the individual plans of partner organisations including the overall ICS and primary care green plans by providing a mutually supportive approach to delivering policies, sharing knowledge, expertise and information on successful initiatives and identifying opportunities for joint work.

12.2. A green champions network is being established locally for this purpose linking to similar initiatives and networks, and a draft environmental sustainability impact assessment guide, is being introduced, to support report writers and project management processes to support the board to properly consider environmental sustainability implications alongside other costs and benefits. In January, the Board also heard about examples of actions locally to reduce the carbon footprint including through community equipment, primary care estate, better use of medicines such as respiratory inhalers for asthma care as well as specific initiatives through partners.

New clinic to treat lower limb wounds

12.3. Following a successful business case presentation to the Partnership Southwark Delivery Executive, a new primary care-led clinic offering patients treatment and care for lower limb wounds opened in November at the Tessa Jowell Health Centre in South Southwark. Patients' views on the current services throughout the borough and what would work better for them were heard. Many patients consulted, highlighted the difficulties often faced managing multiple medical and wellbeing appointments, particularly if they were often changed or cancelled. The new clinic goes some way to ensure that patients have regular, accessible appointments in a convenient location with the same specially trained team looking after them, and access to a social prescriber to support a holistic approach to care delivery.

12.4. Staff involvement was key to the project, and staff from GP surgeries, community and neighbourhood nurses, care home staff and GSTT's Tissue Viability teams took part in the planning process. A new supplier for dressings has been appointed which guarantees the right materials are in the right place at the right time for all patients. The hope is that this collaborative working approach and multidisciplinary service will spread out to all Southwark patients.

Christmas and New Year period

12.5. Southwark worked in collaboration with Lambeth colleagues to develop a robust winter plan to support the system during this busy period of high acuity and high attendance at Emergency Departments. This included additional nursing home beds and step-down flats in the borough. Regular Urgent and Emergency care touchpoint meetings were held to ensure information and support was available between partners as required during both the Christmas and industrial action periods. The regular discussions on arrangements for those requiring hospital discharge to the community between acute, community and social care operational teams were stepped up in this period too.

12.6. Additional appointments were provided by the two primary care enhanced access hubs during the January industrial action periods to bolster primary care services and to

ease demand elsewhere in the system. Primary care colleagues were provided with detailed information on alternatives to emergency departments, such as same day emergency care units and the urgent community response services. Public information has also been made available including details of the Pharmacy First scheme and community led local warm spaces. Primary care also continued to provide COVID 19 and seasonal flu vaccinations in the community.

Integrated Care Board meeting

Item: 4
Enclosure: E

Title:	**Overall Committee Report**
Meeting Date:	31 January 2023
Author:	Simon Beard, Associate Director of Corporate Operations
Executive Lead:	Tosca Fairchild, Chief of Staff

Purpose of paper:	The purpose of the paper is to highlight to the Board any DECISIONS referred to the Board from ICB Committees, and to provide INFORMATION on any decisions made under delegation by those committees.	Update / Information	**X**
		Discussion	
		Decision	**X**

Summary of main points:	The Overall Committees paper provides an overview to the Board members of the activity and decision making that has taken place at the ICB committees which report directly to the Board in the period since the last Board meeting held in public. In particular the Board is asked to note: • Decisions referred to the Board for approval, detailed in section 4. • Remote decisions made during the period. • Decisions made by committees, under their own delegated authority. The Board is asked to consider the decisions referred for approval and to note the other activity that has taken place during the period.
Potential Conflicts of Interest	Where conflicts have been identified with any items discussed at a committee, action has been taken to mitigate the conflict in line with the ICBs Standards of Business Conduct policy.

Relevant to the following Boroughs	**Bexley**	**X**	**Bromley**	
	Greenwich	**X**	**Lambeth**	
	Lewisham	**x**	**Southwark**	

	Equality Impact	No equality impacts identified
	Financial Impact	Any financial impacts are identified in the relevant papers
Other Engagement	Public Engagement	This paper is being presented to a Board meeting held in public for the purposes of transparency.
	Other Committee Discussion/ Engagement	Discussions at other committees are detailed in the attached paper.

Recommendation:	The Board is asked to: • Approve the decisions recommended by its committees • Note the committee decisions and committee activities detailed

Overall Report of the ICB Committees

ICB Board 31 January 2024

1. Introduction

1.1 The purpose of this report is to provide a summary of the activity that has taken place within the committees that report directly to the Board since the last meeting of the Board held in public which received this report, which was on 15 November 2023. In addition the ICS benefits from two provider collaboratives and one provider network and whilst no formal delegation has been made to them from the ICB the Board will receive updates upon their key activities through this report (and in anticipation of their future delegation).

1.2 The report highlights:

- Decisions recommended to the Board from committees, in line with the ICBs Scheme of Reservation and Delegation
- A summary of items discussed at the committees during the period being reported
- Report of activities taking place in the local care partnerships of south east London
- Report of activities taking place in the south east London provider collaboratives and community services provider network

2. Summary of Meetings

2.1 ICB Committees

	Committees								
	Planning and Finance Committee	**Quality and Performance Committee**	**Audit Committee**	**Remuneration Committee**	**Greenwich Charitable Funds Committee**	**Clinical and Care Professional Committee**	**People Board**	**Digital Board**	**Executive Committee**
Meeting date	7 December 2023	10 January 2024	18 January 2024	-	18 December 2023	-	27 November 2023	23 January 2024	8 November 2023
	17 January 2024	-	-	-	-	-	-	-	22 November 2023
		-	-	-	-	-	-	-	6 December 2023
	-	-	-	-	-	-	-	-	20 December 2023
	-	-	-	-	-	-	-	-	3 January 2024

	Local Care Partnerships					
	Bexley	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**
Meeting date	23 November 2023	23 November 2023	25 October 2023	16 November 2023	30 November 2023	2 November 2023
	-	-	-	-	-	12 January 2024

3. Summary of the Principal Role of ICB Committees

Committee	Principal role of the committee	Chair
Planning and Finance Committee	Responsible for co-ordination of ICB strategic, financial and operational plans (including priorities, outcomes and underpinning investment framework/plan), development and implementation of ICB care pathway transformation, in-year oversight and assurance of delivery against plans (including the ICB's financial plan), and sign-off / recommendation of ICB policies as required.	Dr George Verghese, Partner Member
Quality and Performance Committee	Responsible for quality assurance, input to and understanding of standards to be secured as part of ICB strategic and operational plans, in-year oversight and assurance of plan delivery, infection prevention and control, medicines optimisation, and holding links to Local Authority assurance including safeguarding and Oversight and Scrutiny.	Professor Clive Kay, Partner Member
Audit Committee	Responsible for delegated approval of annual accounts, providing an objective view of the ICB's compliance with statutory responsibilities, arranging appropriate audit, and oversight / assurance on the adequacy of governance, risk management and internal control processes across the ICB.	Paul Najsarek, Non-Executive
Greenwich Charitable Funds Committee	Responsible for discharging its duties as a corporate trustee.	Peter Matthew, Non-Executive
Clinical and Care Professional Committee	Responsible for bringing together clinicians, care professionals and south east London residents to ensure the ICB has robust care, patient and public engagement, population health management, and leadership in place to shape and that the ICB's plans are demonstrably influenced by the outputs of its engagement work.	Dr Toby Garrood, Medical Director Paul Larrisey, Acting Chief Nursing Officer

People Board	Responsible for; the design, development and delivery of plans related to the health and care workforce in South East London. This includes meeting any national targets and ensuring sufficient and consistent strategies across the ICS for equality, diversity and inclusion and staff health and wellbeing.	Dr Ify Okocha, Partner Member
Digital Board	The Digital Board is constituted of members from across the SEL Integrated Care System partnership, and provides leadership to the development of strategic priorities for digital and analytics, including ensuring digital capabilities are utilised to reduce inequalities.	David Bradley, Partner Member
Executive Committee	The committee provides a platform for the executive directors of NHS South East London Integrated Care Board (SEL ICB) to discuss key issues relating to the strategy, operational delivery and performance of SEL ICB, and related Integrated Care System or wider issues upon which the executive team should be briefed or develop a proposed approach.	Andrew Bland, ICB Chief Executive
Local Care Partnerships	Responsible for convening local system partners to develop plans to meet the needs of the local population, reduce inequalities and optimise integration opportunities. The ICB will delegate responsibility for the delivery of specified out of hospital care objectives and outcomes, including the management of the associated budget. A representative from each LCP will be a member of the ICB.	Dr Sid Deshmukh (Bexley) Dr Andrew Parson & Cllr Colin Smith (co-chairs, Bromley) Dr Nayan Patel (Greenwich) Dr Di Aitken & Cllr Jim Dickson (co-chairs, Lambeth) Dr Jacqui McLeod (Lewisham) Dr Nancy Kuchemann & Cllr Evelyn Akoto (co-chairs, Southwark)

4. Recommendations to the Board for Decision / Approval

4.1 The following items have been recommended to the Board by its committees for approval:

1. Terms of Reference for the ICB Digital Board, provided at Appendix A, as previously reviewed by the ICB Executive Committee and recommended to the Board for approval.

2. Associated with item 4.1.1 above, the Board is asked to approve a revised Schedule of Reservation and Delegation (Appendix B) to reflect the transfer of responsibilities for:
   - "Approval of the arrangements for ensuring appropriate safekeeping and confidentiality of records and for the storage, management and transfer of information and data records management" from the Planning and Finance Committee to the Digital Board.
   - "Approval of plans to use joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and driver continuous performance and outcomes" from the Planning and Finance Committee to the Digital Board.

3. The Planning and Finance Committee recommend to the Board, approval of the option within the current Living Well Network Alliance Agreement, to extend its length by three years from 1 April 2025 to 31 March 2028, the topic being previously briefed and discussed at the Lambeth Together Strategic board.

4. The Planning and Finance Committee recommend to the Board, amendment to the Standing Financial Instructions of the ICB to include reference to the Provider Selection Regime (Appendix C). As these changes just make reference to the new regulations and do not change the substance of SFI's, the Board is asked to agree that this change does not require approval by NHSE.

5. Decisions made by Committees or Sub-Committees Under Delegation

5.1 Below is a summary of decisions taken by committees under delegation from the Board, or by sub-committees under delegation from the Committees.

No.	Committee name	Meeting date	Agenda item	Items for Board to note
1.	Executive Committee	22 November 2023	Corporate Policies	• The committee approved the following policies, on the recommendation of the Policy Review Group: o ICT Service Escalation Path procedure, o Health and Safety Policy, o Fire Safety Policy, o Manual Handling Policy, o Learning from Safeguarding statutory reviews policy and procedure, o Template policy for GPS – vulnerable adults who DNA, o Care home guidance on photographic recording of wounds and pressures.
2.	Executive Committee	6 December 2023	Corporate Policies	• The committee approved the following policies, on the recommendation of the Policy Review Group: o Freedom to Speak Up and Whistleblowing Policy o Training and Development Policy o Staff Annual Leave policy
3.	Greenwich Charitable Funds Committee	18 December 2023	Staff Support from charity funds – proposal	• All committee members agreed to the proposal.
4.	Quality and Performance Committee	10 January 2024	Patient Safety Strategy	• The Committee approved a Patient Safety Strategy to support PSIRF which set out how the ICB would demonstrate patient safety improvement through a focus on engagement and empowerment.
5.	Planning and Finance Committee	17 January 2024	Provider Selection Regime (PSR)	• The Committee received a briefing on the implementation of the PSR, which came into effect on 1 January 2024, replacing current procurement regulations for healthcare services. The Committee approved:- o Changes to the ICB's Schedule of Matters Delegated to Officers to give effect to the new regulations and

				recommended that the ICB Board approve the proposed changes to Standing Financial Instructions. o The utilisation of existing ICB committees to make decisions under PSR (existing borough committees for contracts delegated to boroughs and the ICB Executive Committee for centrally held contracts), with the inclusion of at least one individual not involved in making the original decision when those committees consider representations against the decisions made and, that if those representations are escalated to the NHS Independent Patient Choice and Procurement Panel, any further decisions would be taken by the Planning and Finance Committee or a sub group.

6. Agenda Items of Note

6.1 Below is a summary of other significant actions and items of note for Board information.

No.	Committee name	Meeting date	Items discussed
1.	Executive Committee	8 November 2023	• The Committee received updates from CEO and executives and an overview of the system in relation to performance and quality. • The Committee were updated on the implementation of a new financial ledger system for the ICB. • Referral guidelines for ENT (Ear Nose Throat) and urology were discussed and approved, noting the benefit of the engagement process and learning for future engagement on care pathways. • The Committee received a high level update of the forthcoming planning round for 2024/25 and the process to identify priorities, discussing some factors to continue and agreeing a inclusive approach that could deliver in a timely way. • The work taking place to engage stakeholders on 111 service transformation was discussed, and the group agreed to a steering group co-ordinating work that already underway in liaison with each borough.
2.	Executive Committee	22 November 2023	• The Committee received updates from CEO and executives and an overview of the system in relation to performance and quality. • The Committee received an update on the exercise to produce revised forecasts for the second half (H2) of 2023/24 accounting for financial assistance to offset the impact of strikes. The group noted the position arrived at and discussed risks. The committee noted the cost modelling impact of the implementation of NICE TA 905 in relation to a Crohn's disease treatment. • The Executive Committee considered options for proposed changes to the ICBs policy in relation to Fertility treatment, asking for further specialist input into the decision making. • The Committee received a briefing on proposed diagnostic treatment centres aimed at increasing the number of patients who could receive necessary treatment within a day, and discussed how the initiative would best fit within the current services.

			• The Committee received a proposed approach to research and innovation across the ICS which recognised capability available within the ICS as well as the need to ensure local people benefited from research outside south east London. The committee endorsed the proposals making comments as to how the approach could best be fostered across the system. The Committee received an update on data and analytics, a key component of a range of the ICS's ambitions including improving services and care through a population health management approach and agreed that a paper could be developed for the ICB board.
3.	People Board	27 November 2023	• **Workforce risk:** The People Board discussed and approved the revised description, controls and rating of the workforce risk. As a result of stronger controls, such as having a People Strategy and Delivery Plan in place and anticipated funding linked to the Long Term Workforce Plan, the risk rating has been reduced from 16 to 12. The workforce risk has now moved off the Business Assurance Framework (BAF) and the People Board will be the committee that will continue to monitor this. • **ICB Board Workforce report**: Members received an update on the Workforce report discussed at the ICB Board. An action was agreed to have further discussions on the SEL current context and looking ahead, at the January People Board. • A **spotlight on Social Care** was presented. The Board discussed the importance of making social care more attractive as a career and explored potential solutions. The importance of thinking radically different, in the context of workforce shortages and financial challenges, was stressed by the group. • **Bi-annual report**: The Board received and commented on the SEL ICS Bi-annual report, which captures the latest position on workforce supply based on system-wide workforce data and intelligence. The demonstrable impact of the People Programme in the first half of the year as well as key priorities for the next 6 months were also highlighted. • Members received an update on the delivery of an ICS-wide, community focused **End of life care programme**, which concluded in June 2023. • The **next People Board** in January will notably focus on: o AHP Spotlight o Health and Care Jobs Hub update o SEL current context and looking ahead
4.	Executive Committee	6 December 2023	• The committee received updates from CEO and executives and an overview of the system in relation to performance and quality.

			• The Committee continued its discussion on diagnostic treatment centres, discussing how they balanced with existing similar services, and the balance between improvements to diagnoses and pathways more generally, interface with primary care, and the finance and planning context of the pilot.
5.	Planning and Finance Committee	7 December 2023	• The Committee received an update on the ICB and ICS financial position. • The Committee were briefed on the development of 2023/24 H2 plans, both in terms of operational and financial forecasts.
6.	Greenwich Charitable Funds Committee	18 December 2023	• The Committee received an update on their logo, website and programme officer, consultation period and plans. • The Committee noted the Charity Finance Update.
7.	Executive Committee	20 December 2023	• The Committee received updates from CEO and executives and an overview of the system in relation to performance and quality.
8.	Executive Committee	3 January 2024	• The Committee noted cost modelling of the impact of implementing NICE TA 922: Daridorexant for treating long-term insomnia. • The Committee considered options presented on the future model and role of the Clinical Effectiveness South East London service, discussing benefits, opportunities for the future and approving a way forward.
9.	Quality and Performance Committee	10 January 2024	• The Committee received the performance and quality report, noting activity since the last meeting. • The Committee received the Board Assurance Framework, noting the risks associated within its own areas of responsibility. • The Committee received an update on the implementation of the Patient Safety Incident Response Framework. • The Committee received for information the Annual Safeguarding Report and an update on the Safeguarding Review and QPC sub committee and sub group report.
10.	Planning and Finance Committee	17 January 2024	• The Committee received the Board Assurance Framework, noting the risks associated within its own areas of responsibility. • The Committee received an update on delivery against H2 commitments in the 2023/24 Operational Plan

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			• The Committee received a report on the month 8 financial position, year end forecasts and actions to mitigate the risks within the forecasts. • The Committee received a paper on operational planning for 2024/25, summarising NHS guidance and ICB plans, and next steps. • The Committee noted a report from the Information Governance Sub-Committee.
11.	Audit Committee	18 January 2024	• The Committee received an update from the ICBs external auditors on progress against the external audit plan and work on the Value for Money conclusion. • The internal audit team reported on the outcomes of recently completed internal audits, confirming completion of the 23/24 audit plan was on track, and presented an assurance map considering how the ICB can obtain quality assurance from the system. • The Committee received two papers on the SEL approach to system risk from the internal audit team and the ICB assurance team, and proposed development of a set of solutions for presentation to the Executive Committee for consideration. • The Committee considered the scope of their role in seeking assurance on whistleblowing arrangements, noting internal audit were planning a deep dive into the ICBs whistleblowing arrangements as part of the 2024/25 internal audit plan. • The Committee received update reports from the CFO on approval of tender waivers, confirmation no bad debt write offs or special payments had been made in the period, development of a new finance ledger (ISFE2), and confirmation that the month 9 accounts process was on track.
12.	Digital Board	23 January 2024	• The Committee received a presentation on the virtual wards and assistive technology development work being undertaken in the sector, with particular focus on some joint work between the ICB and Royal Borough of Greenwich. • The Committee received an update on a refresh of the digital strategy and the current challenges. • An update was provided on some work to complete a Cyber maturity assessment. • Planning for future meeting topics was discussed, along with the sharing of update reports from Digital Board sub-committees.

Appendix 1

Bexley Local Care Partnership – Bexley Health and Wellbeing Partnership

1. Recommendations to the Board for Decision / Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by Bexley Health and Wellbeing Partnership Under Delegation

2.1 No decisions were made under delegation from the Board in the current reporting period.

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	23 November 2023	*Roadmap to Health & Care in Bexley* – Integrated Forward Plan	• The Bexley Wellbeing Partnership Committee received an update on the development of the Integrated Forward Plan, the local system response to the refreshed Joint Local Health & Wellbeing Strategy.
2.	23 November 2023	Community & Mental Services – Oxleas NHS Foundation Trust Partnership Report	• The Bexley Wellbeing Partnership Committee received its first quarterly report from Oxleas NHS Foundation Trust on the delegated function to place of community and mental health services.

3.	23 November 2023	Month 6 Finance Report	• The Bexley Wellbeing Partnership Committee received an update on the financial position of Bexley (Place) as well as the overall financial position of the South East London Integrated Care Board and the Integrated Care System as at Month 6 (September) 2023/24. The Committee agreed that the reports provided were too long and required a summary of those matters related to Bexley to enable better engagement/understanding for members of the public in attendance and the Committee.
4.	23 November 2023	Place Risk Register	• The Bexley Wellbeing Partnership Committee received an update on the current risks on the Bexley place risk register and actions to mitigate those risks in the context of the boroughs risk appetite. The Committee noted that no new additional risks.
5.	23 November 2023	*Let's talk about* Children and Young People	• In its regular *'Let's talk'* sessions the Committee heard from the Bexley Voluntary Service Council who provide an overview of the services and support in the borough for Children & Young People. Bromley Healthcare talked about the Bexley 0-19 Service, which they provide. The Blackfen Community Library, presented on the mental health sessions provided for teenage boys and Little Fish Theatre Company showed a film about their work in Bexley schools.

Appendix 2

Bromley Local Care Partnership – One Bromley

1. Recommendations to the Board for Decision / Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by One Bromley Under Delegation

2.1 The One Bromley LCP considered revisions to the Section 75 agreement in place between the ICB and London Borough of Bromley to reflect the funding allocations.

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	23 November 2023	Public Questions	• A question from a member of the public was received prior to the meeting. The member of the public attended the meeting and presented the questions to the Board, which were in relation to the use of Physician Associates (PAs) in Bromley. • The Board provided a verbal response to the question at the meeting with a written response given post-meeting, which were noted in the minutes and due for publication online.
2.	23 November 2023	Matters arising – 'Right Care Right Person' model	• RCRP implementation began on the 1st November with mitigations agreed and implemented. • High level implementation went well and from a Police perspective, there has been a significant reduction of calls.

			• Councillor Colin Smith will be writing a letter detailing his concerns of the 'Right Care Right Person' model, as Leader of Bromley Council and Co-Chairman of the One Bromley Local Care Partnership Board. Board members were in agreement with this proposal.
3.	23 November 2023	Partnership Report	• Joint partnership report for an overview of key work, improvements and developments undertaken by partners within the One Bromley collaborative. • Dr Angela Bhan introduced the Partnership Report and updated that the system was coping with Winter and the EPIC rollout (a new patient electronic system to share data between Guys and St Thomas Hospital NHS and King's College Hospital NHS Trust). Other key initiatives include the Acute Mental Health Hubs.
4.	23 November 2023	Bromley Homeless Healthcare Clinics	• The outcomes and aims of this initiative are to provide the homeless with access to health and wellbeing services, and to address the health inequalities and barriers they face in accessing health services. • Started as a Winter healthcare clinic initiative by Bromley GP Alliance where a range of treatments were offered to help manage common health issues, with staff on site one evening a week including a GP, Nurse Practioner, Podiatrist, Drug and Alcohol Support Worker and an Administrator. A Nurse Practioner and Care Coordinator are now provided all year round through One Bromley funding. • Two case studies were presented which demonstrated the benefits and positive clinical outcomes for this population, including help with housing and social aspects.
5.	23 November 2023	Bromley Neighbourhoods and PCN Working Showcase	• A high level summary around the aspirations of neighbourhood based care and its role in Bromley's 5 year strategy was shared with the Local Care Partnership Board. The ambitions set out are to connect people, priorities and neighbourhoods to deliver improvements to preventative and personalised care, deliver care close to home and improve access to urgent care, with an emphasis on continuity of care. • A showcase of two examples of successful projects was presented by Bromley Primary Care Networks demonstrating the integrated neighbourhood team working approach and positive outcomes for residents/patients.
6.	23 November 2023	Finance Month 6 Update	• The 2023/24 Bromley ICB/LCP place budget for the year as at Month 6 is £241,722k. • As at Month 6 the year-to-date position was £2,400k overspent. The significant variances related to; prescribing £2,213k overspent, continuing healthcare £404k overspent and mental health services £348k overspent.

			• The key risk for Bromley ICB/LCP place budgets in 2023/24 relates to prescribing as the pressures experienced during 2022/23 have not been fully mitigated and activity continues to increase. Boroughs are expected to manage this risk locally and make savings to manage the overall delegated borough position. • An update on how local financial reporting can be provided at a programme level was included in the presentation to the board.
7.	23 November 2023	Bromley Healthcare Contract	• Following the outcome of the ICB meeting this month, the following has been agreed: o A further two-year contract award will be made to Bromley Healthcare with effect from November 2024. • Approval was gained for the tendering process to commence for Bromley Community services with a new contract to commence in December 2026. Reports on progress will come to Bromley's Local Care Partnership Board.
8.	23 November 2023	Primary Care Group Report	• Following discussions in the Primary Care Group, it has been agreed that quality items will be brought to the Performance, Quality and Safeguarding Group, which is more relevant to this area.
9.	23 November 2023	Contracts and Procurement Group Report	• The new procurement regulations have been released, which will be brought to Bromley's Local Care Partnership Board in the next year.
10.	23 November 2023	Performance, Quality and Safeguarding Group Report	• The report was taken as read. There were no questions or comments from members.

Appendix 3

Greenwich Local Care Partnership – Healthier Greenwich Partnership (HGP)

1. Recommendations to the Board for Decision / Approval

1.1 There were no recommendations made by the Healthier Greenwich Partnership in the period that require Board approval.

2. Decisions made by the Healthier Greenwich Partnership Under Delegation

2.1 Below is a summary of decisions taken by the Healthier Greenwich Partnership under delegation from the Board

No.	Meeting date	Agenda item	Items for Board to note
1.	25 October 2023	Section 75 Extension - Next Steps	The Board agreed to recommend to the ICB Board that a 3-year extension to the S75 agreement be approved.
2.	25 October 2023	HGP approval process for ratification of Primary Care Working Group (PCWG) decision	The Board approved the ratification process and endorsed the PCWG items listed in section 1 of the template.

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	25 October 2023	Public Forum Feedback	The Board note the public forum held on 11 October 2023 was on Musculoskeletal (MSK) services in Greenwich.
2.	25 October 2023	Partner update - Metro GAVS /Voluntary and Community Sector	The Board noted the partner update from Metro GAVs.
3.	25 October 2023	23/24 Winter Planning	The Board noted the winter funding update - the borough has identified £495k of funds, which can be allocated to system winter resilience this year.
4.	22 November 2023	Progress Update re High Impact Activities within LCP	The Board noted six month's progress Update about the High Impact Activities within the Local Care Plan (LCP).
5.	22 November 2023	Proposed new governance – merger of the Health Inclusion Group (HIG) and Integrated Neighbourhood Working Group (INWG)	HGP noted the proposed merger of the Health Inclusion Group and Neighbourhood group and expressed support for it.
6.	22 November 2023	Neighbourhood Development Approach	The HGP expressed support for the neighbourhood development approach and agreed to the principles.

Appendix 4

Lambeth Local Care Partnership – Lambeth Together

1. Recommendations to the Board for Decision / Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by Lambeth Together Care Partnership Under Delegation

2.1 Below is a summary of decisions taken by the Lambeth Together Care Partnership under delegation from the Board

No.	Meeting date	Agenda item	Items for Board to note
1.	16 November 2023	Carers Strategy	Board approved the Lambeth Carers Strategy 2023 - 2028
2.	16 November 2023	Lambeth Together Primary Care Commissioning Committee Update	Board members ratified the decisions made at the Primary Care Commissioning Committee on 7 September 2023.

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting dates	Agenda item	Items discussed
1.	16 November 2023	Place Executive Leads Report	• The Partnership members received a report on key developments since the last LCP meeting.

2.	16 November 2023	Lambeth Community Diabetes Service	• The Partnership received an update on the Lambeth Community Diabetes Service, detailing how it was developing, its aims and current service provision, and current challenges.
3.	16 November 2023	Lambeth Together assurance report	• The Partnership noted the Integrated Assurance report and update from the assurance sub-group.
4.	16 November 2023	Deep Dive – Living Well Network Alliance	• The Partnership received a presentation from the Living Well Network Alliance, detailing its progress against the business plans and current developments underway.

Appendix 5

Lewisham Local Care Partnership – Lewisham Health & Care Partnership

1. Recommendations to the Board for Decision / Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by Lewisham Health & Care Partnership Under Delegation

2.1 Below is a summary of decisions taken by the Lewisham Health & Care Partnership under delegation from the Board

No.	Meeting date	Agenda item	Items for Board to note
1.	30 November 2023	Home visiting service	• Home Visiting Service – the Lewisham LCP Board approved the proposal.
2.	30 November 2023	Lewisham Winter Plan 2023/24	• Lewisham Winter Plan 2023/24 – the Lewisham LCP Board approved the plan.

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	30 November 2023	Public questions	• Cancer Screening update – Dr Esther Appleby (Lewisham GP) and Dr Catherine Mbema (public health consultant) gave a presentation to the Lewisham LCP Board on the latest work within the Lewisham borough. This was noted by the LCP Board.

2.	30 November 2023	Place Executive Lead Report	• PEL (Place Executive Lead) report. The Lewisham LCP Board noted the report.
3.	30 November 2023	Health Inequalities	Health Inequalities update – Dr Catherine Mbema (public health consultant) gave a presentation to the Lewisham LCP Board. This was noted by the LCP Board including the proposed next steps.
4.	30 November 2023	Risk register	• Risk Register. The Lewisham LCP Board noted the latest risk register.
5.	30 November 2023	People's Partnership update	• People's Partnership update. Anne Hooper (Community Representative) updated the Lewisham LCP Board following on from a recent meeting. The LCP Board noted the update.
6.	30 November 2023	Corporate Objectives and Action Plans	• Corporate Objectives & Action Plans. Ceri Jacob, Place Executive Lead Lewisham, presented to the Lewisham LCP Board. The Board noted the update.
7.	30 November 2023	Finance update	• Finance update. The Lewisham LCP Board noted the latest finance update.

Appendix 6

Southwark Local Care Partnership – Partnership Southwark

1. Recommendations to the Board for Decision / Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by Partnership Southwark Under Delegation

2.1 No decisions were made under delegated powers in the period being reported.

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	2 November 2023	Community Spotlight - Parents and Communities Together (PACT)	• A community showcase of PACT highlighting some of their activities in Southwark and results of a parent evaluation exercise. PACT is a community-led social support project to support and empower parents in order to improve the health and development outcomes for young children in Walworth and Camberwell
2.	2 November 2023	Health & Care Plan: 1001 Days Deep Dive	• As part of the Health and Care Plan update the Start Well team presented a deep dive into 1001 days highlighting their vision, progress, key challenges, lessons learned, working collaboratively and future timelines.
3.	2 November 2023	South East London Charter for partnership with the Voluntary, Community and Social Enterprise Sector	• The Board received the South East London Charter for Partnership with the VCSE sector to support the integration of systems to enable work in meaningful way with the sector. This included identifying key issues to overcome barriers.

4.	2 November 2023	State of the Voluntary and Community Sector in Southwark - Progress Update	• Community Southwark presented an update on their State of the Sector Report which included three focus areas of funding, premises and relationships. The following discussion recognised progress made and achievement of partners coming together, as well as challenges.
5.	2 November 2023	Place Executive Report	• The Board noted the Place Executive Report, which included rollout of the electronic records system Epic and winter plans.
6.	12 January 2024	Community Spotlight – Impact for Urban Health	• The Board received a presentation from Impact for Urban Health, highlighting the work they are carrying out in the borough to support communities to address inequalities and live a healthy life, through projects such as providing financial advice to residents with long term conditions, supporting the rollout of free school meals in the borough, and improving access to healthcare support.
7.	12 January 2024	Health & Care Plan	• The Board received an update on the progress with the PSSB Health and Care Plan.
8.	12 January 2024	Green Plan update	• The Board was presented with an update on the work being undertaken by borough teams to develop a borough based Green Plan, aimed at reducing the boroughs carbon footprint and to support the achievement of NHS net zero targets.
9.	12 January 2024	Place Executive Report	• The Board noted the Place Executive Report.
10.	12 January 2024	Forward Plan	• The Board discussed the PSSB forward plan, making suggestions for future PSSB agenda items and reflecting on potential developments for the Board going forward in terms of membership and accessibility.

Appendix 7

Acute Provider Collaborative

1. Key decisions made by the Acute Provider Collaborative (APC)

1.1 Below is a summary of decisions taken by the Acute Provider Collaborative under delegation from the Board between 3 November 2023 and 17 January 2024.

No.	Meeting date	Agenda item	Items for Board to note
1.	APC Executive 17 November	Inequalities	The group agreed to formally establish an Inequalities Group as part of the APC governance structure and appoint an SRO for this work via an Expression of Interest process.
2.	APC Executive 17 November	APC Governance	Following discussions between Leonie Penna and Vanessa Purday, the group approved handover of the ENT SRO role from Leonie to Vanessa.
3.	APC Executive 15 December	Theatres update	The group agreed changes of scope and focus of the Theatres Board to increase impact and benefit.
4.	APC Executive 15 December	MSK proposal	The group approved progressing the proposed service model for MSK single point of access, using ICB funding to support the service for the first 12 months whilst a business case or business cases are developed to secure recurrent funding.

2. Agenda Items of Note

2.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting	Agenda item	Items discussed
1.	APC Executive and other APC Groups	Industrial Action	Discussions regarding the impact of industrial action and individual and collaborative action to mitigate the impacts continue to be a regular agenda item.
2.	APC Ops & Strategy Group (monthly)	Overall elective and diagnostic performance	The APC Ops & Strategy Group (established from April 2023) meets monthly with a focus on reviewing elective and diagnostic performance and collaborative problem solving to address key challenges arising, including issues escalated from the Operational Delivery Group and other forums.

Appendix 8

Mental Health Collaborative

1. Key decisions made by the Mental Health Collaborative

1.1 Below is a summary of decisions taken by the Mental Health Collaborative, for the Boards awareness.

No.	Meeting date	Agenda item	Items for Board to note
1.	8 January 2024	NHS England specialist provider collaborative business case refresh	• NHS England are seeking to extend Provider Collaborative contracts from April 2024 for another 2 (+1) years. As part of assuring this extension, London region have asked for refreshed business cases for the South London Partnership Adult Eating Disorders, CAMHS and Secure Care provider collaboratives. The SLP Portfolio Board approved the refreshed business case and recommended them to the SLP Committees in Common for approval. A summary of the business cases was presented at SEL ICS Mental Health Partnership Group on 15.01.24.

2. Agenda Items of Note

2.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	8 January 2024	NHS 111 and 136 mobilisation update	Feedback for both hubs continues to be broadly positive although there continue to be some pathway and software configuration challenges which the team is working through. A S136 questionnaire launched for police officers to rate their call using their telephone keypads – enabling the hub to gather quantitative data.

2.	8 January 2024	Acute and urgent care	Oxleas and SLAM and the wider South London Partnership are working together and liaising with acute trusts to improve: • Bed capacity • Flow within mental health trusts • Emergency department flow • Crisis care and community services to reduce emergency department attendance as part of the system Mental Health Crisis Care & UEC Improvement Programme. Key Actions for January 2024 include: • Staff recruitment for two new wards • Demand and capacity work to outline the future right size bed capacity across both trusts.

NHS South East London Integrated Care Board
Digital Board

Terms of Reference

30 August 2023

1. Introduction

1.1 The NHS South East London Integrated Care Board (ICB) Digital Board [the Committee] is established as a Committee of the ICB Board [Board].

1.2 The Committee has no executive powers other than those specifically delegated in these terms of reference. These terms of reference reflect the ICB's Scheme of Reservation and Delegation and Schedule of Matters Delegated to Officers and can only be amended by the Board.

1.3 These terms of reference set out the role, responsibilities, membership, and reporting arrangements of the committee under its terms of delegation from the Board.

1.4 All members of staff and members of the ICB are directed to co-operate with any requests made by the committee.

2. Purpose

2.1. Digital capabilities are fundamental to work led by the ICB and ICS to address inequalities, improve care, drive innovation, and integrate care pathways. Digital refers not just to the technology that delivers a digital platform but also covers the enablement of work practices that are supported by data, information, tools and technology. This means that digital is not limited to digital teams but is relevant to the way all health and care providers work with patients and community members to deliver care.

2.2. In line with the ICS's principles of partnership, the ICB and wider partners will take a strategic approach to build shared capability where it makes sense to do so, working across the ICS in south east London (SEL) and the region and beyond. Local areas must also be empowered to make relevant local decisions to meet identified need.

2.3. The committee will provide leadership to the development of strategic priorities for digital and analytics, and will oversee the implementation of programmes, projects and activities that will contribute to delivery against these priorities.

2.4. The committee will also be responsible for consideration of digital inclusion and will work to ensure that digital capabilities are utilised to reduceinequalities.

2.5. The committee is constituted of members from across the SEL Integrated Care System partnership, with members representing both digital and related fields (such as information technology, data collection and management, analytics, information governance, and population health), together with colleagues with leadership responsibilities for clinical and operational activities from across the ICS.

2.6. The committee will also be responsible for considering the risks relevant to the scope of this work, including cyber-security and resilience risks, and will ensure that management of such risks and issues is considered in the prioritisation of resources, both human and financial.

2.7. The wide-ranging membership of the committee is designed to secure agreement amongst SEL health and care providers with regards to the strategic direction, objectives and benefits and their commitment to the delivery of necessary business change.

2.8. The committee will act to hold the ICS partnership and its constituent member organisations to account for the delivery of shared commitments across an agreed portfolio of programmes which support new ways of digital working and best utilise available capability and capacity in SEL.

2.9. The committee will ensure alignment across initiatives, organisations and geographical locations to reduce duplication and support achievement of the highest quality and cost-effective outcomes.

3. Duties

3.1 The committee will represent the interests of all SEL ICS partner organisation to undertake the following activities:

3.1.1 Lead the coordination of strategic developments within its areas of scope, securing agreement amongst ICS partners with regards to the strategic direction, objectives and benefits and their commitment to the delivery of the benefits and necessary business change.

3.1.2 Agree collective objectives and digital priorities, continue to review and refine the SEL ICS Digital Strategy to ensure that clinical, operational and digital and data strategies remain aligned across SEL for best outcomes.

3.1.3 Describe, prioritise and cost the required capabilities, capacity and investment that are needed to deliver joint objectives, in health and social care.

3.1.4 Oversee delivery of the digital/data strategy and associated delivery plans for south east London, agreeing the priority areas and any associated workstreams (with delivery led through a portfolio of programmes).

3.1.5 Ensure alignment across initiatives, organisations and geographical locations to reduce duplication and support achievement of the highest quality and cost-effective outcomes.

3.1.6 Define the budget for the delivery plan, including identifying funding opportunities and providing guidance as to which funding opportunities to pursue, taking into consideration their alignment with the strategic priorities and direction for SEL ICS.

3.1.7 Provide a forum which supports operational teams in SEL to put forward new proposed digital schemes and ideas and check strategic alignment.

3.1.8 Work towards aligning digital solutions and systems across SEL when possible and share good practice across the region.

3.1.9 Highlight and manage risks and issues relating to delivery of objectives at system level via the ICB's risk management process as specified in the ICB's Risk Management Framework 23-24.

3.1.10 Influence regional and national policy to support the ICS in the achievement of its strategic objectives.

4. Accountabilities, authority, and delegation

4.1. The authority delegated to the committee is set out in the ICB's Scheme of Reservation and Delegation (SoRD).

4.2. The SoRD delegates to the committee three functions of the ICB Board, which are to:

4.2..1. *'Agree with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services, putting people at the centre of their care'.*

4.2..2. *'Approval of plans to use joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and driver continuous performance and outcomes.'*

4.2..3. *'Approval of the arrangements for ensuring appropriate safekeeping and confidentiality of records and for the storage, management and transfer of information and data'*

4.3. The committee will act to agree and report against all duties within its scope as recorded in section 3 (above). It will report on its activities and update on its work to the Board.

4.4. As established in the ICB's Schedule of Matters Delegated to Officers, any decision related to the committee's scope requiring the commitment of ICB resources is to be taken by the ICB Board following recommendation from the Digital Board.

4.5. The committee will oversee the activities of designated programmes and designated working groups established as a portfolio of programmes including those that are to be delivered via Local Care Partnerships and at SEL level.

4.6. Committee members are expected to represent not just their organisation, but their broader part of the system. A stakeholder engagement and communication plan will be developed for approval by the committee which will outline the strategy for achieving engagement across the system. Approaches to engagement will include roundtables or other fora for engagement throughout the year as required.

4.7. The committee will be additionally supported by sub-groups and expert reference groups with a specialist scope of responsibility. Sub-groups will be established by agreement of the committee. These will include but not be limited to a Digital Delivery group and a Data and Analytics group. Other groups will be utilised to ensure they are consulted and informed including the Engagement Assurance Committee.

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

4.9. The committee will designate members to attend the London Digital Transformation Portfolio Board (DTPB). These members will be agreed with regional colleagues on the London DTPB. Members of the DTPB will:

- Disseminate and cascade key messages, progress and updates to ICB level governance structures.
- Work in a way that is solution and delivery focussed, being proactive in owning responsibility to find solutions.
- Be empowered as decision makers within local systems (with ICB representatives expected to take any regional decision at DTPB through their ICB governance).

5. Membership and attendance

5.1. Committee members shall be approved by the Board in accordance with the ICB Constitution.

5.2. Committee members are assembled from across the SEL ICS system, including senior clinical and operational leaders across the clinical, digital and transformation agenda. The aim is to have multi-disciplinary representation encompassing a cross-section of professional interests and a good spread of provider and geographical representation.

5.3. When determining the membership of the committee, active consideration will be made to equality, diversity and inclusion.

5.4. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

5.5. The committee will be constituted of the following members:

a. Nominated ICB Partner CEO (Chair)
b. ICB Medical Director (Deputy Chair)
c. ICB Chief Nursing Officer
d. ICB Chief Digital Information Officer
e. ICB Executive Director of Planning
f. ICB CFO
g. Healthwatch representative
h. Nominated ICS social care/local government executive representative
i. Nominated ICS acute provider collaborative executive representative
j. Nominated ICS local authority executive representative
k. Nominated ICS community executive representative
l. Nominated ICS mental health executive representative
m. SEL Primary Care Chief Clinical Information Officer

5.6. The following roles will be in attendance at meetings:

a. ICB Digital and Data Integration Lead
b. ICB Data and Analytics SRO
c. Nominated ICS IG representative
d. Nominated ICS cyber security specialist
e. Nominated ICS data, AI and innovation specialist
f. Nominated ICS data and research specialist
g. ICB business intelligence lead
h. Nominated ICS population health representative

5.7. Other individuals from across the Integrated Care System may be invited to attend as required.

5.8. The committee 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.

6. Chair of meeting

6.1. At any meeting of the committee, the chair if present shall preside. If the chair is absent, the deputy chair shall preside. If the chair is temporarily absent on the grounds of conflict of interest, the deputy chair shall preside.

6.2. The Chair is responsible for ensuring that the ICB's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are implemented.

7. Quorum and conflict of interest

7.1. The quorum of the committee is for at least 50% of members to be present including either the Nominated ICB Partner CEO (Chair) or the ICB Medical Director (Deputy Chair).

7.1. The committee will operate with reference to NHS England guidance and national policy requirements and will abide by the ICB's standards of business conduct. Compliance will be overseen by the Chair of the committee.

7.2. The committee 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).

7.3. Committee members will be required to declare any interests they may have in accordance with the ICB's Conflict of Interest Policy (included within the Standards of Business Conduct Policy). Members will follow the process and procedures outlined in the policy in instances where conflicts or perceived conflicts arise.

8. Decision-making

8.1. The committee is not delegated specific decision-making authority from the Board aside from that stipulated in the Board's scheme of reservation and delegation. That is for the committee to act under delegation to:

8.1.1.1. '*Agree with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services, putting people at the centre of their care*'.

8.1.1.2. 'Approval of plans to use joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and driver continuous performance and outcomes.'

8.1.1.3. 'Approval of the arrangements for ensuring appropriate safekeeping and confidentiality of records and for the storage, management and transfer of information and data'

8.2. Where a decision is required, it is expected that this will be reached by consensus. Where a vote is required to decide a matter, each member may cast a single vote. In the event of equal votes, the committee chair will have a casting vote.

9. Procedure of decisions made outside of formal meetings

9.1. The committee chair will arrange for the notice of the business to be determined and any supporting paper to be sent to members by email. The email will ask for a response to be sent to the committee chair by a stated date. A decision made in this way will only be valid if the same minimum quorum described in the above paragraph, expressed by email or signed written communication, by the stated date for response, states that they are in favour.

9.2. The ICB's governance team will retain all correspondence pertaining to such a decision for audit purposes and report decisions so made to the next meeting. A clear summary of the issue and decision agreed will then be recorded in the minutes of this meeting.

10. Frequency

10.1. The committee will meet once every two months and a minimum of four times over the course of a year.

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 acommittee meeting which needs to be agreed with the chair, and notified to the meeting secretariat, in advance.

10.4. Nominated deputies will count towards the meeting quorum if attendance has been agreed by the committee chair.

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

10.6. Every October/November, the meeting will be held face-to-face, and will be extended to be a half day workshop to plan the priorities for the coming year and to discuss budget sources.

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 committee will report on its activities to the Board via minutes. In addition, an accompanying report will summarise key points of discussion, items recommended for decisions, the key activities undertaken or coordinated by the committee; any actions agreed to be implemented.

11.3. The minutes of meetings shall be formally recorded and reported to the Board for the purposes of assurance and made publicly available as part of ICB meeting papers.

12. Board support

12.1. The committee will be supported by members of the ICB Digital PMO team.

12.2. The meeting secretariat will ensure that draft minutes are shared with the committee 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. Monitoring adherence to the Terms of Reference

13.1. The chair of the committee will be responsible for ensuring the committee abides by the terms of reference.

14. Review of Arrangements

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

14.2. These terms of reference shall be reviewed by the committee chair and ICB chair on an annual basis, with changes proposed for approval by the Board.

NHS South East London Integrated Care Board
Scheme of Reservation & Delegation

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
REGULATION AND CONTROL	Prepare the ICB's overarching Scheme of Reservation and Delegation, which sets out those decisions of the ICB reserved to the Board and those delegated to the o Board o committees and sub-committees of the ICB, or o its employees		√		
REGULATION AND CONTROL	Approval of the group's overarching scheme of reservation and delegation	√			
REGULATION AND CONTROL	Prepare the ICB's operational scheme of delegation (schedule of matters delegated to officers), which sets out those key operational decisions delegated to individual employees of the ICB.		√		
REGULATION AND CONTROL	Approval of the ICB's operational scheme of delegation (schedule of matters delegated to officers) that underpins the ICB's Overarching Scheme of Reservation and Delegation.				Planning & Finance Committee

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
REGULATION AND CONTROL	Consideration and approval of applications to NHS England on any matter concerning changes to the ICB's constitution	√			
REGULATION AND CONTROL	Prepare detailed financial policies that underpin the ICB's standing financial instructions			√	
REGULATION AND CONTROL	Approve detailed financial policies				Executive Committee
REGULATION AND CONTROL	Approve any changes to the ICB's committee structure	√			
REGULATION AND CONTROL	Approve arrangements for managing exceptional funding requests				Planning & Finance Committee
REGULATION AND CONTROL	Exercise or delegation of those functions of the ICB which have not been delegated to the board or other committee or sub-committee or [specified] employee		√		
STRATEGY AND PLANNING	Agree the vision and values of the ICB	√			
STRATEGY AND PLANNING	Agree the overall south east London integrated strategy				Integrated Heath and Care Partnership
STRATEGY AND PLANNING	Agree the overall strategic direction of the ICB	√			

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
STRATEGY AND PLANNING	Approval of the ICB's annual corporate budgets	√			
STRATEGY AND PLANNING	Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the ICB's ability to achieve its agreed strategic aims.	√			
ANNUAL REPORTS AND ACCOUNTS	Approval of the ICB's annual report and annual accounts				Audit committee
ANNUAL REPORTS AND ACCOUNTS	Approval of the arrangements for discharging the ICB's statutory financial duties.	√			
HUMAN RESOURCES	Approval of the ICB's operating structure (in relation to organisational structures within the ICB)		√		
HUMAN RESOURCES	Approval of terms and conditions, pensions, remuneration, fees and allowances payable to board members, employees and to other persons providing services to the ICB outside of agenda for change				Remuneration committee
HUMAN RESOURCES	Approval of responsibility allowances payable to employees in Agenda for Change bands 2-7 which are less than £2,500 p.a.				Executive Committee
HUMAN RESOURCES	Approve disciplinary arrangements for employees, including the Chief Executive (where he/she is an				Remuneration committee

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
	ICB employee) and for other persons working on behalf of the ICB				
HUMAN RESOURCES	Approval of the arrangements for discharging the ICB's statutory duties as an employer	√			
HUMAN RESOURCES	Leading system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers				People Board
HUMAN RESOURCES	Approve human resources policies for employees and for other persons working on behalf of the ICB				Executive Committee
QUALITY AND SAFETY	Approve arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes				Quality & Performance committee
QUALITY AND SAFETY	Approve quality and safety policies to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes				Executive Committee
QUALITY AND SAFETY	Approve arrangements for supporting NHS England in discharging its responsibilities in				Quality & Performance committee

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
	relation to securing continuous improvement in the quality of general medical services.				
OPERATIONAL AND RISK MANAGEMENT	Approval of the ICB's counter fraud and security management arrangements				Audit committee
OPERATIONAL AND RISK MANAGEMENT	Approval of the ICB's risk management arrangements.				Audit committee
OPERATIONAL AND RISK MANAGEMENT	Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other Integrated Care Boards or pooled budget arrangements under section 75 of the NHS Act 2006).	√			
OPERATIONAL AND RISK MANAGEMENT	Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the ICB				Audit committee
OPERATIONAL AND RISK MANAGEMENT	Approve proposals for action on litigation and claims handling against or on behalf of the ICB				Executive committee
OPERATIONAL AND RISK MANAGEMENT	Approval of the ICB's arrangements for business continuity and emergency planning				Executive committee

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
OPERATIONAL AND RISK MANAGEMENT	Development of the ICB's Operational plans				Executive Committee
OPERATIONAL AND RISK MANAGEMENT	Authority to make decisions relating to operational matters, within the financial limits specified in the Schedule of Matters Delegated to Officers, where not explicitly delegated elsewhere or defined elsewhere in the Schedule of Matters				Executive Committee
GOVERNANCE	Approval of the ICB's arrangements for handling complaints				Quality & Performance committee
INFORMATION GOVERNANCE	Approval of the arrangements for ensuring appropriate safekeeping and confidentiality of records and for the storage, management and transfer of information and data				Digital Board
INFORMATION GOVERNANCE	Approval of Information Governance Policies				Executive Committee
TENDERING AND CONTRACTING	Approval of the ICB's contracts for any contracting / commissioning support including in respect of any commissioning functions delegated by NHSE		√		
TENDERING AND CONTRACTING	Approval of the ICB's contracts for corporate support (for example finance provision)		√		

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
TENDERING AND CONTRACTING	Approval of changes to the provision or delivery of assurance services to the ICB including internal audit, security management and counter fraud				Audit Committee
TENDERING AND CONTRACTING	Approve the appointment (and where necessary dismissal) of external auditors (and where necessary change/removal) of external audit				Auditor Panel
PARTNERSHIP WORKING	Approve decisions that individual members or employees of the ICB, participating in joint arrangements on behalf of the ICB, can make. Such delegated decisions must be formally recorded	√			
PARTNERSHIP WORKING	Approval of a new pooled budget, with a south east London local authority	√			
PARTNERSHIP WORKING	Approve decisions delegated to joint committees established under section 75 of the 2006 Act.	√			
PRIMARY CARE COMMISSIONING	Approve primary care commissioning arrangements in south east London (Bexley, Bromley, Greenwich, Lambeth, Southwark, Lewisham)				Planning & Finance committee
PRIMARY CARE COMMISSIONING	Approval of the arrangements for discharging the ICB's responsibilities and duties associated with its primary care commissioning functions for promoting improvement in the quality of services, reducing inequalities in relation to its primary care				Planning & Finance committee

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
	commissioning functions and promoting the involvement of each patient, patient choice, public engagement and consultation				
PRIMARY CARE COMMISSIONING	Approval of the arrangements for discharging the ICB's responsibilities and duties associated with Pharmacy, Optometry & Dentistry (PODs) (delegated by NHS England) for promoting improvement in the quality of services, reducing inequalities in relation to its POD functions and promoting the involvement of each patient, patient choice, public engagement and consultation				Planning & Finance committee via the joint London POD Commissioning Oversight Group
PARTNERSHIP WORKING	Approval of the arrangements for promoting integration and co-ordinating the commissioning of services with other integrated care boards, provider collaboratives, place and/or with the local authority/ies, where appropriate	√			
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions for promoting improvement in the quality of services				Quality & Performance Committee
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions including promoting the				Engagement Assurance Committee

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
	involvement of each patient, patient choice, public engagement and consultation				
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions to promote reductions in inequalities	√			
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the arrangements for co-ordinating the commissioning of services with other integrated care boards, provider collaboratives, place and/or with the local authority(ies), where appropriate	√			
DELEGATED COMMISSIONING ARRANGEMENTS	Decisions delegated by formal resolution of the board				√
DELEGATED COMMISSIONING ARRANGEMENTS	Overseeing the work of Pharmacy, Optometry & Dental, delegated by NHSE, via a Hub within NEL ICB to include: oversight of the POD Hub's contract management function and the commissioning activity and advice they undertake on behalf of the ICB, under the direction of the MoU (between NEL ICB and all other ICBs)				Planning & Finance committee via the joint London POD Commissioning Oversight Group
DATA AND DIGITAL	Agree with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services, putting people at the centre of their care				Digital Board

Policy Area	Decision	Reserved or delegated to Board	Chief Executive	Chief Financial Officer	Committees and Sub-committees
DATA AND DIGITAL	Approval of plans to use joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and driver continuous performance and outcomes				Digital Board
SUSTAINABILITY	Agree joint working on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability	√			

NHS South East London Integrated Care Board Standing Financial Instructions

July 2022

Contents

1. Purpose and statutory framework

1.1.1 These Standing Financial Instructions (SFIs) shall have effect as if incorporated into the NHS South East London Integrated Care Board's (ICB) constitution. In accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022, the ICB must publish its constitution.

1.1.2 In accordance with the Act as amended, NHS England is mandated to publish guidance for ICBs, to which each ICB must have regard, in order to discharge their duties.

1.1.3 The purpose of this governance document is to ensure that the ICB fulfils its statutory duty to carry out its functions effectively, efficiently and economically. The SFIs are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions.

1.1.4 SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services.

1.1.5 The ICB is established under Chapter A3 of Part 2 of the National Health Service Act 2006, as inserted by the Health and Care Act 2022 and has the general function of arranging for the provision of services for the purposes of the health services in England in accordance with the Act.

1.1.6 Each ICB is to be established by order made by NHS England for an area within England, the order establishing an ICB makes provision for the constitution of the ICB.

1.1.7 All members of the ICB (its board) and all other Officers should be aware of the existence of these documents and be familiar with their detailed provisions. The ICB SFIs will be made available to all Officers on the intranet and internet website for each statutory body.

1.1.8 Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the chief executive or the chief financial officer must be sought before acting.

1.1.9 Failure to comply with the SFIs may result in disciplinary action in accordance with the ICB's applicable disciplinary policy and procedure in operation at that time.

2. Scope

2.1.1 All officers of the ICB, without exception, are within the scope of the SFIs without limitation. The term officer includes, permanent employees, secondees and contract workers.

2.1.2 Within this document, words imparting any gender include any other gender. Words in the singular include the plural and words in the plural include the singular.

2.1.3 Any reference to an enactment is a reference to that enactment as amended.

2.1.4 Unless a contrary intention is evident, or the context requires otherwise, words or expressions contained in this document, will have the same meaning as set out in the applicable Act.

3. Roles and Responsibilities

3.1 Staff

3.1.1 All ICB Officers are severally and collectively, responsible to their respective employer(s) for:

- abiding by all conditions of any delegated authority
- the security of the statutory organisation's property and avoiding all forms of loss
- ensuring integrity, accuracy, probity and value for money in the use of resources and
- conforming to the requirements of these SFIs

3.2 Chief Executive Officer

3.2.1 The ICB constitution provides for the appointment of the chief executive officer by the ICB chair. The chief executive is the accountable officer for the ICB and is personally accountable to NHS England for the stewardship of the ICB's allocated resources.

3.2.2 The chief financial officer reports directly to the ICB chief executive officer and is professionally accountable to the NHS England regional finance director.

3.2.3 The chief executive will delegate to the chief financial officer the following responsibilities in relation to the ICB:

- preparation and audit of the annual accounts
- adherence to the directions from NHS England in relation to accounts preparation
- ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners
- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss
- meeting statutory requirements relating to taxation
- ensuring that there are suitable financial systems in place (see Section 6)
- meeting the financial targets set for it by NHS England
- use of incidental powers such as management of ICB assets, entering commercial agreements
- ensuring that the Governance statement and annual accounts & reports are signed
- planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets

- making use of benchmarking to make sure that funds are deployed as effectively as possible

- executive members (partner members, ordinary members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs

- specific responsibilities and delegation of authority to specific job titles are confirmed

- financial leadership and financial performance of the ICB

- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions and

- the chief financial officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and processes are in place to minimise risk

3.3 Audit committee

3.3.1 The board and chief executive officer should be supported by an audit committee, which should provide proactive support to the board in advising on:

- the management of key risks

- the strategic processes for risk

- the operation of internal controls

- control and governance and the governance statement

- the accounting policies, the accounts, and the annual report of the ICB

- the process for review of the accounts prior to submission for audit, management's letter of representation to the external auditors and the planned activity and results of both internal and external audit

4. Management accounting and business management

4.1.1 The chief financial officer is responsible for maintaining policies and processes relating to the control, management and use of resources across the ICB.

4.1.2 The chief financial officer will delegate the budgetary control responsibilities to budget holders through a formal documented process.

4.1.3 The chief financial officer will ensure:

- the promotion of compliance to the SFIs through an assurance certification process
- the promotion of long-term financial heath for the NHS system (including ICS)
- budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for
- the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training
- that the budget holders are supported in proportion to the operational risk and
- the implementation of financial and resources plans that support the NHS Long term plan objectives

4.1.4 In addition, the chief financial officer should have financial leadership responsibility for the following statutory duties:

- the ICB , in conjunction with its partner NHS trusts and NHS foundation trusts, should exercise its functions with a view to ensuring that, in respect of each financial year:
    - local capital resource use does not exceed the limit specified in a direction by NHS England
    - local revenue resource use does not exceed the limit specified in a direction by NHS England
    - the duty of the ICB to perform its functions as to secure that its expenditure does not exceed the aggregate of its allotment from NHS England and its other income and
    - the duty of the ICB, in conjunction with its partner trusts, to seek to achieve any joint financial objectives set by NHS England for the ICB and its partner trusts

4.1.5 The chief financial officer and any senior officer responsible for finance within the ICB should also promote a culture where budget holders and decision makers consult their finance business partners in key strategic decisions that carry a financial impact.

5. Income, banking arrangements and debt recovery

5.1 Income

5.1.1 An ICB has power to do anything specified in section 7(2)(a), (b) and (e) to (h) of the Health and Medicines Act 1988 for the purpose of making additional income available for improving the health service.

5.1.2 The chief financial officer is responsible for:

- ensuring order to cash practices are designed and operated to support, efficient, accurate and timely invoicing and receipting of cash. The processes and procedures should be standardised and harmonised across the NHS System by working co-operatively
- ensuring the debt management strategy reflects the debt management objectives of the ICB and the prevailing risks

5.2 Banking

5.2.1 The chief financial officer is responsible for ensuring the ICB complies with any directions issued by the Secretary of State with regards to the use of specified banking facilities for any specified purposes.

5.2.2 The chief financial officer will ensure that:

- the ICB holds the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract and
- the ICB has effective cash management policies and procedures in place

5.3 Debt management

5.3.1 The chief financial officer is responsible for the ICB debt management strategy.

5.3.2 This includes:

- a debt management strategy that covers end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures;
- ensuring the debt management strategy covers a minimum period of 3 years and must be reviewed and endorsed by the Audit Committee every 12 months to ensure relevance and provide assurance
- accountability to the Planning & Finance Committee that debt is being managed effectively
- accountabilities and responsibilities are defined with regards to debt management to budget holders and
- responsibility to appoint an officer responsible for day-to-day management of debt

6. Financial systems and processes

6.1 Provision of finance systems

6.1.1 The chief financial officer is responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for the ICB.

6.1.2 The systems and processes will ensure, inter alia, that payment for goods and services is made in accordance with the provisions of these SFIs, related procurement guidance and prompt payment practice.

6.1.3 As part of the contractual arrangements for ICBs officers will be granted access where appropriate to the Integrated Single Financial Environment ("ISFE"). This is the required accounting system for use by ICBs, access is based on single access log on to enable users to perform core accounting functions such as to transacting and coding of expenditure/income in fulfilment of their roles.

6.1.4 The chief financial officer will, in relation to financial systems:

- promote awareness and understanding of financial systems, value for money and commercial issues
- ensure that transacting is carried out efficiently in line with current best practice – e.g. e-invoicing
- ensure that the ICB meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems
- enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records
- ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable
- ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICB
- ensure that risk is appropriately managed
- ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers
- ensure the ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB
- ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing,

transmission and storage. The contract should also ensure rights of access for audit purposes and

- where another health organisation or any other agency provides a computer service for financial applications, the chief financial officer shall periodically seek assurances that adequate controls are in operation

7. Procurement and purchasing

7.1 Principles

7.1.1 The chief financial officer will take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting, monitoring and performance arrangements in place to ensure the delivery of effective health services.

7.1.2 The ICB must ensure that procurement activity is in accordance with the relevant regulations in force at the time, this is currently The Healthcare Services (Provider Selection Regime) Regulations 2023 for healthcare services, Public Contracts Regulations 2015 (PCR) for non-healthcare services, and associated statutory requirements whilst securing value for money and sustainability.

7.1.3 The ICB must consider, as appropriate, any applicable NHS England guidance that does not conflict with the above.

7.1.4 The ICB will have a procurement policy which sets out all of the legislative requirements.

7.1.5 All revenue and non-pay expenditure must be approved, in accordance with the ICB business case policy, prior to an agreement being made with a third party that enters a commitment to future expenditure.

7.1.6 All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB standards of business conduct policy.

7.1.7 Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for. This includes obtaining the necessary internal and external approvals which vary based on the type of spend, prior to procuring the goods, services or works.

7.1.8 Undertake any contract variations or extensions in accordance with relevant regulations in force at the time, this is currently The Healthcare Services (Provider Selection Regime) Regulations 2023 for healthcare services, PCR 2015 for non-healthcare services, and the ICB procurement policy.

7.1.9 Retrospective expenditure approval should not be permitted. Any such retrospective breaches require approval from any committee responsible for approvals before the liability is settled. Such breaches must be reported to the audit committee.

8. Staff costs and staff related non pay expenditure

8.1 Director of Human Resources

8.1.1 The director of human resources is accountable to the chief of staff. The director of human resources will lead the development and delivery of the long-term people strategy of the ICB ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS.

8.1.2 Operationally the director of human resources will be responsible for:

- defining and delivering the organisation's overall human resources strategy and objectives and
- overseeing delivery of human resource services to ICB employees

8.1.3 The director of human resources will ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments.

8.1.4 Where a third-party payroll provider is engaged, the director of human resources shall proactively manage this supplier through effective contract management.

8.1.5 The director of human resources is responsible for management and governance frameworks that support the ICB employees' life cycle.

9. Annual reporting and Accounts

9.1.1 The chief financial officer (responsibility for the annual accounts) and chief of staff (responsibility for the annual report) will ensure, on behalf of the chief executive officer and ICB board, that:

- the ICB is in a position to produce its required monthly reporting, annual report, and accounts, as part of the setup of the new organisation and
- the ICB, in each financial year, prepares a report on how it has discharged its functions in the previous financial year

An annual report must, in particular, explain how the ICB has:

- discharged its duties in relation to improving quality of services, reducing inequalities, the triple aim and public involvement
- review the extent to which the board has exercised its functions in accordance with its published 5-year forward plan and capital resource use plan and
- review any steps that the board has taken to implement any joint local health and wellbeing strategy

9.1.2 NHS England may give directions to the ICB as to the form and content of an annual report.

9.1.3 The ICB must give a copy of its annual report to NHS England by the date specified by NHS England in a direction and publish the report.

9.2 Internal audit

9.2.1 The chief executive, as the accountable officer, is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the chief financial officer to ensure that:

- all internal audit services provided under arrangements proposed by the chief financial officer are approved by the Audit Committee, on behalf of the ICB board
- the ICB must have an internal audit charter. The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards (PSIAS)
- the annual ICB internal audit plan must be endorsed by the audit committee
- the head of internal audit must provide an annual opinion on the overall adequacy and effectiveness of the ICB Board's framework of governance, risk management and

internal control as they operated during the year, based on a systematic review and evaluation

- the head of internal audit should attend audit committee meetings and have a right of access to all audit committee members, the chair and chief executive of the ICB

- the appropriate and effective financial control arrangements are in place for the ICB and that accepted internal and external audit recommendations are actioned in a timely manner.

9.3 External Audit

9.3.1 The chief financial officer is responsible for:

- liaising with external audit colleagues to ensure timely delivery of financial statements for audit and publication in accordance with statutory, regulatory requirements

- ensuring that the ICB appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, the ICB must appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year. The ICB must appoint a local auditor at least once every 5 years, and

- ensuring that the appropriate and effective financial control arrangements are in place for the ICB and that accepted external audit recommendations are actioned in a timely manner

10. Losses and special payments

10.1.1 HM Treasury approval is required if a transaction exceeds the delegated authority, or if transactions will set a precedent, are novel, contentious or could cause repercussions elsewhere in the public sector.

10.1.2 The chief financial officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risks from losses and special payments.

10.1.3 NHS England has the statutory power to require an integrated care board to provide NHS England with information. The information, is not limited to losses and special payments, must be provided in such form, and at such time or within such period, as NHS England may require.

10.1.4 As part of the new compliance and control procedures, ICBs must submit an annual assurance statement confirming the following:

- details of all exit packages (including special severance payments) that have been agreed and/or made during the year
- that NHS England and HMT approvals have been obtained before any offers, whether verbally or in writing, are made and
- adherence to the special severance payments guidance as published by NHS England

10.1.5 All losses and special payments (including special severance payments) must be reported to the ICB Audit Committee and NHS England noting that ICBs do not have a delegated limit to approve losses or special payments.

10.1.6 For detailed operational guidance on losses and special payments, please refer to the ICB losses and special payment guide which is appended to this document.

11. Fraud, bribery and corruption (Economic crime)

11.1.1 The ICB is committed to identifying, investigating and preventing economic crime.

11.1.2 The ICB chief financial officer is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the board and audit committee, and defined roles and accountabilities for those involved as part of the process of providing assurance to the board. These arrangements should comply with the NHS Requirements: the Government Functional Standard 013 Counter Fraud as issued by NHS Counter Fraud Authority and any guidance issued by NHS England and NHS Improvement.

12. Capital Investments & security of assets and Grants

12.1.1 The chief financial officer is responsible for:

- ensuring that at the commencement of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use
- ensuring that the ICB and its partner NHS trusts and NHS foundation trusts exercise their functions with a view to ensuring that, in respect of each financial year, local capital resource use does not exceed the limit specified in a direction by NHS England
- ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans
- ensuring that there are processes in place for the management of all stages of capital schemes, which will ensure that schemes are delivered on time and to cost
- ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences and
- for every capital expenditure proposal, the chief financial officer is responsible for ensuring there are processes in place to ensure that a business case is produced

12.1.2 Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:

- authority to spend capital or make a capital grant
- authority to enter into leasing arrangements

12.1.3 Advice should be sought from the chief financial officer or nominated officer if there is any doubt as to whether any proposal is a capital commitment requiring formal approval.

12.1.4 For operational purposes, the ICB shall have nominated senior officers accountable for ICB property assets and for managing property.

12.1.5 ICBs shall have a defined and established property governance and management framework, which should:

- ensure the ICB asset portfolio supports its business objectives and
- comply with NHS England policies and directives and with this standard

12.1.6 Disposals of surplus assets should be made in accordance with published guidance and should be supported by a business case which should contain an appraisal of the

options and benefits of the disposal in the context of the wider public sector and to secure value for money.

12.2 Grants

12.2.1 The chief financial officer is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to:

- any of its partner NHS trusts or NHS foundation trusts, and
- to a voluntary organisation, by way of a grant or loan

13. Legal and insurance

13.1.1 This section applies to any legal cases threatened or instituted by or against the ICB. The ICB should have policies and procedures detailing:

- engagement of solicitors / legal advisors
- approval and signing of documents which will be necessary in legal proceedings and
- Officers who can commit or spend ICB revenue resources in relation to settling legal matters

13.1.2 ICBs are advised not to buy commercial insurance to protect against risk unless it is part of a risk management strategy that is approved by the chief executive officer.

Appendix 1 - ICB Losses and Special Payment Guidance

Contents

1. Introduction and guidance statement

1.1.1 The Losses and Special Payments guidance is prepared as procedural guidance for integrated Care Boards (ICBs).

1.1.2 The purpose of this document is to establish best practice that can be incorporated into the ICB's Standing Financial Instructions.

1.1.3 It should be noted that the user of this procedural guidance should be compliant with the respective ICB's SFIs. If there is a need to interpret or difficulty in application of this guidance, please send an email to the NHS England, head of assurance and counter fraud: england.assurance@nhs.net

1.1.4 HM Treasury retains the authority to approve losses and special payments which are classified as being either:

- novel or contentious
- contains lesson that could be of interest to the wider community
- involves important questions of principle
- might create a precedent and/or
- highlights the ineffectiveness of the existing control systems

1.1.5 Losses and special payments are therefore subject to special control procedures compared to the generality of payments, and special notation in the accounts to bring them to the attention of parliament. The annual accounts reporting requirements are detailed herein.

1.1.6 For the avoidance of doubt, as NHS England, has not delegated authority to ICBs for the approval of losses and special payments, all cases relating to ICB losses and special payments must be submitted to NHS England for approval.

1.1.7 NHS England cannot delegate any authority to ICBs as this would result in "double delegation".

1.1.8 This should be clearly reflected in the detailed financial policies for all ICBs.

1.1.9 For losses that indicate or give rise to suspicion of fraud or corruption, please follow the guidance as provided by your local counter fraud specialist.

1.1.10 In dealing with individual cases, ICBs must consider the soundness of their internal control systems, the efficiency with which they have been operated, and take any necessary steps to put failings right.

1.1.11 The outcome of the review of the case under consideration (1.1.10) must be clearly indicated when submitting cases to NHS England as part of the account's consolidation process at year end or as part of the approval process.

2. Scope

2.1.1 This procedural document is applicable to the following NHS bodies:

- Integrated Care Boards

3. Definitions

3.1.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this document will have the same meaning as set out in HMT managing public money. As per the DHSC Group Accounting Manual, Managing Public Money applies to all DHSC group bodies.

3.2 Losses

3.2.1 A loss refers to any case where full value has not been obtained for money spent or committed.

3.2.2 Examples of types of losses which cannot be treated as business as usual are cash losses, bookkeeping losses, fruitless payments and claims waived or abandoned.

3.3 Special Payment

3.3.1 Special Payments relate to the following:

- any compensation payments
- extra-contractual or ex-gratia payments and
- any payment made without specific identifiable legal power In accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022.

3.4 Special Severance and retention payments

3.4.1 ICBs have not been delegated a limit to approve special severance or retention payments. For detailed guidance, please refer to the ICB special severance payments document as published on the NHSEI SharePoint finance library.

3.4.2 For clarity, any special severance payments that are being considered for approval must be submitted to NHS England (england.assurance@nhs.net) prior to settlement.

3.4.3 The table below lists all the various expenditure classifications for losses and special payments.

Payment Type	Classification	Definition
Fruitless Payment	Loss	A fruitless payment is a payment which cannot be avoided because the recipient is entitled to it even though nothing of use to the department will be received in return Fruitless payments include payments for rail fares and hotels that are not required but could not be cancelled without a partial or full charge being incurred
Bookkeeping Losses	Loss	Bookkeeping losses (un-vouched or incompletely vouched payments) including missing items or inexplicable or erroneous debit balances
Constructive loss	Loss	A constructive loss is a similar form of payment to stores losses and fruitless payments, but one where procurement action itself caused the loss. For example, stores or services might be correctly ordered, delivered or provided, then paid for as correct, but later, perhaps because of a change of policy, they might prove not to be needed or to be less useful than when the order was placed
Administrative costs	Loss	An expense incurred in controlling and directing an organisation
Claims Waived or Abandoned	Loss	Losses may arise if claims are waived or abandoned because, though properly made, it is decided not to present or pursue them
Extra-contractual payments	Special Payment	Payments which, though not legally due under contract, appear to place an obligation on a public sector organisation which the courts might uphold. Typically, these arise from the organisation's action or inaction in relation to a contract. Payments may be extra-contractual even where there is some doubt about the organisation's liability to pay, e.g. where the contract provides for arbitration, but a settlement is reached without it. A payment made as a result of an arbitration award is contractual
Extra-statutory	Special Payment	Payments which are within the broad intention of the statute or regulation but go beyond a strict interpretation of its terms
Extra-regulatory payments	Special Payment	Payments which are within the broad intention of the statute or regulation but go beyond a strict interpretation of its terms
Compensation payments	Special Payment	Payments made to provide redress for personal injuries (except for payments under the Civil Service Injury Benefits Scheme), traffic accidents, and damage to property etc., suffered by

		civil servants or others. They include other payments to those in the public service outside statutory schemes or outside contracts
Special severance payments	Special Payment	Payments made to employees, contractors and others beyond above normal statutory or contractual requirements when leaving employment in public service whether they resign, are dismissed or reach an agreed termination of contract
Ex gratia payments	Special Payment	Go beyond statutory cover, legal liability, or administrative rules, including payments: • made to meet hardship caused by official failure or delay • out of court settlements to avoid legal action on grounds of official inadequacy and • payments to contractors outside a binding contract, e.g. on grounds of hardship
Retention payments	Special Payment	Payments, designed to encourage staff to delay their departures, particularly where transformations of ALBs are being negotiated, are also classified as novel and contentious. Such payments always require explicit Treasury approval, whether proposed in individual cases or in groups. Treasury approval must be obtained before any commitment, whether oral or in writing, is made.

3.5 Annual assurance statements

3.5.1 As part of the new compliance and control procedures, ICBs must submit an annual assurance statement confirming the following:

- details of all exit packages (including special severance payments) that have been agreed and/or made during the year
- that NHS England and HMT approvals have been obtained before any offers, whether verbally or in writing, are made and
- adherence to the special severance payments guidance as published by NHS England

3.6 Interpretation

3.6.1 Should any difficulties arise regarding the interpretation or application of any part of this losses and special payment guidance, the advice of the head of assurance and counter fraud (england.assurance@nhs.net) must be sought before acting.

3.7 Delegation of Function, Duties and Powers

3.7.1 The ICB Constitution must have a governing body that makes provision for the appointment of the Audit Committee.

3.7.2 The ICB standing financial instructions should clearly indicate the role that the audit committee has in reviewing and approving losses and special payments.

3.7.3 The ICB schedule of matters delegated to officers should indicate the delegated limits that have been agreed by the governing body for operational purposes, however, it should be noted that they are localised limits and not delegated from NHS England or the Department of Health and Social Care.

4. Integrated care board reporting requirements

4.1 Capturing of losses and special payments

4.1.1 The ICB chief financial officer is responsible for ensuring that processes and procedures that facilitate the capturing and reporting of losses and special payments are in place and ensure that a losses and special payments register is maintained.

4.1.2 All losses and special payments for ICBs must be recorded in the register and reviewed as part of the internal controls process.

4.2 Parliamentary accountability and audit report

4.2.1 The ICB must maintain a losses and special payments register that provides the requested information to complete the NHS England group account.

4.2.2 It should be noted that ICBs do not have a mandatory requirement to produce a Parliamentary accountability and audit report as other entities that report directly to Parliament do. However, it is a mandatory requirement that ICBs produce an audit certificate and report.

There will be a need to collect data for the NHS England consolidated account. NHS England will also use this information to complete the DHSC summarisation schedule for the DHSC consolidated account. Therefore, regardless of applicability of this report, all ICBs must ensure the summarisation schedule is completed.

4.2.3 If there are any individual cases or a group of losses or special payments that exceed the aggregate value of £100,000, the related payment should be noted separately on the ICB year-end template completed for the NHS England group account.

5. Roles and responsibilities

5.1 Financial Control

5.1.1 Chief Financial Officer

5.1.2 It is noted and acknowledged that the roles and responsibilities for the chief financial officer vary in all the ICBs. The chief financial officer should implement a system of internal control that details the process for reporting losses, recording losses, monitoring and reporting the losses and special payments to the ICB's audit committee based on existing reporting cycles.

5.1.3 The reporting cycle should also clarify the delegated sum that the chief financial officer can authorise as a loss or special payment. The delegated sum should be in line with the ICB escalation process for losses and special payments.

Integrated Care Board meeting

Item 5
Enclosure F

Title:	**ICB Board Assurance Framework**
Meeting Date:	**31 January 2024**
Author:	Kieran Swann, Associate Director of Assurance Tara Patel, Head of Assurance
Executive Lead:	Tosca Fairchild, Chief of Staff

Purpose of paper:	This paper presents the updated Board Assurance Framework (BAF). It aims to provide SEL ICB with key risks and assurance that the key risks are being managed appropriately as stipulated in the ICB's Risk Management Framework 2023/24 (RMF).	Update / Information	
		Discussion	
		Decision	*x*

Summary of main points:

The ICB Board is responsible for setting the strategic direction for risk management in the organisation and for formal approval of the BAF document.

The Board agreed the scope of delegated activity to be undertaken by the Executive Committee (ExCo) and the six local care partnerships (LCPs) on its behalf in relation to risk management and has delegated the detailed oversight of risks to the ExCo. ExCo most recently met on 17 January 2024 to consider the current ICB BAF and other key risks.

The RMF states that the Board should be kept appraised of significant risks facing the organisation and the actions taken on its behalf by the ExCo and other relevant committees

Key points to note:

- The risks included reflect the assessed position of ICB risks as recorded on the ICB's Datix risks management system on 15 December 2023.
- For this BAF, only risks above threshold are included for SEL, Bexley and Bromley LCPs. There are no risks above threshold for Greenwich, Lambeth, Southwark and Lewisham LCPs.
- Following the last update to the ExCo on the BAF, place executive leads (PELs) have completed a review of risks between the LCP risk registers. This work has resulted in adjustments in risk scores and additions of risks to LCP registers of common areas of risks. The PELs have agreed to continue with this approach on quarterly basis.

- The BAF incorporates a response to the actions agreed by the ICB Quality & Performance Committee (QPC) on 10 January 2024. The BAF has consequently been updated to include a new BAF risk relating to cancer waiting times (504), and further updates have been made to the existing BAF risk on UEC pressures (386). These changes were completed and endorsed week commencing 15 January 2024 by the ICB Executive Director of Planning, Medical Director and Chief Nurse. Additional amendments have been made to other risks discussed by QPC on 10 January, but these are scored lower than the agreed thresholds for inclusion on the BAF. This includes the previous BAF risk related to discharge funding (365) which is proposed for de-escalation.

Summary of key changes:

- There are 15 SEL risks which are above risk appetite threshold, and two LCP risks. This is a decrease in the number of BAF risks since the last update.

Four new risks with scores greater than the risk appetite thresholds have been added to the BAF:

- SEL risk 484 relates to disruption to primary care activity through the change initiatives being implemented by acute providers and/or pathology providers. There is a risk that patients may be harmed if such disruption results in delays to care. This risk falls under the data and information management category and has a current score of 12.

- SEL risk 490 relates to reinforced aerated autoclaved concrete (RAAC) within the SEL estates portfolio, including acute providers and general practice, which could impact on staff and patient safety and means that those sites may not be usable. This risk falls under the clinical, quality and safety category and has a current score of 10.

- SEL risk 491 relates to the ICB not being able to discharge its duty of having system oversight of quality and patient safety systems at providers. This is due to transition to the learning from patient safety events (LFPSE) for reporting safety events which currently does not allow the ICB access to provider data. This leaves the ICB 'blind' to information on LFPSE. This risk falls under the clinical, quality and safety category and has a current score of 16.

- SEL risk 504 relating to the ICB not being able to meet its operational plan commitments with regards to cancer access and wait times. This risk falls under the strategic commitments and delivery priorities category and has a current score of 16.

One risk has escalated to the BAF:

- Bexley risk 450 – relating to a risk that planned changes aimed at increasing capacity to support urgent and emergency care services, will not be successful – has been increased to 16. This is due to a lack of available

resources meaning capacity has had to reduce in some areas (i.e. virtual wards).

Seven risks have de-escalated from the BAF:

- SEL risk 23 – relating to transfer of high costs learning disabilities and autism clients resulting in potential unbudgeted costs – has had the risk description updated to include a scale of the financial cost and subsequently the residual risk score was reduced to 12.
- SEL risk 365 - relating to loss of discharge funding meaning that some provision may no longer be able to be commissioned, resulting in flow challenges across our hospital pathways and patients staying in hospital longer than they need to. The residual risk score was reduced to 12 since planning over 2023/24 has effectively mitigated the risk.
- SEL risk 395 – relating to the size of the health and care workforce across the system being insufficient to meet clinical and performance demands – has had the risk description and controls updated. The residual risk score reduced to 12 following review by the People Board in November 2023.
- Bexley risk 444 – relating to insufficient capacity to meet the demand for supported discharge – has been reduced to 12 as partners in the Bexley system have collaborated to ensure that patients' discharges are increasingly completed as early as possible.
- Lambeth risk 319 – relating to CHC overspend has been reduced in score to 12 due to the implementation of a recovery plan that ensures costs are recovered and allocated appropriately to achieve budget savings.
- Southwark risk 124 - relating to initial accommodation centres and health pressures in the borough, has been reduced in score to 8 due to a reduction in the number in arrivals.
- Southwark risk 454 - relating to performance issues with the integrated community equipment services has been reduced in score to 9, due to an improvement in service performance.

Three risks have been closed since approval of the previous BAF (November 2023):

- SEL risk 407 relating to an increase in cyber security threats has been closed because the acute trusts have introduced a new IT system which means this is no longer considered a specific risk.
- Bexley risk 402 relating to Bexley residents discharged under Home First arrangements will achieve less than optimal outcomes from the service, has been closed as this has been incorporated into Bexley risk 450.

	• Bexley risk 446 relating to overspend on cost-per-case budgets because the fee uplift process has been completed and the outstanding financial risk is being dealt with through a CHC recovery plan.

Potential Conflicts of Interest	None identified				
Relevant to the following Boroughs	**Bexley**	**X**	**Bromley**	**X**	
	Greenwich	**X**	**Lambeth**	**X**	
	Lewisham	**X**	**Southwark**	**X**	
	Equality Impact	Not directly applicable to the production of this paper.			
	Financial Impact	Not directly applicable to the production of this paper.			
Other Engagement	Public Engagement	Not directly applicable to the production of this paper.			
	Other Committee Discussion/ Engagement	Quality and Performance Committee, 10 January 2024 Planning and Finance Committee, 17 January 2024 ICB Executive Committee, 17 January 2024			
Recommendation:	The Board is asked to: • Review and approve the ICB's Board Assurance Framework, following endorsement by the Executive Committee.				

SEL ICB Board Assurance Framework 2023/24 January 2024

Prepared for SEL ICB Board, 31 January 2024

Context

- Following extensive engagement with the Board, ICB Executive, Audit Committee and Planning Finance Committee, the updated risk management framework with the risk appetite statement and matrix was approved by the Board at its meeting in Public on 19 July 2023.
- The ICB's risk appetite matrix is a way for the Board to set risk tolerance levels for various categories of risk across the organisation. This approach is designed to promote and support local ownership of risk across the ICB's governance and delegation arrangements. It also means that the Board will receive a view on those risks that have been assessed as exceeding the tolerance levels set.
- The new Board Assurance Framework (BAF) document therefore represents the full range of ICB risks that sit above the permitted level of risk tolerance, rather than be a summary of key strategic risks, regardless of their risk rating, as was the case previously.

Structure of the BAF

- All risks on the SEL and LCP risk registers have been updated by designated risk owners working with their teams.
- **Appendix 1**: includes all the SEL risks which are above the tolerance levels (summarised on slides 8 - 10).
- **Appendix 2:** includes all the LCP risks which are above tolerance levels (summarised on slide 11).
- The risks include the following information:
  - risk owners and sponsors
  - the risk category that the risk falls into
  - the risk appetite for that category of risk
  - a description of the risk
  - controls that are in place to mitigate the risk
  - assurances
  - initial and residual risk scores
- **Flightpaths**
  - Residual risk score “flightpaths” show changes in risk scores over time and a short narrative providing the rationale for the score change.
  - Scores have been shown since April 2023, when the updated ICB risk management framework, with risk appetite statement has been applied.
  - Flightpaths are shown for those risks where there have been score changes since November (one BAF risk, see slide 12).
  - There have been no changes in risk scores for all other risks that remain on the BAF.

Role of the Board and recommendation

The ICB Board

- is responsible for setting the strategic direction for risk management and overseeing the arrangements for identifying and managing risk across the organisation (including those exercised by joint committees or committees-in-common).
- has a role in agreeing the scope of delegated activity to be undertaken by the Executive Committee (ExCo) on its behalf in relation to risk.

- The Board has delegated the detailed oversight of risks to the ExCo and is kept appraised of risk-related activity undertaken by relevant Board committees. The ICB Board however retains overall responsibility for formal approval of the ICB's BAF.

Key points to note

- The risks included reflect the assessed position and risks were downloaded from Datix on 15 December 2023.
- There are **15 SEL risks** included in the current version of the BAF (i.e. risks scored in excess of agreed risk thresholds) and **two LCP risks** (Bexley and Bromley). There are no risks above threshold identified in Greenwich, Lambeth, Southwark and Lewisham LCPs. This represents a decrease in the number of BAF risks since the last update.
- Following the last update to the ExCo on the BAF, place executive leads (PELs) have completed a review of risks between the LCP risk registers. This was done through a summary assessment of the actual risks recorded, as well as the variance in residual risk scores for risks that are common across the LCPs collated by the assurance team. PELs agreed an approach to consider common and differential risks across their risk registers, as well look at scoring of risks to ensure that a consistent scoring approach has been applied by all LCPs. This work has resulted in adjustments in risk scores and additions of risks to LCP registers of common areas of risks. The PELs have agreed to continue with this approach on a quarterly basis.

Recommendation to the Board

- Approve the ICB BAF, endorsed by the ExCo on 17 January 2024.

The current BAF and a summary of changes (1 of 3)

- **Four new risks** with scores greater than the risk appetite thresholds have been added to the BAF:
    - **SEL risk 484** relates to disruption to primary care activity through the change initiatives being implemented by acute providers and/or pathology providers. There is a risk that patients may be harmed if such disruption results in delays to care. This risk falls under the data and information management category and has a current score of 12.
    - **SEL risk 490** relates to reinforced aerated autoclaved concrete (RAAC) within the SEL estates portfolio, including acute providers and general practice, which could impact on staff and patient safety and means that those sites may not be usable. This risk falls under the clinical, quality and safety category and has a current score of 10.
    - **SEL risk 491** relates to the ICB not being able to discharge its duty of having system oversight of quality and patient safety systems at providers. This is due to transition to the learning from patient safety events (LFPSE) for reporting safety events which currently does not allow the ICB access to provider data. This leaves the ICB 'blind' to information on LFPSE. This risk falls under the clinical, quality and safety category and has a current score of 16.
    - **SEL risk 504** relating to the ICB not being able to meet its operational plan commitments with regards to cancer access and wait times. This risk falls under the strategic commitments and delivery priorities category and has a current score of 16.
- **One risk has escalated** to the BAF:
    - **Bexley risk 450** relating to a risk that planned changes, and efforts to increase capacity to support urgent and emergency care services, will not be successful has been increased to 16 due to a lack of resources which means that capacity has had to reduce in some areas (i.e. virtual wards).

The current BAF and a summary of changes (2 of 3)

- **Seven risks have de-escalated** off the BAF:
  - **SEL risk 23** relating to transfer of high costs Learning Disabilities and Autism clients resulting in potential unbudgeted costs – risk description was updated to include a scale of the financial cost and subsequently the residual risk score was reduced to 12.
  - **SEL risk 365** relating to loss of discharge funding meaning that some provision may no longer be able to be commissioned, resulting in flow challenges across our hospital pathways and patients staying in hospital longer than they need to. The residual risk score was reduced to 12 since planning over 2023/24 has effectively mitigated the risk - system investment to support the process improvements associated with Transfer of Care Hub review and further agreed targeted investments through the national Discharge Fund and the BCF. The initiatives agreed as part of this 2023/24 funding, alongside 'business as usual' budgets and associated discharge support, has enabled the system to maintain the position with regards transfer of care/discharge.
  - **SEL risk 395** relating to the size of the health and care workforce across the system being insufficient to meet clinical and performance demands – risk description and controls were updated. The residual risk score reduced to 12 following review by the People Board in November 2023.
  - **Bexley risk 444** relating to insufficient capacity to meet the demand for supported discharge has been reduced to 12 as partners in the Bexley system have collaborated to ensure that patient discharges are increasingly completed as early as possible.
  - **Lambeth risk 319** relating to CHC overspend has been reduced in score to 12 due to the implementation of a recovery plan that ensures costs are recovered and allocated appropriately to achieve budget savings.
  - **Southwark risk 124** relating to initial accommodation centres and health pressures in the borough has been reduced in score to 8 due to a reduction in the number in arrivals.
  - **Southwark risk 454** relating to performance issues with the integrated community equipment services has been reduced in score to 9, due to an improvement in service performance.

The current BAF and a summary of changes (3 of 3)

- **Three risks** included on the previous version of the BAF (approved by the Board in November 2023) **have been closed**:
  - **SEL risk 407** relating to an increase in cyber security threats has been closed because the acute trusts have introduced a new IT system which means this is no longer considered a specific risk.
  - **Bexley risk 402** relating to Bexley residents discharged under 'Home First' arrangements will achieve less than optimal outcomes from the service has been closed as this has been incorporated into Bexley risk 450.
  - **Bexley risk 446** relating to overspend on cost-per-case budgets (CHC/MH/LD/CYP) because the fee uplift process has been completed and the outstanding financial risk is being dealt with through a CHC recovery plan.

Summary of SEL risks exceeding tolerance levels (1 of 3)

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Finance	**394**	System financial balance	12	16
Data and Information Management	**279**	ICB paper records left on the NHS SEL sites	9	12
	434	Variation in CHC digitalisation means that SEL will not meet the CHC mandatory patient level dataset submission		12
	435	Variation in CHC digitalisation means that SEL will not meet the all age continuing care patient level dataset submission		12
	437	Disruption to IT/Digital systems across provider settings due to external factors		10
	484	Disruption to primary care activity through the change initiatives being implemented by acute providers and/or pathology providers.		12

Summary of SEL risks exceeding tolerance levels (2 of 3)

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Governance: Adherence to legal and statutory responsibilities	**433**	Potential reputation damage to the ICB due to a provider's potential failure to meet statutory requirements with increase in numbers of patients presenting with safeguarding concerns not being addressed.	12	20
Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	**386**	Ongoing pressures across SEL UEC services	12	16
	504	Cancer performance – access and wait times		16

Summary of SEL risks exceeding tolerance levels (3 of 3)

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Clinical, Quality and Safety	391	Increased waiting times for autism diagnostics assessments	9	16
	404	New and emerging High Consequence Infections Diseases (HCID) & pandemics		12
	431	Harm to patients due to unprecedented operational pressures		16
	468	Risk of variation in performance across SEL with FNC (funded nursing care) reviews		12
	490	Reinforced aerated autoclaved concrete in SEL estates including primary care and acute providers		10
	491	System oversight of patient quality and safety systems		16

Summary of LCP risks exceeding tolerance levels

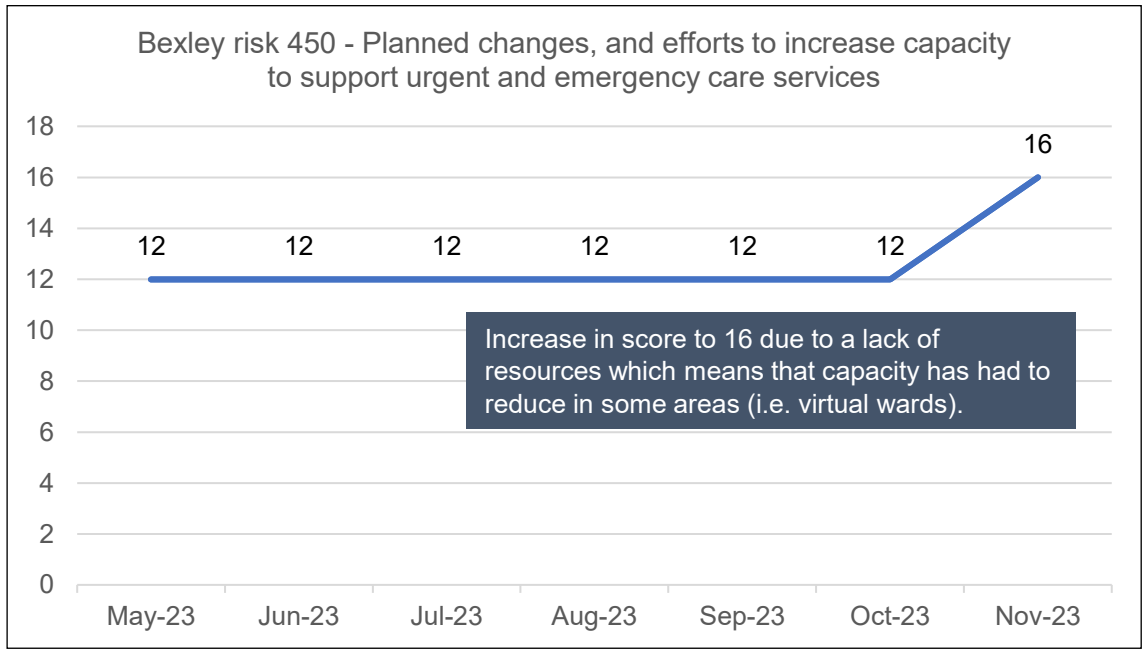
Bexley risk

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	**450**	Planned changes, and efforts to increase capacity to support urgent and emergency care services, will not be successful	12	16

Bromley risk

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Finance	**467**	The new pan-London community equipment provider is delivering poor quality services, with a high financial risk to Bromley Council and SEL ICB	12	20

Flightpath for BAF risks with in-year score changes



Appendices: risk scoring matrices

Risk scoring matrices (1 of 3)

The matrices below are taken from the ICB's Risk Management Framework and represent the possible combined risk scores based on a measurement of both the likelihood (probability) and severity (impact) of risk issues. A combination of likelihood and severity score provides the combine risk score.

Likelihood x Severity = Risk Score

			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Severity	5	Catastrophic	5	10	15	20	25
	4	Major	4	8	12	16	20
	3	Moderate	3	6	9	12	15
	2	Minor	2	4	6	8	10
	1	Negligible	1	2	3	4	5

Likelihood Matrix:

Likelihood (Probability) Score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency Time-frame	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Frequency Will it happen or not?	<0.1%	0.1 to 1%	1 to 10%	10 to 50%	>50%

Risk scoring matrices (2 of 3)

Severity matrix

Severity (Impact) Score	1	2	3	4	5
Descriptor	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Service Business Interruption	Loss interruption of 1-8 hours Minimal or no impact on the environment /ability to continue to provide service	Loss interruption of 8-24 hours Minor impact on environment / ability to continue to provide service	Loss of interruption 1-7 days Moderate impact on the environment / some disruption in service provision	Loss interruption of >1 week (not permanent) Major impact on environment / sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked	Permanent loss of service or facility Catastrophic impact on environment / disruption to service / facility leading to significant “knock on effect”
Personal Identifiable Data [Information Management Risks]	Damage to an individual’s reputation. Possible media interest e.g. celebrity involved Potentially serious breach Less than 5 people affected or risk assessed as low e.g. files were encrypted	Damage to a team’s reputation. Some local media interest that may not go public. Serious potential breach and risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected.	Damage to a service reputation. Low key local media coverage. Serious breach of confidentiality e.g. up to 100 people affected.	Damage to an organisations reputation. Local media coverage. Serious breach with either particular sensitivity e.g. sexual health details or up to 1000 people affected.	Damage to NHS reputation. National media coverage. Serious breach with potential for ID theft or over 1000 people affected.

Risk scoring matrices (3 of 3)

Severity matrix (contd.)

Severity (Impact) Score	1	2	3	4	5
Descriptor	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Complaints / Claims	Locally resolved complaint Risk of claim remote	Justified complaint peripheral to clinical care e.g. civil action with or without defence. Claim(s) less than £10k	Below excess claim. Justified complaint involving lack of appropriate care. Claim(s) between £10k and £100k	Claim above excess level. Claim(s) between £100k and £1 million. Multiple justified complaints	Multiple claims or single major claim >£1 million. Significant financial loss >£1 million
HR / Organisational Development **Staffing and Competence**	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level that reduces service quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory / key training.	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objectives / service due to lack of staff Ongoing unsafe staffing levels or incompetence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Financial (damage / loss / fraud) **[Financial Risks]**	Negligible organisational / financial loss (£< 1000	Negligible organisational / financial loss (£1000- £10000)	Organisational / financial loss (£10000 -100000)	Organisational / financial loss (£100000 - £1m)	Organisational / financial loss (£>1million)
Inspection / Audit	Minor recommendations Minor non-compliance with standards	Recommendations given Non-compliance with standards Reduced performance rating if unresolved	Reduced rating Challenging recommendations Non-compliance with core standards Prohibition notice served.	Enforcement action Low rating Critical report. Major non-compliance with core standards. Improvement notice	Prosecution. Zero rating. Severely critical report. Complete systems change required.

Appendix 1: SEL risks exceeding tolerance scores

Risk ID	Risk Owner	Risk Sponsor	Risk Type	Risk Appetite	Risk Title	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Control Summary	Assurance in Place
279	Director of IT - Nisha Wheeler	Director of Corporate Operations - Michael Boyce	Data and Information Management	7 - 9	IG - (ICB) Paper records left on NHS SEL sites	There is a risk that hardcopy records left on NHS SEL sites will not be appropriately managed, archived or destroyed in line with the NHS Records management code of practice retention schedule. This is caused by offices having documents on site which have been left following the Covid 19 Pandemic and where staff have left the organisation and nolonger being managed. This could lead to a potential data breach as a result of information being vulnerable to inappropriate access or theft, which could then lead to reputational and financial loss as a result of penalties/fines from the Information Commissioners office for not adhering to the NHS Code of Practice/Data Protection Act/UK GDPR.	4	3	12	4	3	12	Staff are being encouraged to review records at NHS SEL sites, when visiting the office, Staff are provided guidance through various media (Bulletins, Intranet, Staff briefings, Policies and Procedures) to support them in their roles and responsibilities.	Communications to staff regarding records management review (including hardcopy records), Inspection of Tooley street has taken place and paper records locked away and desks cleared, Staff to digitalise and save records electronically as much as possible, Communications relaunched to encourage records review on sites, Archive contract review and update completed and new Archive process established as part of new Information management policy, Staff contacted following premises review where staff/teams have been identified and asked to review and tidy the premises., Premises audit of documentation being undertaken throughout 2023 in over 120 units, Report of outcomes of audit now with Director of ICT and IG and outcomes presented to IG SC Dec 2022, Storage plan developed and registered users of storage facilities completed and maintained, Draws under desks reviewed and cleared - 25 draws removed by Southwark council to reduce storage of hardcopy information
386	Kelly Hudson and Sara White	Sarah Cottingham	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	Ongoing pressures across SEL UEC services	There is a risk of not being able to make improvements on waiting times, pathway flow and timely transfer of care as a result of demand and flow challenges across the system. This will impact the ICB's ability to meet operational plan commitments and impact on the service users affected by these services, affecting patient experience. Increased waits - for ambulance support, in the Emergency Department or for transfer of care (e.g. from a physical to a mental health facility) increases the risk of poorer clinical outcomes.	4	4	16	4	4	16	Robust daily intensive system support in place, led and coordinated by the SEL ICB System Control Centre, to review, manage and smooth pressures across the system, agree mutual aid and support site safety. SCC operates 24/7 providing in and out of hours system support. Operational plan for 2023/24 includes a SEL system Urgent and Emergency Care recovery narrative plus a number of performance improvement trajectories. Local system actions: each local system has an action plan to support urgent and emergency care pathway improvement including reviewing and making best use of available estate/capacity, workforce, care pathway changes (aligned to recommended best practice), protocols and escalation arrangements to support the effective management of pressures, focussed particularly on admission avoidance and supported and timely discharge. Proactive work to develop community offer including the roll out of urgent community response and development of our virtual ward offer. SEL System actions: SEL improvement work across the system to develop and implement supportive measures, for example, increasing direct access to and the further development of Same Day Emergency Care, direct booking from 111, increasing crisis support for Mental Health, SEL discharge improvement plan and actions. This work is manged via local and system groups: SEL Acute Flow Improvement Group; MH UEC Task and Finish Group; SEL Discharge Solutions and Improvement Group plus local and SEL UEC Boards. SEL actively participates in London and national learning groups and processes. From a quality and safety perspective on going quality and outcomes monitoring and surveillance plus within organisations regular safety huddles. Our MH crisis improvements have included a specific focus on quality and safety.	The daily SCC calls are providing the immediate system support to retain site safety across all SEL sites, with assurance having been completed regional and nationally of SEL's SCC arrangements. Review of revised OPEL (escalation) framework through SCC, aligned to national expectations, to ensure parity of escalation and system response. SEL operational plan for 2023/24 and supporting recovery narrative and templates - signed off post assurance process. Monthly call with UEC local system leaders to review current performance issues, challenges and successes; to understand key issues driving local performance and planned solutions; to understand key successes and opportunities for spread - plus formal local and SEL Urgent and Emergency Care Boards overseeing progress and performance with a supporting UEC performance dashboard. Further assurance through London UEC and MH UEC Boards. Winter planning process and outputs - noting assurance processes completed around plans internally, regionally and nationally.
391	Carol-Ann Murray	Sarah Cottingham	Clinical, Quality and Safety	7 - 9	Increased waiting times for Autism diagnostic assessments	There is a risk of increased waiting times for a diagnostic assessment for Autistic Spectrum Disorder (ASD) for adults and children and resulting non-contracted activity costs due to patient choice referrals to private providers. This is caused by increased demand for assessments combined with historical waiting lists. The impact on the ICB will be on its ability to meet statutory oblications. Achieving timely access to assessment will reduce diagnosis waiting times and ensure support can be put in place earlier and help improve patient outcomes.	3	4	12	4	4	16	Implementation of services for backlog clearance by Oxleas and SLaM and plans to reduce the waiting time by end of March 2024 including development of services to meet the demand and maintain waiting times within 6 months., Clinical and care professional leaders recruited to focus on autism across all ages, particularly post-diagnostic support for autism only diagnoses., All age autism strategy approved and launched, with non -recurrent funding (Â£240k) provide to each borough LA (S256) to align with strategic framework., Core offer for CYP Autism assessment developed and agreed with stakeholder. Set up of Community of practice to share best practice and find solutions to ongoing issues.	SEL LDA Strategic Executive Group Agenda and Minutes List the assurance evidence., SEL LDA Operational Board agenda and minutes., Minutes from 6-8 weekly Joint Region and System LDA heath Partnership meeting., Minutes from Monthly monitoring of ASD Support services and workforce with providers (Oxleas and SLaM).
394	Tony Read	Mike Fox	Finance	10 - 12	System financial balance, and delivery of efficiency and savings plans	There is a risk that Risk that ICS does not deliver its breakeven revenue financial plan and system capital financial plan for 2023/24, due to: Inability to deliver planned savings Under-delivery against elective recovery commitments Impact of industrial action Over commitment on capital programmes	4	4	16	4	4	16	Breakeven plan for 2023/24 agreed by ICS Executive and ICB Planning and Finance Committee., Component parts of ICS plan agreed by SEL organisation Boards. Monthly review and reporting to ICB Executive and SEL CEO group on delivery against financial plans and risk of organisational efficiency plans. Oversight of revenue and capital financial position and efficiency by SEL CFO group, meeting fortnightly. Agency limit and monitoring of spend reported routinely each month. External review of SEL performance working with NHSE. Increased organisational control mechanisms. Monitoring of financial impact of industrial action by CFO group. Quarterly review and reporting to ICB Planning and Finance Committee on delivery against financial plans and risk of organisational efficiency plans. Monthly CEO & CFO group in place, including oversight of system financial performance. Formal review of trust year end forecasts and risks to delivery undertaken Oct/Nov.	Breakeven plan in place per 4th May 2023 submission to NHSE, Review of forecast out-turns, underlying positions and risks in progress and initial draft results reported to CEOs & CFOs., At month 6 revenue forecast out-turn reported as breakeven, assuming cost impact of industrial action is funded and risks to FOT delivery are mitigated., At month 6 capital forecast is on plan, including prioritised use of system capital reserve., NHSE has revised elective recovery targets for early months of year as part mitigation to impact of industrial action., SEL CFO group meeting weekly instead of fortnightly.
404	Simon Beard - Associate Director Corporate Governance	Tosca Fairchild - Chief of Staff	Clinical, Quality and Safety	7 - 9	New and emerging High Consequence Infections Diseases (HCID) & pandemics	There is a risk that new and emerging HCID & pandemics could occur at any time and are likely to occur in one or more waves. This could cause disruption to the operation of the ICB with staff illnesses/absence and reprioritisation of workload which could lead to a detrimental effect of communities and staff within SE London.	4	4	16	4	3	12	Staff are offered flu and covid-19 vaccines to mitigate as far as possible the impact on the workforce., HCID & pandemic plan is in place. Antiviral plan in place for SEL system., Collaboration with organisations across the system through forums such as Borough Resilience Forums enables the ICB to horizon scan for potential emerging HCID issues and put mitigating actions in place early to minimise impact to the workforce and ICB operations., Hybrid working arrangements are in place, supported by cloud-based access to IT systems, which enables the ICB to reduce face to face interactions between staff should this be necessary as a measure to reduce spread of infections., The ICB has an established process for considering staff redeployment to focus on business critical services., Employee assistance is available - e.g. mental health first aiders; occupational health and employee assistance programme.	SEL ICB - System approach utilised and implemented for HCIDs, EPRR Practitioners network is in place enabling early sharing of information/ horizon scanning in relation to HCIDs, which will ensure organisations can take early mitigating actions (P)
431	Paul Larrisey	Tosca Fairchild	Clinical, Quality and Safety	7 - 9	Risk of unintended harm to patients due to unprecedented operational pressures	There is a risk of unintended harm to patients. This is caused by operational pressures within the system exacerbated by industrial action by clinical staff. This will impact on the ICB's duty to ensure that the services it commissioned meet fundamental standards of care with particular regard to clinical effectiveness, safety and patient experience. All providers are currently experiencing longer waiting times for routine appointments which may lead to deterioration of patient conditions.	3	4	12	4	4	16	Datix is reviewed daily to spot trends from providers. Quality team attend provider committees to understand individual provider risks and mitigations. Risk of harm assessments and prioritisation and reprioritisation of patients and signposting to other services is routinely completed by SEL trusts., Any treatment delays that do lead to significant harm are reported and investigated as Serious Incidents to ensure learning is shared across the system., Regular meetings are held with the providers to ensure delivery of agreed recovery trajectories and to review issues related to the quality of care, including notified Serious Incidents (SI's),., Regular update meetings with commissioning teams and quality teams. Robust governance for operational pressures including industrial action., UEC programme of work to improve patient flow across the system aimed at mitigating delays., Mutual aid is being provided to support provider specialties to reduce waiting lists., The ICB have convened a quarterly themes and concerns group which will review all key themes and concerns arising as an additional level of assurance	Governance: Quality and Performance Committee where risks are escalated, Governance: System Quality Group where system wide risks are explored and learning shared, Thematic analysis of SI reports, Quality Alerts provide assurance that where incidents do occur, lessons are learned, shared and acted on appropriately., Quality Alert System provides early warnings, ICB incident command stood up for specific system wide incidents such as IT outtages in GSTT and SLaM in summer 2022 to ensure risk of harm identified and mitigated.
433	Paul Larrisey - Acting Chief Nursing Officer	Margaret Mansfield - Designated Nurse Safeguarding Children and Young People Interim Designated Nurse Children Looked After and Care Leavers	Governance: Adherence to legal and statutory responsibilities	10 - 12	There is the risk of reputational damage to SEL ICB due to the potential failure of a provider to meet statutory requirements, with an increase in numbers of patients presenting with safeguarding concerns not being addressed.	There is the risk of reputational damage to SEL ICB due to the potential failure of a provider to meet statutory requirements, with an increase in numbers of patients presenting with safeguarding concerns not being addressed. This risk has been identified through a Safeguarding Learning Event held within the provider which highlighted their lack of knowledge in discharging their statutory safeguarding functions, as well as from other Child Safeguarding Practice Reviews and the Trust external review.	5	4	20	5	4	20	Work underway within the Local Safeguarding Children Partnership (s) LSCP/ LSCPs partnerships to monitor the risks., ICB Safeguarding Designate professionals to quality assure SLaM strategic Safeguarding risk/learning action plan in relation to discharge of safeguarding arrangements via attendance at SLaM's safeguarding committees., SLaM audit plan around recommendations to ensure learning is embedded into practice, An independant scrutiner will be supporting a trust wide improvement plan with SLAM safeguarding leads, SLAM have a safeguarding improvement plan in place., Bi monthly SEL ICS & SLAM Safeguarding Monitoring Group to provide strategic oversight of the improvement plan., A SLAM & ICB Place safeguarding designates safeguarding working group to operationalise the improvement plan, track actions, escalate emerging risks and report to the Safeguarding Monitoring Group., A SEL ICB & SLAM quality safeguarding review group to to accompany the SLAM quality assurance officer completing quality assurance reviews.	There is an experienced Trust Named Nurse for Safeguarding Adults. Newly appointed and experienced Trust Named Nurse for Safeguarding Children. There are some Safeguarding Leads in place bases. SLaM are reviewing their Safeguarding supervision arrangements, also reviewing their Safeguarding Policy. The named nurse on long term sick has has fully returned to work. Workstreams and workplans are in place to look at different areas of concern. Safeguarding Business officer post appointed to. All safeguarding vacancies are filled as of June 2023 except for Lambeth. The trust have recruited a substantive Associate Director for Safeguarding who started work in August 2023. SLAM Task and finish group chaired by the Director of Therapies and consisting of Service Directors, Chief Nurse, Chief Operating Officer. Chief People officer and Medical Director meeting monthly to oversee the completion and implementation of the safeguarding action plan. All safeguarding vacant posts have interim cover and substantive recruitment is in process. A revised structure for the safeguarding team has been developed and agreed. This supports staff retention and progression which is not achieved by the current flat structure. SLAM shares the assurance reports for Lewisham, Southwark, Lambeth and Croydon. Safeguarding meeting held with the Director of social care for SLAM on 01 September to review SLAM safeguarding programme update. A SLAM safeguarding programme meeting was held on 08 November with the Director of Social Care (SLAM), the Associate Director (SLAM). Named Nurse (SLAM) and SEL designated nurses, including Croydon, to provide a progress update on the improvement plan.
434	Jane Waite - SEL Head of CHC/CYPCC	Lizzie Wallman - Director of Quality	Data and Information Management	7 - 9	There is a risk that SEL will not meet the CHC mandatory Patient Level Dataset submission due to variation in CHC digitalisation across the six boroughs by the deadline of 1st April 2024 to coincide with month 1 of 24/25.	There is a risk that SEL will not meet the CHC mandatory Patient Level Dataset submission due to variation in CHC digitalisation across the six boroughs by the deadline of 1st April 2024 to coincide with month 1 of 24/25. This will result in file rejections to NHSE. This will have an adverse reputational impact on SEL ICB	5	4	20	3	4	12	Boroughs are completing monthly data quality checks as part of the PLDS data set review., Patient Level Dataset reports are being circulated to boroughs and PELS monthly, The development of a combined single database/system was agreed in principle by quality and Place executive directors on the 15th August 2023., The AACC digital capability assessment tool will identify system capability and the percentage of the known available system capability SELAACC are using., Working group set up to consider the procurement of a single database/system with key stakeholders.	There is an interim plan to continue to submit data via a lower tier submission as opposed to the required singular sub-ICB location in line with CHC PLDS current guidance., Patient Level Dataset reports are being circulated to boroughs and PELs monthly

Risk ID	Risk Owner	Risk Sponsor	Risk Type	Risk Appetite	Risk Title	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Control Summary	Assurance in Place
435	Jane Waite - Head of CHC/CYPCC	Paul Larrisey - Acting Chief Nursing Officer	Data and Information Management	7 - 9	There is a risk that SEL will not meet the AACC (All Age Continuing Care) Patient Level Dataset submission due to variation in CYPCC digitalisation across the six boroughs by the provisional deadline of 1st April 2024 to coincide with month 1 of 24/2	There is a risk that SEL will not meet the AACC (All Age Continuing Care) Patient Level Dataset submission due to variation in CYPCC digitalisation across the six boroughs by the provisional deadline of 1st April 2024 to coincide with month 1 of 24/25. This could lead to an adverse reputational impact on SEL ICB.	5	4	20	3	4	12	The development of a combined single database/system was agreed in principle by quality and Place executive directors on the 15th August 2023., Working group set up to consider the procurement of a single database/system with key stakeholders.	CHC have started to identify potential gaps in data collections across the CYPCC teams, There are already local CYPCC meetings at place level
437	Philippa Kirkpatrick	Andrew Bland	Data and Information Management	7 - 9	Disruption to IT/Digital systems	There is a risk of significant disruptions to the IT and digital systems across our provider settings due to external factors such as extreme weather conditions or cyber attacks	2	5	10	2	5	10	Individual organisations accountable to boards to demonstrate sustainability of their digital and IT infrastructure, In some cases, cross system data sharing platforms can support in case of outages, GSTT taking action to reduce risk on their IT estate following incident in July 2022., Workshop held with board on 14th April, ICB exec supported approach set out in digital delivery plan and Â£240k funding for audit May 2023, Interim digital governance group supported paper for ICB Board, which will be submitted for approval in July 2023, GPIT services are mostly 3rd party managed cloud-based solutions. GP services are required to have business continuity, including for their IT services, built into their contracts., Paper on the 2022 cyber and resilience incidents provided to the Board in July 2023, including lessons learnt and actions taken following the incident.	Procurement for the cyber and resilience maturity assessment is well progressed. It is expected a contract will be signed by mid Decmeber. Board cyber training was planned for October but had to be rescheduled due to a clash. New dates being identified.
468	Jane Waite - Head of CHC/CYPCC Governance Assurance and QIPP	Paul Larrisey - Acting Chief Nursing Officer	Clinical, Quality and Safety	7 - 9	There is a risk of variation in performance across SEL with the FNC (Funded Nursing Care) reviews.	There is a risk of variation in performance across SEL with the FNC (Funded Nursing Care) reviews. This is due to a significant number of reviews over the required time frames (National Standard). This will impact on the service users. This is a clinical risk which will may also impact on financial control across the system.	4	4	16	3	4	12	This risk is monitored at the NHSE assurance meeting monthly, This risk is also monitored locally at CHC review meetings monthly., The SEL Head of CHC/CYPCC governance assurance and QIPP has oversight of this risk., There is a monthly assurance pack produced which goes to the CHC review meetings. The CHC monthly assurance report tracks FNC reviews., There are monthly meetings held at place level where this risk is discussed., There are individual borough plans setting out how boroughs will clear the overdue reviews., Paper presented to PELs on 16/10/2023 and agreement in principle for contingency agreement to address backlog of CHC Standard and Fast Track reviews. Contingency agreement progressed and mobilisation of additional resource expected to commence mid December., The impact of the contingency agreement will be that teams can focus on FNC reviews	There are minimal vacancies across the place based teams., Individual borough plans in place and teams are working towards reducing the backlogs
484	Philippa Kirkpatrick	Andrew Bland	Data and Information Management	7 - 9	Disruption to primary care	There is a risk that primary care activity will be significantly disrupted through the change iniatives being implemented by acute providers and/or pathology providers. There is a risk that patients may be harmed if such disruption results in delays to care.	4	3	12	4	3	12	Engagement forums with primary care have been established. Lessons learned being documented from previous projects. Primary care leaders have been identified., GPs have been advised to continue to raise clinical safety alerts if they are concerned about clinical risk associated with any disruption.	GSTT/Kings have committed to an ongoing forum with primary care to mitigate risks of disruption in the future.
490	Tim Borrie	Mike Fox	Clinical, Quality and Safety	7 - 9	Identification of Reinforced aerated autoclaved concrete (RAAC) within SEL Estates portfolio, including acute providers and general practice.	There is a risk that there are a small number of NHS properties within SEL estate portfolio where RAAC forms part of the building infrastructure. This could impact on staff and patient safety which means those sites affected cannot be used.	3	5	15	2	5	10	Following the guidance published by the Department for Education regarding their approach to the presence of RAAC in schools, there has been heightened interest in other public sector buildings. The NHS already has a national programme of work (running since 2019) to manage areas where RAAC is found in NHS premises., A small number of additional NHS sites nationally were identified as the result of a questionnaire and data collection conducted in May 2023. Further inspection and investigations are now taking place within these sites to confirm or rule out the presence. In South East London (SEL) no provider has reported the presence of RAAC on their estate, other than Lewisham and Greenwich NHS Trust (LGT)., LGT have said that there is one occurrence of RAAC slabs at UHL located in the boiler house, which is a relatively low risk location in terms of colleague and patient safety. In line with national guidance, further laser surveys have been instructed and will be able to report back on the mitigation measures needed., Our GP contractors all received information and guidance back in January 2023 clearly setting out what is required of them. Following the heightened interest in public buildings, all GPcontractors in SEL have been reissued with this information and have been asked to acknowledge that they understand what is required of them. In the background, desktop studies are being undertaken to identify any sites that may be of interest which we will follow up directly with, Our property companies NHS Property Services and Community Health Partnerships have been involved in the national programme and at this current time there are no reported issues in London. A London regional oversight group has been established which SEL are fully engaged with.	Ongoing monitoring is in place and updates provided at SEL Programme Board, ICS Estates Group Meeting, Local Estates Forums and London Estates & Infrastructure Board.
491	Fiona Leacock - Associate Director of Quality	Paul Larrisey - Acting Chief Nursing Officer	Clinical, Quality and Safety	7 - 9	There is a risk the ICB is unable to discharge its duty of having system oversight of quality and patient safety systems at providers	There is a risk the ICB is unable to discharge its duty of having system oversight of quality and patient safety systems due to transition to the Learning from patient safety events (LFPSE) for reporting safety events which currently does not allow the ICB access to provider data which leaves the ICB 'blind' to information on LFPSE. This could lead to reputational harm to the ICB, impact on oversight of patient safety and result in adverse publicity.	5	4	20	4	4	16	Continuation of STEIS (serious incident report database) until October 2024, Extended rollout of the ICB quality alerts reporting links, Regular touch point/update meetings with NHSE, system developers and providers	Providers are continuing to report on STeIS, Oversight provided by the ICB Themes and Concerns Group, Regular Stakeholder meetings with escalation processes embedded., ICB Datix System updated to allow for LFPSE data to be uploaded as and when available
504	Carl Glenister	Sarah Cottingham	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	Cancer Performance	These is a risk that the ICB does not meet the operational plan commitments it has made for 2023/24 with regards cancer access and wait times - including the Faster Diagnosis Standard, the 62 day treatment standard and the number of patients waiting more than 62 days for treatment. Failure to meet agreed access and waiting times standards exacerbates the risk of poorer clinical outcomes due to diagnosis and treatment delays.	5	4	20	4	4	16	2023/24 operational plan included agreed commitments in relation to cancer performance in relation to access and waiting time standards and the system Cancer Recovery Plan set out the planned actions that would support delivery. Cancer planning took place as part of overall operational and capacity planning to ensure cancer requirements were modelled and considered as part of overall planning and prioritisation. Plans were assured internally and externally, through regional and national processes. In year refresh of plans as part of H2 planning process - plans were further assured, in the context of a commitment to recovering to secure year end operational plan commitments. Plans regularly reviewed and monitored through the SEL ICB Cancer Executive, plus further review through regional meetings - further recovery actions developed and agreed through these processes. In January 2024 SEL entered into the system oversight framework support process (at Tier 1 - the highest level of support) in the context of a very challenged year to date position driven by overall operational pressures and the impact of Epic and industrial action. Recovery actions considered through this process to be the right actions to support recovery, with a focus on both short term recovery actions and medium term sustainability plans. On quality and safety, ongoing quality monitoring and surveillance including identifying potential and actual harm as a result of waits.	Governance - and associated minutes, papers and reports e.g. monitoring against trajectories and recovery plan actions - at a provider and SEL system level. ICB team works alongside providers and the Cancer Alliance to support planning and delivery. Plans/delivery are further reviewed in regional and national meetings - ICB co chairs Tier 1 meetings with Regional team. Plans have been assured in terms of covering the right areas - challenge is operational delivery across a complex range of services/pathways and providers - support being given to better secure delivery

Appendix 2. LCP risks exceeding tolerance levels

Risk ID	Risk Owner	Risk Sponsor	Risk Type	Risk Appetite	Risk Title	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Control Summary	Assurance in Place
450	Gemma O'Neil	Diana Braithwaite	Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	10 - 12	Delivery of change and increased capacity	There is a risk that planned changes, and efforts to increase capacity to support urgent and emergency care services, will not be successful due to: * Reductions in funding, such as the discharge funds, which mean that established services / pilots must be reduced or stopped * The reliance on short-term, non-recurrent funding of discharge programmes, winter schemes etc which result in a reliance on short-term contracts which are less appealing to colleagues seeking a substantive appointment. * The availability of colleagues locally across many professions and disciplines and the inequity in the London weighting. There is a risk that planned changes, and efforts to increase capacity to support urgent and emergency care services, will not be successful due to; * Reductions in funding, such as the discharge funds, which mean that established services / pilots must be reduced or stopped * The reliance on short-term, non-recurrent funding of discharge programmes, winter schemes etc which result in a reliance on short-term contracts which are less appealing to colleagues seeking a substantive appointment. * The availability of colleagues locally across many professions and disciplines and the inequity in the London weighting when compared to inner London boroughs This would impact the ICBs ability to deliver on national performance standards and local quality improvements in service of providing Bexley residents with the satisfactory health and wellbeing outcomes.	4	4	16	4	4	16	Commencement of winter planning earlier in the year, Programme impact monitoring to understand which programme are making a difference and therefore require business cases for long-term investment, Identification of key programmes requiring long-term funding to incorporate into planning rounds, Collaboration with system partners to identify opportunities for joint appointments / joint business cases to enable risk sharing	Programme monitoring within Home First programme ops group and boards, with escalation to Bexley Wellbeing Partnership as required.

Risk ID	Risk Owner	Risk Sponsor	Risk Type	Risk Appetite	Risk Title	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Current Likelihood	Current Consequence	Current Rating	Control Summary	Assurance in Place
467	James Postgate, Associate Director of Integrated Commissioning	Sean Rafferty, Director of Integrated Commissioning	Finance	10 - 12	The new pan-London community equipment provider is delivering poor quality services, with a high financial risk to Bromley Council and SEL ICB	Bromley Council is a member of a pan-London community equipment consortium. SEL ICB (Bromley) has a s75 agreement with Bromley Council by which it accesses these services, The Council and ICB jointly authorise other providers in the borough, including Kings College Hospital, Bromley Healthcare, Oxleas NHS Foundation Trust and St Christopher's, to be able to prescribe equipment for service users in need including specialised mattresses, seating, toilets and hoists. The pan-London consortium oversaw a procurement for a new community equipment provider (NRS) from 1st April 2023. Following mobilisation, the provider is not meeting its contractual requirements with the following impact: - service users (including people awaiting hospital discharge) are not receiving the right community equipment to meet their clinical and care needs. - service users (including people awaiting hospital discharge) are not receiving community equipment in a timely way, with missed, late or partial orders taking place. - providers are not able to access the right community equipment for service users due to issues with the NRS IT system and equipment catalogue. - the new pan-London catalogue of community equipment may not have adequate value for money products for Bromley residents with a risk that there is a higher spend on equipment than in previous years. - the new pan-London catalogue of community equipment gives providers access to purchase additional items for service users which were not previously available in Bromley, with a risk that there is a higher spend on community equipment than in previous years. - the new pan-London community equipment system is managed centrally which limits the controls that the Council/ICB could previously place on clinical activity, with a risk that there is a higher spend on community equipment than in previous years. - the community equipment provider is not recycling existing community equipment to the level available previously, resulting in a higher spend on new equipment, and lower "credits" for items re-used.	5	4	20	5	4	20	The Bromley Community Equipment Board oversees the delivery of integrated community equipment services (ICES) in Bromley with representation from leads from the ICB and Bromley Council. The Board is chaired by the joint Director of Commissioning.	Bromley Community Equipment Board overseeing current performance/risk - includes LBB/ICB lead representation, Ongoing work with NRS to improve performance, including with Sidcup Depot, Joint clinical lead for community equipment across LBB/ICB overseeing work and quality, Escalation of issues to Place Executive Lead (ICB) and Director of Adult Services (LBB), South-East London ICB work across Lambeth, Southwark, Greenwich, Bexley (affected boroughs)

Integrated Care Board meeting

Item: 6
Enclosure: G

Title:	**Digital as an Enabler**
Meeting Date:	**31 January 2024**
Author:	Philippa Kirkpatrick, CDIO
Executive Lead:	Andrew Bland, CEO

Purpose of paper:	• To seek input into the review of the Digital Strategy and the proposed expansion of scope to include data, analytics system intelligence capacity and capability alongside digital, and endorsement as to the approach to finalise it. • To demonstrate progress of priority activities outlined in the Joint Forward Plan and the impact of the Digital programme. • To present the plans for 2024/25, the challenges that require attention and to seek advice about areas of potential gap in the workplan/budget and whether these should be prioritised.	Update / Information	*x*
		Discussion	*x*
		Decision	
Summary of main points:	• The Digital Strategy is being updated to include Digital, Data and System Intelligence. An outline of the revised strategy is provided for feedback from the Board to inform final scope. • Progress of activities outlined in the Joint Forward Plan and Digital Delivery Plan are progressing well. Key achievements against each of the priorities are outlined. • Priority activities for 2024/25 have been identified but there remain opportunities we need to ensure SEL leverages, and challenges to delivery. We highlight some activities where resourcing may be a challenge and seek guidance from the Board about the relative priority of these activities and the proposed approach to take these forward.		
Potential Conflicts of Interest	None		

Relevant to the following Boroughs	**Bexley**	**x**	**Bromley**	**x**
	Greenwich	**x**	**Lambeth**	**x**
	Lewisham	**x**	**Southwark**	**x**

	Equality Impact	Digital inclusion activities are being supported by the Corporate EDI team. A focus on inequalities is included in the development of the Strategy.
	Financial Impact	Nil at this time
Other Engagement	Public Engagement	We will work with HealthWatch to agree the extent of, and approach to, public engagement in the update of the Digital, Data, Analytics and System Intelligence Strategy.
	Other Committee Discussion/ Engagement	The updated Strategy was discussed at the Digital Board on 23 January 2024. Due to timing, the Board will be verbally briefed on any input from that forum.
Recommendation:	**The Board are asked to:** 1. Agree the direction of development of the Digital, Data and System Intelligence Strategy 2024 – 2027, and/or provide feedback to influence its direction. 2. Agree that the Strategy can be endorsed by the Digital Board and provided to ICB Board members for information (out-of-session). 3. Note the progress of activities against the 2023/24 Digital Delivery Plan. 4. Provide advice about the opportunities and challenges for 2024/25 and whether the proposed areas of activity are appropriate, and whether other areas should be considered as priorities.	

Digital as an Enabler

1. Introduction

1.1. Delivery of the South East London Integrated Care System (SEL ICS) Joint Forward Plan and Strategic Priorities is reliant on key enablers including workforce, digital and data, estates and finance. It is clear that we cannot deliver the change that we need to see unless we embrace the digital revolution and the opportunities that data-driven technologies provide.

1.2. This paper outlines how SEL will transition to digitised workflows across our system, consolidating onto fewer, contemporary, user-friendly systems to support efficient care provision. It also points to our strategy for how we will ensure our data capabilities are established so that it can be used to generate insights to improve population health through the proactive targeting of services, for planning and improvement of services and for research and innovation – that is, how we move to a data-driven health service.

2. Digital Strategy

Background to and refresh of the strategy

2.1. The 5-year SEL ICS Digital Strategy was published in 2021. Since this time there have been many changes in the system, including the following:

- In June 2022, NHS England (NHSE) published the Data Saves Lives strategy. Since this time, NHSE has procured a national Federated Data Platform (FDP) and is developing a secure data environment for research. London region in collaboration with all London ICBs are developing a business case covering the data capabilities that the system needs now and into the future. SEL needs to decide where to invest time and resources to ensure we are placed to deliver transformative change that is possible by becoming a data-driven health service.
- In March 2023, NHSE published their Cyber Strategy. They advise that the NHS is being increasingly targeted, and that health services that are targets of a ransomware attack can experience worse health outcomes including increased mortality. The responsibilities of each ICB are outlined in the plan and each ICB will have to have a draft Strategy by May 2024. The SEL ICB has included a Chief Information Security Officer in the post-MCR structure, who will take responsibility for coordination of efforts to align with the responsibilities and mitigate risks for SEL.
- On the 1 April 2023, Integrated Care Boards (ICBs) took on delegated responsibility for commissioning pharmacy, general ophthalmic, and dental (POD) services from NHS England. No specific funding has been allocated at this time for the ICB to support the digital enablement of these organisations.
- On 5 October 2023, GSTT and Kings implemented the Epic electronic patient record. This is a significant step forward for our system as it is a system that allows for consolidation of the patient record across the health service, drives data

collection at the point of care, and provides a contemporary platform from which to drive continuous practice improvement. It is important that we take action to ensure SEL is able to derive greatest benefit from this significant investment.

- Both Lewisham and Greenwich NHS Trust (LGT) and South London and the Maudsley Trust (SLaM) require new Electronic Patient Record systems by early 2026. This will require financial investment and wider resourcing but will improve patient care in the long term. It will also improve data collection and provide an opportunity to improve standardisation of workflows across SEL.
- The ICB has undertaken work to review future requirements around data, analytics and system intelligence linked to the core purpose of ICBs/ ICSs and in the context of future facing requirements e.g. development of population health management, the external reviews into data infrastructure and data, as well as the needs of users of data, analytics and insights.

2.2. In light of these developments it is proposed that our strategy be refreshed earlier than previously planned to allow us to:

- reflect changes to ways of working resulting from the formal establishment of ICBs and ICSs
- align with the SEL integrated care strategy and Joint Forward Plan
- expand the scope to include data and analytics (collaboratively developing this with the data and BI team) to reflect future requirements and direction of travel as per the information gathered as part of the development of the Digital Delivery Plan, SEL Health Data Sciences Blueprint and SEL System Intelligence Specification.

3. Proposed revisions to the Strategy

3.1. An outline of the proposed strategy is provided below. This includes a proposal to widen the scope of the current strategy to include digital, data and system intelligence. We would welcome any feedback from the ICB Board on the proposed scope, vision, objectives, principles and priorities, which have been developed on the basis of significant engagement on the 2023/24 Digital Delivery Plan as well as the system data and analytics reviews that have recently occurred. It is proposed that the final endorsement of the Strategy (aligning with this outline if endorsed by the ICB Board) will be undertaken by the Digital Board. We are seeking the ICB Board's agreement to this approach.

- **Title** - To reflect the wider scope, it is proposed the title will be changed from the Digital Strategy to the Digital, Data and System Intelligence Strategy 2024-27.

- **Vision** - The vision outlined the long-term desired outcome for our system that will be enabled through digital, data and system intelligence. Our proposed vision is: *To improve the health and care of our population through the use of digital technology and data insights that help people manage their own health, support provider decision-making, inform the design of services and interventions, and transform care delivery.*

- **Objectives** - The objectives provide detail to the vision by outlining what we will pursue to achieve our vision. These objectives will drive our priorities and

investment throughout the period of this strategy. We will measure success against these objectives. The proposed objectives are:

  - People are empowered to manage their health and wellbeing through access to their information and insights about their health and wellbeing, as well as the ability to engage with the health and care system.
  - The care record is available to providers at the point of care to support decision-making.
  - Information collected is used to generate data-driven insights in population health, proactive care and research, to improve decision-making, reduce inequalities in health and care provision, improve health outcomes, and make the best use of finite resources.
  - Service transformation is supported by innovative digital and data products, and existing capabilities are well-supported and continuously improved.

- **Principles** - Principles will outline universal concepts and rules that help you deliver successful projects. While every project we work on may be different, we will apply these fundamental principles during their development and implementation. The proposed principles are:

  - People centred – ensuring the needs of the SEL community are at the centre of all decision-making.
  - Collaborative – working smarter to deliver the best outcomes, working in partnership across SEL to drive change and improvement.
  - Enabling – driving transformation by focussing not only on the delivery of a technical capability or raw data but on the tranformation needed and the insights provided.
  - Equitable – delivering insights to support the delivery of equitable care, with the aim of reducing the experience of poorer health outcomes in some community sectors.
  - Inclusive – ensuring our systems are accessible by as many people as possible and identifying opportunities for digital capabilities to reduce exclusion.
  - Efficient – adopting the share, reuse and design principles, our approach will be to share best practices, leverage existing infrastructure and capabilities, build on what is already out there and generate efficiencies through standardising systems and processes where appropriate.

- **Goals and Priorities** - There is much that could be done across our system to support achievement of our vision, but we cannot do everything. We are proposing six goals under which our priority activities will be organised. These are similar to the priorities outlined in our current 2023/24 Digital Delivery Plan, but changes have been made to incorporate data, analytics and system intelligence, as well as our core work on primary care IT, which was not considered in our current Delivery Plan.

Proposed goal	What this goal means	Relevant objective	Mapping to the current priority from the Digital Delivery Plan	Commentary on rationale for change from current priority
Empower people through digital and data	Giving citizens the tools to be active participants in their own health and wellbeing.	People are empowered to manage their health and wellbeing through access to their information and insights about their health and wellbeing, as well as the ability to engage with the health and care system.	Empower people to manage their health and care	No real change - simply brings in digital and data to the language
Digital solutions for connected care	Ensuring health care records are digital and that information is shared across the care team regardless of physical location or organisation.	The care record is available to care providers at the point of care to support decision-making.	Digitise and share care records	Digital solutions for connected care is broader than just care records. For example, it better incorporates priority activities such as transitions of care between services.
Deliver data-driven insights	Bringing together data for analysis and insight generation to enable the efficient and effective delivery of health services, making use of opportunities including artificial intelligence and machine learning.	Information collected is used to generate data-driven insights in population health, proactive care and research, to improve decision-making, reduce inequities in health and care provision, improve health outcomes, and make best use of finite resources.	Develop our data infrastructure	Acknowledging that achievement of the vision is not just about the data infrastructure but the data, tools and people required to make use of that. This is expanded scope reflecting the inclusion of data, analytics and system intelligence.
Ensure system resilience, data integrity and cyber security	Ensuring our systems are always available, the data in the systems reflects the real-world is only accessible to those that need to access it to care for our population.	The care record is available to care providers at the point of care to support decision-making.	Ensure system resilience and cyber security	Brings in data integrity, which can be incorporated into cyber security, but is an important component relating to ensuring our data is not tampered with (export of the data is not the only risk)
Drive continuous improvement and innovation	Always looking for opportunities to build on how digital and data and data can improve ways of working for our health and care teams as well as the broader population.	Service transformation is supported by innovative digital and data products, and existing capabilities well-supported and continuously improved.	N/A	A new goal to pick up that we need to be continuously investing in enhancement of existing services to ensure they remain contemporary, as

Proposed goal	What this goal means	Relevant objective	Mapping to the current priority from the Digital Delivery Plan	Commentary on rationale for change from current priority
				well as driving innovation.
Undertake workforce planning to support our digital, data and analytics activities	Acknowledging that the skills needed in digital and data are changing and working to ensure that we have the right people for the work required, both now and into the future.	This is an enabling goal required to support our population to make use of the tools available to them.	N/A	A new goal which recognises the challenges we have in the current and future data and analytics specialist workforce, as well as with our broader workforce in engaging with digital, data and insights.

3.2. Two priorities of our current Digital Delivery Plan have not been included in the strategy, as outlined below:

3.3. **Understanding our digital maturity** - this is a foundation piece that spans the goals listed above. For example, we are doing work on the maturity of our clinical systems (which fits into our Digital Solutions for Connected Care Goal) and in understanding the maturity of our cyber and resilience processes (which fits into our Ensure System Resilience, Data Integrity and Cyber Security). In fact, a baseline understanding of our maturity is an important part of scoping any new digital or data activity. Therefore, this work is not lost, but simply incorporated into activities across goals in the new Strategy.

3.4. **Establish our Digital Governance and Operating Model** - this is critical and while it was important for digital delivery, it is not a priority in its own right. Ensuring appropriate governance is critical to work across the system, not specifically to digital and data. Further, the baseline work to establish the Digital Board (a subcommittee of the ICB Board) and the Digital Board subcommittees has been completed.

4. The 2023/24 Digital Delivery Plan

4.1. The Joint Forward Plan and the Digital Delivery Plan 2023/24 identify seven digital priorities. Key achievements against each of the priorities is outlined below. The majority of activities are multi-year, with work continuing in 2024/25.

Priority 1: Understanding our Digital Maturity

4.2. Completed national digital maturity assessment (scope covers acute hospitals but will be expanded to include General Practice in the current year assessment) – outcomes of the assessment have been considered in the plans of our health service providers. We expect the 2024 assessment to improve significantly for Guys and St Thomas Foundation Trust and Kings Foundation Trust following their implementation of Epic.

Priority 2: Digitise and Share Care Records

4.3. Epic implementation – On 5 October 2023, GSTT and KCH implemented the Epic electronic patient record. This was the single biggest implementation of this system and will deliver significant improvements to patient care. Some statistics are below:

- 50,000 staff accessing the system with approximately 6,000 concurrent users every day.
- More than 80 interfaces to other systems implemented to improve seamless working.
- Moving to a single way of working for the six acute hospitals involved.

4.4. In 2024/25, work will shift to focus on business cases and activities to support new electronic patient records for LGT and SLaM.

4.5. Virtual Wards - A virtual ward is an alternative to inpatient care that allows a patient to receive their care, monitoring, and treatment they need in the place they call home, including care homes. Virtual wards prevent avoidable hospital admissions and support early discharge out of hospital beds. Across South East London, there are currently 29 virtual wards supporting 38 pathways. In November 2023, SEL ICB received £700,000 national funding to increase the technology enablement with remote monitoring aspects of its virtual wards. This will enable virtual ward teams to be able to support and remotely monitor more patients' vital signs such as heart rate, blood oxygen levels and temperature while patients remain at home. The project will continue through 2024.

Priority 3: Develop our Data Infrastructure

- LGT are part of the pilot of the national Federated Data Platform, and there are plans to extend this to GSTT and KCH in 2024/25.
- SEL is partnering with London to develop an approach and business case for regional data and analytics capabilities. Development work has commenced on London-level infrastructure supported by national funding to develop a sub-national secure data environment for London. We are working across our region to explore the best way to do this and how this shared data service can then be used to:
    - Improve direct care and population health management – by further improving existing systems like the London Care Record and Universal Care Plan platform as well as develop even more effective ways to identify, support and treat those at risk of ill health.
    - Support better health and care planning – by giving partners the right tools to more effectively analyse demand for services and to predict likely future needs based on a better understanding of the needs of London's communities.
    - Support our health and care academic teams and industry partners, potentially helping more Londoners benefit from the latest cutting edge research.
    - This work will continue in 2024/25.

4.6. Locally, our pilot to move our data repository onto a more contemporary platform is progressing well. This will enable our business intelligence teams to better support

our system through the provision of insights to support decision-making. This work will continue in 2024/25.

Priority 4: Enable Interoperability

4.7. London Care Record – this is a secure way to share patient information with health and care professionals, so they have the information they need at the point of care to inform their clinical decision-making. The system was introduced in 2020, but we continue to invest in its improvement and expansion. In 2023:

- there were over 500,000 views per month of the London Care Record in SEL alone
- an independent economic evaluation found the London Care Record has saved health and care professionals' time up to a value of £44.4 million (across the region), helping them provide safe and effective care more quickly
- role based access was implemented (further improving the security of the solution)
- GSTT and KCH new electronic patient record, Epic, was integrated to upload and view records
- Lewisham and Southwark Adult Social Care was integrated with the London Care Record (Lambeth already complete). Work is underway on integration of other boroughs.

4.8. 2024/25 activities are discussed in the opportunities and challenges section below.

4.9. Communication between GPs and acute services – achievement of concurrent integration of three systems to support communication with primary care including DocMan for letters, ICE for radiology ordering and results and TQuest for pathology ordering. These systems facilitate communication between acute providers and general practice.

4.10. During 2024, ICE implementation will be expanded to include Lewisham and Greenwich Foundation Trust, as well as to incorporate ordering and results receipt for pathology.

Priority 5: Ensure System Resilience and Cyber Security

4.11. Cyber and resilience maturity assessment – EY have been engaged to support this work, which is underway.

4.12. Chief Information Security Officer (CISO) – the ICB has prioritised recruitment of a system CISO in the ICB (recruitment to commence shortly). This role will not take from the responsibilities of each of our providers to ensure cyber and resilience, but will be responsible for the information security and resilience strategy across the South East London Integrated Care Board and for working across the Integrated Care system to develop a risk-based strategy across our system.

Priority 6: Empower People to Manage their Health and Care

4.13. The NHS App – the NHS App is an app for citizens (over 13 years old) to allow them to access a range of NHS services. Key achievements are:

- 56% of people in SEL (aged 13+) are registered with the NHS App. There is a local campaign underway to increase registrations as well as a national campaign planned (subject to financial approval).
- 36% of patients having opted in to receive notifications in the App. This is the first step in shifting communications from SMS (paid service) to messaging within the App (free service).
- 100% of GPs have signed up to sharing information with patients in the NHS App
- Approximately 7,000 appointments per month (in SEL) booked via the NHS App
- Early adopter of digital prescriptions within the NHS App, with the SEL ICS having the greatest number of repeat prescriptions ordered in the App compared with other London ICBs

4.14. Work to promote increased use of the NHS App as well as incorporating information from more services into the NHS App will continue in 2024/25.

4.15. Digital inclusion – work is progressing well on understanding the digital inclusion capabilities of each of our boroughs, which can be used to inform SEL-wide goals and priorities for digital inclusion. We are also commencing work to understand the patient-facing digital services across our system, so that we are able to consider whether there are opportunities to improve their implementation to support digital inclusion. A digital inclusion lead has been included in the ICB organisation structure from 2024/25, ensuring a continued, ongoing focus on this important work.

Priority 7: Establish our Digital Governance and Operating Model

4.16. The ICB Board has a Digital Board as a designated subcommittee. During 2023, work was undertaken to establish this Board by agreeing ToR and membership. The first meeting was held in November 2023, with the subsequent meeting on 23 January 2024.

4.17. The Terms of Reference for the Digital Board (in draft) proposes delegation of the two items from the Board to the Digital Board:

- *'Agree with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services, putting people at the centre of their care' (already delegated).*
- *'Approval of plans to use joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and driver continuous performance and outcomes.'*
- *'Approval of the arrangements for ensuring appropriate safekeeping and confidentiality of records and for the storage, management and transfer of information and data'*

4.18. Following your endorsement of this delegation (as per Item 7 of the Board papers), the ToR will be finalised.

4.19. As discussed above, our work to continue to optimise and improve services does not fit well within the existing priorities (which will be resolved in the new Strategy), but there has been significant achievements in moving forward with the primary care IT programme, including:

4.20. GP remote consultation – In December 2023, a contract was signed with Accurx to support SEL general practices to move to a consistent remote consultation product that supports online consultation and video consultation, 2-way SMS, patient questionnaire, batch messaging, booking and appointment reminders and best serves the needs of SEL Primary Care and patients. The implementation is underway and is planned to be completed by end March 2024.

5. Opportunities and Challenges

5.1. Prioritising our work is always difficult as many opportunities and challenges present throughout the year. Below we outline where expansion of our existing work programmes or where inclusion of a new work programme has been suggested as a priority for enabling delivery of our objectives.

Shared Care Records (Digital Solutions for Connected Care priority)

5.2. Continuation of the London Care Record programme is critical to ensure progression of work underway to expand the breadth of services connected, including to care homes and community pharmacy. There is also potential for a project to take action to improve the quality of data uploads and display, so that we can ensure the London Care Record continues to meet the needs of our health and care system into the future. While there is one dedicated programme manager, the rest of the programme is funded by a mix of recurrent and non-recurrent revenue of the ICB. 2024/25 funding is being considered in the current the financial planning round.

5.3. In addition to the London Care Record (which provides a read-only view of a person's care) we need to ensure that we have care records that health and care providers from different organisations can write to. Trials planned for 2024/25 include:

- Expansion of the Universal Care Plan, which is the shared care record currently used for end-of-life care. It has been agreed this will be expanded to support the care of people with sickle cell disease. Other priority areas are being considered. This work is being led at the London level but will likely require local resources to support it.
- Use of Epic for virtual wards. This was proposed by GSTT/Kings as part of the Health Technology Adoption and Acceleration Fund. It would enable development of EpicCare Link, which is a module of Epic that allows the care team who do not work for GSTT or Kings to both view the patient record and contribute to it (notes, social determinants of health etc). This alongside the patient portal, MyChart, which enables home-based devices to be integrated, would potentially provide a platform for virtual wards. The advantage of this over a third-party product like Doccla is it is already integrated with the London Care Record and leverages a product the ICS has already heavily invested in. Due to tight timeframes for expenditure of the national funding for this work, the pilot is at risk. We are working closely with GSTT to agree a way forward.

5.4. Following completion of these trials, we will assess the outcomes and propose next steps, which may include further expansion or cessation.

Primary care digital transformation (Digital Solutions for Connected Care priority and Drive Continuous Improvement and Innovation priority)

5.5. This programme incorporates projects that support primary care providers. Key projects include:

- implementation of the remote consultation solution from Accurx
- support for social prescribing
- implementation of advanced telephony solutions
- improving NHS App utilisation.

5.6. One of the challenges for this programme is the inclusion of pharmacy, optometry and dental services from 1 April 2023. Digital transformation funding for this programme has not increased to enable dedicated support for these additional areas. Work is underway to determine the requirements of these services and the roles and responsibilities for managing their digital enablement. One of the most pressing areas is enabling digital interactions between general practice and community pharmacy to support the expanded scope of pharmacies.

5.7. Data, analytics and system intelligence (Deliver Data Driven Insights priority). In SEL (and across the majority of health systems in the UK), decisions are often made in the absence of data to support those decisions. While there is high quality analysis that is provided when data sources are available to analytics teams, barriers to using data to inform decisions include:

- Timeliness - data is not always documented in real-time by health services.
- Availability - data may be collected into systems that are not easily accessible (e.g. from VCSE providers).
- Structure - data may be recorded in free text fields that are much harder to analyse.
- Capacity - BI teams have limited capacity and there is a very small pool nationally to recruit from (note impact of MCR on ICB Analytics team).
- Capability - ensuring that users of intelligence from the top to the bottom of the organisation have skills and understanding to be confident in making full use of the intelligence available to them.

5.8. There is much work being undertaken at the local, regional and national levels to address these barriers, including:

- Locally, work to re-platform the ICB data repository so that it is on contemporary infrastructure. The data generated from this work will provide information to support a decision regarding expansion of this repository so that it can provide greater functionality across SEL.
- Regionally, work to develop a London Data Strategy including a data service layer, a repository to support research and a repository to support population health management and proactive care.
- Nationally, a repository to support research and a service (the Federated Data Platform) to support population health management and proactive care.

5.9. There is also work required to develop an Information Governance framework, at SEL ICS and London level, to enable the adoption of the data systems being developed, e.g. ICS Sub-licencing agreement, inter organisations Data Sharing Agreements, etc.

5.10. It is important that we take advantage of the opportunities being presented locally, regionally and nationally. If we do not do this, we will be in the same position in five years' time, wondering why other industries are using data-driven insights, artificial intelligence and machine learning to enable improvements to their system while we are still discussing data collection, infrastructure, consolidation and governance.

5.11. SEL ICS are partnering in the development of a London-region business case that will outline the investment needed to deliver the infrastructure and tools that would enable a transformation toward a data-driven health service. When the business case is ready, we will engage with the Board in more detail about the proposed approach, investment required and the value of this investment for SEL. This may include resourcing required for local engagement in the London work and/ or local resourcing to support our partnering with London region.

Cyber Security and System Resilience

5.12. There is much work being done in the ICB to support our corporate cyber security, as well as across partners to ensure resilience and cyber security of their own systems. However, there are potential benefits from working together, given that risks in one service often impact the entire sector, and that there is a known shortage of cyber expertise. This does not suggest that the ICB not take over any of the responsibilities of partner organisations to identify, manage and mitigate their cyber and resilience risks, but will provide strategic leadership, coordination and support across the sector.

5.13. As described in the section on achievements against the 2023/24 Delivery Plan, the ICB has commissioned a review of cyber security and system resilience across the ICS, led by EY. Following the completion of the review, the Board will be briefed on its outcome, the areas of risk and any investment that may be required across our system to mitigate areas of greatest concern.

Transitions of Care (Digital Solutions for Connected Care priority)

5.14. One area where partners have reached out to the ICB to request additional support for digital enablement is patient flow – particularly, the transitions of care between health providers, rather than patient flow within a single health service. For example, referral forms are currently attached to electronic referrals, but are essentially digital versions of paper forms. They require manual processing on receipt and effort and expense required to maintain a register of the referrals forms for each service and the pathways to send the referral to.

5.15. Transition to a digital system that supports transfers of care between services, including fully digitising forms so that the data is transferred electronically and referral pathways are integrated into the system, and discharge processes are supported may improve patient flow.

5.16. The ICB does not have a current work programme focussed on this area. We seek input from the Board as to whether development of digital capabilities to support system-wide patient flow between services should be considered as a high priority. If

this is supported, resourcing to support a scoping and planning phase would be considered put forward as a priority project ICB Planning round for 2024/25.

5.17. We seek advice from the Board as to these programmes and whether there are other priority areas that the digital teams across our system need to focus.

Integrated Care Board meeting

Item: 8
Enclosure: H

Title:	**Development of the Integrated Care Partnership Strategy – Early Years**
Meeting Date:	31 January 2024
Author:	Rupi Dev, Director for Mental Health, Children and Young People (CYP) & Inequalities
Executive Lead:	Martin Wilkinson, Place Executive Lead – Southwark/Commissioning SRO for Mental Health & CYP

Purpose of paper:	The purpose of this paper is to provide the ICB Board with: • An overview of the early years strategic priority including the importance of the early years agenda in the context of our system. • A summary of progress to date with the work underway to further define the scope and actions required for this change programme. • An overview of the work already underway across south east London on the early years agenda.	Update / Info	x
		Discussion	x
		Decision	
Summary of main points:	• There is a strong evidence base on the importance of early years and the impact this can have on the life course of individual, and the inequalities experienced in the early years of life have lifelong impacts (see Appendix 1 for further details). • The ICB has a key role in the early years agenda, however, it's an area of planning and service provision where working across health and local authorities is vital if we are to optimise outcomes and secure joined up integrated approaches to early years provision. • Early years has been identified as one of the five strategic change programmes identified in the Integrated Care Partnership's strategy. Since publication of the strategy, work has focused on series of workshops and round tables with key stakeholders and subject matter experts, to clarify the aims and priorities for this strategic area. The feedback from this work is set out in the paper. • The paper recognises that early years isn't a new area of focus for the ICB and the six local care partnerships in south east London, and this has been a key emerging theme from the strategy development work to date. The paper therefore contains a summary of the projects and programmes of underway across south east London. Further information on these projects can be found in Appendix 1, and this item is supplementary to the information already presented in the Southwark Deep Dive on the First 1001 Days and the inequalities deep dive on maternity and perinatal care.		

	• The Board are asked to consider a series of questions and discussions points on how they build on the work already underway in the system, drive further improvements in early years service delivery and provide their views and input into the development of the strategy through the Integrated Care Partnership, specifically for early years.			
Potential Conflicts of Interest	Not applicable.			
Relevant to the following Boroughs	**Bexley**	X	**Bromley**	X
	Greenwich	X	**Lambeth**	X
	Lewisham	X	**Southwark**	X
Impacts	Equality Impact	The inequalities experienced in the early years of life have lifelong impact and this is recognised both nationally and internationally. A summary of the inequalities in early years can be found in the paper and in the Appendix 1.		
	Financial Impact	There is no financial impact of this paper. However, national and international evidence demonstrates that investing in early years is cost effective and yields a return on investment across the life course of an individual (The Marmot Review, 10 Years On, Feb 2020).		
Other Engagement	Public Engagement	No specific public engagement has been carried out in the development of this paper. However, public engagement has taken place as part of the ICP strategy development (including identification of the five strategic priorities) and borough based engagement is ongoing with local communities as local, place-based models and initiatives are developed and implemented.		
	Other Committee Discussion/ Engagement	A formal update on the overall strategy development process and progress to date (including early years) is planned for discussion at the next Integrated Care Partnership meeting.		
Recommendation:	The Board are asked to: • Recognise the work already underway across the early years agenda and the agenda item on Southwark's first 1001 days and inequalities in maternity and perinatal care (as an example of the detailed work underway at a borough level). See Appendix 1 for more detail. • Consider how the ICB should work collaboratively with our communities and partners across the system to shape and further develop this partnership priority in the coming months, building from and enhancing the work already underway to improve outcomes and reduce inequalities in this area for our population.			

Development of the Integrated Care Partnership Strategy – Early Years

1. Context and Purpose

1.1. In February 2023 south east London (SEL) published its Integrated Care Partnership Strategic Priorities. The document was the first milestone in developing the integrated care strategy for the next five years and outlined several key areas of focus for change programmes for specific services (known as the five strategic priorities): (i) prevention and wellbeing; (ii) early years; (iii) children and young people's mental health; (iv) adults mental health; and (v) primary care and people with long term conditions. A summary of these strategic priorities can be found in Figure 1 below.

Figure 1: Summary of the Five Strategic Priorities, as set out in the Integrated Care Partnership Strategy, February 2023

1.2. The purpose of this paper is to provide the Integrated Care Board (ICB) with an overview of the early years strategic priority including the importance of the early years agenda in the context of our system, and progress to date with the work underway to further define the scope and actions required for this change programme.

1.3. This item follows a planned discussion at the ICB Board meeting on 31st January 2024 on a deep dive in Southwark on the first 1001 days and inequalities in maternity and perinatal care. In reading this paper, the Board are asked to:

- Recognise the work already underway across the early years agenda and the agenda item on Southwark's first 1001 days and inequalities in maternity and perinatal care (as an example of the detailed work underway at a borough level). See Appendix 1 for more detail.
- Consider how the ICB should work collaboratively with our communities and partners across the system to shape and further develop this partnership priority in the coming months, building from and enhancing the work already underway to improve outcomes and reduce inequalities in this area for our population.

2. The Importance of Early Years and Partnership Working

2.1. The early years of life, including pregnancy and birth, are a significant period of human growth and development and the importance of this period in the life course of an individual is well-established[1,2] . Investing in early years services can improve babies' and children's health outcomes including, early

[1] The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf (publishing.service.gov.uk)
[2] Health matters: giving every child the best start in life - GOV.UK (www.gov.uk)

cognitive and non-cognitive development, social development, children's readiness for school, and later educational outcomes.

2.2. The NHS has a key role to play in ensuring every child receives the best start in life including pre-conception care, pregnancy, birth and early weeks of life, and through supporting physical and cognitive development before children start school. However, early years spans many services falling under the commissioning responsibility of both local authorities (particularly public health) and health. This is therefore a key area of planning and service provision where partnership working across health and local authorities is vital if we are to optimise outcomes and secure joined up integrated approaches to early years provision.

2.3. In SEL, children and young people account for approximately 22% of the population (one in five of our population) and therefore maternity and early years are especially important for SEL for early intervention to optimise outcomes for children and families.

2.4. A key challenge and opportunity is addressing the considerable variation that exists across SEL's current service offer, which alongside population factors, drives differential health status and outcomes, inclusive of inequalities in access and experience of services for our population. Figure 2 below provides a spotlight on the some of the key indicators for early years (further detailed information can be found in Appendix 1) – these represent a number of areas which if addressed would positively impact on health and population outcomes.

Figure 2: Spotlight on Key Facts and Inequalities in Early Years in SEL

Parental health	The prevalence of **smoking in pregnancy** was 6.8% in SEL, in comparison to 6.0% in London region. There is notable variability across SEL (Lambeth 4.7%, Bexley 9.0%) 18.5% of the population had **obesity in early pregnancy** in SEL, which is higher than 17.8% in London, but lower than 22.1% in England. In 2020, the **under-18s conception rate** in SEL was 11.9 per 1,000, which is higher than the London region rate of 9.8 per 1,000. There is notable variability across SEL (Southwark 7.5, Lewisham 16.5).
Child health	The prevalence of **reception-aged children who are overweight** (including obesity) was 23.8% in SEL, which is higher than the prevalence in London region (21.9%) and England (22.3%). In 20/21, the crude rate of **emergency admissions** (0 – 4 yrs) in SEL was 83.3 per 1,000 which is higher than London (62.7) but lower than England (91.2). There is notable variability across SEL (Lambeth 57.5, Greenwich 133.0) In SEL in 21/22, **hospital admissions due to (un)intentional injuries in children** (0 - 4 years) was 86.3 per 10,000. There is notable variability across SEL (Bromley 54.5, Greenwich 119.1).

3. Progress with Development of the Strategic Priority Area

3.1. Early years was selected as one of the five strategic priorities for the following reasons:

- The scale of the opportunity to deliver improvements in health and wellbeing for the whole of people's lives**.**
- The opportunity to work together across services to put in place effective, proven models of care with a view to reduce the variation in service provision across SEL, whilst also targeting our offer to ensure it is responsive to different population factors and needs.
- The opportunity to strengthen pathways across statutory and non-statutory services, to provide a range of service offers and options for residents.

3.2. Since publication of strategic priorities, a series of workshops and round tables have been held with key stakeholders and subject matter experts. This has included representation from the ICB, local authorities, NHS providers/trusts and the voluntary and community sector. The aim of these sessions

has been to identify the aims and ambitions of the strategic priorities and the challenges within the current programmes of work or service delivery, to enable us to develop informed solutions that learn from current experience and feedback.

3.3. For early years, these discussions have reconfirmed the challenges and opportunities around fragmentation in service provision and the lack of continuity of care, particularly for mothers, birthing people and families who are at risk of experiencing inequalities, including families living within our most deprived neighbourhoods, families with known drug and alcohol addictions, and people experiencing poor mental health, including severe mental illness.

3.4. Potential solutions as part of these discussions have therefore focused on how to further develop and expand models that offer generalist and holistic approaches to care, with two emerging themes from this work.

3.5. Firstly, there is recognised need to reflect the work already happening within our system and with this in mind, to focus our efforts on building or extending this work across the system (rather than creating a new change programme), inclusive of challenging ourselves around driving common but targeted offers and standards, delivered locally and securing over time a demonstrable improvement in some of the key underpinning health indicators that will make a different to outcomes for our population. Early years is already a priority for the ICB and within the Joint Forward Plan, whether that be within cross-cutting programme plans (e.g. maternity) or in local care partnership plans, so we have a positive foundation and system commitment from which to build.

3.6. The Southwark 1001 Days deep dive (item 7 on the ICB Board agenda) demonstrates the work underway in one borough to better integrate services for babies, children and their families, and similar programmes of work are also underway across our remaining five boroughs. Additional case studies from the other five boroughs in SEL can be found in Appendix 1 to provide a greater flavour of the borough-based work already underway. This includes:

- Improving language and communication skills in the early years (Bexley and Greenwich).
- Focusing on tackling obesity and smoking in pregnancy (Bexley).
- Providing support at home for acute unwell children, with a specific focus on those under five years of age (Bromley).
- Providing stronger parenting support (including for fathers/males) and support for parental mental health (Lambeth and Lewisham).
- Stronger integration across services, improving multi-disciplinary working across the sector (Bexley and Lewisham).

3.7. Secondly the underpinning focus on prevention and early intervention suggests that the population groups and communities we would want to work with to design solutions are likely to be similar across the five strategic priority areas, with community activation and engagement being at the core of this work to build confidence and trust, and ensure we are developing locally responsive offers for residents.

3.8. Furthermore, for early years the evidence demonstrates a clear overlap with the other five strategic priority areas. For example, vaccination and immunisation, both during pregnancy and for children forms part of the discussions on prevention and has a clear overlap with early years. Similarly, adult mental health (and to some extent the drivers of CYP mental health) also has an overlap with the early years' agenda. Discussions are therefore ongoing regarding the best way to approach the strategic priorities from a cross cutting perspective e.g. approaches to community engagement, joined up support for residents across the life course, seamless and joined up services that meet the needs of children and their families. We are aiming to provide enabling and pump priming support through the 2024/25 planning round to take forward and test the ideas and proposals that are being generated both through

our existing work and through the dedicated focus on these areas as part of our on-going integrated care strategy work, which will enable us to demonstrate tangible actions in support of our objectives over 2024/25.

4. Discussion and Next Steps

4.1. Early years is a key priority for the ICB and for its system partners. The ICB is a key player within the Integrated Care Partnership, the sponsor of the strategic priorities and the decision-making group overseeing progress and delivery. However, along with its NHS Trusts, the ICB has a key role in helping to shape the direction of travel within its partnership role as well as maximising health's role and input into this work.

4.2. As set out in this paper and in the supporting appendix, there is significant work already underway across our six boroughs on the early years agenda and focused on integration of services at a local care partnership level.

4.3. It will be important as we develop our operating plan for 2024/25 and undertake the refresh of our Joint Forward Plan that these plans are captured within our delivery plans, ensuring we have clear and concerted actions to address the inequalities identified in Figure 2, inclusive of our Core20PLUS5 framework and routed in evidence-based approaches and interventions.

4.4. To support this work and also the wider strategy development, board members are asked to consider and discuss:

- The health contribution to the early years' strategic priority the what the opportunities might be for stronger co-ordination across health services.
- How we develop and embed transformation within all the early years work across our ICB, to ensure we are sharing learning and maximising opportunities for spread and scale of best practice.
- How we could work strategically with our partners through the Integrated Care Partnership to go further on the early years' agenda, with a focus on concerted whole system action and joined up solutions.

South East London Integrated Care System

Development of the Integrated Care Partnership Strategy – Early Years

Appendix 1

ICB Board, 31st January 2024

Background & Context

- In February 2023 south east London (SEL) published its Integrated Care Partnership Strategic Priorities and early years was identified as being one of five strategic priorities for our system.
- The January 2024 ICB Board will be receiving an update on the development of the early years strategic priority.
- This is a supporting appendix to a main paper for the ICB Board and provides further details and information on:
    1. The key facts and figures on early years in south east London, including the inequalities in infant mortality and early years.
    2. Examples/case studies from the boroughs in south east London to demonstrate the breadth of work already underway across the early years agenda.

South East London Integrated Care System

Early Years in South East London

Key Facts and Figures

Inequalities spotlight – Why the early years?

- Inequalities experienced in the early years of life have lifelong impacts
- It is the period of life when interventions to disrupt inequalities are most effective
- Interventions in the early years have been shown to be cost-effective and to yield significant returns on investment.
- It is the most cost-effective and equity-effective time to invest

Source: The Marmot Review, 10 Years On, Feb 2020

Indicators spotlight – Early Years

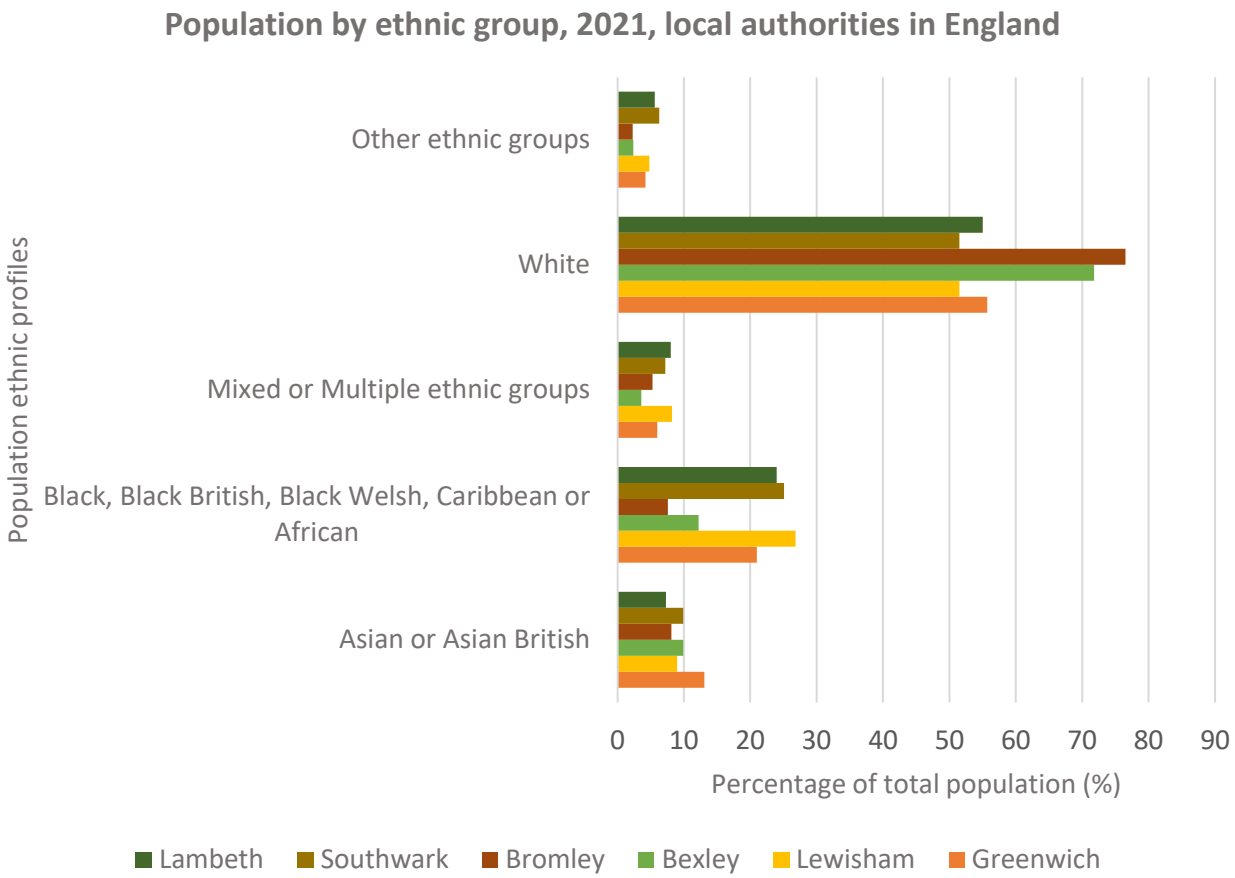
The early years of life, including pregnancy and birth, are a significant period of human growth and development. This means that maternity and early years are especially important for early intervention to prevent or reduce the negative impacts of problems experienced by a child or family.

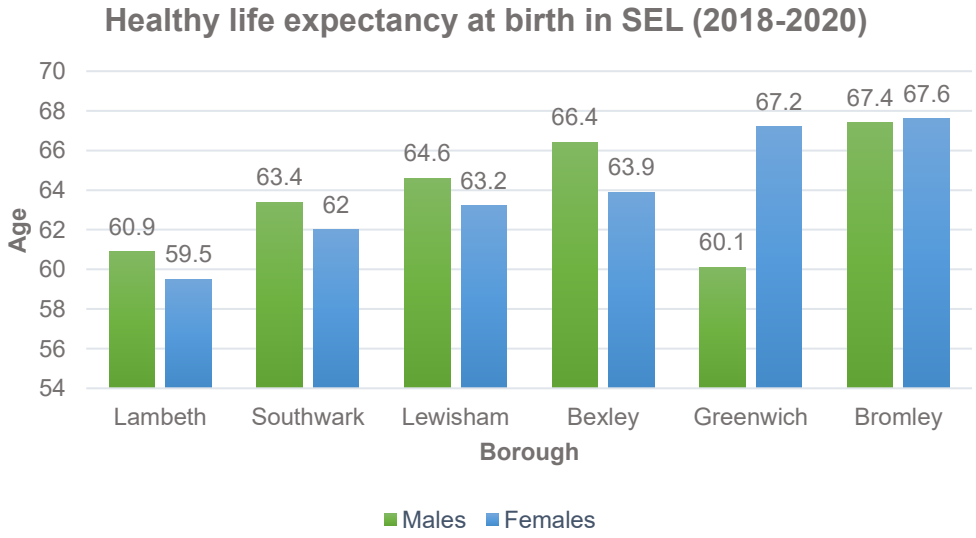
Parental health	The prevalence of **smoking in pregnancy** was 6.8% in SEL, in comparison to 6.0% in London region. There is notable variability across SEL (Lambeth 4.7%, Bexley 9.0%)
	18.5% of the population had **obesity in early pregnancy** in SEL, which is higher than 17.8% in London, but lower than 22.1% in England.
	In 2020, the **under-18s conception rate** in SEL was 11.9 per 1,000, which is higher than the London region rate of 9.8 per 1,000. There is notable variability across SEL (Southwark 7.5, Lewisham 16.5).
Child health	The prevalence of **reception-aged children who are overweight** (including obesity) was 23.8% in SEL, which is higher than the prevalence in London region (21.9%) and England (22.3%).
	In 20/21, the crude rate of **emergency admissions** (0 – 4 yrs) in SEL was 83.3 per 1,000 which is higher than London (62.7) but lower than England (91.2). There is notable variability across SEL (Lambeth 57.5, Greenwich 133.0)
	In SEL in 21/22, **hospital admissions due to (un)intentional injuries in children** (0 - 4 years) was 86.3 per 10,000. There is notable variability across SEL (Bromley 54.5, Greenwich 119.1).

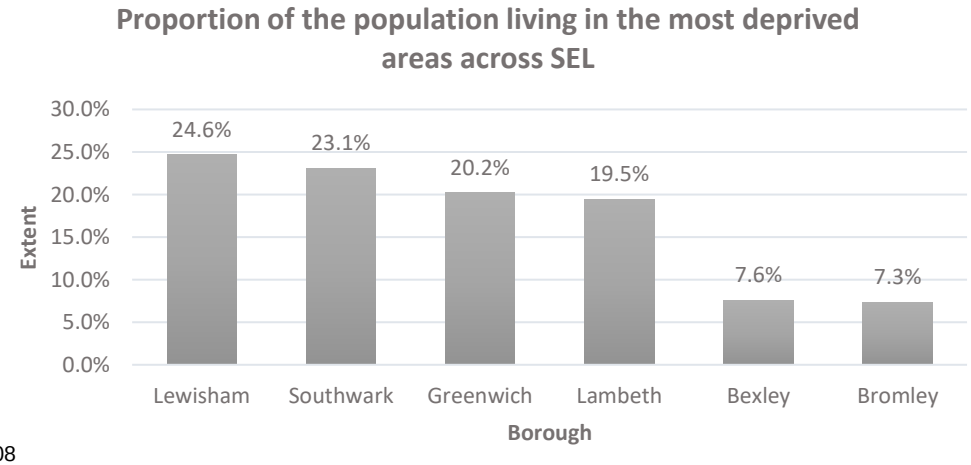
Source: Child Health Profiles, Fingertips, multiple years

Inequalities spotlight – Early Years

Inequalities experienced in pregnancy, early childhood and beyond contribute to the likelihood of experiencing adverse and possibly lifelong consequences. Variation exists in the offer available to women and birthing people across SEL, which feeds into inequalities. In South East London, income deprivation has been directly linked to indicators of poor health, such as infant mortality, unplanned hospital admissions, and childhood obesity in black and ethnic minority populations.



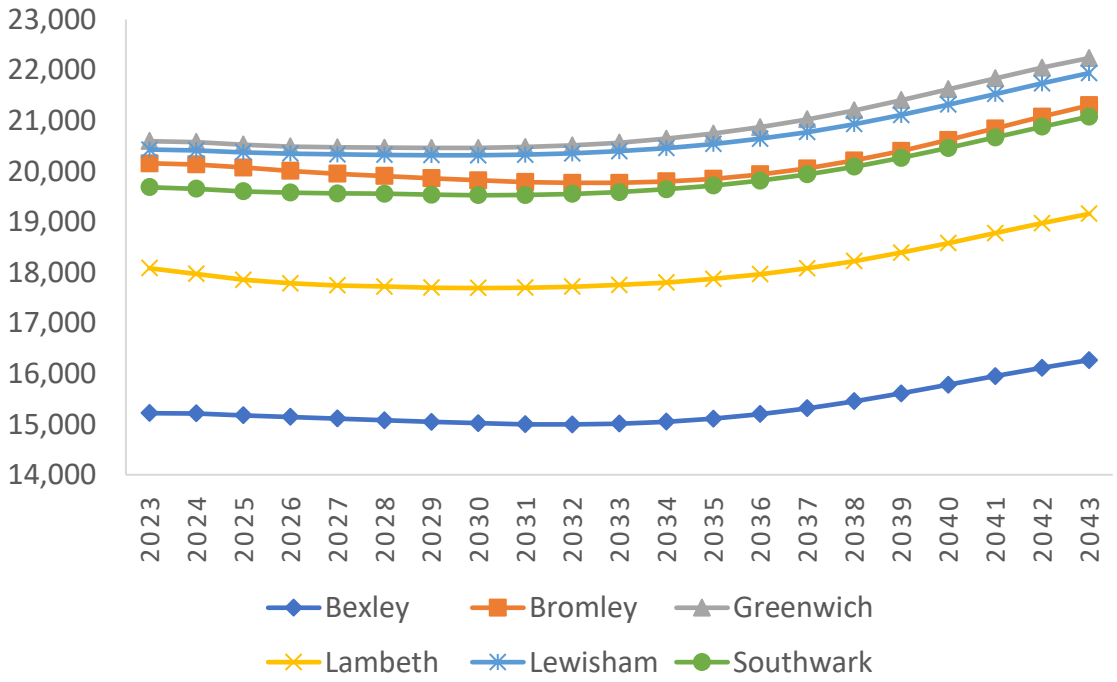




Demographic outlook in SEL

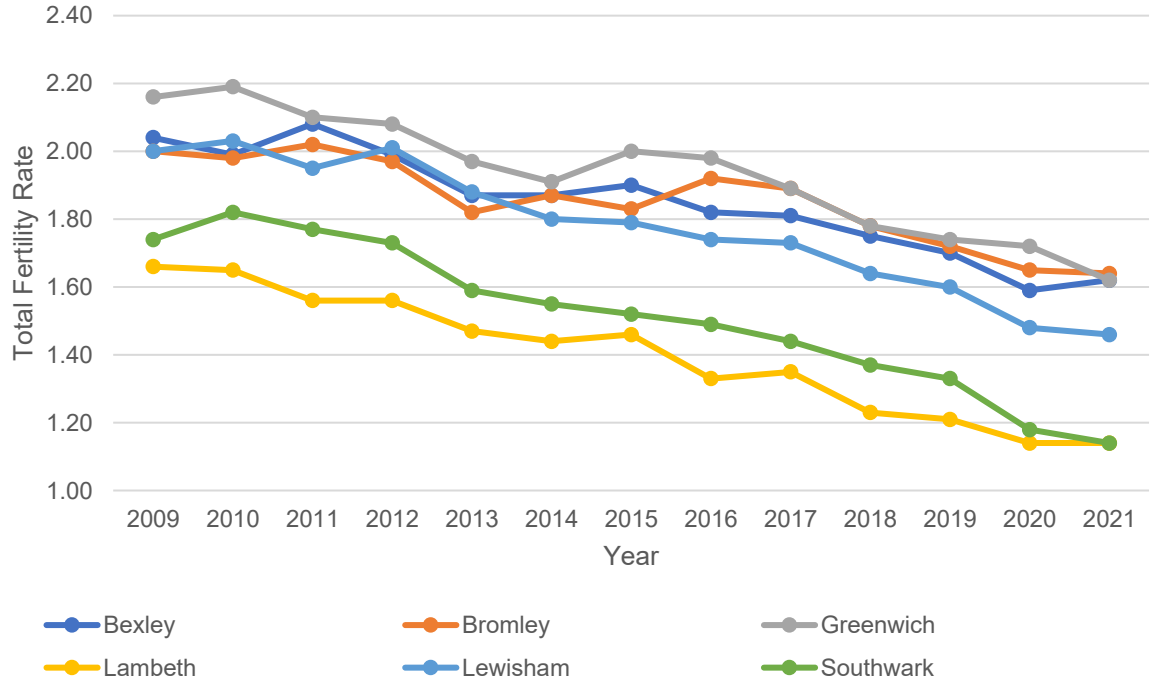
Population trends are driven by many factors, including total fertility rate and the age 0-4 population. In SEL, we can observe that there has been a drop in the total fertility rate. On the other hand, the population trend of the 0-4 is due to remain constant over the next ten years with a projected increase starting from 2033. This is valuable input to how we plan services for the future.

Population projection for 0-4 from 2023-2043



Source: Population projections 0-4, ONS, 2021. Available at: here

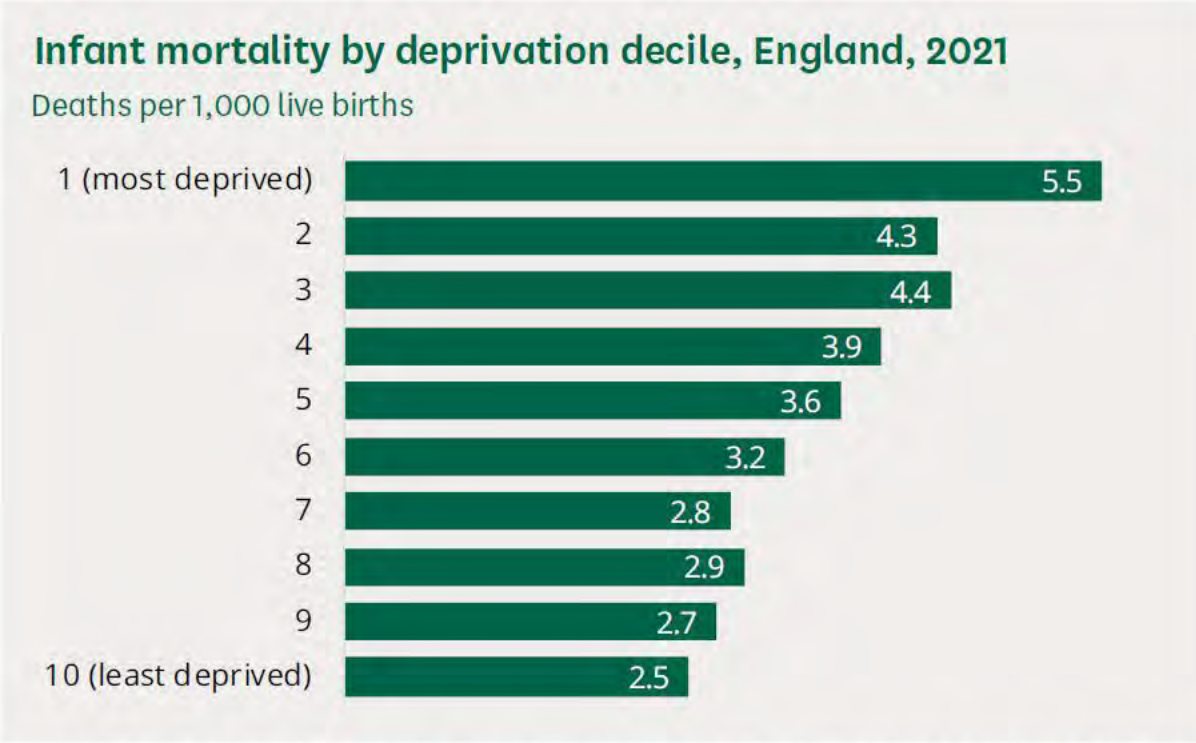
Total fertility rate (TFR) (15-44 years) 2009-2021



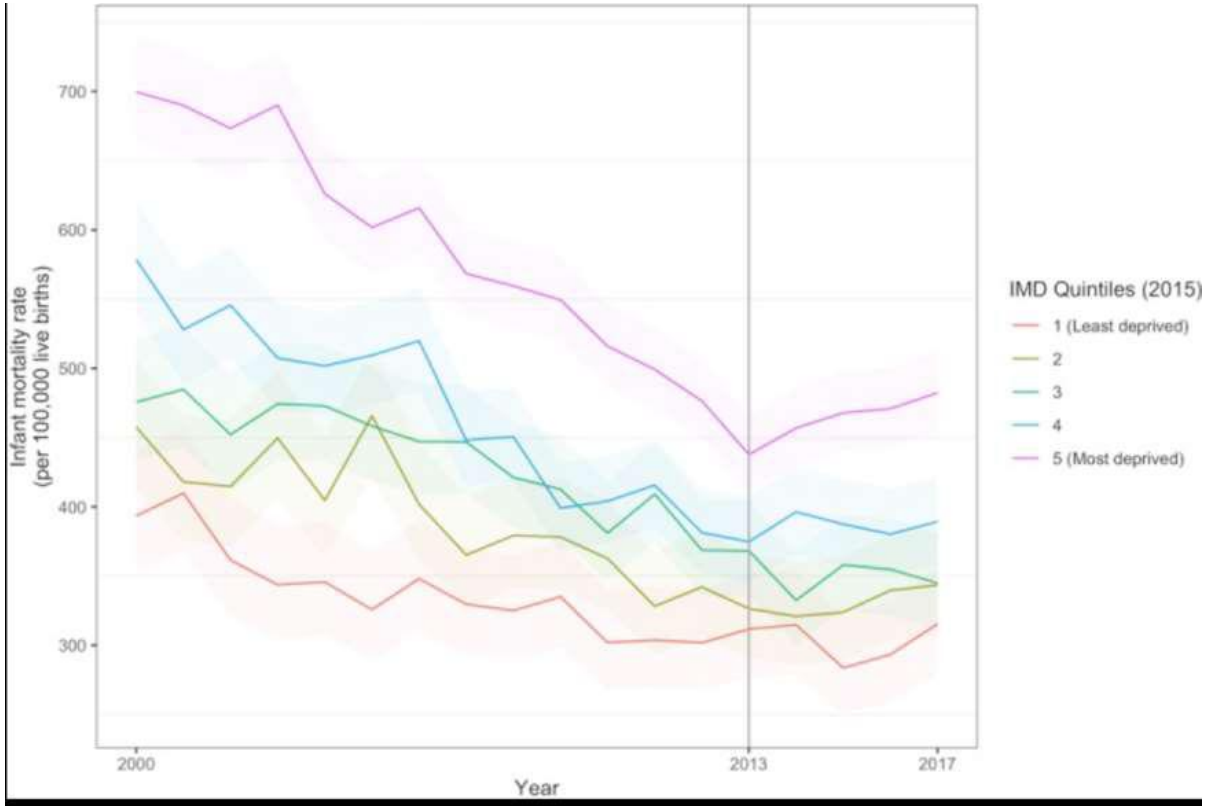
Source: General Fertility Rates, ONS, 2021. Available at: here

Inequalities spotlight – Infant Mortality & Deprivation

One quarter of all deaths under the age of 1 would potentially be avoided if all births had the same level of risk as those to women with the lowest level of deprivation.
Source: The Marmot Review, 10 Years On, Feb 2020



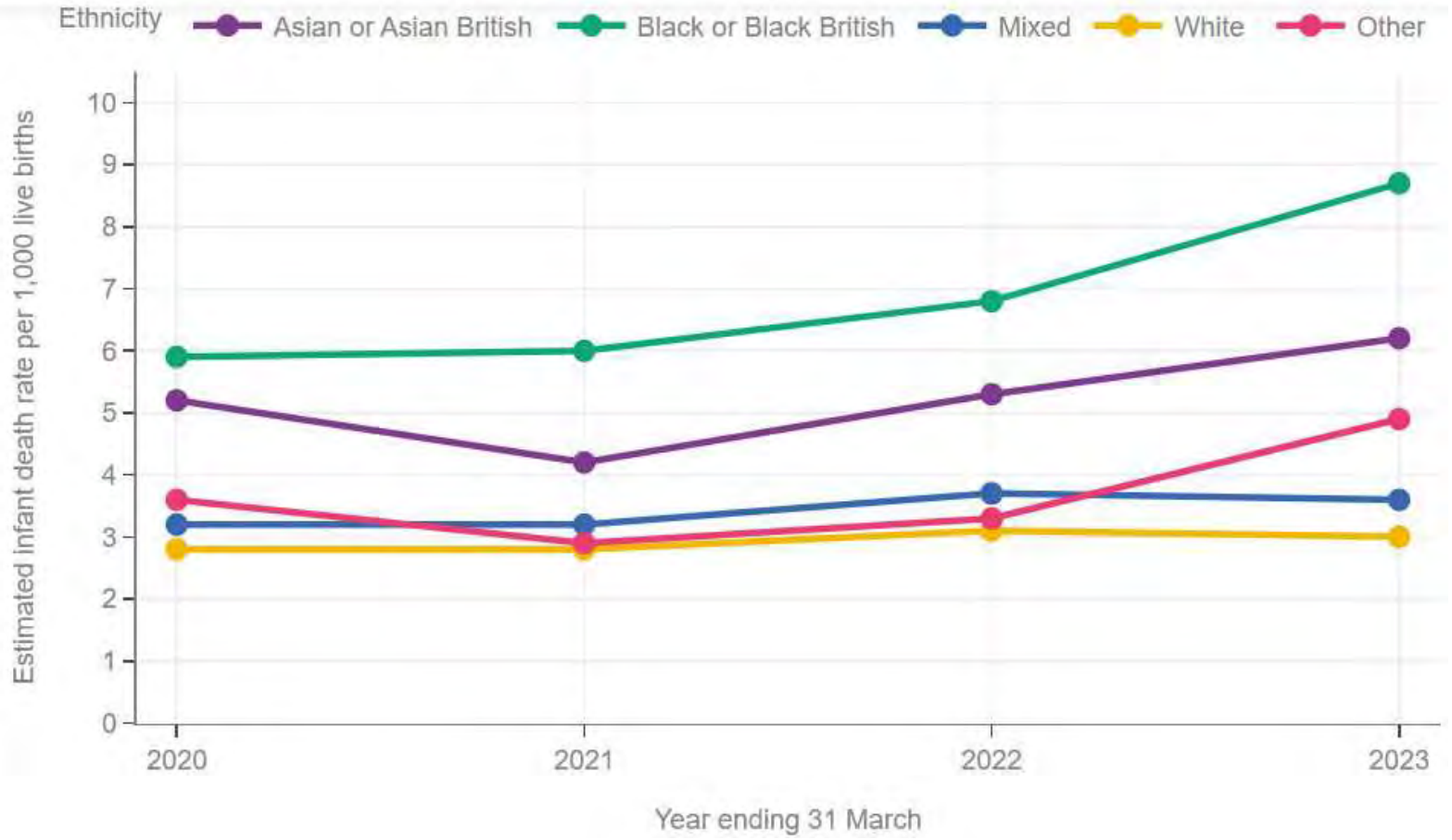
Source: ONS, Child and Infant Mortality in England and Wales, 2021, death cohort data file, table 21



Source: Taylor-Robinson D, Lai ETC, Wickham S, Rose T, Norman P, Bambra C, Whitehead M, Barr B. Assessing the impact of rising child poverty on the unprecedented rise in infant mortality in England, 2000-2017: time trend analysis. BMJ Open. 2019 Oct 2;9(10):e029424. doi: 10.1136/bmjopen-2019-029424. PMID: 31578197; PMCID: PMC6954495

Inequalities spotlight – Infant Mortality & Ethnicity

- In the year 2022/23, the estimated infant mortality rate was nearly 3 times higher for infants of Black or Black British ethnicity compared to those of white ethnicity - 8.7 per 1,000 live births compared to 3.0 per 1,000 respectively.
- It was more than twice as high for infants of Asian or Asian British ethnicity compared to white infants - 6.2 death per 1,000 live births compared to 3.0 deaths per 1,000.

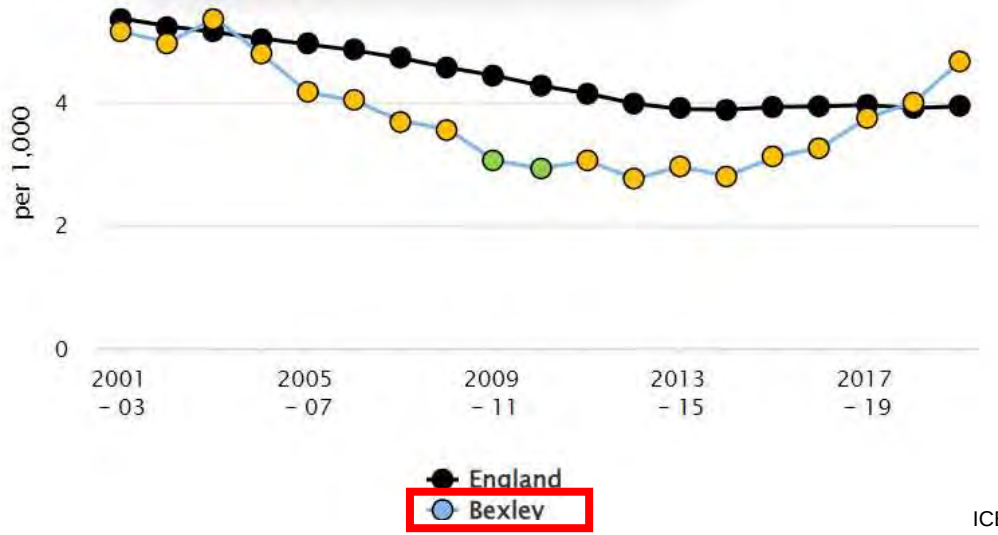


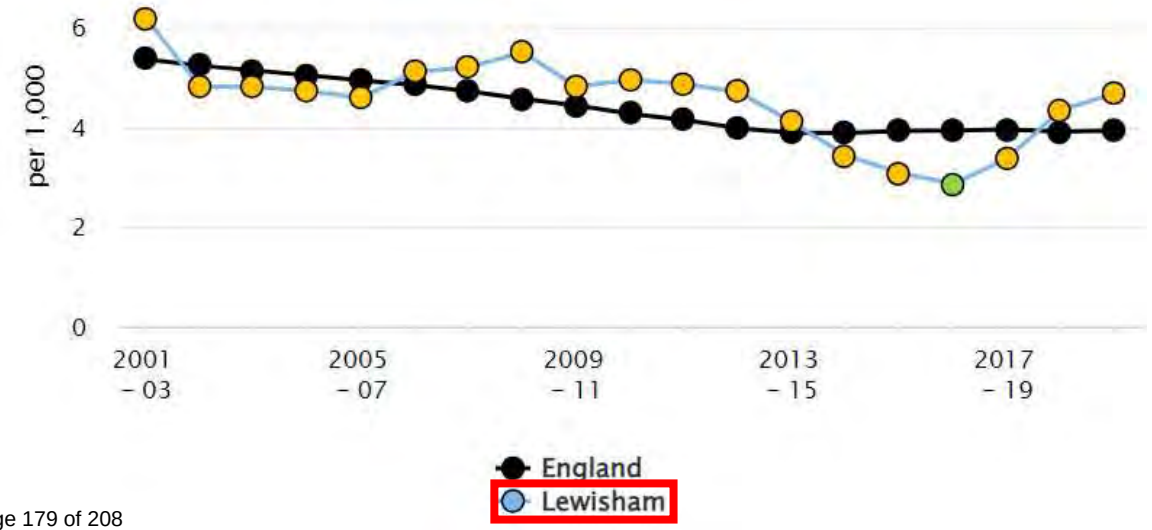
Source:National Child Mortality Database, www.ncmd.info/cdr23/

Inequalities spotlight – Infant Mortality in SEL

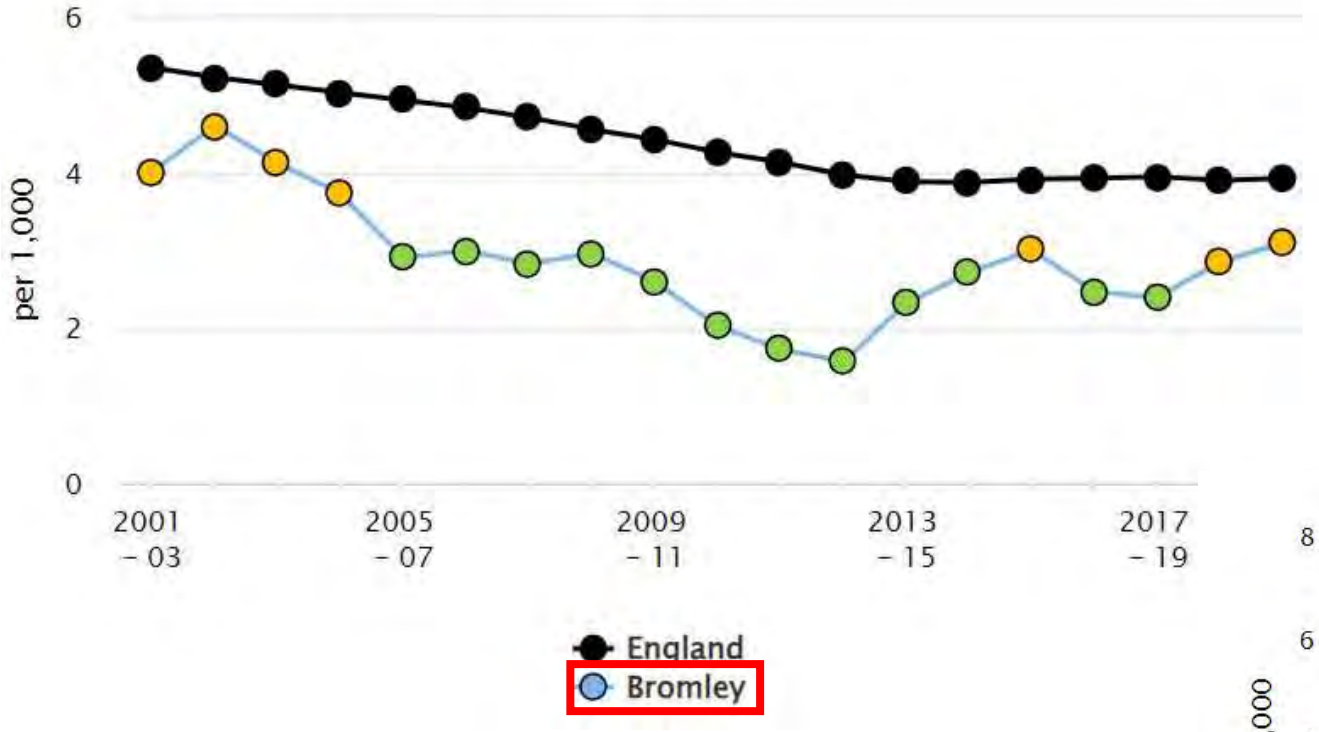
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	7,036	3.9	3.8	4.0
London	–	1205	3.5	3.4	3.7
Lewisham	–	58	4.7	3.5	6.0
Bexley	–	40	4.7	3.3	6.4
Greenwich	–	55	4.6	3.4	5.9
Lambeth	–	45	4.1	3.0	5.5
Southwark	–	39	3.5	2.5	4.8
Bromley	–	35	3.1	2.2	4.3

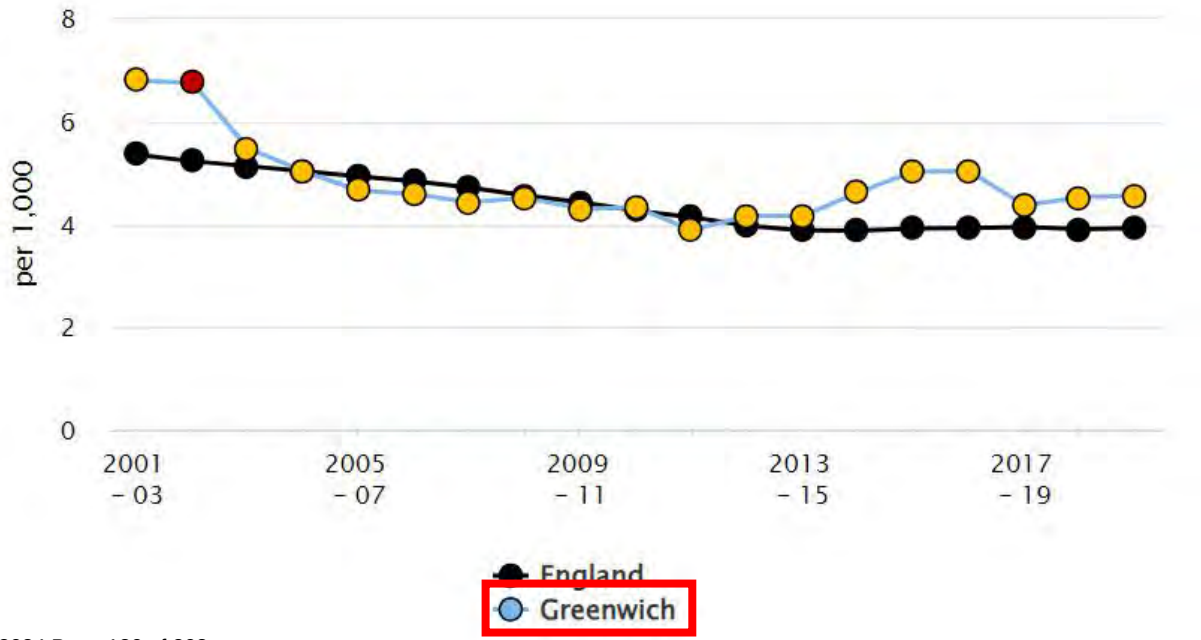
Source: Office for National Statistics (ONS)



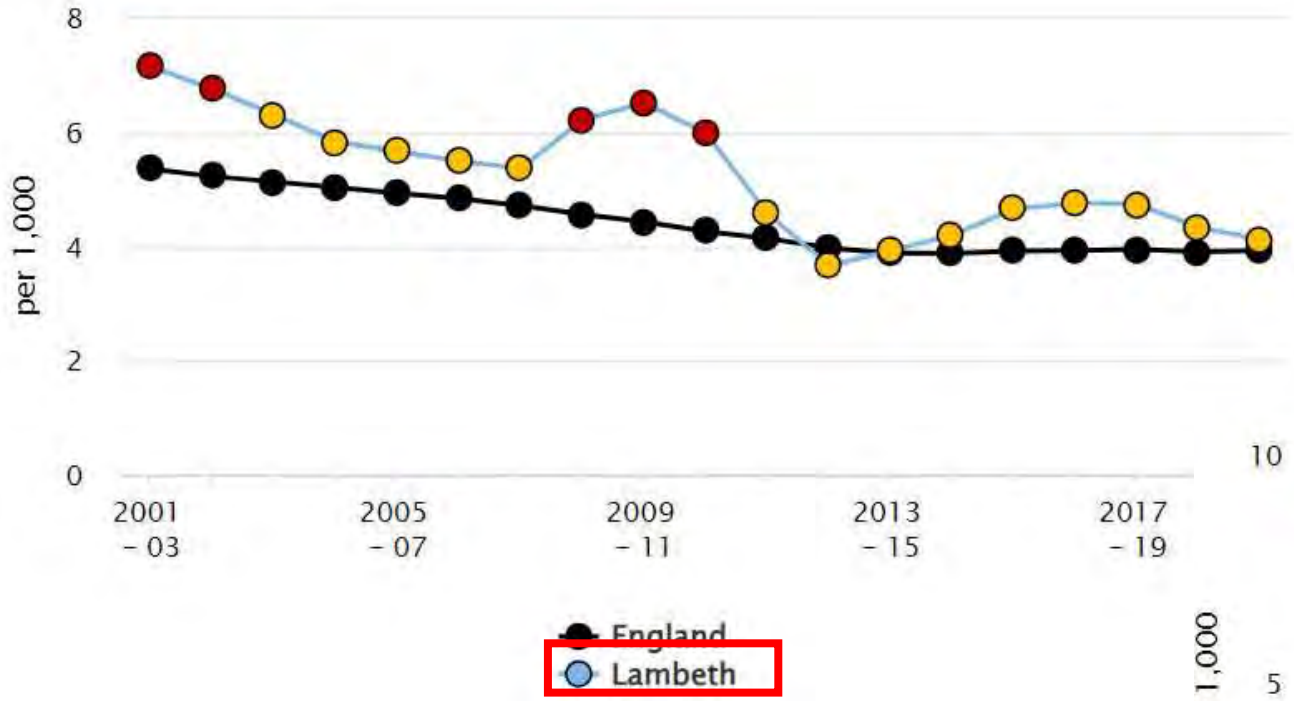


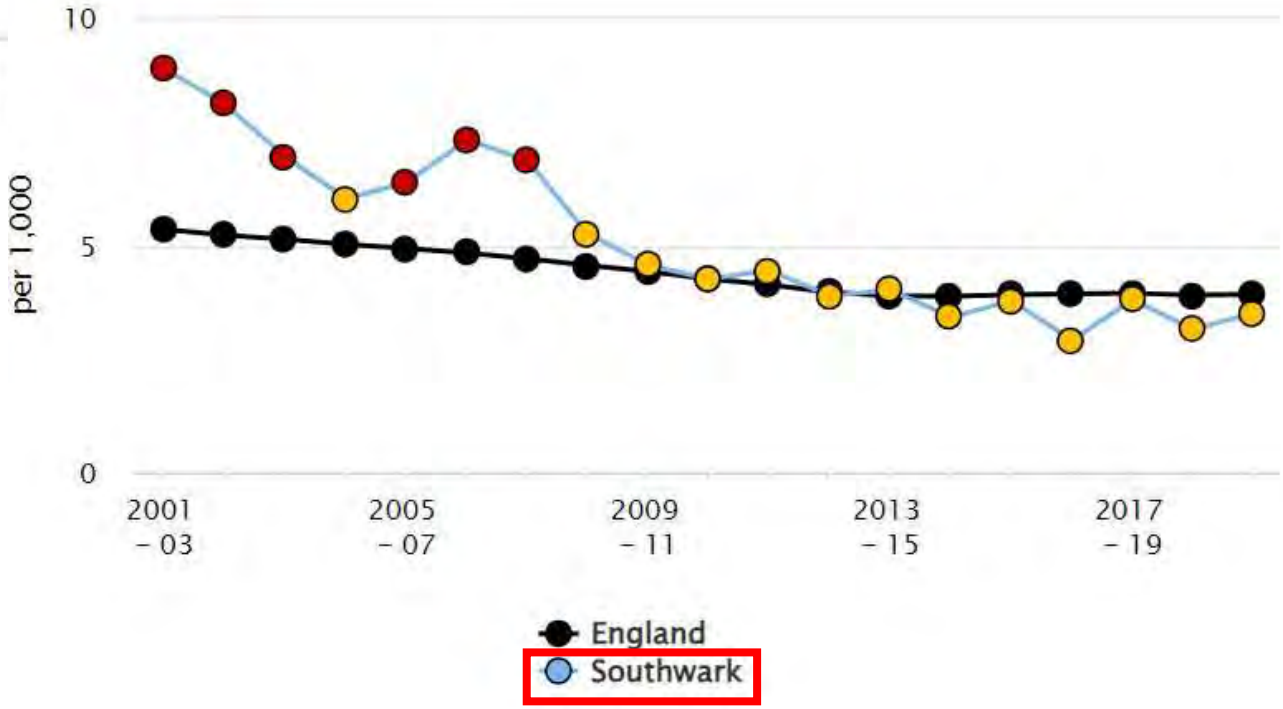
Inequalities spotlight – Infant Mortality in SEL





Inequalities spotlight – Infant Mortality in SEL





Inequalities spotlight – Infant Mortality – causes and risk factors

Immaturity-related conditions (complications from being born prematurely) are the primary cause of nearly 50% of neonatal deaths (deaths within 28 days of birth)

Source: ONS Child & Infant Mortality in England and Wales 2021

Risk factors that increase the risk of infant mortality:

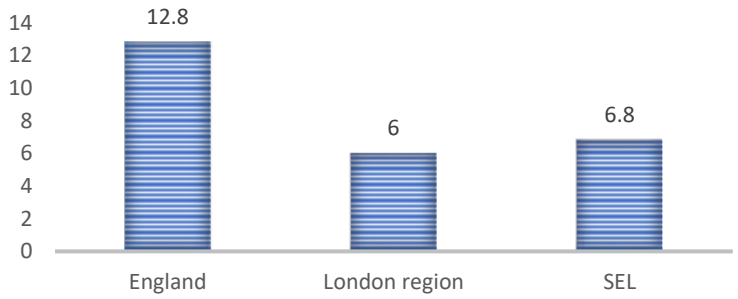
- Social and demographic factors, such as social inequalities and deprivation, as well as birth and maternal characteristics:
- Ethnicity (particularly Black, Asian and Mixed ethnicities)
- Smoking tobacco in pregnancy
- Obesity and being overweight in pregnancy
- Maternal age (particularly those who are aged under 20 years and over 40 years)

Source: Infant mortality and Health Inequalities, House of Commons Research Report, November 2023

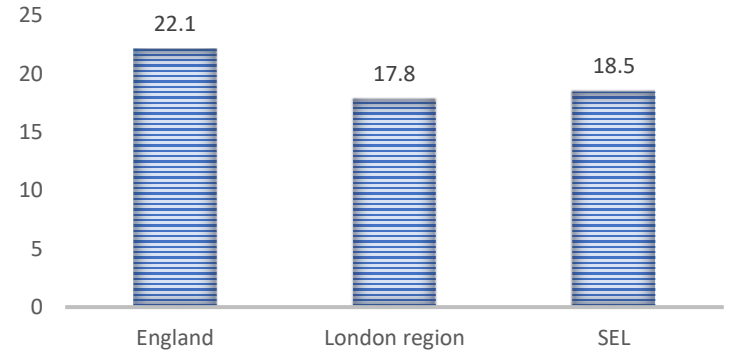
Inequalities spotlight - About SEL

Parental health in South East London

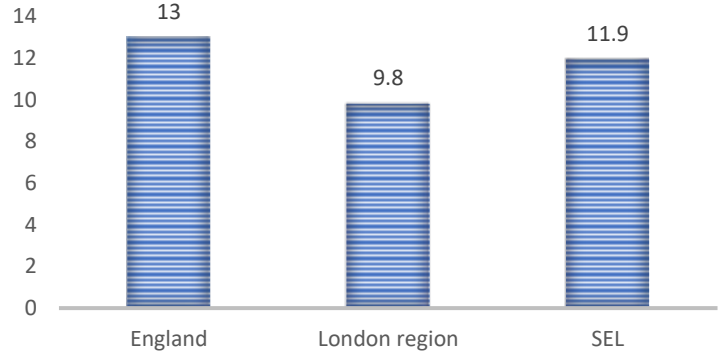
Smoking in pregnancy (%) – 18/19



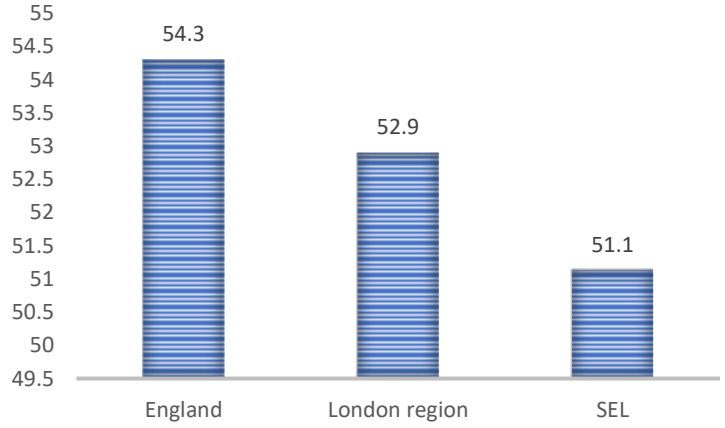
Obesity in early pregnancy (%) – 18/19



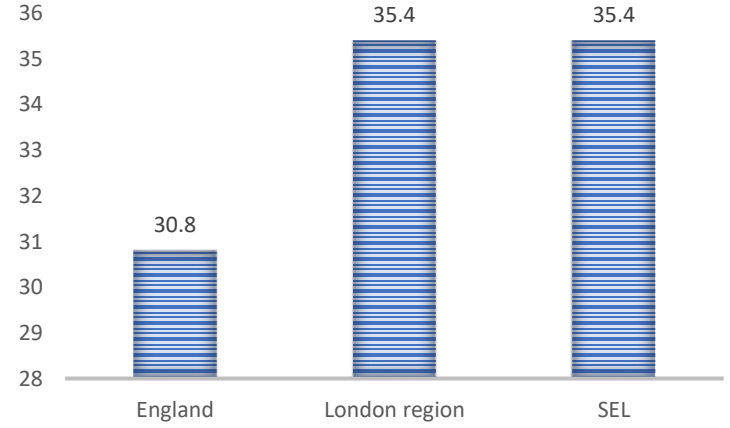
<18s conception (crude rate per 1,000) – 2020



General fertility (crude rate per 1,000) – 2021



Domestic abuse related incidents and crimes (crude rate per 1,000) – 21/22



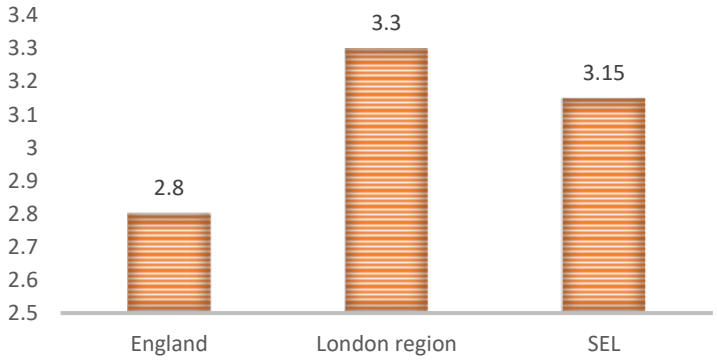
Depression: QOF prevalence 18+ (%) – 21/22

Source: Fingertips

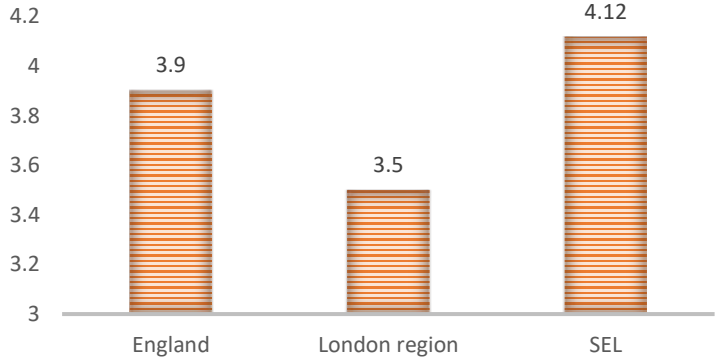
Inequalities spotlight - About SEL

Infant health in South East London

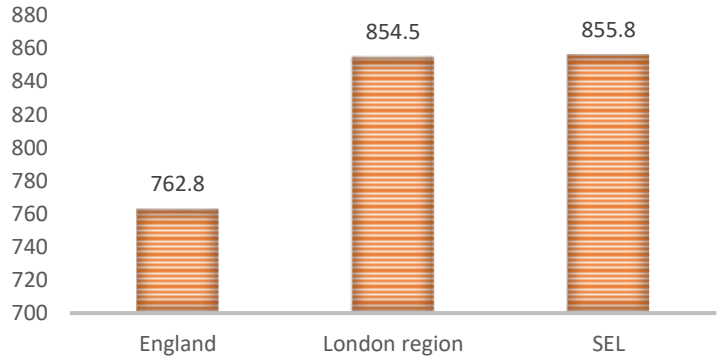
Low birthweight babies (%) - 2021



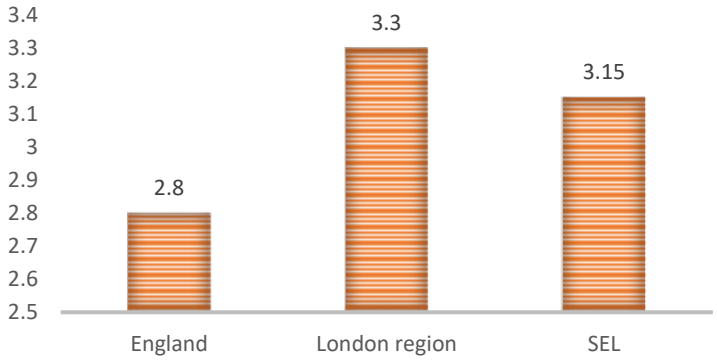
Infant mortality rate (Crude rate per 1,000) – 2019-2021



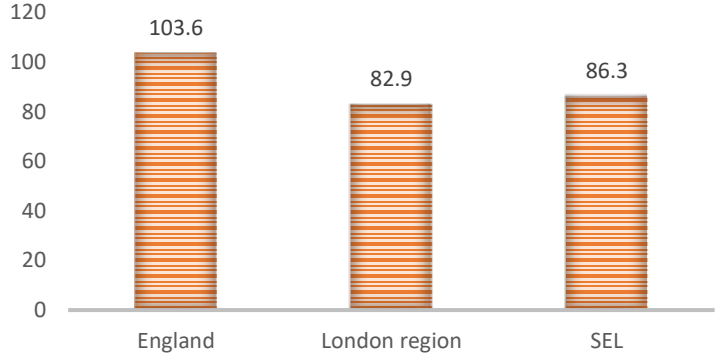
A&E attendance (0 - 4 y/o) (Crude rate per 1,000) – 21/22



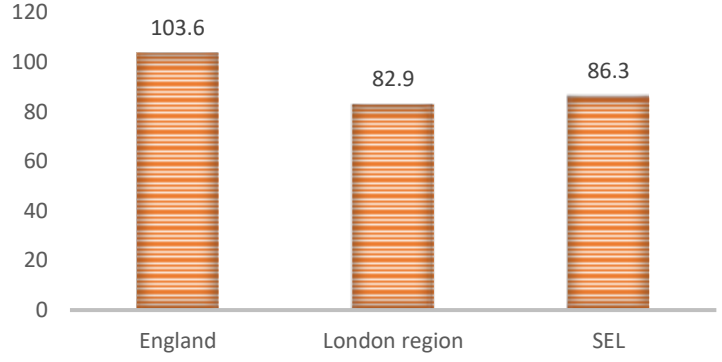
First feed is breastmilk (2020/2021 - proportion %)



Emergency admissions (0 - 4 y/o) (Crude rate per 1,000) – 21/22



Hospital admissions due to unintentional injuries in children (0 - 4 y/o) (Crude rate per 10,000) – 20/21

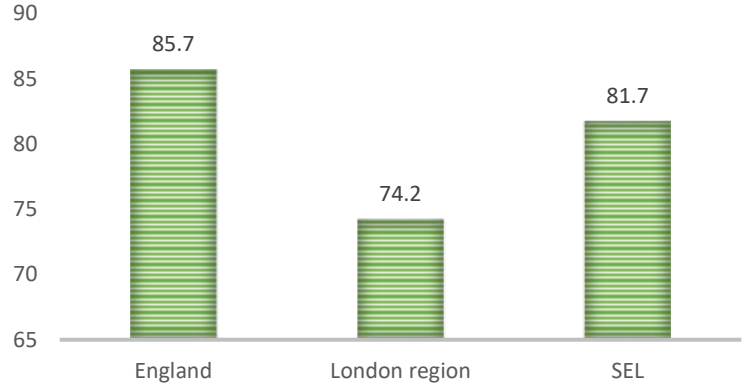


Source: Fingertips

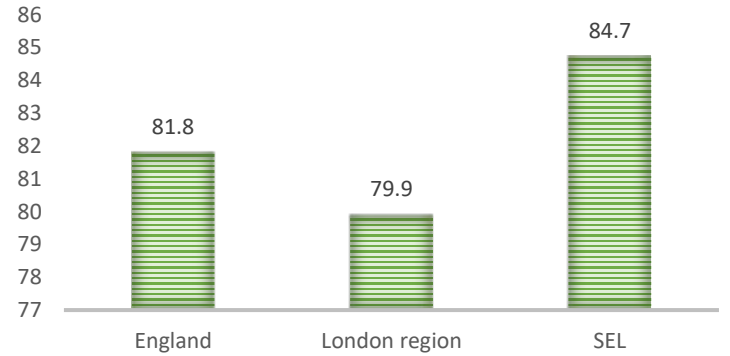
Inequalities spotlight - About SEL

Child health in South East London

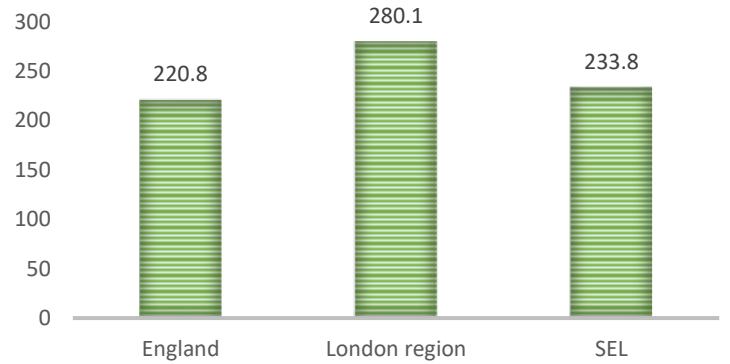
Vaccination coverage: MMR for two doses (5 y/o) (%) – 21/22



Child development: percentage of children achieving a good level of development at 2 -2.5 years (%) - 21/22

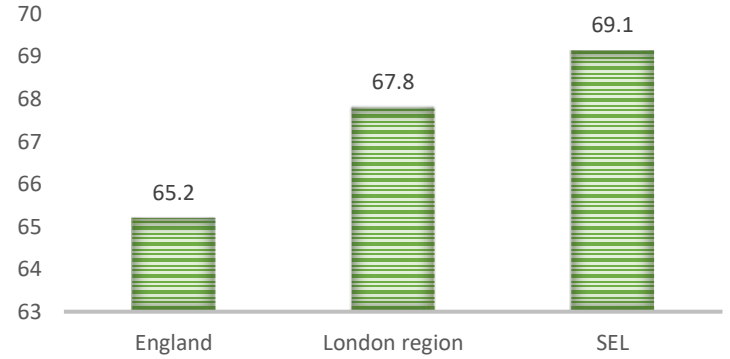


Hospital admissions for dental caries (0 - 5 y/o) (Crude rate per 100,000) - 2018 - 2021

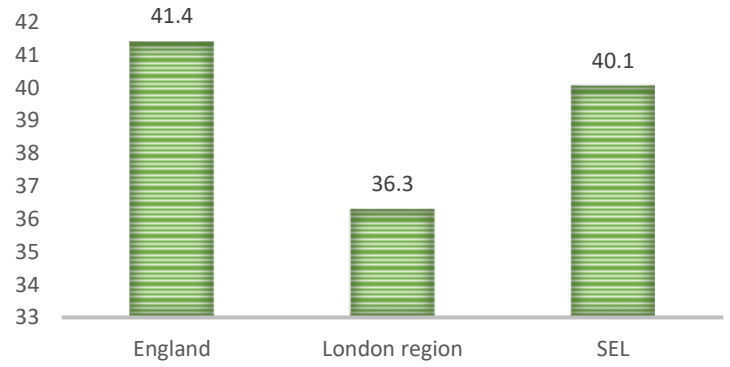


Reception: prevalence of overweight (including obesity) (%) - 21/22

School readiness: percentage of children achieving a good level of development at the end of Reception (%) – 21/22



Children on child protection plans (2020/2021 - rate per 10,000 <18yo)

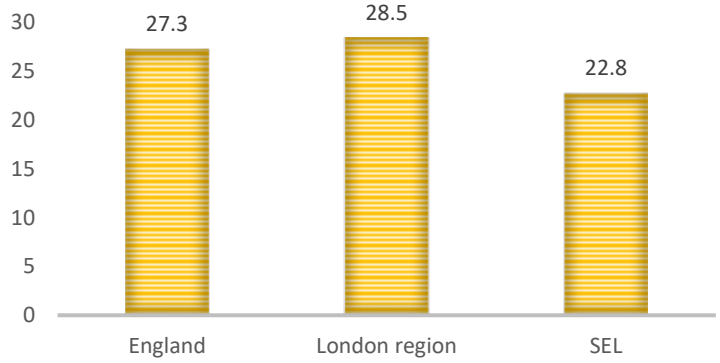


Source: Fingertips

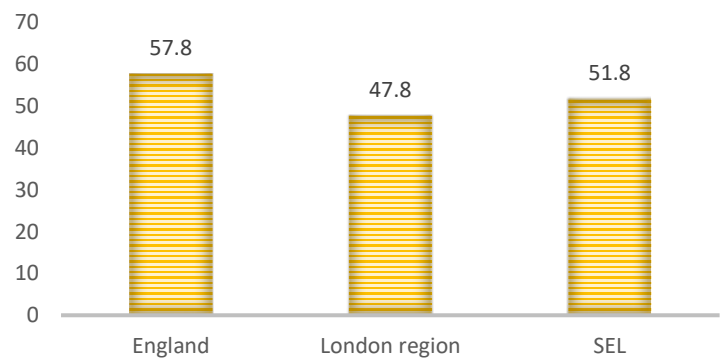
Inequalities spotlight - About SEL

Access to services in South East London

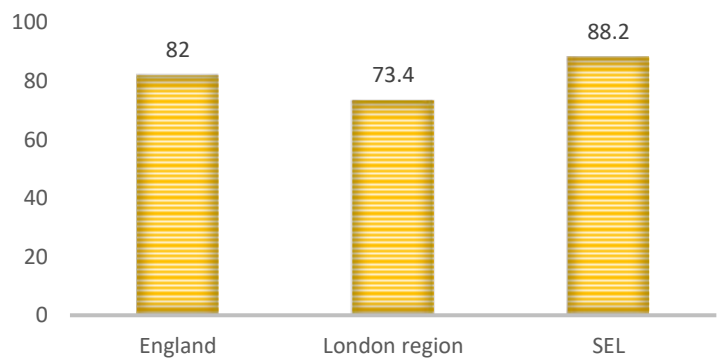
Folic acid supplements before pregnancy (%) – 18/19



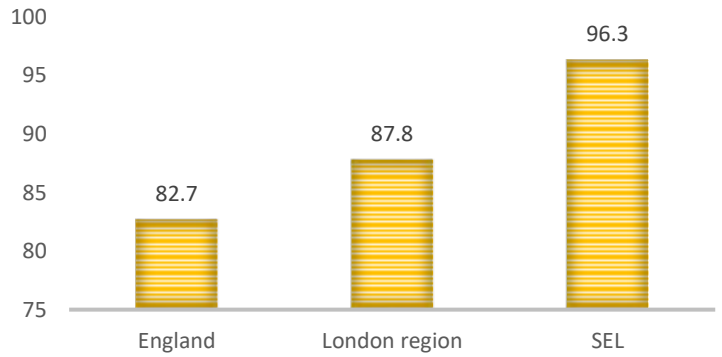
Early access to maternity care (%) - 18/19



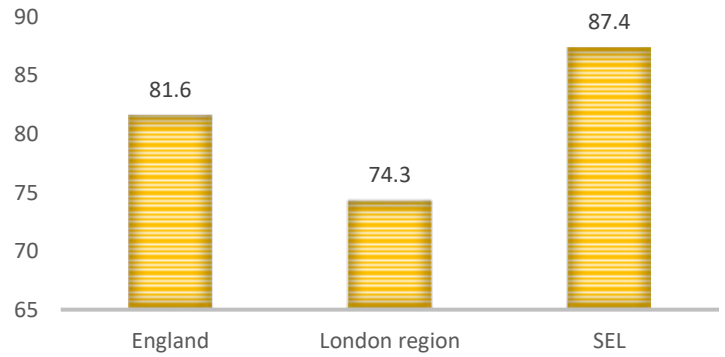
Proportion of infants receiving 12 month review (%) - 21/22



Proportion of NBVs completed within 14 days (%) - 21/22



Proportion of infants receiving 6 to 8 week review (%) - 21/22



Source: Fingertips

Borough Case Studies

Bexley

START WELL: Early Years Programmes

Tackling Obesity

Children's Centres deliver the HENRY (Health, Exercise, Nutrition in the Really Young) programme to address Bexley's obesity rates. Workshops focussing on weaning and fussy eating are delivered to families.

Bexley's 0-19 service has achieved **Level 3 UNICEF** Breastfeeding Friendly Initiative.

Early Language Intervention Measure

This intervention is delivered by the 0-19 service to improve speech, language and communication skills in the early years.

Smoking in Pregnancy

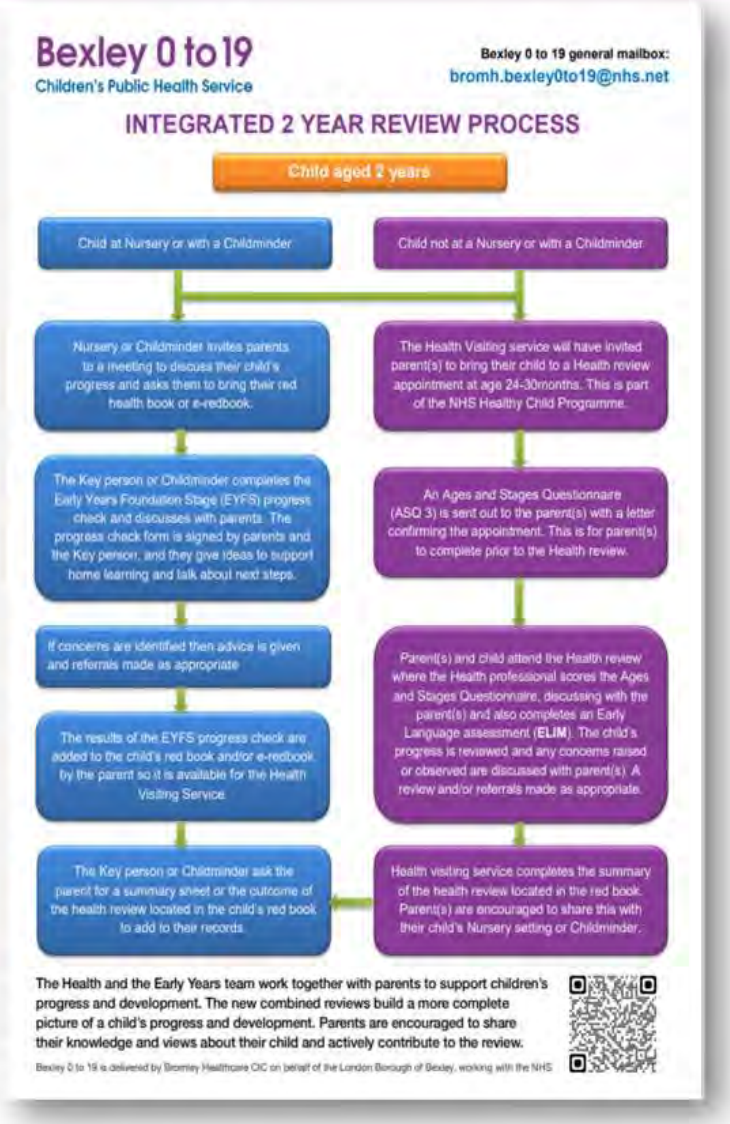
Pregnant people are a priority for referral to the Bexley stop smoking service.

Early Years Integrated Reviews

The London Borough of Council Bexley developed a process for integrating the Early Years Foundation Stage check carried out by nurseries, childminders and early years settings and the Health Check carried out at 2.5 years by the Bexley 0-19 Service.

The Health and the Early Years team work together with parents to support children's progress and development. The new combined reviews build a more complete picture of a child's progress and development. Parents are encouraged to share their knowledge and views about their child and actively contribute to the review.

This process has also improved **integrated working** and increased the knowledge and skills of the workforce.



Bromley (1/2)

Childrens Hospital at Home Service

- Childrens H@H was born out of a collaborative working partnership from members of One Bromley. Those partners are Bromley Healthcare, the SEL Commissioning, and Princess Royal University Hospital Paediatric team (PRUH).
- The link between the community and acute services was paramount to perpetuating and maintaining the project vision. These services collaborated to create an essential service which since its inception has proven to be an extremely valuable resource.

The Team

- CYP H@H are a team of experienced paediatric nurses who visit children and young people in their home.
- The paediatric nurses ensure a smooth transition from hospital to home, allowing ongoing medical treatment and review for acutely unwell children and young people, and supporting families to feel confident caring for their child during their episode of illness
- The service has grown over time and soon the service will be able to support jaundiced neonates in their home using phototherapy, reducing LoS and aiding the bonding between baby and parents in the days immediately after birth.
- The service will shortly be opening up a direct referral from primary care, reducing the likelihood of admission for BCYPs

Impact for Early Years

- Between October-December 2023, 186 of the 219 patients seen were under 5 years old. Roughly 59% of our patients have a respiratory condition and 36% require IV antibiotics

Bromley (2/2)

Patient and family feedback

The nurses were incredibly warm, compassionate, professional and knowledgeable. They showed empathy and patience. I'm genuinely blown away by how brilliant this service is.

This is an incredible service. Means that a sick child who needs IV medication can receive hospital grade care in the comfort and security of their own home.

The H@H team have saved my postpartum mental health from deterioration. The girls are so friendly and kind, I cant thank them enough.

Staff feedback

Hospital@Home team has helped decongest hospital admission and able to continue giving care to stable patients needing medical treatment and also give assurance and peace of mind to parents as well.

They engage with ED and the Ward in a supportive way and feel like an integrated part of the team.

They make a huge difference to our patients and the care they receive and take a huge pressure off the ED department and children's ward.

Improved patient experience and a seamless transition from inpatient care to home care.

100% for the Friends and Family Test
34% response rate

Greenwich

GREENWICH – EARLY YEARS LANGUAGE DEVELOPMENT

Since Covid-19 we have seen a significant impact on the language development of children in the early years of life. Early Years Settings and Schools have reported children turning up with limited language development in comparison to prior to the pandemic. In response, we have invested further in strengthening our early years language and communication offer and join up across the borough to address this, below is a snapshot on some of the work that has taken place.

Why is Early Years Communication Important?

As highlighted by the Royal College of Speech and Language Therapists (SLT), communication is a fundamental life skill. The impact of early language development ranges from:

- **School readiness:** Children's vocabulary and ability to talk in two-to-three word sentences at the age of two is a strong predictor of school readiness at four.
- **Educational attainment:** Children with poor spoken language at five are 6 times less likely to reach the expected standard in reading and writing at 11.
- **Wellbeing and life chances:** Children with poor vocabulary skills at age five are three times as likely as their peers to have mental health problems in adulthood, and twice as likely to be unemployed.

What are we doing in Greenwich to improve this?

Recognising the workforce challenges in recruitment of specialist SLT roles, Greenwich has looked at other ways to upskill the wider workforce, working across early years settings including School nurseries and private, voluntary and independent provision.
To date:

- Over 276 early years practitioners trained in **Early Talk Boost**
- Over 131 early years practitioners and other staff including librarians trained in **Makaton** to support non-verbal children and those with SEND.
- Roll out of 67 **Tiny Talk and Small Talk Cards** to settings supporting parent-child interactions

Development of a new multi-agency **Speech, Language and Communication Need (SLCN) Hub** integrating training, Early Communication stay and plays, parent drop-ins and outreach worker visits.

What is the impact of our work?

Early Talk Boost in Schools
500 children benefitted from the first term of intervention with ***47 % of them closing the gap towards expected levels*** of development in language and communication skills and a **further 30% narrowing the gap by 50 % or more.**

Ofsted Inspection Report recognitions on the impact of Makaton:

- "There is a focus on...giving them the tools to be able to express themselves...Makaton [has provided] non-verbal children with additional means of communication" – Plumstead Manor Nursery
- "all staff use sign language and develop creative strategies to support younger children's communication and languages skills." – Eltham Pre-School
- "Recent training in signing has also had a positive impact on communication in the baby room." – Zippys Day Nursery

Lambeth

The Parent Infant Relationship Service (PAIRS)

- The multi-disciplinary team within Lambeth CAMHS (SLAM) was developed as one of the core interventions of the Lambeth Early Action Partnership (LEAP) A Better Start programme, and will be expanded as part of Lambeth's Start for Life offer
- The team will continue to provide a tiered offer consisting of:
    - Universal promotion of attachment principles across the early years workforce and within the community
    - Consultation, supervision and workforce development for practitioners directly delivering parent infant relationship interventions
    - Delivery and oversight of Together Time groups, and supervision of Baby Steps and Circle of Security Parenting
    - One to one Parent Infant Psychotherapy.

Start for Life Programme: Parenting and Parent Infant Relationship Interventions

- Baby Steps – a perinatal parenting programme developed by NSPCC in partnership with Warwick University and delivered in Lambeth by a multi agency team consisting of midwives; health visitors and parenting workers. Borough wide delivery will enable an increased focus on targeted delivery to unborn children and parents with more complex needs, including those known to Children's Social Care.
- Together Time – a targeted therapeutic group developed by the PAIRS team with the intention of supporting parental attunement to infants' cues; developing capacity for reflective functioning and Mentalisation of their infants; experiences; and encouraging and strengthening the parent infant relationship to promote secure attachment
- Circle of Security Parenting (COS) – an international, evidence based programme focused around attachment theory, and designed to help parents and care givers to:
    - **Understand** their child's emotional world by learning to read emotional needs
    - **Support** their child's ability to successfully manage emotions
    - **Enhance** the development of their child's self esteem
    - **Honor** the innate wisdom and desire for their child to be secure

Lewisham

Early Years - Supporting fathers and male carers in Lewisham

The Lewisham CYP Joint Commissioning Team is building our support offer for fathers and male carers in the Early Years, focusing on the critical period from conception to age 2.

In line with the Early Years priority of the Integrated Care Strategy, our aim is to *ensure children get a good start in life and there is effective support for mothers, babies and families before birth and in the early years of life* by supporting new and expectant fathers and male carers to:

- Stay resilient and emotionally well
- Improve parenting skills and confidence, and empower fathers to support the wellbeing of their baby and wider family
- Have more opportunities for peer support, with fathers able to connect and build an ongoing support network
- Be actively engaged in the pregnancy and immediate postnatal period.

This integrated programme of work aligns with Lewisham ICB's priority objective to - *provide families with integrated, high quality, whole-family support services.*

The CYP Commissioning Team are working across Maternity and Early Years services to ensure that they **are inclusive and welcoming to fathers and male caregivers**, through empowering fathers to speak up about their experience of perinatal care, and through changing working practices and attitudes.

Being Dad is a peer–led programme of support with mental wellbeing and resilience, which was piloted in Lewisham in 2022 and commenced full-scale delivery in 2023. It is delivered by Bromley, Lewisham and Greenwich Mind.

It has been co-designed through engagement with local fathers, and is delivered by fathers that have lived experience of perinatal mental health issues.

The programme has supported **25 fathers** in the first four months of delivery, with 85% reporting feeling happier and more positive, 85% feeling less isolated, and 92% having improved confidence in themselves and their parenting.

Future Dads is an antenatal education course for new and expectant fathers, delivered at Lewisham Hospital.

The programmes aims to increase the provision of information and practical skills, so that new fathers engage more actively in the pregnancy and feel empowered to support their partners through the birthing process.

108 fathers have been supported over the last year.

A network of support from conception to age 2

In Spring 2024 we will be commencing delivery of the **Solihull 'Understanding Your Baby'** programme specifically for male caregivers, delivered in partnership between Future Men and Lewisham Health Visiting Service. The programme focuses on improving parent-infant bonding and attachment.

The **Start for Life Fathers Programme** commenced in 2023, providing targeted support for fathers and male carers, focusing on marginalised and vulnerable groups that may be less likely to access mainstream provision. It is delivered by Future Men.

18 fathers have been supported in the first six months of delivery, delivering **123 sessions of support**.

Future Men are upskilling the network of professionals within Family Hubs and early years services, via **training and consultation on father-inclusive practice.** This includes training sessions as well as one-to-one consultations for practitioners.

112 practitioners received consultations and **13** have been trained to date.

Integrated Care Board meeting

Item: 9
Enclosure: I

Title:	**Perinatal Care Update**
Meeting Date:	**31 January 2024**
Author:	Jacqui Kempen, ICB Head of Maternity
Executive Lead:	Paul Larrisey, ICB Chief Nurse

Purpose of paper:	This paper offers a comprehensive update to the board regarding the ongoing initiatives addressing perinatal inequalities within the Local Maternity and Neonatal System (LMNS).	Update / Information	*x*
		Discussion	*x*
		Decision	

Summary of main points:	The UK remains one of the safest places in the world to have a baby however, there continues to be disparities in access, experience, and outcomes for several women and birthing people, especially Black, Asian, and ethnic minorities and those living with deprivation. This report offers insights at both the national and local levels and provides information on the ongoing initiatives within the LMNS aimed at addressing the disparities encountered by many throughout their maternity journey."
Potential Conflicts of Interest	**None**

Relevant to the following Boroughs	**Bexley**	**X**	**Bromley**	**X**
	Greenwich	**X**	**Lambeth**	**X**
	Lewisham	**X**	**Southwark**	**X**

Impact	Equality Impact	Supports strategic and provider commitments on reducing inequalities across maternity and neonatal providers
	Financial Impact	None
Other Engagement	Public Engagement	None
	Other Committee Discussion/ Engagement	None

Recommendation:	The board is asked to **note** the update and the following requests for support: • Across SEL boroughs and maternity and neonatal providers, there is commonality in the inequalities that some women and birthing people face. The LMNS works as a system with shared challenges and a common goal, to improve services for women and birthing people, especially those that experience or are at risk of the worst outcomes. We recognise the need for wider collaboration across the ICS and ask the board to support more joined up working with primary care and local authority colleagues. • We ask the board to support the LMNS by improving the collection and analysis of local data to better inform our work. • In 2024 the LMNS will publish a revised Equality and Equity action plan which will build on existing efforts and incorporate and initiate the changes essential to reduce inequalities. • We ask the board to support the appropriate resourcing for Maternity and Neonatal Voices Partnerships to enable them to function as service user experts, central to and reflective of the communities we care for. • We also ask the board to consider how we can sustainably resource VSCE organisations as trusted institutions, to deliver support in the maternity and newborn space.

Perinatal Care Update

1. Introduction

1.2 The UK remains one of the safest places in the world to have a baby however, there continues to be disparities in access, experience, and outcomes for several women and birthing people, especially Black, Asian, and ethnic minorities and those living with deprivation.

1.3 Perinatal (pregnancy to 1 year after birth) mortality and morbidity can be influenced by several factors including individual, societal, and health-care related elements, maternal health both physical and mental, migrant status, lifestyle factors such as smoking, alcohol and drug use, social determinants of health, timeliness and adequacy of preconception care, previous obstetric history, and systemic healthcare issues.

1.4 The purpose of this paper is to update the board about the ongoing programme of work within maternity and perinatal services to address the inequalities faced by many of the women and birthing people that we care for.

2. Background

2.1 Investigations into maternity and neonatal services across the UK, such as those in Morecambe Bay, Shrewsbury & Telford, East Kent, and the expectations of future reports Nottingham and Thirwall (in response to the Countess of Chester hospital findings), have revealed significant failings in care for women, birthing people, and their babies. These findings have rightfully brought maternity and neonatal services under scrutiny, leading to recommendations for improvement across the wider NHS.

2.2 National initiatives have emerged from these investigations, focusing on transparency, monitoring, and oversight to reduce the risk of harm, and increase equality and equity, in the form of the maternity and neonatal three-year delivery plan which encompasses all national expectations and statutory obligations of the services.

2.3 The Local Maternity and Neonatal System (LMNS) as the maternity and neonatal arm of the Integrated Care Board/Integrated Care System plays a vital role in supporting and overseeing the implementation of the delivery plan and a wider number of local initiatives, including reducing inequalities.

3. The National Picture - Maternal

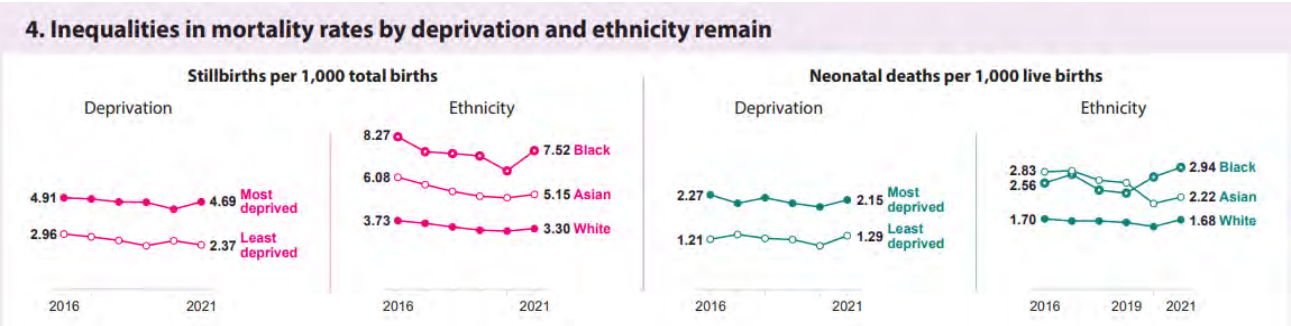
3.1 National evidence such as the MBRRACE (Reducing risk through audit and confidential enquiries) UK 2020-2022 data, continues to indicate significant disparities in maternal outcomes. Black women and birthing people are three times more likely to die during pregnancy and after birth compared to their white counterparts, while Asian women and birthing people are two times more likely to face such risks. Notably those living in the most deprived areas continue to have a maternal death rate more than twice that of women living in the least deprived areas.

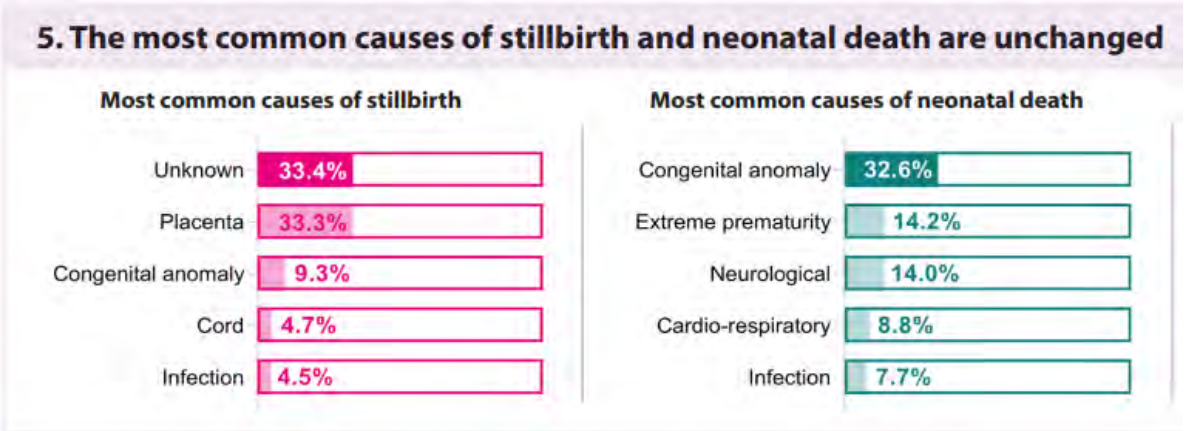
3.2 In 2020-22, **272** (13.4 per 100,000) women and birthing people died during or up to six weeks after the end of pregnancy, among 2,028,543 giving birth in the UK. The report has highlighted a statistically significant increase in the overall maternal death rate in the UK since 2017-19. The table below shows the causes of deaths in the UK.

Direct causes of maternal death UK 2020-2022	Number per 100,000 maternities	Indirect causes of maternal death UK 2020-2022	Number per 100,000 maternities
Thrombosis and thromboembolism	2.17	**COVID-19**	1.98
Psychiatric	0.89	**Cardiac disease**	1.73
Sepsis	0.89	**Psychiatric**	0.64
Haemorrhage	0.84	**Neurological**	1.23
Early pregnancy	0.74	**Sepsis**	0.3
Amniotic fluid embolism	0.39	**Malignancies**	0.35
Pre-eclampsia	0.35		

4. Neonatal

4.1 National evidence around fetal and neonatal mortality from 2021 has shown that perinatal mortality rates increased in this period. Again, inequalities in outcomes continue for Black, Asian and ethnic minority women, and birthing people, and those living in deprivation.





4.2 Factors affecting fetal and neonatal mortality and morbidity include the maternal factors discussed previously affecting the development of the baby in-utero, congenital abnormalities, placenta problems, infection, and preterm birth.

4.3 If a trust is recognised as being an outlier for mortality, based on the MBRRACE data, they are asked by the national maternity team to perform a deep dive for the reporting period. This deep dive provides a more robust review of each case, themes and learning to be shared. Lewisham and Greenwich NHS Trust (LGT) are currently conducting a deep dive into neonatal deaths.

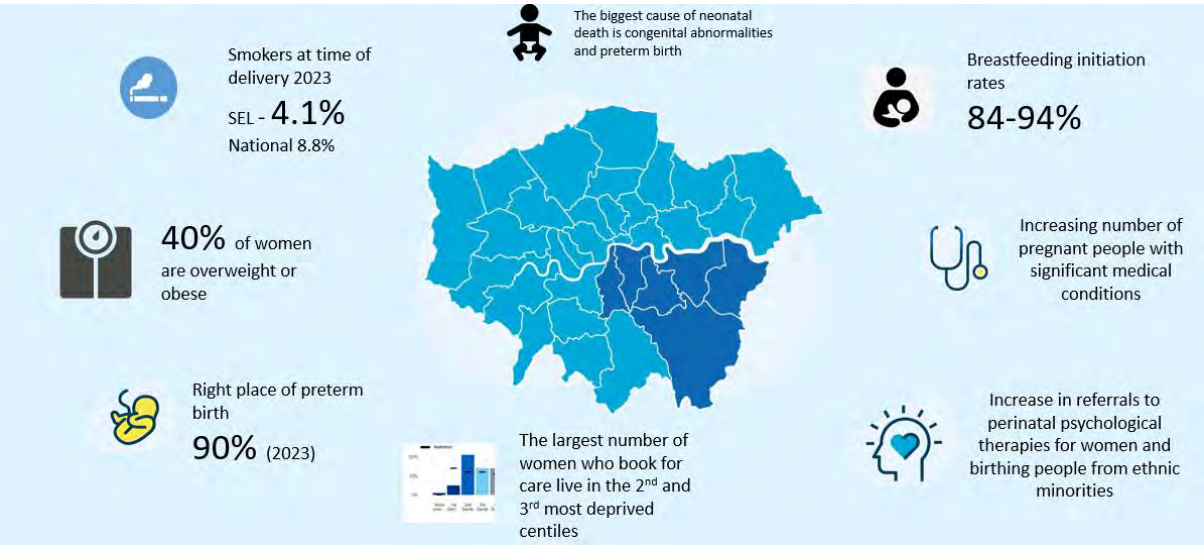
5. The SEL Position

5.1 Local data for south east London provides valuable insight into the demographics and health characteristics of women and birthing people across the system, but we recognise that there is further work needed to ensure that data is recorded well, is of high quality and captured correctly. Locally collected data is in a crude format and describes only what happened to an organisation or area, thankfully, maternal mortality numbers are generally low and as such there is a risk of chance variation. National MBRRACE perinatal data is stabilised and closer to the average rates compared to crude data and adjusted to account for key factors which are known to increase perinatal mortality such as socio-economic deprivation, multiple birth, gestational age at birth. As all of our maternity services input data the national maternity services dataset and also to MBRRACE it can be more reliably used for local interpretation and to support local action plans.

5.3 From October 2023 there has been a challenge in the collection of data locally due to the introduction of a new electronic patient record at both Guy's and St Thomas' Hospital NHS FT (GSTT) and King's College Hospital NHS FT (KCH). Ensuring that data can be extracted in a timely way is a priority for each Trust.

5.4 It is difficult to benchmark or make comparisons with other LMNS's and Trusts due to the variation of the services that are provided, the availability of data, and the demographics of the populations that we care for.

6. SEL snapshot



6.1 Maternal mortality rates are low within our system, but the maternity and neonatal providers with the LMNS are working hard to ensure that we learn from any mortality, particularly any death that was avoidable, and implement any changes required to prevent this occurring again. This includes the implementation of national

programmes that have been shown to reduce perinatal mortality (please see national programmes section) and improved investigative processes.

6.2 Tragically since September 2022 there have been six maternal deaths within SEL. Among these cases, one was attributed to an amniotic fluid embolism, with a second case pending investigation. Additionally, there was one instance of a pulmonary embolism, another due to cancer, and an intracerebral haemorrhage due to severe pre-eclampsia.
Of the deceased women and birthing people 50% were from a Black background and 50% from a white background, and two of the cases resided outside of SEL.

6.3 Within SEL LMNS there are two tertiary level referral units for both women and birthing people and babies. This means that KCH and GSTT care for a large number of women and birthing people from outside of SEL that may have complex medical needs, they will also accept transfers from other areas if a woman or birthing person or baby is acutely ill. These contribute to their rates of mortality compared to non-tertiary level units.

6.4 The ICB Maternal Medicine Network (MMN) also monitors the number of women and birthing people that are admitted to the intensive care units (ICU) during their pregnancy or after the birth of their baby(s). We recognise that many ICU admissions are near misses and therefore review if the care of these women and birthing people was of the correct standard and how can we reduce and ultimately prevent the need for these admissions.

6.5 Since August 2022 the total number of women admitted to an ICU within SEL was 67. Of those admissions 23% were from outside of SEL. The reasons for the admission vary, with the highest number admitted for cardiac problems (19.4%), 18% for pre-eclampsia or eclampsia, 7% for liver failure, 6% for pneumonia and 3% for thrombosis. The ethnicity of the women and birthing period was as follows, 21% Black, 18% White (other), 16% White, 9% Asian and 4% Black (mixed). The majority lived in deciles 2 and 3.

6.6 Rates of stillbirths (> 24 weeks and per 1000 births) and neonatal deaths (within 28 days of life and per 1000 births) are monitored by the LMNS. Data from October 2022 to September 2023 showed the following rates for each trust site:

Trust	Trust site	Stillbirths per 1000 births (>24 weeks gestation)	Neonatal deaths per 1000 births (within 28 days of birth)
Lewisham and Greenwich NHS Trust	Queen Elizabeth	2.7	1.1
	University Hospital Lewisham	1.6	0.9
Guy's and St Thomas' NHS Trust	St Thomas' Hospital	3.8	3.3
King's College Hospital NHS trust	Denmark Hill	7.3	3.8
	Princess Royal	3.2	1.1

6.7 The main causes of neonatal death within SEL are congenital abnormalities and preterm birth. The preterm birth rate across SEL is approximately 6%. The LMNS is currently working with the neonatal network and providers on improving the collection and quality of this data.

7. Combating the causes of maternal deaths in relation to SEL

7.1 Maternal mortality due to thrombosis remains a prominent issue nationally, with recent data indicating a concerning rise in rates. Various risk factors, such as being over 35 years old, having given birth to three or more babies, a history of thrombosis or familial predisposition, clotting disorders, and medical conditions like heart or lung disease, contribute to thrombosis during pregnancy. Other risk factors include a high BMI, smoking or drug use, reduced mobility, dehydration, severe infection, pre-eclampsia, prolonged labour, caesarean birth, and significant post-birth blood loss. To mitigate these risks, service providers conduct comprehensive risk assessments for all pregnant individuals, ensuring timely and appropriate interventions for those at higher risk.

7.2 Pregnant women and birthing people are at an increased risk of COVID-19 complications, making the promotion of immunisations during pregnancy a top SEL priority. Recent initiatives include extending the hours of immunisation clinics in maternity units, conducting webinars for maternity staff to facilitate meaningful conversations about immunisations, and launching a targeted social media campaign for the winter season. The LMNS has outlined a strategic action plan for 2024-25 to support services and the Integrated Care System (ICS) in improving immunisation uptake.

7.3 Cardiac disease remains a significant contributor to national mortality, with many women receiving diagnoses during or after pregnancy. The SEL Maternal Mortality Network (MMN) has established pathways to ensure evidence-based care for affected individuals, including planning for subsequent pregnancies. Recognising the heightened risk of cardiac disease in the future for those with cardiac or hypertensive conditions during pregnancy, ongoing follow-up throughout the life course is crucial for early detection.

8. National programmes

8.1 Providers with the support of the LMNS are tasked with implementing initiatives that are shown to reduce risk and improve outcomes, especially for those known to have a greater chance of complications.

8.2 The NHS Resolution maternity incentive scheme supports the delivery of safer maternity care through an incentive element to trust contributions to the clinical negligence scheme for trusts (CNST), maternity incentive scheme (MIS). MIS rewards trusts that can demonstrate they meet 10 safety actions which are designed to improve the delivery of best practice in maternity and neonatal services. If successful they can recover an element of their contribution to CNST MIS, plus a share of any unallocated funds available. MIS is a self-certified scheme with all submissions requiring sign off by trust Boards and ICBs.

8.3 A national programme called ‘Saving Babies Lives Care Bundle’ (SBLCB), which is part of the MIS scheme. SBLCB provides evidence based best practice for providers and commissioners of maternity and neonatal care to reduce perinatal mortality. The NHS prior to COVID-19 was working towards a national maternity ambition to halve rates of perinatal mortality by 2025. Whilst significant achievements have been made, more recent data has shown that there is still more to do to reduce the rates. The bundle incorporates six elements that include, reducing smoking in pregnancy,

fetal growth - risk assessment, surveillance, and management, raising awareness of reduced fetal movements, effective fetal monitoring in labour, reducing preterm births and optimising perinatal care and management of pre-existing diabetes in pregnancy.

8.4 Understanding more fully the women and birthing people that we care for in SEL and their specific needs is crucial to ensuring that services meet their requirements and improve perinatal outcomes. The LMNS uses both national and local data, intelligence, and service user feedback to inform our improvement projects and service delivery. Please see below for further details about the LMNS role.

9. Local Maternity and Neonatal Systems (LMNS)

9.1 LMNSs were set up in response to a National maternity review that took place in 2016. The review set out a vision for maternity and subsequent neonatal services to become safer and more personalised. The LMNS is working to redress imbalance in maternity and newborn care outcomes and experience through the implementation of a programme of work that encompasses both National guidelines and local improvements.

9.2 Leadership within the LMNS incorporates a small operational group and a wider network of clinical leaders, commissioners, and local service users. Recognising that maternity and neonatal traverses and impacts other networks within the ICB, collaborative work has commenced which will ensure that there is a wider understanding of work programmes and the opportunity for collaboration.

Maternity and Neonatal Delivery Group (MNDG)

9.3 The MNDG is a small operational group that includes the LMNS senior responsible officer (SRO), clinical chairs and leads, ICB director of quality, ICB head of maternity and project managers who are responsible for the day-to-day operational function of the LMNS.

LMNS Board

9.4 The board has membership from senior maternity and neonatal decision makers who work together to collaborate on the direction of the LMNS and service delivery

Maternity Quality Surveillance Group (MQSG)

9.5 The MQSG regularly brings together clinical leaders, clinicians, managers, commissioners, external stakeholders, including MNSI, and service user representatives, to review and oversee quality and safety of services in line with the national Perinatal Quality Surveillance Framework (PQSM). Key data metrics and information are presented and discussed and supports the actions required by the MQSG.

LMNS network meeting

9.6 The network meeting is an entire system sharing and learning network, providing key updates around the service user voice, workstreams and SEL wide projects. Membership includes a wide range of stakeholders from across SEL and regional and national teams.

10. The LMNS Programme

10.1 Considerations when focusing on perinatal inequalities includes the ability to utilise local data and feedback from women and birthing people and inform service delivery. The following information provides an overview of some of the work that is taking place across SEL LMNS in response to these.

LMNS workstreams

10.2 These are working groups delivering on actions appropriate to the wider maternity and neonatal programme including but not exhaustively, public health, optimisation of preterm birth and newborn health and choice and personalisation and inequalities. The workstreams use data and service user feedback, national requirements, and local need, to inform the programmes of work**.**

Smoking

10.3 Smoking in pregnancy significantly increases the chance of miscarriage, stillbirth, fetal abnormalities, fetal growth restriction, bleeding, and preterm birth. Babies born to women and birthing people that smoke are at greater risk of sudden infant death syndrome (SIDS), asthma and common infections and behavioral problems. The SEL rate of smoking at the time of delivery is **4.1%,** significantly lower than the national rate of 8.8%, but because any smoking during pregnancy is associated with poor perinatal outcomes, the maternity units within the LMNS are implementing the Long-Term Plan requirements of an in-house maternity smoking cessation service following the Ottowa Model for Smoking Cessation. This allows for a pathway of care specific to the woman/birthing persons needs and provision of close support from the midwives and healthcare professionals caring for them.
This model has been shown to improve long-term quit rates by 11%.

Weight

10.4 Approximately **40%** of women and birthing people in SEL are either overweight or obese during pregnancy. Being overweight and obese in pregnancy is associated with a greater risk of experiencing high blood pressure, pre-eclampsia, gestational diabetes, thrombosis, induction of labour and caesarean birth. Weight management and diet and nutrition support for women and birthing people during pregnancy is important to prevent excessive weight gain, but providing support during the pre-conception period for those of childbearing age supports planning for a healthy pregnancy. SEL LMNS is working on a preconception programme of work that will provide education, support, and interventions that positively contribute to pregnancy planning including health weight. Any new intervention will be based on best practice guidance, with potential to support any current offer such as the Lewisham Pregnancy Plus programme, and the LEAP CAN programme.

Deprivation

10.5 Evidence shows that those living in deprivation are at greater risk of poorer health, this includes a greater chance of having negative maternity and neonatal outcomes. SEL deprivation data is collected from across the system and enables services to target those women and birthing people living in more deprived areas. A large number of women and birthing people booking for care within the SEL maternity services live in areas of higher deprivation (deciles 1 and 2).

10.6 The maternity continuity of carer model has been shown to reduce inequalities for those at greatest risk and reduce rates of poor maternal and neonatal outcomes.

NHS England is currently piloting an enhanced continuity of carer project across the country. A Kings community midwifery team is taking part. This model will support the recruitment of Band 4 maternity support workers (MSWs) to enhance the current offer within the team and provide holistic support for those living in Deciles 1 and 2.

10.7 Unfortunately, due to current workforce challenges within maternity services, the ability to provide continuity of care across the whole maternity pathway (antenatal, intrapartum, and postnatal) is unattainable at present. There are no current national expectations to deliver maternity continuity of carer for all women and birthing people at present. The SEL LMNS workforce and education workstream in conjunction with the choice and personalisation workstream are working on an action plan to potentially deliver continuity in the antenatal and postnatal periods, this model has also been shown to reduce inequalities and risk.

Medical conditions

10.8 Both nationally and locally more women and birthing people with medical conditions are becoming pregnant. To ensure that they receive the care they require, Maternal Medicine Networks (MMNs) have been established across the country aligning with LMNS footprints. The objective of the MMN is to ensure robust care pathways are in place for those with medical complexities with a focus on inequalities, ensuring they are provided with the right care, by the right people in the right place. SEL MMN is now functional and provides support to Sussex and Kent networks. One of the objectives of the network is to monitor if ethnicity and deprivation are contributory factors for those requiring high dependency or intensive care and those who die. The network has put in place specialist multi-disciplinary pathways and clinics at all five sites. On review of the most recurring conditions affecting women and birthing people in SEL approximately 20% is cardiac, after this endocrine/diabetes and gastrointestinal and hematological. The effects of pregnancy and childbirth on future pregnancies and the life course must be examined when considering women's health and preventative interventions

Perinatal Mental Health

10.9 The rising demand for perinatal mental health care in recent years has triggered the development of offers available to women and birthing people with mental health needs.

10.10 For those with moderate to severe maternal mental health needs (such as bipolar disorder, severe depression, obsessive compulsive disorder etc) or challenges in the developing parent-infant relationship, specialist community perinatal mental health teams are available in every borough (provided by South London and Maudsley NHS FT (SLaM) support populations in Lambeth, Lewisham, and Bexley, and Oxleas, supporting populations in Bexley, Bromley, and Greenwich). These specialist services offer a range of medical, psychological, and social interventions during pregnancy and up to two years postpartum. Both providers also offer pre-conception counselling to women with pre-existing serious mental illness.

10.11 From November 2022 to October 2023, 1500, women, and birthing people across SEL had accessed specialist community mental health services. Data shows that access to services is lower in the boroughs of Bexley, Bromley, and Greenwich at 6% of the population compared to 8% in the boroughs of Lambeth, Southwark,` and Lewisham (SLAM). Data on service access by ethnicity is not always complete, but it appears that the proportion of Black women who make up the SLaM caseload is higher than the proportion of Black women in borough populations, which indicates

that women of Black background are not underrepresented in specialist community services. For example, 33% of those accessing services in Lambeth were of Black ethnicity compared to the census population estimate of 19%. However, access for women of an Asian background appears to be lower in services than the population and may warrant further investigation.

10.12 In 2023 a newly developed service 'Healing Experiences of Loss & Trauma' (Helix) designed to support women and birthing people who experience moderate and complex mental health needs associated with their maternity experience and who would not be suitable for accessing perinatal mental health services. This cohort includes those facing mental health difficulties following birth trauma, perinatal loss, stillbirth, multiple miscarriages, termination, loss due to safeguarding issues, and also severe fear of childbirth (tokophobia). Due to the disproportionate poorer outcomes that Black, Asian and ethnic minority women, the Helix team has focused on how it can best support access to services for these women and has appointed a lived experience engagement lead to support this work programme

10.13 Perinatal mental health teams and Helix form part of a wider pathway of mental health offers available to women and birthing people during pregnancy and the post-partum period. For example, four of South East London's 6 boroughs are in receipt of Family Hub funding to enhance access to more universal perinatal and parental mental health offers.

Breastfeeding

10.14 Breastfeeding initiation rates across SEL range from 84% to 96%. High initiation rates are positive indicators for infant and child health, reducing the risk of infections and diseases, but ongoing support and education is needed to promote longer breastfeeding.

10.15 In conjunction with borough level leads, family hubs, infant feeding specialists and public health colleagues the LMNS has created an infant feeding strategy. The strategy document will form the basis of an action plan which all areas will adopt to provide women, birthing people, and families with consistent, evidence based, and timely support for infant feeding and working to reduce the variation in service provision for issues such as tongue tie and local community breastfeeding support.

Preterm birth

10.16 Preterm birth remains one of biggest causes of neonatal death. SEL LMNS has delivered a programme to reduce and optimize preterm birth for several years. This has included standardising and embedding pan London guidelines, resourcing preterm midwife champions to improve preterm care pathways, and improving in-utero transfers as severely preterm babies have better outcomes if they are birthed in a maternity unit co-aligned with a neonatal intensive care unit. Data collected by the Neonatal Operational Delivery Network (ODN) for SEL shows that in 2023 on average the number of babies born less than 27 weeks gestation (90%) were born in the right place. The rate of preterm birth across SEL is approximately 5.5% of all births of which we have around 21,000.

10.17 All cases of preterm births in the wrong place are reviewed to support learning and service changes as required, with a focus on whether ethnicity or deprivation played a part. This is part of an ongoing programme wide improvement plan.

11. Further LMNS projects in progress

Equality and Equity Action Plan	A LMNS wide five-year plan working to reduce inequalities across the system looking at cultural humility, staff training, improving data collection, access to information in different formats, staff support.
Perinatal Pelvic Health Service	A new service for women and birthing people experiencing pelvic dysfunction due to childbirth, providing education, physiotherapy, and expert clinical assessment to reduce and alleviate issues. SEL data shows that Asian women are more likely to experience significant pelvic health issues, much community engagement has taken place to ensure these women are aware of how to access support as needed.
Personalised Care and Support Plans	LMNS wide PCSPs supporting individualised and person-centered care and a birth choices project providing information, resources, and recommendations for personalised maternity care with the aim to give consistent evidence-based information in response from feedback of service users. Enabling women and birthing people to have open conversations about their needs with their healthcare professionals.
Parent Education in different languages	An LMNS wide pilot to deliver parent education for women and birthing people who do not speak English. Initially this will be delivered in Spanish, Portuguese, Somali, Romanian, Arabic and French.
Maternity Mates	A Southwark and LMNS funded advocacy pilot that will enable local women and birthing people to be trained as a mate and function as an advocate for those who are struggling to access or understand their care options.
Momma's Together	LMNS funded weekly group sessions for Black and Brown mothers in Bexley with input from mental health midwives. The group provides a venue and safe space to meet like-minded mums on all things' motherhood, mental health, family culture and more. The group is now also being rolled out in Greenwich.
Empowering colourful wallets	A colourful wallet designed by FiveXMore and King's maternity. The wallets are offered to Black, Asian and ethnic minority women booked for maternity care across SEL. The wallets are a practical resource and provide empowering and encouraging messages.
Preconception care	The LMNS is leading on a programme to improve preconception care and planning for a healthy pregnancy across SEL, recognising the life course effects that pregnancy and childbirth can have on women later in life, such as risks of cardiac disease after pre-eclampsia

12. Trust projects underway with a particular focus on inequalities

12.1 Maternity and Neonatal providers in SEL have several different initiatives to reduce inequalities relevant to their local populations. Some examples of these can be found below.

Trust	Project	Details
All	Equality Delivery System (EDS) 22	All provider trusts in SEL made the decision to conduct a review of maternity services provision and how individuals with protected characteristics are cared for within the service.
LGT	Cultural Humility	The Quality Standard for Cultural Humility was developed by Lewisham MVP in conjunction with LGT and the CCG. The Quality standard has been designed to function as guidance for professionals and aims to support staff through training to understand and respect diverse cultural backgrounds and increase the involvement of Black, Asian and ethnic minority service users in quality assurance of the maternity services.
	Pride in Practice	Lewisham maternity services were awarded Gold honors, the first maternity service in the country. Pride in Practice is a national quality assurance training programme that strengthens and develops healthcare providers relationships with the LGBTQIA+ service users.
	NHS charging	Data from 2019 showed that 6.9% of the LGT maternity population were not entitled to free NHS care. Collaborating closely with the migrant and refugee network the trust listened to the experience of the people in this cohort and as a result have written a compassionate charging policy which voids bills for all pregnancy losses and adverse outcomes such as brain injury and neonatal deaths.
GSTT	ARIA maternity group	The maternity Anti-Racism Implementation Advisory group leads on several initiatives within the trust to improve the experience of service users from Black, Asian, and ethnic minority backgrounds. Examples of their work includes the development and delivery of training for maternity staff on anti-racism and bias in maternity care.
King's	Enhanced continuity of carer pilot	Sapphire team- project to recruit band 4 Maternity Support workers to enhance current ream working and provide holistic care for those living in areas of high deprivation.
	Co-production and QI projects to reduce inequalities	EDI Welcome posters EDI sessions for staff BRAINS – choices support resource LGBTQ+ and parents WhatsApp group

13. Co-production with service users

Maternity and Neonatal Voices Partnerships

13.1 Maternity and Neonatal Voices Partnerships are a partnership between service user representatives, including a user representative chair, commissioners and maternity and neonatal providers working together to develop and improve services. There is a MNVP in each borough linked in to the local provider trust(s) and they work on local initiatives as a direct result from service user feedback. Some examples of their inequalities work are listed below.

King's and PRUH	Regular Walk the Patch and '15 steps' reviews are performed throughout the year. These provide feedback to the provider services on the experience of service users and provide recommendations for change.
	Local engagement sessions with Black and Brown women on the experience of the services
	High BMI and gestational diabetes projects to increase knowledge and education and cultural needs.
	Induction of labour focus group
Lewisham	Infographic for Black, Asian and ethnic minority women and birthing people providing information about their increased risks around childbirth.
	Jolly Trolley – MVP members walking round the maternity unit with mocktails and armed with information about Lewisham services that promote good mental health and prevent loneliness and isolation

14. Community Engagement Project

14.1 Five community organisations commissioned by the LMNS to engage with underrepresented women and birthing people about their experience of accessing maternity services.

14.2 The communities engaged with include migrant and asylum seekers, Black, Asian, and ethnic minorities, LGBTQ+, those that have experienced a pregnancy/neonatal loss.

14.3 Various approaches have taken place from focus groups to the employment of peer researchers. Reports and recommendations are starting to be shared and will be incorporated into the LMNS equality and equity action plan.

15. ICB Maternity and Neonatal Engagement hub

15.1 Part of the Let's talk Health and Care in South East London online community. The hub will enable the LMNS to involve service users and those with lived experience to engage in various projects and transformation programmes at a system wide level.

16. What women and birthing people say.

16.1 Collaborating with women and birthing people to gain a better understanding of their needs and utilise their feedback and insights to deliver service improvements is a priority for the LMNS. The LMNS has built links and relationships through MNVPs, local community groups and through the maternity and neonatal services. When planning a service change or improvement co-production is at the heart of what we do. More recent feedback which will feed into our future plans, has highlighted that we need to do more preconception education, improve postnatal care, and recognise the cultural expectations and needs.

17. Next steps

17.1 Across SEL boroughs and maternity and neonatal providers, there is commonality in the inequalities that some women and birthing people face. The LMNS works as a system with shared challenges and a common goal, to improve services for women and birthing people, especially those that experience or are at risk of the worst outcomes. We recognise the need for wider collaboration across the ICS and ask the board to support more joined up working with primary care and local authority colleagues.

17.2 We ask the board to support the LMNS by improving the collection and analysis of local data to better inform our work.

17.3 In 2024 the LMNS will publish a revised Equality and Equity action plan which will build on existing efforts and incorporate and initiate the changes essential to reduce inequalities.

17.4 We ask the board to support the appropriate resourcing for Maternity and Neonatal Voices Partnerships to enable them to function as service user experts, central to and reflective of the communities we care for.

17.5 We also ask the board to consider how we can sustainably resource VSCE organisations as trusted institutions, to deliver support in the maternity and newborn space.