NHS HWE ICB Board meeting held in Public

Friday 24 May 2024

Conference Room 2

The Forum

Hemel Hempstead

HP1 1DN

Meeting Book - HWE ICB Board meeting held in Public

Agenda

	Part One - ICB Business		
11:30	**1. Welcome and apologies**		Chair
	2. Declarations of Interest		Chair
11:35	**3. Minutes of last meeting held on 22 March 2024 and 26 April 2024**	Approval	Chair
	4. Action Tracker - No open actions		Chair
11:40	**5. Chair's update report**	Information	Chair
11:50	**6. Chief Executive Officer's Report**	Information	Jane Halpin
12:00	**7. Governance Report**	Information	Michael Watson
12:10	**8. Integrated reports for finance, workforce, quality and performance**	Assurance	ICB Executive Team
	Lunch break 12:30 - 13:00		
	Exception reports		
13:00	**9. Quality Report**		Natalie Hammond
	10. Performance Report		Frances Shattock
	11. Finance Report		Alan Pond
	12. ICB Committee summary reports		Committee Chair's
	Part Two - System, Leadership and Strategy		
13:05	**13. Medium Term Plan**	Approval	Michael Watson
13:30	**14. Deep Dive: Frailty**	Discuss/Assurance	Sharn Elton / Rachel Joyce
	Closing Items		
14:20	**15. Question from the Patient Engagement Forum and members of the public**	Assurance	ICB Executive Team
14:30	**16. What would services users, patients, carers and staff take away from our discussions today?**		All

14:35	**Close of meeting**	Chair
	Date of next meeting: Friday 26 July 2024	

Herts & West Essex Strategic Framework- 2022-2027

Our mission

Better, healthier and longer lives for all

We will achieve this by

- **Improving physical and mental health across our population**
- **Tackling unequal access, experience and outcomes**
- **Enhancing productivity and value for money**
- **Ensuring the NHS supports broader social and economic development.**

In the first 3-5 years we will

- Increase healthy life expectancy, and reduce inequality
- Give every child the best start in life
- Improve access to health and care services
- Increase the numbers of citizens taking steps to improve their wellbeing
- Achieve a balanced financial position annually

The ICB will deliver this by:

- Setting direction for the NHS in Hertfordshire and West Essex
- Allocating NHS resources fairly and effectively
- Supporting, equipping, and empowering our people
- Working with and pooling resources with our partners
- Enabling improvement and driving change, with a focus on quality
- Using data and evidence to generate insight and assess impact

Hertfordshire and West Essex Integrated Care System

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	NHS HWE ICB Board meeting held in Public		**Meeting Date:**	**24/05/2024**
Report Title:	**Board Declarations of Interest**		**Agenda Item:**	**02**
Report Author(s):	Gay Alford, IG and Governance Officer			
Report Presented by:	Iram Khan, Corporate Governance Manager, Board & Committees			
Purpose:	**Approval / Decision** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☒
Which Strategic Objectives are relevant to this report:	▪ Relevance to all five ICB Strategic Objectives			
Key questions for the ICB Board / Committee:	▪ Please see the 'Recommendations' section			
Report History:	▪ The full ICB Declarations of Interest Register is routinely reported to the Audit & Risk Committee in line with the Committee Workplan and Terms of Reference			
Executive Summary:	▪ The ICB is required to publish declaration of interests of the Board, this is in line with statutory guidance and the ICB's Standards of Business Conduct (Conflicts of Interest) Policy. ▪ At the point of drafting this report, all Board member/regular attendees have returned their declarations for the 2023/24 financial year.			
Recommendations:	The Board is asked to: ▪ Note the returned declarations and whether these reflect the current membership/regular attendees for this Committee, ▪ Review any potential conflicts of interest that need to be managed at the meeting in accordance with the agenda, ▪ Remind members and regular attendees that - whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests (e.g., where an individual takes on a new role outside the ICB or enters into a new business or relationship), a further declaration should be made to reflect the change in circumstances as soon as possible, and in any event within 28 days. The revised declaration will countersigned by their			

	Line Manager or lead, and then forwarded to hweicbwe.coi@nhs.net for logging.			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A			
Implications / Impact:				
Patient Safety:	N/A			
Risk:	N/A			
Financial Implications:	N/A			
Impact Assessments:	***Equality Impact Assessment:***		N/A	
	Quality Impact Assessment:		N/A	
	Data Protection Impact Assessment:		N/A	

Hertfordshire and West Essex Integrated Care System

Herts and West Essex ICB Register of Interests

Name:		Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Type of Interest					Date of Interest		Action taken to mitigate risk
Surname	Forename			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct interest	Indirect interest	From	To	
Bailey	Ruth	Non-Executive Member, NHS HWE ICB Deputy Chair. NHS HWE ICB	Expert advisor to Boston Consulting Group in the Middle East on a public sector project that is not healthcare related.	√					2021	Ended 2022	Verbal declaration to be made at the beginning of any meeting when relevant and appropriate
			Associate HR Consultant for 3XO. Not engaged on any healthcare related projects.	√					2022	Ended 2022	
			Husband is a Director in UK Health Protection Agency.					√	2016	Current	
			Executive Director of People and Organisational Effectiveness for the Nursing and Midwifery Council (job share)	√					2022	Current	
			Non-Executive member of South West London ICB.		√				2022	Current	
Burstow	Rt. Hon. Paul	Non-Executive Member, NHS HWE ICB Chair NHS HWE ICB	I am chair of the trading charity, the Social Care Institute for Excellence. The charity undertakes consultancy and improvement support in social care and beyond	-		-	-		2017	Present	I play no part in the charity's tendering processes nor do I play a role in selecting contractors within the ICS. Should a discussion or paper relate to this provider, I will declare an interest either in advance of the meeting or at the point a direct or perceived conflict is identified.
			I am chair of the trading charity, St Andrew's Healthcare. The charity provides a range of secure mental health services, primarily in the Midlands, and several community-based specialist services	-		-	-		Oct-20	Present	I play no part in the charity's tendering processes nor do I play a role in selecting contractors within the ICS. Should a discussion or paper relate to this provider, I will declare an interest either in advance of the meeting or at the point a direct or perceived conflict is identified.
			I am the chair of the CIC, Technology Enabled Care Services Association. The CIC mission is the product agnostic and non-proprietorial promotion of TEC and the setting and auditing of industry standards. The CIC also offers consultancy services to local government, housing associations, NHS etc	-		-	-		2018	Present	I play no part in the CIC's tendering processes nor do I play a role in selecting contractors within the ICS. Should a discussion or paper relate to this provider, I will declare an interest either in advance of the meeting or at the point a direct or perceived conflict is identified.

			I am the chair of Tavistock and Portman NHS FT. The Trust runs a number of specialist services including some national services.	-		-	-		2015	2022 Ended	
			I am the Managing Director of Indy Associates Limited. The company is jointly owned by myself and my wife and undertakes a limited amount of consultancy, advisory and public policy work including acting as an adviser to MHP Communications working with clients in the charity and life sciences sectors.	-		-	-		2015	Present	The company does not tender for work from NHS organisations. If any NHS organisation within the ICS were to engage the MHP Communications, I would declare the interest and would take no part in the delivery of the work. Should a discussion or paper relate to this provider, I will declare an interest either in advance of the meeting or at the point a direct or perceived conflict is identified.
			I was a Trustee, Action on Smoking and Health. The charity is a research, public policy and advocacy organisations. I stepped down in September 2020.						2015	Sep-20 Ended	N/A
Coles	Toni	Place Director - West Essex	Nil	-	-	-	-	-	-	-	-
Disney	Elizabeth	Director of Operations, HWE ICB	Sister is employed by the ICB on a fixed term basis within the ICB Medical Directorate	-	-	-	-	√	Jan-23	Feb-24	No involvement in recruitment process or decision to employ
Dugmore	Catherine	Non -Executive Member, NHS HWE ICB	Cambridgeshire Community Services NHS Trust, Non Executive Director	√					Apr-22	Present	Declare as required.
			Hertfordshire Partnership Foundation NHS Trust, Non Executive Director	√					Aug-16	Ended Jul - 2022	
			Natural England, Board Member	√					Mar-18	Present	
			Housing 21, Board Member	√					Sep-21	Present	
			WWF-UK, Trustee			√			2017	Present	
			School Governor			√				Present	
Elton	Sharn	ENH Place Based Director	Parish Councillor, Sutton Parish Council, Central Bedfordshire	-	-	√	-	-	May-23	Mar-27	-

Flowers	Beverley	Director of Strategy , HWE ICB Deputy CEO	Non remunerated Director role with Herts at Home Ltd a company established and fully owned by Hertfordshire County Council to provide care and support within the County. Herts at Home Ltd. Company number 11360947. Registered office address County Hall, Pegs Lane, Hertford, United Kingdom, SG13 8DE.)	-	√	-	-	√	01/01/2019	Ongoing	Declare at meetings where relevant. Exclude self from decision making process in meetings if necessary.
Halpin	Jane	Chief Executive Officer, NHS HWE ICB	Son works in admin support for the ICB via an external agency	-	-	-	-	√	Sep-22	Ended 01/01/2023	-
			Son works in admin support to the ICB CHC team 9th Jan 2023					√	09.01.2023	Ended 22.06.2023	
Hammond	Natalie	Director of Nursing & Quality, HWE ICB	Husband - company - Aqua Kare, leak detection.	√						Ongoing	Does not commission/tender for work.
Howard -Jones	Elliott	Partner Member - Community Provider Representative	Role of CEO at Hertfordshire Community NHS Trust	√	√	-	-	-	-	Present	I recuse myself from making any decisions that may cause a conflict.
Joyce	Rachel (Dr)	Medical Director	Married to an NHS consultant who works for East and North Herts Trust.	-	-	-	-	√	Jun-01	On-going	To be logged on ICB DoI registers and declared if relevant in meetings/ work
			Director for Ranine Ltd - a company that provides private medical services by one consultant (spouse as above) to local independent hospitals. From 1st April 2022, I resigned my role as Director and now act as secretary who also holds shares in the company. The company does not however provide, or intend to provide, services to the NHS, social care, or NHS patients.	√	-	-	-	-	2018	Ongoing	
Khan	Iram	Corporate Governance Manager - Board & Committees	Nil	-	-	-	-	-	-	-	-
Lavington	Adam	Director of Digital Transformation	Nil	-	-	-	-	-	-	-	-
Mapley	Owen	Partner Member	As Chief Executive of Hertfordshire County Council, decisions made by the ICB are likely to have a direct impact on the operational and financial management of health and care services provided by the County Council.			√			01/07/2022	Ongoing	Remain alert to specific potential conflicts and flag ahead of decision making to ICB Chair.
Marcus	Tania	Chief People Office	NIL								
Marovitch	Joanna	Partner Member - Voluntary Community Faith and Social Enterpirse (VCSFE) Alliance	CEO of Hertfordshire Mind Network	√					2021	Current	Verbal declaration to be made at the beginning of any meeting
			Chair of VCFSE Board			√			2022	Current	Verbal declaration to be made at the beginning of any meeting
McCarthy	Lance	Partner Member, NHS and Foundation Trusts - Acute	CEO of PAHT - provider in the system	√					May-17	Current	Verbal declaration to be made at the beginning of any meeting as appropriate
			Member of NHS Employers Policy Board		√				Jan-23	Current	Verbal declaration to be made at the beginning of any meeting as appropriate
Moberly	Nick	Non-Executive Member HWE ICB	CEO MS Society UK	√					Jan-19	Present	
			Non-Executive Director, NHS Property Services	√					May-21	Present	
			Adviser/Acting Chair, Dr Mortons Ltd						Jan-21	Present	
			Trustee - Christian Aid							Present	

Moodley	Pragasen	Partner Member for the ICB - Primary Medical services	Partner at Stanmore Medical Group 5 Stanmore Road, Stevenage, SG1 3QA	√	-	-	√	-	2004	Continuing	Verbal declarations to be made at the beginning of any meeting
			Director of AVM Medical. Suite 3 Middlesex House, Rutherford Close, Stevenage, Hertfordshire, United Kingdom, SG1 2EF. Company number 10507387 I use this company to carry out private medicals and nursing home ward rounds	√	-	-	√	-	2012	Continuing	
			Co-clinical director North Stevenage PCN	√	-	-	√	-			
			Partner at Larksfield Medical Practice	√	-	-	√	-	2019	Continuing	
			Partner, Dr A Saha, is a partner at King George Medical Practice	-	-	√	-	√	2016	Continuing	
Perry	Dr Ian	Partner Member, Primary Medical Services	GP Partner in Maynard Court Surgery	√	-	-		-	2013	To date	Verbal declaration to be made at the beginning of any meeting
			Epping Forest North PCN GP Partner	√					2019	To date	
			Stellar Healthcare Shareholder		-	-		-	2014	To date	
Pond	Alan	Chief Finance Officer, HWE ICB	I am the public sector appointed Director of Assemble Community Partnership Ltd (Company Number 06471276) and associated companies Assemble Fundco 2 Ltd (Company Number 08309498) Assemble Holdco 2 Ltd (Company Number 08309495) Wolverton Holdings (Company Number 08307564) Wolverton Fundco 1 Ltd (Company Number 08306830 Assemble Fundco 1 Ltd (Company Number 06471659) Assemble Holdco 1 Ltd (Company Number 06471233) Assemble (MKHQ) HoldCo Ltd (Company Number 06710941) Assemble (MKHQ) Ltd (Company Number 06711023) All of 128 Buckingham Palace Road, London, SW1W 9SA.			√			Jul-08	Current	My role on the Board of the LIFT Company Group is to represent the interests of the local public sector, provide insight, but also to oversee the financial and governance arrangements of the companies. The Group of Companies was created to provide benefits to the NHS locally and a conflict is highly unlikely to occur. Should any conflict of interest arise, I would excuse myself from both parties for the relevant matter and should an ongoing conflict arise I would resign my director position with the Group of Companies.
			My Partner (Dr Corina Ciobanu) is a GP Partner of a Practice associated with HWE ICB (at Haverfield Surgery, Kings Langley) and is engaged as a clinical lead by the HWE ICB.	-	-	-	-	√	Aug-10	Current	On matters relating to primary care generally, I would always declare my relationship to Dr Ciobanu so anyone could question me on my motives. For matters relating specifically to Haverfield Surgery only, I will excuse myself from any discussion and take no part in any decision making. I will keep confidential any information I receive that could be of benefit to Haverfield Surgery and/or Corina Ciobanu.

Randhawa	Professor Gurch	Non Executive member, NHS HWE ICB	Professor of Diversity in Public Health & Director. Institute for Health Research University of Bedfordshire. Honorary Academic Contract, UK Health Security Honorary Academic Contract, Office for Health Improvement & Disparities Expert Expert Advisor, NICE Centre for Guidelines, UK Facilitator, faculty of Public Health accredited Practioner Program, UK Faculty of Public Health Non-Executive Director, Forestry England. Adjunct Professor, Ton Due Thang University, Vietnam, Trustee, Race Equality Foundation, UK National Member, National Black and Minority Ethnic Transplant Alliance, UK Member, British Medical Association Ethics Committee, UK Deputy Lieutenant, Bedfordshire Patron of the Bedfordshire Rural Communities Charity Ambassador, Keech Hospice Care Volunteer, Luton Sikh Soup Kitchen Junior Cricket Coach, Harpenden Cricket club							Current	To be declared as appropriate.
			Patient, Davenport House surgery, Harpenden							Current	To be declared as appropriate.
			Extended family member employed by Harpenden Health PCN							Current	To be declared as appropriate.
Shah	Avni	Director of Primary Care HWE ICS	Spouse works for a Pharmaceutical Industry – Scope, who distribute a number of eye products across the UK.					√	Nov-20	Current	As Director of Primary Care I am not directly involved in the local decision making process of new drugs hence managing conflict
			Spouse provides supervision and support via CPPE to foundation year community pharmacist who required support. This is commissioned through HEE and covered London and South East Area					√	Apr-23	Current	This is commissioned directly from HEE to CPPE hence NO involvement in commissioning and contracting of this
Shattock	Frances	Director of Performance	Nil	-	-	-	-	-	-	-	-
Small	Dr Nicolas	Partner Member Primary Medical Services	Partner Schopwick Surgery Elstree. Provider of GMS Services	√	-	-	√	-	1996	Ended 30.09.2023	To be declared as appropriate
			Schopwick Surgery is part of the Herts Five Primary Care Network (PCN)	√						Ended 30.09.2023	
			Practice has shares in GP provider Federation Herts Health & Herts One providing extended GP and community services across south & west Hertfordshire	√	-	-	√	-	2008	Ended 30.09.2023	
			Schopwick Surgery provides extended GP services to Sunrise Assisted Living, Elstree & Kestrel GroveNursing Home, Bushey	√					1997	Ended 30.09.2023	
			GP Trainer Schopwick Surgery for North Hertfordshire GP Vocational Training Scheme & Northwick Park Hospital VTS	-	√		-		2007	Ended 30.09.2023	
			Siblings hold NHS primary and dental care contracts as providers of GP and dental services	-	-		-	√	2001	Present	
			Sibling - associate medical director primary care services, NW London ICS.		-	-		√	2022	Present	
			Patient , Surgery Berkhamsted	-	-	√	-	-	2018	Current	
			Patient, RNOH Stanmore			√			2005		
			Patient, Stoke Mandeville Hospital			√			2010		

Stober	Thelma	Non-Executive Member, NHS HWE ICB	Employee of Local Government Association	√	-	-	-	-	2013	Current	HWE Conflict of interest Policy . NHS England » Managing conflicts of interest in the NHS and Best practice in corporate governance
			Trustee of London Emergencies Trust						2016	Current	
			Trustee of the National Emergencies Trust						2020	Current	
			Non-Executive Director, Peabody Trust Board committee						2021	Current	
			Deputy Lieutenant Greater London						2022	Current	
Surgenor	Simone	Deputy Chief of Staff - Governance & Policies	Director of Select Project Management Ltd	√	-	-	-		2011	Ongoing	Family company. No contracts held in the health and care sector
			Dependant with Type 1 Diabetes	-	-	-	-	√	2019	Ongoing	Declaration made in meetings where papers or discussions relate to this condition..
Taylor	Karen	Mental Health Trust partner member (Hertfordshire Partnership Foundation Trust)	Chief Executive and employee of HPFT	√					Dec-21	Current	Declare interest
			Board Trustee - NHS Providers		√				Jul-23	Current until Jul-26	Declare interest
			Chair of Hertfordshire - MH & LD Autism Health & Care Partnership		√				Dec-21	Current	Declare interest
Turnock	Philip	Managing Director of HBL ICT Shared Services	Nil	-	-	-	-	-	-	-	-

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DRAFT MINUTES

Meeting:	**NHS Herts and West Essex Integrated Care Board** **Board meeting held in Public**			
	Meeting in public	☒	*Meeting in private (confidential)*	☐
Date:	**Friday 22 March 2024**			
Time:	**11:30 – 15:00**			
Venue:	**Latton Bush Conference Centre, Harlow and remotely via MS Teams**			

MINUTES

Name	Title	Organisation
Members present:		
Paul Burstow (PB)	ICB Chair	Herts and West Essex ICB
Catherine Dugmore (CD)	Non-Executive Member	Herts and West Essex ICB
Natalie Hammond (NH)	Director of Nursing and Quality	Herts and West Essex ICB
Jane Halpin (JH)	Chief Executive Officer	Herts and West Essex ICB
Elliot Howard-Jones (EHJ)	Partner Member (NHS Community Trust)	Herts and West Essex ICB
Rachel Joyce (RJ)	Medical director	Herts and West Essex ICB
Lance McCarthy (LM)	Partner Member (NHS Acute Trust)	Herts and West Essex ICB
Nick Moberly (NM)	Non-executive Member	Herts and West Essex ICB
Prag Moodley (PM)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Ian Perry (IP)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Alan Pond (AP)	Chief Finance Officer	Herts and West Essex ICB
Nicolas Small (NS)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Thelma Stober (TS)	Non-Executive Member	Herts and West Essex ICB
In attendance:		
Toni Coles (TC)	Place Director, West Essex	Herts and West Essex ICB
David Evans (DE) Deputising for Karen Taylor	Chief Strategy Officer	Hertfordshire Partnership Foundation Trust
Elizabeth Disney (ED)	Director of Operations	Herts and West Essex ICB
Beverly Flowers (BF)	Director of Strategy	Herts and West Essex ICB

Iram Khan (IK)	Corporate Governance Manager Board and Committees	Herts and West Essex ICB
Tania Marcus (TM)	Director of Workforce	Herts and West Essex ICB
Chris Martin (CM) Deputising for Lucy Wightman	Director of Strategic Commissioning & Policy	Essex County Council
Sarah Perman (SP) Deputising for Owen Mapley	Director of Public Health	Hertfordshire County Council
Avni Shah (AS)	Director of Primary Care Transformation	Herts and West Essex ICB
Frances Shattock (FS)	Director of Performance	Herts and West Essex ICB
Simone Surgenor (SS)	Deputy Chief of Staff Governance and Policies	Herts and West Essex ICB
Michael Watson (MW)	Chief of Staff	Herts and West Essex ICB
Tracey Norris (TN)	Meeting Clerk	HFL Education
Via Microsoft Teams:		
Gurch Randhawa (GR)	Non-Executive Member	Herts and West Essex ICB
Matt Webb (Mwe)	Place Director, South West Herts	Herts and West Essex ICB

ICB/19/24	**Welcome, apologies and housekeeping**
19.1	The Chair welcomed all to the meeting. He confirmed that this was not a public meeting but a meeting being held in public (members of the public were welcome to attend to observe the meeting).
19.2	Apologies for absence had been received from: Members: • Ruth Bailey • Owen Mapley (represented by Sarah Perman) • Karen Taylor (represented by David Evans) • Lucy Whitman (represented by Chris Martin) Members joining on Teams were: • Gurch Randhawa Attendees: • Sharn Elton • Matt Webb (joined virtually)
ICB/20/24	**Declarations of interest**
20.1	The Chair invited members to update any declarations relating to matters on the agenda and reminded them of their responsibility to update their declarations: • For item 13: Green Plan: Catherine Dugmore: Board member of Natural England. All members declarations were accurate and up to date with the register available on the website: Declaration of interests – Hertfordshire and West Essex NHS ICB
ICB/21/24	**Minutes of the previous meeting**
21.1	**The minutes of the previous meeting held on Friday 26 January 2024 were approved as an accurate record.**
ICB/22/25	**Action Tracker**
22.1	There were no outstanding actions.
22.2	**The Board noted the updates to the action tracker.**
ICB/23/24	**Chair's update report**
23.1	The Chair's update (pages 18-22 of the document pack) was noted.
23.2	Questions and comments were invited: • Feedback on the equality objectives would be shared with all board members via email and the wording would be finalised by the end of March. • Condolences were offered to the family, friends and colleagues of Steve Palmer, the former chair of Health Watch Hertfordshire who had sadly passed away.
23.3	**The Board noted the Chair's update**
ICB/24/24	**Chief Executive Officer's report**
24.1	Jane Halpin (JH) referred to her report (see pages 23-46 of the document pack) drawing the board's attention to the following: • Since the report had been written, staff survey results had been collated. Feedback in the main was positive and it was particularly encouraging to see the upward trajectory of staff engagement at PAH.
24.2	There were no questions arising.
24.3	**The Board noted the CEO's report**

ICB/25/24	Governance Report
25.1	Michael Watson referred to the report (see pages 47-58 of the document pack) and presented each item: Governance Review: update • Changes to the governance operating model would be rolled out in a phased approach from March as agreed at the February Board Day. Terms of reference were being aligned to the HCP. • It might be necessary to move the April Board Day to a public meeting of the board to approve the finalised terms of reference and the ICB's approach to the HCPs. • Non-executive directors would have input into the re-drafting of the terms of reference in the coming weeks
25.2	Constitutional amendment proposal: to increase the Board membership by two.
25.3	**The Board approved the proposal to increase the board membership by two.**
25.4	Remote approval to re-distribute funds. A request was made for the redistribution of funds under the provisions for urgent decisions set out under SO 4.9.5 on 4 March 2024; this had been approved by email by eleven board members.
25.5	**The Board noted the remote approval on 4 March 2024 for the redistribution of funds**
25.6	Amendment to the scheme of reservation and delegation in relation to the deputy CEO.
25.7	**The Board approved the amendment to the scheme of reservation and delegation in relation to the deputy CEO.**
25.8	Updates to the Governance Handbook: these related to general practice name changes following mergers which would come into effect on 1 April 2024.
25.9	**The Board approved the updates to the Governance Handbook**
25.10	Board Assurance Framework • The executive team were comfortable with the level of assurance provided by the framework. • Work would continue to ensure risks were accurately recorded and scoring was correct and consistent. Some scores were still too pessimistic and did not reflect HWE's strong performance in certain areas compared to other ICBs.
25.11	**The Board discussed and noted the Board Assurance Framework**
ICB/26/24	**Integrated report for finance, performance, quality and workforce**
26.1	The chair introduced this agenda item (see pages 59-78 of the document pack) and invited each of the area leads to present their highlight report before opening for questions.
26.2	**Finance overview:** Alan Pond (AP) summarised the financial position: • Financial balance would be achieved by year end (31 March 2024) across the system. • The level of elective activity had increased, and all members had worked hard to effect efficiencies. • The previously reported risks around capital and financial reporting standards had now decreased as NSHE had confirmed that funds would be made available to cover these. • There might be a capital underspend against national capital programmes, but the ICB had met all its 2023/24 requirements. • 2024/25 financial position: achieving financial balance in the coming year would be more challenging: a draft budget had been submitted to NHSE and AP was awaiting a response. A continued upward trajectory in elective work had been planned and performance standards would be met but this would not be achieved within the current financial envelope. • The financial gap was estimated at 2.5% • It was possible that the ICB would start the new financial year without a balanced plan in place.

26.3	**Performance overview:** Frances Shattock (FS) provided the following update: • Urgent care: performance against the 4hr standard had improved to 67.8% in January against an 16% growth in attendance. • The level of elective activity has increased and waiting lists have fallen by 10,000 since August 2023. • Cancer: 28-day faster diagnosis achieved 75% for the first time and the 31-day cancer performance achieved the 96.4% national standard. • Waiting time for children/young people in community/mental health services remained high –see summary of children's metrics on page 34 and 67.
26.4	**Workforce overview:** Tania Marcus (TM) provided the following update: • A reduction in workforce in the coming 12 months (as per the workforce operational plan) was planned. • Targeted reductions in agency usage have been identified. • The use of establishment reviews and skill mix reviews were crucial to the successful identification of the most efficient staffing structures. • The focus on domestic recruitment would continue. • The new diagnostic productivity tool would continue to be developed. It was not yet available/suitable for community providers or Primary Care.
26.5	**Quality overview;** Natalie Hammond (NH) provided the following update: • *c-diff* – no identified outbreaks had been reported although rates remained above ceiling points. • Watching brief - measles: contact tracing had been initiated and an action plan was in place. A push for immunisations rates was underway and comms had been shared with primary care. • Ophthalmology: Improvement work continues across the system. Learnings from "Getting it right first time" visit to PAHT had been shared with the wider system. • Audiology: improvement had been made at ENHT in pathway and recruitment. Mutual aid for urgent patients remained in place.
26.6	Questions and comments were invited: • How would the reduction in bank staff be managed? Bank workforce would not be eliminated completely, all providers benefited from the ability to flex its workforce at certain times. • A working party was meeting monthly to review bank and agency staffing rates. Each service deployed a different mix of solutions (fixed term contracts as well as temporary roles). Any areas of best practice were shared across the system eg WHT nursing skills mix analysis. • The system wide approach to measles was celebrated. Strategies to improve MMR vaccination rates were being implemented in primary care, but this was having with little impact in some cohorts who had fixed views on vaccinations. • Children SEND: Following the HCC SEND inspection report and action plan, additional clinic space had been created in December and January.
26.7	**The Board noted the integrated reports for finance, workforce, quality and performance**
ICB/27/24	**Quality Escalation Report**
27.1	See pages 79-103 of the document pack
27.2	**The Board noted the Quality Report**
ICB/28/24	**Performance Report**
28.1	See pages 104-158 of the document pack.
28.3	**The Board noted the Performance Report**
ICB/29/24	**ICB Finance Report**

29.1	See pages 159-181 of the document pack.
29.2	**The Board noted the ICB Finance Report**
ICB/30/24	**Committee Summary Reports**
30.1	See pages 182-207 of the document pack.
30.2	**The Board noted the Committee Summary Reports**
ICB/31/24	**Green Plan: progress and future road map**
31.1	Mark Spriggs (MS) presented this agenda item (see pages 208-214 of the document pack) drawing the Boards attention to: • Significant progress had been made across the service. • The ICS working group was meeting with regional colleagues bi-monthly to challenge and support green targets. • The target to achieve 80% of net zero emissions by 2032 would be challenging. • The refreshed road map would be completed by March 2025 and the golden thread of sustainability and net zero would be woven into all areas, for example, the estates infrastructure strategy, the travel and transport strategy. • The ICS was required to report to the Environment Agency on any breaches of the notional cap on energy usage. • There was a balance between the costs of achieving net zero vs the long-term health and environmental benefits and MS welcomed board input on this.
31.2	Questions and comments were invited: • No additional funding would be made available from NHSE to support net zero projects. • The ICB would face some difficult choices in the coming months and years: how much could it afford to invest in the green agenda without putting too much pressure on current services. • The cost of achieving 80% net zero had not yet been calculated. Planned redevelopments at Watford and for PAHT would come under the national "New Hospitals Programme", which should result in significant reduction in energy usage. The Finance Committee would have oversight of this area of work. • The impact on health and wellbeing and prevention from improvements in the natural environment was highlighted. • The ICB had a moral and legal obligation to embrace the green agenda and the existing interdependences and relationships within HWE were raised and should be developed. • Transformation plans across the whole of the ICS should achieve positive environmental impact and metrics from the joint forward plan should be included in the Green Plan. • Sustainability leads across the system were working collaboratively and sharing best practice, for example, EPUT's carbon footprint reductions in the last four years. • The Green agenda could be a powerful tool for workforce engagement and staff retention.
31.3	**The Board noted the Green Plan and approved the road map to 2025**
ICB/32/24	**HWE Joint Forward Plan: Refresh Update**
32.1	Beverley Flowers (BF) and Stephen Madden presented this agenda item (see pages 215-258 of the document pack) drawing the Board's attention to: • This was a rolling five-year plan which was refreshed each year. • It outlined the integrated care strategy of health care providers within HWE covering the two main areas of statutory commitments and care plans, as well as the evolution of health care partnerships. • A short summary document would be created to share with patients.
32.2	Questions and comments were invited:

	• The plan provided clear assurance of compliance with regional and national expectations. Progress to date was noted and celebrated. • Work will take place over the coming months to ensure that all strategies and plans fit within a common narrative under the Medium Term Plan.
32.3	**The Board approved the Joint Forward Plan**
ICB/33/24	**HWE ICS Urgent and Emergency Care Strategy**

33.1	Elizabeth Disney (ED) presented this agenda item (see pages 259-324 of the document pack) drawing the Board's attention to:
	• Previous iterations of the strategy had been shared with the Board, this had now been finalised and the five-year plan was presented for approval (2024-29).
	• The strategy reflected 18 months of system-wide input based on analysis of HWE population and health needs and focused on three main areas:
	  ○ System coordination
	  ○ Performance improvement
	  ○ Transformation and change
	• The strategy was flexible enough to respond to any changes in national priorities.

33.2	Questions and comments were invited: • Board members welcomed the strategy. • Transformation work had been ongoing whilst the strategy had been drafted – see table 3 – and the benefits of having the right response in place were clear to see – reduction in inappropriate treatment pathways. • Communication to patients (the enabling section) would be developed in 2024/25 - it would take time to educate the population about where the right response should lie. • A quarterly meeting would be held to assess the integrity of the strategy and track progress of implementation. A clear governance structure was in place. • The five-year plan included different priorities and initiatives which were being rolled out on different time horizons. • Board members encouraged proactive comms in relevant journals on the improvements already sustained.
33.3	**The Board approved the Urgent and Emergency Care Strategy**
PCB/34/24	**Deep Dive: Review of Winter and Innovations in Demand Management**
34.1	Elizabeth Disney (ED) was joined by Jo Burlingham (JB), Glenn Young (GY) and colleagues from EEAST, to present this deep dive (see presentation at pages 325-343 of the document pack): • All strategies were focused on the reduction in waiting times in A&E and the de-crowding of emergency departments. The use of data to influence decisions was key. • The Winter Implementation Group (WIG) held fortnightly meetings to ensure a shared understanding of system risk and the OPEL framework. • The stack system was explained, and a summary shared of the impact of the transformation programmes underway (eg AP impact and UCCH creation). • There had been a reduction in the number of C3-C5 conveyances to emergency care since the creation of the UCCH as well as an increase in acceptance rates. • Action cards have reduced pinch points. • EEAST staff shared their experiences working in the front line. • Finding workable solutions to enable patients to receive treatment in the community or at home was rewarding. • The UCCH team was growing in confidence and had built up good relationships and networks with colleagues across the ICS. • There were still areas for improvement and contact with some GPs during the day and particularly out of hours was not always easy. • The handover delays at A&E had lessened and crews were completing 3 or 4 jobs per shift rather than only one (as on the worst days of winter).

34.2	Questions and comments were invited: • Identification of end of life and discussions of advance care plans was essential to help all professionals make the best decision for patients. • The Board agreed that where possible Frailty C2s should be kept out of hospital; a systematic process could assist this ambition; collaborative working between UCCH and community services had made a real difference to the quality of end of life experienced by a number of patients. • There was potential for the voluntary sector to become a part of the UCCH's network of contacts. • Board members congratulated the team on the progress made since October and that planning for the coming winter was already underway. • Empowering front line staff with more autonomy should be encouraged; this would require a change in culture. • PC Webinars on the lived experiences of advanced paramedics was a possible way to share learnings from UCCH. • Primary care colleagues would consider how to address the out of hours contact between GPs and advanced paramedics/ambulance crews. • It was noted that whilst the progress in increasing interventions for C3-C5 categorised 999 calls was welcome, the real impact of this work will be in extending the approach systematically to appropriate C2 category patients.
34.3	**The Board noted the review of winter and innovation in demand management and thanked EEAST colleagues for joining the meeting.**
ICB/35/24	**Questions from the public**
35.1	Two questions had been submitted in advance of the meeting by the Patient Engagement Forum and these had been answered in the document pack – see pages 344-345. Q1: What steps is the ICB taking to promote patient choice to ensure the success of the elective hub at St. Albans City Hospital? Q2: What steps is the ICB taking to secure redevelopment at PAH and WGH and what do you believe are the prospects of success?
ICB/36/24	**What would service users, patients, carers and staff take away from our discussion today?**
36.1	The following observations were made: • The empathy and initiative of all staff but particular front-line staff to provide the best care for the patient. • Despite the growing financial challenges, all partners in the ICS were continuing to deliver transformation and put in plans for future demand surges. • The power and impact of collaboration to deliver a single service to patients.
Date of next meeting: Friday 24 May 2024	
The meeting closed at 3.00pm	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DRAFT MINUTES

Meeting:	**NHS Herts and West Essex Integrated Care Board** **Board meeting held in Public**			
	Meeting in public	☒	*Meeting in private (confidential)*	☐
Date:	**Friday 22 March 2024**			
Time:	**11:30 – 15:00**			
Venue:	**Fielder Centre, Hatfield and via MS Teams**			

MINUTES

Name	Title	Organisation
Members present:		
Paul Burstow (PB)	ICB Chair	Herts and West Essex ICB
Ruth Bailey (RB)	Non-Executive Member	Herts and West Essex ICB
Matthew Coates (MC)	Chief Executive Officer	West Herts Teaching Hospitals NHS Trust
Catherine Dugmore (CD)	Non-Executive Member	Herts and West Essex ICB
Natalie Hammond (NH)	Director of Nursing and Quality	Herts and West Essex ICB
Jane Halpin (JH)	Chief Executive Officer	Herts and West Essex ICB
Rachel Joyce (RJ)	Medical director	Herts and West Essex ICB
Lance McCarthy (LM)	Partner Member (NHS Acute Trust)	Herts and West Essex ICB
Nick Moberly (NM)	Non-executive Member	Herts and West Essex ICB
Prag Moodley (PM)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Ian Perry (IP) Via MS Teams	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Alan Pond (AP)	Chief Finance Officer	Herts and West Essex ICB
Gurch Randhawa (GR)	Non-Executive Member	Herts and West Essex ICB
Adam Sewell-Jones (ASJ)	Chief Executive Officer	East and North Herts Trust
Nicolas Small (NS)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Thelma Stober (TS)	Non-Executive Member	Herts and West Essex ICB
Karen Taylor (KT)	Partner Member, Mental Health Trust	Herts and West Essex ICB

Chris Martin (CM) Deputising for Lucy Wightman	Director of Strategic Commissioning & Policy	Essex County Council
Scott Crudington (SC) Deputising for Owen Mapley	Interim Chief Executive Officer	Hertfordshire County Council
Kate Robson (KR) Deputising for Joanna Marovitch	Deputy Chair	Herts & West Essex VCFSE Alliance
In attendance:		
Elizabeth Disney (ED)	Director of Operations	Herts and West Essex ICB
Sharn Elton (SE)	Place Director, East and North Herts	Herts and West Essex ICB
Iram Khan (IK)	Corporate Governance Manager Board and Committees	Herts and West Essex ICB
Avni Shah (AS)	Director of Primary Care Transformation	Herts and West Essex ICB
Simone Surgenor (SS)	Deputy Chief of Staff Governance and Policies	Herts and West Essex ICB
Michael Watson (MW)	Chief of Staff	Herts and West Essex ICB
Matt Webb (Mwe)	Place Director, South West Herts	Herts and West Essex ICB

ICB/37/24	Welcome, apologies and housekeeping
37.1	The Chair welcomed all to the meeting. He confirmed that this was not a public meeting but a meeting being held in public (members of the public were welcome to attend to observe the meeting).
37.2	The Chair welcomed, Matthew Coates and Adam Sewell-Jones as members of the ICB Board following approval of the Constitution by NHSE.
37.3	NS informed the Board that he will be standing down from his role as Partner Member as he takes on a new role as Chair for Hertfordshire Community Trust.
37.4	Apologies for absence had been received from: Members: • Elliot Howard-Jones • Owen Mapley (represented by Scott Crudington) • Lucy Whitman (represented by Chris Martin) • Joanna Marovitch (represented by Kate Robson) Attendees: • Beverley Flowers • Frances Shattock • Tania Marcus • Toni Coles • Matt Webb
ICB/38/24	**Declarations of interest**
38.1	The Chair invited members to update any declarations relating to matters on the agenda and reminded them of their responsibility to update their declarations. All members declarations were accurate and up to date with the register available on the website: Declaration of interests – Hertfordshire and West Essex NHS ICB
ICB/39/24	**Governance Report**
39.1	Michael Watson presented the report highlighting the following points: • Governance Review: It was identified early on to make changes to the ICB Board and committee membership, this has been reflected within the proposed Terms of References. • It was identified that there is a gap in our governance in terms of progress against strategy within the Board Sub-Committees. • Merging of finance and commissioning discussions and decisions and delegation to the Health Care Partnerships (HCPs). • The governance has progressed through phases as described in the report, with the first stage implemented to included amendments to the Constitution to increase the Board membership by two and recruitment is underway for Primary Care Partner Members. • The second phase of the review focuses on Committee Terms of References and HCP governance.
39.2	• Terms of References for approval: • ICB Audit and Risk Committee - Approved. • ICB People Committee - Approved. • ICB Remuneration Committee – Approved • ICB System Transformation and Quality Improvement Committee – Approved. • ICB Primary Care Transformation Group: Name to be amended Committee. • Primary Care representative for Mental Health and Learning Disabilities to be added as a member of the committee. Following these changes, the Terms of References are approved.

	• ICB Strategic Finance and Commissioning Committee – To be reviewed and include Section 75 and BCF – Approved. • ICB Strategy Committee – Amendment required to include members from all Provider organisations – Following this change the Terms of References are approved. • MHLDA HCP Board – Approved.
39.3	• HCP Board – MW highlighted that the ToRs would need to be amended under membership to include Partner Member. Following a Board discussion, it was agreed this should be specific to a GP role. • Amendment required to include Primary Care (GP) Partner Member, Voluntary sector, and Local Authority representatives (or deputies) for each HCP sub-committee. • HCP Board Terms of References to be presented at the next Board meeting for approval.
39.4	**The Board approved the ICB Committee Terms of References as identified in 39.2.**
Date of next meeting: Friday 24 May 2024	
The meeting closed at 14:45	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	NHS HWE ICB Board meeting held in Public		**Meeting Date:**	**24/05/2024**
Report Title:	**Chair's update report**		**Agenda Item:**	**05**
Report Author(s):	With contributions from the ICB Executive Team and Partner Members			
Report Presented by:	Paul Burstow, ICB Chair			
Report Signed off by:	Paul Burstow, ICB Chair			

Purpose:	**Approval / Decision**	☐	**Assurance**	☒	**Discussion**	☐	**Information**	☒

Which Strategic Objectives are relevant to this report **[Please list]**	▪ Increase healthy life expectancy and reduce inequality ▪ Give every child the best start in life ▪ Improve access to health and care services ▪ Increase the number if citizens taking steps to improve their wellbeing ▪ Achieve a balanced financial position annually
Key questions for the ICB Board / Committee:	N/A
Report History:	N/A
Executive Summary:	This report provides the ICB Board with a high-level update of the range of key operational & transformational workstreams across the organisation and wider system.
Recommendations:	The Board is asked to note the contents of the report.

Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A			
Implications / Impact:				

Patient Safety:	*N/A*	
Risk: *Link to Risk Register*	*N/A*	
Financial Implications:	*N/A*	
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Chair's Report

As we convene for our first board meeting of the new Financial Year, 2024/25, I extend a warm welcome to all colleagues. It is necessary to acknowledge the juxtaposition between the immediate imperative of achieving financial balance in 2024/25 and the positive strides we are making across our system to better meet the changing needs of our residents and the demographic trends driving them.

Adopting the Medium-Term Plan

Today marks a significant milestone for our Integrated Care Board (ICB) as we adopt the Medium-Term Plan, a collaborative endeavour developed in partnership with stakeholders across the system. This plan sets out our organisational vision and strategy, aiming for a transformative shift in our approach to enhancing the health of residents throughout this decade.

The Medium-Term Plan addresses four pivotal challenges confronting Hertfordshire and West Essex.

1. the rapidly growing older population, while a testament to increased longevity, poses novel challenges in managing multiple health conditions and delivering effective care.
2. disparities in health outcomes between the most and least deprived residents highlight the imperative for equitable healthcare access and provision.
3. the overreliance on repeated episodic care can increase patient dependency and result in poorer outcomes.
4. the underlying financial deficit underscores the urgency of achieving financial sustainability as a system.

To navigate these challenges, the Medium-Term Plan proposed three fundamental shifts in our approach. We aim to transition from reactive acute care to preventive, community-based interventions, from siloed models to integrated, patient-centric care, and from a model that treats people as passive recipients of care to one emphasising patient empowerment, self-management, and collaborative care planning.

Implementing our new governance approach

Furthermore, I can report the successful completion of the governance review, paving the way for streamlined processes and enhanced focus on our medium-term objectives. The establishment of a Strategy Committee underscores our commitment to aligning our efforts to realise the Medium-Term Plan's objectives effectively.

The review also consolidates our discussions on quality, performance, and other critical aspects into a single System Transformation Committee, dedicated to implementing the plan effectively. Additionally, it facilitates our journey toward financial sustainability by amalgamating commissioning and finance deliberations into a unified Strategic Finance and Commissioning Committee.

Health and Care Partnerships

Health and Care Partnerships (HCPs) constitute another pivotal aspect of our ongoing transformation. Recently, I participated in a briefing session for Non-Executive Members with colleagues from both the Integrated Care Board (ICB) and HCPs. Our medium-term plan prioritises the principle that decisions regarding health and care should be made as locally as possible, aligning with the needs of affected communities. Over the past two years since the establishment of the ICB, our HCPs have made significant strides. In July, they enter the next phase of operation, marking a significant milestone in our journey.

Integrated Care Partnership

On May 9th, I took part in a development session of the Integrated Care Partnership (ICP). During this session, we discussed how our collaborative approach can support our system to meet the evolving needs of our population. It was agreed that the ICP has the potential to address major societal challenges that no single organisation can tackle alone. We agreed that childhood obesity should be the focus as a test case for this way of working. We also recognised that all partners have roles to play in creating the conditions in which making healthier choices is easier.

Looking ahead, our Medium-Term Plan ensures that the efforts of the Integrated Care Board (ICB) align with the broader objectives of the Integrated Care Strategy. Without the collaborative support of the ICP, many of the objectives outlined in our plan would remain out of reach. Similarly, the effectiveness of the ICP relies on the commitment of the ICB and the wider NHS community.

In essence, our medium-term plan underscores our commitment as active and engaged partners within the Integrated Care Partnership. It reaffirms our collective commitment to fostering the conditions in which integrated, proactive care thrives, benefiting all our residents.

Integrated Urgent Assessment and Treatment Centre

Earlier this month, I had the opportunity of seeing a practical demonstration of the innovative care approach we aspire to implement across our system with visit to the Integrated Urgent Assessment and Treatment Centre (IUTC) at the Princess Alexandra Hospital.

This partnership, provided by local GPs collaborating with nurse practitioners and other clinicians, is enhancing urgent care pathways for the local population. I was impressed by the energy and dedication exhibited by the staff at the service, as well as the evident positive impact it is having.

NHS Constitution consultation

I would like to highlight to colleagues that the consultation period on the proposed changes to the NHS constitution has now begun. You can find more about the proposed constitution via NHS Constitution: 10 year review - GOV.UK (www.gov.uk) and it is open until the 25th of June. The ICB will be submitting its own response.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	NHS HWE ICB Board meeting held in Public		**Meeting Date:**	**24/05/2024**
Report Title:	**Chief Executive Officer's report**		**Agenda Item:**	**06**
Report Author(s):	With contributions from the ICB Executive Team and Partner Members			
Report Presented by:	Jane Halpin, Chief Executive Officer			
Report Signed off by:	Jane Halpin, Chief Executive Officer			

Purpose:	**Approval / Decision**	☐	**Assurance**	☒	**Discussion**	☐	**Information**	☒

Which Strategic Objectives are relevant to this report **[Please list]**	▪ Increase healthy life expectancy and reduce inequality ▪ Give every child the best start in life ▪ Improve access to health and care services ▪ Increase the number if citizens taking steps to improve their wellbeing ▪ Achieve a balanced financial position annually
Key questions for the ICB Board / Committee:	N/A
Report History:	N/A
Executive Summary:	This report provides the ICB Board with a high-level update of the range of key operational & transformational workstreams across the organisation and wider system.
Recommendations:	The Board is asked to note the contents of the report.

Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A			
Implications / Impact:				

Patient Safety:	*N/A*	
Risk: *Link to Risk Register*	*N/A*	
Financial Implications:	*N/A*	
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Chief Executive Officer's Report

Today is a particularly exciting moment in the evolution of Hertfordshire and West Essex ICB, as our Medium-Term Plan comes to the board for final approval. Thank you to all colleagues on the board and across the system that have supported its development in recent months.

I am looking forward to today's discussion on the plan, and to hearing the board's views on the direction it will set for the system over the next six years.

As set out in the paper for the Medium-term Plan agenda item, there are a number of changes that we would like to make to our approach to ensure that delivery of the plan is at the centre of everything we do. With that in mind, I have made some changes to the second section of my report today, and moving forward we will no longer have updates by organisation but will instead have updates focused on the delivery of the priorities set out in the plan.

Our Financial Position

Whilst we are right to focus on the delivery of our vision for the medium term, we should also recognise that the system's current financial situation is one of the most challenging we have seen in many years. As set out elsewhere on todays agenda, we continue to do all we can to reach a forecast breakeven position for this year. However, creating the plan is just the first step. To deliver that plan will require a system-wide effort in which we will all need to be willing to work beyond organisational boundaries and to make some very challenging decisions. I am also conscious of the important role the board will play in relation to this.

Local Government Elections

Following the outcome of this month's elections, I wanted to take this opportunity to reflect on the role and function of district councils in local Health and Care Partnerships (HCPs).

The most important function of our HCPs is to tailor delivery of our plans to local need. A key driver of that local knowledge and perspective are District and Borough Councils. They have a long-established history as providers of services that have a significant impact on the social determinants of health, such as housing, planning, leisure, recreation, and the environment. In many cases they have existing programmes of work and priorities that support the overarching aims of the HCPs in which they operate. They are vital repositories of local expertise, often adopting holistic approaches to wellbeing that complement and support the activities of their NHS partners. They are typically able to respond quickly, due to their close connections with local communities and play an essential role in ensuring that prevention is at the heart of the work of all HCPs.

In recent years, HCP initiatives within Hertfordshire and west Essex have included development of the Hospital at Home service, support for the work of integrated neighbourhood teams, the establishment of an urgent treatment centre, participation in advanced care planning activities, and providing support for falls. I look forward to continuing to work with my district council colleagues as we build upon existing workstreams and initiate new programmes that are targeted to the unique needs of our four HCPs.

Congratulations to those who were newly elected or returned to office, and commiserations to those former colleagues who did not manage to secure the result they were looking for.

New campaign- blood pressure checks

Some of you will have seen that the ICB and other health and care organisations across Hertfordshire and west Essex have launched a campaign urging those aged 40 and over to come forward for a potentially life-saving blood pressure check.

Around one in four adults in the UK have high blood pressure, but only half of those are aware of it. High blood pressure (hypertension) doesn't usually have any obvious symptoms, making it an invisible threat to many. If left untreated, high blood pressure can lead to heart attacks, strokes, kidney disease and vascular dementia. Regular blood pressure checks are essential to reduce people's risks of developing these conditions.

The 'Invincible feeling, invisible danger' campaign aims to remind people that just because they may feel fit and well, doesn't mean that their blood pressure is at a healthy level. Over the coming weeks, the campaign about the hidden dangers of high blood pressure will feature on posters across our area as well as in local magazines and newsletters, on town centre display screens, buses and bus shelters and online. We are hoping that the message to 'take a sec to check' will reach as many people as possible aged 40 and over. People who are Black or South Asian are more likely to be at risk from high blood pressure, so if this applies to you or your family members, please do come forward for a quick, free, and painless check.

More than 200 pharmacies across Hertfordshire and west Essex are signed up to provide free blood pressure checks for anyone over 40 who hasn't had their blood pressure taken in the past six months. Find more information about the campaign and your nearest participating pharmacy at: hertsandwestessex.ics.nhs.uk/bp

ICB personnel Changes

Elizabeth Disney, ICB Director of Operations will be leaving the ICB on 31st August to take up a new role as Chief Transformation Officer at Staffordshire and Stoke-On-Trent ICB. Elizabeth will be relocating to the NW of England is to be closer to her extended family. We will be sorry to see Elizabeth go, and I am grateful to her for all of her work during her time with the ICB, which have had a real impact- especially in relation to our system approach to Urgent and Emergency care.

Wider system Changes

Many of you will have seen the news that Tom Abell will leave his role as Chief Executive of the East of England Ambulance Service Trust after three years, to lead Mid and South Essex ICB. I would like to take this opportunity to congratulate Tom on this change of role.

Future consultation on services at Mount Vernon

NHS England have informed us that subject to the completion of some internal approval processes, they plan to launch a consultation on the future of services at Mount Vernon this year. I will provide the board with a further update at the July board, by which time I should have further information.

24-25 priorities:

Reduce inequality with a focus on outcomes for CVD and hypertension:

- An ICS wide communications and engagement campaign went live on 7th May raising awareness of the importance of hypertension and the different places that people can have their blood pressure checked. The campaign includes posters/adverts across the ICS and on the bus network, targeted social media advertising, The campaign uses the slogans 'Invincible feeling, Invisible danger' and 'take a sec to check'.
- West Essex HCP promoting "May Measure Month" to increase blood pressure checks. Alongside preparation for a Harlow targeted event for hard-to-reach patients to have their blood pressure taken.
- The ICB has funded hypertension champions across our local acute and community providers, with the first successful and productive meeting held at the end of April. The champions shared their plans and ideas as to how we can increase blood pressure checks, using a 'Making Every Contact Count' approach and in sharing information on blood pressure results with general practices.
- The ICB will be sharing insights with practices on their current position with regards to hypertension prevalence and treatment to target to support practices with identifying what they can do to improve detection and treatment for people living with high blood pressure.
- The ICB continues to fund practices and community pharmacies to provide home and ambulatory blood pressure monitoring.

Improve UEC through more anticipatory/SDEC care:

- Focussing on ten high impact initiatives for 24/25 aimed at delivering a 25% reduction in admissions of frail elderly through provision of improved admission avoidance and same day emergency care services. The ten initiatives are:
  - an enhanced Urgent Care Coordination Hub,
  - system wide implementation of SDEC for acutely unwell frail individuals,
  - development of linked and integrated Urgent Treatment Centres,
  - medication reviews and positive deprescribing,
  - falls prevention service review,
  - implementation of digital Advance Care Plans, implementation of the Community Services Review through a range of care closer to home services including at scale implementation of Integrated Neighbourhood Teams (INT), ongoing development and integration of urgent community response services and hospital at home services,
  - strengthening place-based care coordination centres, and
  - focussing on intermediate care models including early supported discharge pathways.

- The INT Proactive Care Blueprint is now rolled out across the 6 INTs in west Essex. All INTs now in their second phase and working through the second cohort within the Advanced Disease and Complexity Cohort. INTs will soon launch the Proactive Care Blueprint for the End of Life, Severe Frailty and Dementia cohort.

- A dedicate medical SDEC clinical navigator is now in place in PAHT to proactively in reach into the ED to identify patients suitable for SDEC. Improvements have also been made for Primary Care to access SDEC with a dedicated GP referral line managed by ACPS to providing advice and guidance and direct access to SDEC pathways.

- The Population Health Management team continue to support the development of a number of Integrated Neighbourhood Teams across the ICS. These teams are being supported with

insights that help identify the groups most at risk of emergency care, and identify people who are at risk of needing emergency care so that they can be proactively reviewed by the INT. This includes people with frailty and people with advanced disease and multimorbidity.

Better care for those in mental health crisis:

- Work continues across both Hertfordshire and West Essex with wider County partners on the planned implementation of Right Care Right Person programme with Hertfordshire and Essex Police. This work aims to ensure there is a joined-up response across partners when someone is in crisis. There remain significant operational and demand pressures on progressing this work in the timeframes expected. However, there are good working relationships between partners in counties and forces in the ICB area, with some elements already implemented. For example, in Hertfordshire the police have implemented a revised approach to concern for safety calls, releasing officer time and working differently with wider system partners. In Essex the police are working with partners to implement a similar process.

- Suicide prevention 'distress pathway' are being developed, led by EPUT on behalf of WEHCP.

- EPUT MH crisis service is visiting the ICB Unscheduled Care Hub to improve access to MH support for EEAST and to avoid ambulance conveyances to ED where there is no physical need.

- Through the 2024/25 annual planning process work is ongoing to sustain a range of crisis alternatives and improve the connections between services. There has been an increase in referrals into crisis alternatives directly from statutory partners and more work is needed to ensure new developments, such as the Mental Health Urgent Care Centre, work coherently with both secondary and voluntary and community services to maximise the impact for the population and ensure people are supported in the most effective settings. The Hertfordshire Crisis Care Partnership Board is holding a system workshop in June to review the overall Crisis pathway and the connections between services, and work is ongoing to scope an Integrated Crisis Offer for Children and Young People.

Elective Care recovery:

The total elective waiting list reduced for the sixth consecutive month. 65- and 52-week backlogs continue to improve. Building work continues on the system "elective hub" at St Albans, which will provide further elective capacity when it is completed and opens.

Childrens care backlog recovery:

- The total number of children on community waiting lists remains very high.

- Pressures are predominantly in Community Paediatrics, as well as therapies and Audiology services.

- Autism Spectrum Disorder (ASD) lists and waiting times remain high. Backlog funding ended in December 23. Without continuation of the backlog funding investments, ASD waiting lists will start to grow.

- CAMHS caseloads have increased for the last three months, and the 28-day access standard has not been achieved since 2021.

- Children's waits for a Community MH 1st appointment are better than the national average. However median waits are 110 days, compared to 84 days for a 2nd contact in adult services.

- The Neurodiversity Transformation programme has developed a needs-led care model to provide timely, tailored and appropriate services to neurodiverse children and their families and carers. This is a biopsychosocial model with the aim of improving the clinical and wellbeing outcomes for the young person and their families and carers, both now and as they grow into adulthood.

- The model has been developed in partnership with the Hertfordshire Mental Health, Learning Disabilities and Autism Health and Care Partnership (MHLDA HCP). It has involved statutory NHS and Local Government partners, VCFSE organisations, local GPs and people with lived experience through Herts Parent/Carer Involvement Network (HPCI).
- Next steps for this work will be the completion of a business case and implementation plan by the end of May.

Medium Term Plan ambitions:

Ensuring every child has the best start in life:

- WEHCP is working with partners to create healthy places, initially focusing on areas of inequality in each of the three west Essex districts. Also developing a 'place partnership' initiative with Sport England and Active Essex. WEHCP continues to progress work with Harlow early years settings and schools, focusing on parenting skills, language, healthy weight and oral health.

  Plans for 24/25 will focus on these key priority areas:

  - Working with both county councils to improve the way the local SEND partnerships support children to achieve their potential.
  - Further reduction in waiting times for ASD/ADHD diagnostic assessment with improved multiagency support around the child and family across HWE.
  - Further roll-out of asthma friendly schools and embedding practice across HWE.
  - Further implementation of the Balanced System model across Essex, and evaluation.

Increasing healthy life expectancy and reduce inequality:

- The system's bid for the Department of Work and Pension's WorkWell scheme, encouraging those living with disability or currently sick to be able to work through delivery of supportive projects across the system's areas of highest deprivation has unfortunately been declined. Cambridgeshire and Peterborough have been selected as the only system within the region to participate – and will include Royston as part of their bid.

Improve access to health and care services:

Primary Care:

- Work continues in all areas of primary care under improving access, including:
  - Continued roll out modern telephony systems across practices approved with NHSE funding;
  - Increased use of NHS app: month on month logins increased by 9%; are up to 61% uptake across eligible population this month (national average is 56%);
  - Delivery of appointments with average 45% same day and improving in achieving 85% metric within 2 weeks per place;
  - Implementation of the different models of general practice;
  - Monthly increased in Pharmacy First and Blood pressure monitoring;
  - Increased urgent dental access (pilot with 4 sites) with capacity now delivered at 70%; INT approach assuming is coming from HCP with the frailty update and delivery plan as part of the solution.

- WEHCP is continuing efforts with partners to join up frontline services to increase access to health checks and connections with related wider determinants of health, eg employment

- PAHT IUATC moves into its second phase of development. This includes working with primary care to support improvement in primary care access and the development of the hub and spoke model making effective use of the collaboratives combined resources and capacity.

Workforce

- The System has completed its final operational planning submission for 2024/25 – submitting the final workforce projections on the 2 May 2024 for the five NHS secondary care organisations within our system, primary care, as well as the key performance indicators required within the plan. The plan forecasts for an overall system reduction in Whole Time Equivalents (WTE) of 2.4% (-572.3). The majority of the systems reductions relate to bank staff reducing by 15% (-304.1) and agency staffing by 25.3% (-119.4).

- A further analysis of the 2023 NHS Staff Survey has been provided to the system and is being shared with the People Committee, alongside additional system-based analysis to understand the core areas of progress that have been achieved, but also areas of work that can be focussed on as a system and that support the individual provider action plans. Hertfordshire Partnership Foundation Trust are the second cohort of the People Promise agenda and a lead for the project is now in post and developing plans to support the organisation going forwards.

- We would like to welcome Sally Judges into a new role working across the system as the System Allied Health Professional (AHP) Lead. Sally has been pivotal in developing and leading the AHP council across the ICS, and we look forward to working with her more in delivering the strategic leadership this diverse range of professions requires across the system.

Increase the number of residents taking steps to improve their wellbeing:

- Two emerging ‘deep dive’ exercises with key partners and communities in Harlow and the healthy places work/potential ‘place partnership’ in Harlow with Sport England and Active Essex referred to above.

Achieve financial sustainability:

- There is much more information on this subject elsewhere on the agenda.
- WEHCP is working with the ICB in the implementation of its Delivery Plan and the plans contribution to the ICBs Financial Plan 2425. This includes the delivery of the Care Closer to Home Model in west Essex and the review of use of collective resources supporting our frail population.
- Colleagues from across the system, including representatives from the University of Hertfordshire, met with regional colleagues to discuss the nationally proposed modelling and some of the challenges and opportunities there are within the system to develop the domestic pipeline of clinical staff. The system is refining its approach to education development with a new provider group and is being supported by the Health and Care Academy to further develop and improve the pathway from Further Education Colleges to either employment or further study.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐				
	HWE ICB Board meeting held in Public				**Meeting Date:**	**24/05/2024**		
Report Title:	**Governance report**				**Agenda Item:**	**07**		
Report Author(s):	Michael Watson, Chief of Staff							
Report Presented by:	Michael Watson, Chief of Staff							
Report Signed off by:	Michael Watson- Chief of Staff							
Purpose:	**Approval / Decision**	☒	**Assurance**	☐	**Discussion**	☐	**Information**	☐
Which Strategic Objectives are relevant to this report	• Increase healthy life expectancy, and reduce inequality • Give every child the best start in life • Improve access to health and care services • Increase the numbers of citizens taking steps to improve their wellbeing • Achieve a balanced financial position annually							
Key questions for the ICB Board / Committee:	N/A							
Report History:	N/A							
Executive Summary:	The purpose of the Governance report is to update the board on key areas relating to governance, key areas for decision and to present the Board Assurance Framework. Today's paper covers: • An update on the implementation of the Governance Review- final Terms of Reference for Approval • The Board Assurance Framework							
Recommendations:	Members are kindly requested to: ▪ Note the Board Assurance Framework ▪ Approve the HCP Board Terms of Reference and ICB System Transformation and Quality Improvement Committee Terms of Reference. ▪ Approve proposal to amend the ICBs Scheme of Reservation and Delegation and Standing Financial Instructions.							

<table>
<tr><td></td><td colspan="4">▪ Approve proposal to amend the ICBs Scheme of Reservation and Delegation and Standing Financial Instructions.</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">[Consider the impact of the paper on patient safety, e.g. Does the paper support improvement in patient safety and mitigate risks to patient safety]</td></tr>
<tr><td>Risk: Link to Risk Register</td><td colspan="4">[Refer to latest Risk Register when completing]</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">[State funding costs and potential savings]</td></tr>
<tr><td rowspan="3">Impact Assessments:
(Completed and attached)</td><td colspan="2">Equality Impact Assessment:</td><td colspan="2">NHS Constitution proposed changes are supported by an approved EQIA.</td></tr>
<tr><td colspan="2">Quality Impact Assessment:</td><td colspan="2">< N/A ></td></tr>
<tr><td colspan="2">Data Protection Impact Assessment:</td><td colspan="2">< N/A ></td></tr>
</table>

1. Governance Review

Background.

1.1 The Board approved, in principle, the adoption of the recommendations of the Governance review at its meeting in January.

1.2 There was a further opportunity to discuss the implementation of the plans at the February Board Day.

1.3 The Governance review is being conducted alongside, and is aligned to, the work to develop the ICBs operating model and in particular the creation of Health and Care Partnerships.

1.4 The Board discussed several Terms of Reference at its April meeting. It is asked to approve the outstanding Terms of Reference as set out below.

1.5 The Board is also asked to approve the amendments to NHS Hertfordshire and West Essex ICBs Scheme of Reservation and Delegation, and Standing Financial Instructions.

Summary of changes:

Scheme of Reservation and Delegation:

- Audit and Risk Committee – "including Cyber Security" added.
- Strategic Finance and Commissioning Committee – added, with decisions and functions.
- System Transformation and Quality Improvement Committee – added, with decisions and functions.
- Strategy Committee – added, with decisions and functions.
- Health Care Partnership (HCP) Board – applicable to each HCP within the geographical area of HWE ICB – added, with decisions and functions.

Standing Financial Instructions:

- At delegation levels, Commissioning Committee alongside Finance and Investment Committee – now reads – Strategic Finance and Commissioning Committee.

2. Board Assurance Framework

2.1 The Board is asked to note and discuss the risks contained in the Board Assurance Framework.

Hertfordshire and West Essex ICB's Board Assurance Framework

Date: 16/05/2024

APPENDIX A: Assurance Framework Report (16+)

SO IDs	2022/27 Strategic Objectives	No of risks	Strategic Leads
SO1	Increase healthy life expectancy and reduce inequality	0	
SO2	Give every child the best start in life	1	
SO3	Improve access to health and care services	5	
SO4	Increase the number of citizens taking steps to improve their well-being	0	
SO5	Achieve a balanced financial position annually	1	

Assurance Statement

We would like to provide the Board with assurance that we have reviewed the corporate risks for the ICB. Currently, there are 114 risks on the Datix Risk Register. Out of these, 48 are corporate risks (12+). Of these, seven risks are identified as the most significant (16+) to achieving the ICB's strategic objectives. The Datix ID number of these risks are 679, 649, 611, 610, 608, 526, 351.

Risk 582 have now been de-escalated from the corporate risk register due to misalignment until the team completes their UEC risk review..

The Audit and Risk Committee on behalf of the ICB (Board) gains assurance on these risks, including control effectiveness, and the alignment of our risk management processes with the three lines of defence within our assurance framework, ensuring that the real risks are identified, assessed, and mitigated appropriately.

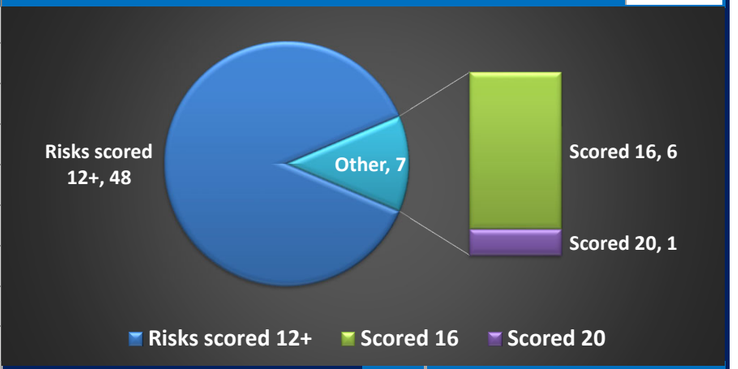
RAG rating of overall perfomance: **Amber** ↔ Progress

TRIGGER ZONES FOR MANGEMENT ACTION PLANS

Risk Matrix		Consequence (C)				
		1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
Likelihood (L)	5. Almost Certain				1	
	4. Highly Likely				6	
	3. Possibly					
	2. Unlikely					
	1. Rare					

No#	HWE ICB Directorates	No of risks (16+)
1	Chief of Staff (Communication, Corporate Governance, Information Governance)	0
2	Finance, Contract, Premises	1
3	Medical	0
4	Operations (3 Places & HBLICT)	1
5	Performance (Business Intelligence, Digital Transformation & Performance)	3
6	Primary Care	0
7	Quality and Nursing	1
8	Strategy (People, Workforce, Strategy)	1
		7

Further breakdown into principal risks scored 16+



RISK ID	Date open	SO ID	Risk Owner	Directorates	Risk Description (16+)	Rational for current risk score	Risk Appetite	L = Likelihood C = Consequence L	C	Current risk score L x C = RS	Key Controls	Direction	Assurance levels 1st line	2nd line	3rd line
7										1					
351	19/05/2022	SO3	Jo Burlingham	Operations	**Pandemic and Infectious Outbreaks:** If there is a pandemic flu/Influenza type disease (pandemic), infectious outbreak or disease including - Localised legionella or meningitis outbreak - Major outbreak of a new or emerging infectious disease Then- this will cause additional pressure on healthcare services and organisational business continuity issues. Resulting in- the increased potential for compromised patient care and safety and organisational business continuity failures(EPRR)	Existing risk is currently being mitigated by controls in place but further work is required. Completed mitigating actions include: Incident Response Plan, Business Contunity Plan and Oncall system review on 11/1/23. The following are being updated Herts Pandemic Flu Framework, Infectious Disease Framewrok, BIA, & Mutual Aid MOU.	**Open**	4	4	**16**	1. Hertfordshire Pandemic Flu Framework in place 2. Business Impact Assessments (BIAs) completed for each team/department 3. Business continuity plans and incident response plans in place for ICB 4. Various training, exercise programs, and vaccination arrangements in place for staff and community	↔	Substantial	Substantial	Substantial
526	06/09/2022	SO2	Natalie Hammond	Nursing and Quality	**Children's Community Services Demand:** If the demand for children's community services continues to increase then statutory requirements will not be met resulting in delays to accessing care, poor patient experience and poorer patient outcomes (wellbeing and educational)The main services impacted include: Community Paediatrics incl. ASD/ADHD, Children's Therapies (OT/SLT), Community Allergy and Dietetics, Community Audiology, Special School Nursing.	November 2022- focused discussion at WE Transformation Committee, highlighting pressures and contributing factors, escalating concerns with the Place Director, WE Health Care Partnership and advising of need to address the capacity gap. Business case in development. There are a few gaps with the controls identfied and there are no mitigating actions in place.	**Seek**	4	4	**16**	1. Investment made to clear backlogs in ASD and ADHD in Herts and WE. Further investment agreed for ADHD backlog in S&W Herts. 2. Community Paediatric Transformation Programme proposed to review all community paediatric services and ensure consistency and efficiency, with learning shared across ICS and Essex systems. 3. Clinical prioritisation being done in impacted services with transformation programmes in place for some areas. 4. Regular review and monitoring of data through contract management and performance meetings, with risk escalation to ICB and impacted providers.	↔	Reasonable	Reasonable	Reasonable
608	10/03/2023	SO3	Frances Shattock	Performance, Business Intelligence, Digital Transformation	**Emergency Department Targets and Patient Outcomes:** If UEC targets are not met and patients are not assessed with a management plan and treated, admitted and/or discharged out of the Emergency Department within 4hrs, then there is an immediate risk to patient health and wellbeing, resulting in a significant risk to patient outcomes. Additionally, there is a reputational risk to the ICB which carries a risk of NHSE interventions. The delays in assessment and treatment could cause patients with serious illnesses/conditions to wait for long periods, increasing the risk of harm to their health. These delays could also negatively impact performance targets, leading to reputational risk.	This is a new risk description, combined with risk 582. UEC standards are not being met with sustained period of deterioration in performance. Performance is behind improvement trajectory delivery for March 23. Plans for 23/24 to meet new 76% target but the risk to delivery is high	**Open**	4	4	**16**	See Operations Directorate UEC plans and Board Assurance Framework related to UEC Priority Metrics. Actions linked to Performance Improvement Trajectories. Cross reference to UEC mitigations for ENH / SWH / WE place required	↔	Reasonable	Substantial	*None*

Hertfordshire and West Essex ICB's Board Assurance Framework

Date: 16/05/2024

RISK ID	Date open	SO ID	Risk Owner	Directorates	Risk Description (16+)	Rational for current risk score	Risk Appetite	L = Likelihood C = Consequence L	C	Current risk score L x C = RS	Key Controls	Direction	Assurance levels 1st line	2nd line	3rd line
7										1					
610	10/03/2023	SO3	Frances Shattock	Performance, Business Intelligence, Digital Transformation	**Waiting Lists and Patient Health:** If waiting lists are not reduced, there a risk to patient health and outcomes, then patients conditions may worsen resulting in deterioration of patient health. Additionally there is a reputational risk to the ICB which carries a risk of NHSE interventions.	The constitutional standards of 18 weeks are not being met. The target to reduce 78ww to be 0 at the end of March 2023 will not be met; specifically at ENHT with pressure in community paediatrics, T&O and Gastro. Plans to meet 65ww target of 0 by end March 2024 in place, although there are risks to that delivery including IA strikes and the current community paediatric pressures at ENHT.	Open	4	4	16	1. Work is continuing at both system and providers to reduce waiting lists with a focus on 78ww and 65ww. 2. Work has begun on HVLC programme with a focus on improving efficiency and increasing theatre utilisation	↔	Reasonable	Reasonable	*None*
611	10/03/2023	SO3	Frances Shattock	Performance, Business Intelligence, Digital Transformation	**Diagnostics** If: the constitutional standards for diagnostics are not met Then: this could result in increased risk for patients Resulting in: a worsened health condition	The 6 week standard for diagnostics is not currently being met with performance remaining static; the risk is moderate as target is to improve performance to meet standard by end of March 25 and recovery trajectories are in place.	Open	4	4	16	There is an ICB wide transformation programme which works with all providers and across the system to improve diagnostic performance Cross reference to diagnostic programme mitigations	↔	Reasonable	Substantial	*None*
649	08/08/2023	SO3	Natalie Hammond	Nursing and Quality	**Paediatric Audiology Service Delays and Patient Safety Concerns:** IF the timeliness and quality of care provided across the HWE paediatric audiology services (recognising current quality challenges identified at ENHT) does not meet the UKAS accredited standards, THEN there is a risk that access to time critical testing does not occur in a safe and timely way RESULTING in potential harm to our population both in terms of safety and patient experience.	December 2023 Review with Providers improvement plan against system recommendations at SPQRM. October 2023 At the monthly Quality and Performance Meetings, all HWE acute, and where appropriate community providers, are being asked to review their paediatric audiology services against the UKAS accreditation standards and provide their plans to achieve accreditation A Paediatric Deep Dive is planned for a future System Quality Group to share local learning and	Averse	4	4	16	None stated	↑	Reasonable	Reasonable	Reasonable
679	14/09/2023	SO5	Alan Pond	Finance	**Financial Efficiency Risk:** If the Integrated Care System and its component organisations fail to deliver the agreed efficiencies contained within the 24/25 financial plan, and the additional measures required to deliver that plan, then the system will end the year with a financial deficit, resulting in reduced funding in future years and potential harm to future service delivery and organisational reputation.	Newly identified for the 24/25 financial plan	Seek	4	5	20	Being developed as part of financial planning, discussed at the Finance and Commissioning Committee	⇆	*None*	*None*	*None*

Document coding guide

Over all status (RAG)	Red	Effective controls may not be in place and / or appropriate assurances are not available to the ICB
	Amber	Effective controls thought to be in place but assurances are uncertain and / or possibly insufficient
	Green	Effective controls definitely in place and the Board is satisfied that appropriate assurances are available
Risk Directional Movement	⇆	New risk
	↑	Higher
	↔	No Change
	↓	Lowered
Overall performance (RAG)	↔	No Change
	→	Progress, if on amberGood progress, if on green
	←	Losing progress
Progress on actions	Complete	
	On schedule	
	Expected delay	
	Delayed	
	Major delay	
Issues	Progress and Assurance / Issues	Provide an overview of the progress and assurances for this, list any identified issues
	Key workstreams	List the key workstreams that will enable delivery of the objective
5 x 5 Risk Matrix	Indication of risk score	
Assurance level - measures the quantity	**H**	**High** - Oversight functions are provided on the controls. Two or more assurances equals high (H)
	M	**Medium** - Oversight functions are provided on the controls. One assurance equals high (M)
	L	**Low** - Oversight functions are provided on none of the controls equals (L)
Assurance rating - measures the quality/strength	*None*	
	Limited	

Report Author:

Leon Adeleye, Corproate Governance Lead - Risk and Regulation

Tatiana Njendu, Risk Compliance Office

Hertfordshire and West Essex ICB's Board Assurance Framework

Date: 16/05/2024

RISK ID	Date open	SO ID	Risk Owner	Directorates	Risk Description (16+)	Rational for current risk score	Risk Appetite	L = Likelihood C = Consequence		Current risk score	Key Controls	Direction	Assurance levels		
								L	C	L x C = RS			1st line	2nd line	3rd line
7										1					

	Reasonable	
	Substantial	
Risk Appetite Matrix	Averse	Avoidance of risk is a key objective. Activities undertaken will only be those considered to carry virtually no or minimal inherent risk.
	Cautious	Preference for very safe business delivery options that have a low degree of inherent risk with the potential and only a limited reward potential
	Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of reward.
	Seek	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)
	Significant	Confident in setting high levels of risk appetite because controls, forward scanning and respective systems are robust

ICB Risk Domains	Risk Appetite	Appetite statement
Financial How will we use our resources?	Seek	Consistently seek to use available funding to develop and sustain the greatest benefit to health and healthcare for our population and partners, accepting the possibility that not every programme will achieve its desired goals, on the basis that controls are in place.
Compliance and Regulatory: How will we be perceived by our regulator?	Open	Conform with regulatory expectations but challenge them where we feel that to do so would be to improve outcomes for our residents.
Innovations, Quality and outcomes	Seek	Pursue innovation and challenge existing working practices, seeking out and adopting new ways of working and new technologies to the benefit of the residents of Hertfordshire and West Essex Operate with a high level of devolved responsibility Accept that innovation can be disruptive and to use that as a catalyst to drive positive change
Reputation How will we be perceived by the public and our partners	Seek	We will be willing to take decisions that are likely to bring scrutiny to the organization but where potential benefits outweigh the risks.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

APPENDIX 15

NHS Hertfordshire and West Essex Integrated Care Board

Scheme of Reservation and Delegation

Decisions and functions reserved to the Board

Functions will be exercised by the Board unless they are delegated. This is the default position for any function that is not expressly delegated. The Board has set out specifically those matters it is choosing to reserve. The Board, regardless of any delegation arrangements it has made, remains legally accountable for the exercise of its functions.

	Decisions and functions reserved to the Board	Reference
The Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers. The Board will establish the necessary systems and processes to comply with relevant law and regulations, directions issued by the Secretary of State, directions issued by NHS England, statutory guidance and advice issued by NHS England and relevant authorities and respond to reports and recommendations made by Healthwatch organisations in the ICB area.	Constitution 4.2.2
The Board	**Regulations and Control** Consider and approve proposed amendments to the ICB Constitution by the Chief Executive prior to making an application to vary the constitution to NHSE.	Constitution 1.6.2, Standing Orders 2.1.3, 2.1.4

	Decisions and functions reserved to the Board	Reference
	Approve Standing Orders (SOs), a schedule of matters reserved to the Board (Scheme of Reservation and Delegation (SoRD) of powers delegated from the Board to the Executive Team and other Committees, Functions and Decisions Map, Standing Financial Instructions (SFIs) and the Governance Handbook for the regulation of its proceedings and business.	Constitution 1.6.2, 1.7.2, 4.4.2, Standing Orders 2.1, 2.3
	Approve to vary or amend the Standing Orders in accordance with the procedures for amending the Constitution as described above. Approve delegation arrangements to ICB Committees, Joint Committees, to other Statutory Bodies, individual Board Members and employees is reserved to the Board. Including approval of committee terms of reference.	Constitution 1.6.2; Standing Orders 2.3 Constitution 4.6.1, 4.6.3, 4.6.6, 4.7.1
	The power to approve arrangements for Pooled Funds is reserved to the Board.	Constitution 4.7.3
	Approve arrangements for the management of conflicts of Interest defined within the Conflicts of Interest Policy, including publication of registers of interest.	Constitution 6.1.1, 6.3.2
	Require and receive the declaration of Board members' (and others as required) interests to discharge its duty to manage conflicts of interest.	Constitution 6.1.3, 6.1.4, 6.1.5, 6.3.1, 6.3.2, 6.3.7
	Approve arrangements for dealing with complaints and ensure a clear complaints process is published.	Constitution 7.3.4
	Ensure the ICB Complies with the Freedom of Information Act 2000 and Information Commissioner Office requirements.	Constitution 7.3.5
	Ensure systems and processes exist to comply with the requirements of the NHS Provider Selection Regime.	Constitution 7.4.2, 7.4.3
	Comply with Local Authority Health Overview and Scrutiny Requirements.	Constitution 7.4.4

	Decisions and functions reserved to the Board	Reference
	Adopt the Executive structure to facilitate the discharge of business by the ICB and to agree modifications thereto except where these functions have been delegated to a Joint Committee. Receive reports from committees including those that the ICB is required by the Secretary of State or other regulation to establish and to action appropriately. Confirm the recommendations of the ICB's committees where the committees do not have executive powers. Approve arrangements relating to the discharge of the ICB's responsibilities as a corporate trustee for funds held on trust. Discipline members of the Board who are in breach of statutory requirements or SOs.	Constitution 2.2
The Board	**Appointments/Dismissal** Appoint each Ordinary Member of the Board, exercised by the Chair. Approve dismissal of members of the Board at the recommendation of the Chair, to be executed by the Chair. The Chair of the ICB will be appointed by NHS England as set out within legislation. Appoint and dismiss other committees (and individual members) that are directly accountable to the Board. Appointment of Internal or External Auditors and the Counter Fraud officer following recommendations from the Audit Committee.	Constitution 2.1.5, 2.2.2, 2.2.4 Constitution section 3 Constitution 4.6.8
The Board	**Strategy, Annual Operational Plan and Budgets** Approve a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years.	Constitution 4.3,

	Decisions and functions reserved to the Board	Reference
	Approve and publish an Integrated Care System Plan and Capital Resource use Plan.	Constitution 1.4.10, 7.3.8
	Oversee and maintain accountability for the management of key strategic risks, evaluate them and ensure adequate responses are in place and are monitored, including the approval of the ICB Risk Management Policy.	
	Approve plans in respect of the application of available financial resources to support the agreed Annual Operational Plan (Financial Framework and Annual Budgets), except where these functions have been delegated to a Joint Committee.	
	Approve proposals for ensuring quality and developing clinical governance in services provided by the ICB or its constituent practices (ICB Quality Strategy), having regard to any guidance issued by the Secretary of State, except where these functions have been delegated to a Joint Committee.	
	Approve annually (with any necessary appropriate modification) the annual refresh of system plan, except where these functions have been delegated to a Joint Committee.	
	Approve annually and publish the ICB Engagement Framework setting out how the ICB complies with and delivers its duties to engage with the public.	
	Approve Outline and Final Business Cases for Commissioning Investment if this represents a variation from the Plan, in line with the ICB SFIs and Schedule of Detailed Delegated Financial Limits.	Constitution 9.1.1
	Approve the ICB's organisational development proposals.	

	Decisions and functions reserved to the Board	Reference
	Approve Executive Team proposals on individual contracts (other than NHS contracts) of a revenue, except where these functions have been delegated in line with the ICB Schedule of Detailed Delegated Financial Limits. Approve Executive Team proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Resources (for losses and special payments) as per the ICB SFIs and detailed scheme of delegated limits.	
The Board	**Policy Determination** Approve ICB Policies (including HR policies incorporating the arrangements for the appointment, removal and remuneration of staff), except where delegated to specific committees (set out below) for the approval of minor changes and updates.	
The Board	**Audit and Counter Fraud** Receive the annual management letter from the External Auditor and agreement of the Executive Team's proposed action, taking account of the advice, where appropriate, of the Audit Committee. Receive an annual report (and Head of Internal Audit Opinion) from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee. Receive an annual report from the Counter Fraud officer and agree action on recommendations where appropriate of the Audit Committee.	
The Board	**Annual Reports and Accounts** Receive and approve the ICB's Annual Report and Annual Accounts, to be externally audited and published. Receive and approve the Annual Report and Accounts for funds held on trust.	Constitution 7.5

	Decisions and functions reserved to the Board	Reference
The Board	**Monitoring** Receipt of such reports as the Board sees fit from the Executive Team and other committees in respect of its exercise of powers delegated.	

Decisions and functions delegated by the Board to the ICB committees

Committee	Decisions and functions reserved to the Committee	Reference
Audit & Risk Committee	• The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide oversight and assurance to the ICB Board on the adequacy of the governance, risk management and internal control processes within the ICB including: - Integrated governance, risk management and internal control - Internal Audit, External Audit and Counter Fraud - Freedom to Speak Up - Information Governance - Financial Reporting - Conflicts of Interest - Security (including Cyber Security) - Governance - Emergency Planning, Preparedness and Resilience - Sustainability • The Audit Committee shall review instances of non-compliance with Standing Orders.	Constitution 4.6.4, 4.6.8 Standing Orders 3.6
Remuneration Committee	• The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, exercise the functions of the ICB relating to	

Committee	Decisions and functions reserved to the Committee	Reference
	paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006 and implement NHSE guidance, including: - Determining the remuneration of the Chief Executive, Directors and other Very Senior Managers and Board members (other than non-executive members). - Determining arrangements for the termination of employment and other contractual and non-contractual terms of the Chief Executive, Directors and other Very Senior Managers and Board members (other than non-executive members). - Agreeing the pay framework for clinical staff working within the ICB but outside of Agenda for Changes Terms and Conditions. - Determining the arrangements for termination payments and any special payments for all staff. • The Remuneration Committee shall establish a Non-Executive Remuneration Panel to consider and agree arrangements for remuneration of Non-Executive Members.	Constitution 4.6.8, 8.1.6 Constitution 3.13.1
Strategic Finance & Commissioning Committee	The Strategic Finance and Commissioning Committees is delegated by the Board to focus its purpose on improving the health and wellbeing outcomes of the ICBs population taking into account financial resource alongside national and local evidence to support affordability. It will do this through: • Oversight and development of strategic finance management: • Consider Commissioning and investment proposals based on their contribution to the overall delivery of the ICB objectives • Oversee the development and delivery of a robust, viable and sustainable system financial plan. This will include: • financial performance of the ICB • financial performance of NHS organisations within the ICB footprint; • To seek assurance that an effective system financial framework and operating model (for capital and revenue funding) is in place for collectively distributing and	

Committee	Decisions and functions reserved to the Committee	Reference

	managing resources, and that they can be used in accordance with the ICB's Integrated Care Strategy.
	
	• Oversight and accountability of strategic commissioning:
	  • Oversee procurement and contracting processes.
	  • Make decisions about proceeding with commissioning changes including commissioning of new services, significant commissioning changes, decommissioning, and redesign of health services with proposals supported by completed or proposed evaluation.
	  • Identify opportunities for commissioning services at scale, including sharing of best practice and innovation across the ICS, and identifying opportunities for improvement, cost efficiency and sustainability.
	
	• Oversight and assurance in the delivery of ICB strategic priorities by HWE Health Care Partnerships:
	  • To ensure an assurance framework is effectively in place to proactively oversee system productivity and efficiency programmes to meet agreed priorities.
	  • To monitor financial performance against approved budgets, ensuring alignment with ICB strategic priorities.
	  • Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation but may not delegate any decisions to such groups.
	
	  • **This Committee has delegated authority to approve ICB policies in respect of the following**:	

Committee	Decisions and functions reserved to the Committee	Reference
	• Policies concerning dispute resolution for Primary Care, Community Pharmacy, Optometry and Dentistry contract holders will be referred to the Primary Care Commissioning Committee for approval. • Evidence Based Interventions (EBI) policies which describe procedures that are not routinely commissioned or are only routinely commissioned when certain clinical criteria (or thresholds) are met will be referred to the Clinical Policies Group for approval. The Clinical Policies Group will not make recommendations or decisions about funding for individual patients; this is the responsibility of the Individual Funding Request panels. The group will not make recommendations or decisions about interventions which are the commissioning responsibility of NHSE. • **This Commissioning Committee has delegated authority for the following to the ICBs Primary Care Commissioning Committee.** With that authority will come approval for expenditure, business cases and contract awards as specified in the ICBs Standing Financial Instructions: • To oversee implementation of the delivery of quality commissioning and contracting within Primary Care inclusive of Primary Medical services, Dental, Community Pharmacy and Optometry across Herts and West Essex. • To provide assurance that action plans and risks relating to primary care quality are being addressed and that practices are being supported to improve quality. • To approve bids or returns on behalf of the ICB e.g. estates/capital submissions. • To liaise directly with the regional and national teams of NHSE on matters relating to Primary Care.	

Committee	Decisions and functions reserved to the Committee	Reference

	• To take an overview of the financial position for primary care in Herts and West Essex, including tracking investment against the agreed financial plan. Financial position to include the delegated budget, system development funding and other resource received, or utilised, for investment in primary care, ensuring value for money.
	• To monitor and review risks within the Committee's remit and identify any additional risks.
	• To oversee the robustness of the arrangements for and assure compliance with the ICB's responsibilities around primary care prescribing and medicines optimisation
	• To exercise the ICB's delegated primary care commissioning decisions in relation to:
	  • GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract).
	  • Newly designed Local Enhanced Services and Directed Enhanced Services.
	  • Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF).
	  • Decision making on whether to establish new GP practices in an area,
	  • Delegation of Pharmacy, Optometry and Dental Commissioning, Section 7A Public health functions and Health and Justice Commissioning – oversight of future model, governance and financial impacts.
	• Working closely with the Primary Care Board to agree the primary care priorities that are included in the ICB strategy/annual plan including priorities to address variations and inequalities	

Committee	Decisions and functions reserved to the Committee	Reference
	• To review primary care provider performance through quantitative and qualitative information across system and place and neighbourhood to continuously improve outcomes • To evaluate primary care commissioned services and provide assurance as appropriate to the Commissioning Committee and others. • Primary Care Commissioning Committee will provide regular assurance update to the Commissioning Committee. • **This Commissioning Committee has delegated authority for the following to the ICBs Provider Selection Regime (PSR) Review Group**: • The Group will review of formal representations – in compliance with the Health Care Services (Provider Selection Regime) Regulations 2023 (the Regulations). • **ICB Commissioning Committee grants the following delegated authority to the Hertfordshire and West Essex Area Prescribing Committee (HWE APC):** • HWE APC recommendations can be made and implemented in advance of formal ratification by Commissioning Committee if recommendations are: • both drug and activity cost neutral or cost saving. • implementation resources, developed to support a recommendation previously made and not associated with an additional separate cost-pressure. • for a mandatory NICE Technology Appraisal (drugs may be added to formulary in advance of formal ratification to allow for implementation within the mandated time scales) • Where a non-NICE TA recommendation has a cost pressure this must be reported for consideration before implementation. The recommendation will then be reviewed for prioritisation and consideration for affordability and formal ratification by the HWE ICB Commissioning Committee or other agreed mechanism.	

Committee	Decisions and functions reserved to the Committee	Reference
System Transformation and Quality Improvement Committee	The responsibilities of the System Transformation and Quality Improvement Committee will be authorised by the ICB Board. It is expected that the Committee will: Quality: • Be assured that there are robust processes in place for the effective management of quality. • Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern. • Agree and submit to ICB put forward the key quality priorities that are included within the ICB strategy/ annual plan. • Oversee and monitor delivery of the ICB key statutory requirements (e.g. Continuing Health Care) as applicable to quality. • Review and monitor those risks on the Strategic and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner. • Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health and Social Care (DHSC), NHS England & Improvement (NHSEI) and other regulatory bodies / external agencies (e.g. Care Quality Committee (CQC), National Institute for Health and Care Excellence (NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained. Maintain an overview of changes in the methodology employed by regulators and changes in	Constitution 1.4.7

Committee	Decisions and functions reserved to the Committee	Reference
	legislation/regulation as applicable to quality and assure the ICB that these are disseminated and implemented across all sites. • Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes. • Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place. • Receive assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded. • Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and Prevention of Future Death (PFD) report). • To be assured that service users are systematically and effectively involved as equal partners in quality activities. • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children. • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control. • Clinical or Quality related policies should come through the Quality committee for oversight, scrutiny and comment prior to approval and adoption by the ICB. Policy approval will be met through compliance with the ICBs Scheme of Reservation and Delegation. • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety. • Have oversight of the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g., System Quality Groups, Infection Prevention and Control, Safeguarding Boards / Hubs etc). Performance:	

Committee	Decisions and functions reserved to the Committee	Reference
	• The Terms of Reference sets out how Hertfordshire and West Essex ICB will work in partnership with the regional and national NHS England teams to provide effective, streamlined oversight for quality, performance, collective use of resources, and delivery of the 2021/22 Operational Planning requirements. • These requirements include: Covid-19 restoration and recovery, a greater emphasis on population health management, and improving health inequalities, outcomes, and access. The Committee is the primary governance forum to oversee the Partnership's mutual accountability arrangements. Its primary function is to monitor system performance and provide assurance relating to quality, finance, workforce and operational performance against constitutional standards, national priorities, and local strategic plans. • The TOR describe the scope, function, and ways of working for the Committee. They should be read in conjunction with the Hertfordshire and West Essex (HWE) Partnership Memorandum of Understanding. Primary Care Transformation: • Propose the strategic direction for local primary care services and identify the key priority areas needing change. • Enable local clinical perspectives to inform strategic decision-making. • Set the strategic context for transformation and take oversight of its implementation. Enable codesign/co-production across areas of primary care transformation and redesign in partnership with patients/citizens and all partners across the wider system. • Set out the principles and methodology for transformation in the strategic delivery plan. Lead the development of the primary care strategy and make recommendations to the Integrated Care Board. • Oversee the implementation and delivery of the primary care strategic delivery plan. • Drive quality and reduce unwarranted variation in outcomes for patients in primary care across HWE.	

Committee	Decisions and functions reserved to the Committee	Reference
People Committee	The People Committee will be responsible for: • Strategic workforce leadership supporting care and health service delivery and transformation and developing innovative new working practices and meeting workforce challenges within the system and the emerging Integrated Care Partnership. • Provide workforce leadership and support for emerging ICPs and oversight of system wide strategic workforce challenges and solutions. • Play a key role in future proofing workforce challenges and ensuring plans are developed to minimise future stresses. • Supporting the development of the health and social care sector as anchor institutions, supporting the economic and social development of our community. • Effective workforce planning at an ICS and ICP level. • Ensuring a truly equal, diverse and inclusive approach to attracting, supporting and developing the health and care workforce across the system. • Fostering effective cross-organisational, multi-disciplinary working is enabled across the health and social care system, and incorporates wider stakeholders such as Education, Housing, and the Voluntary, Community and Social Enterprise sectors. • Overseeing the workforce transformation programme with specific responsibility for effective delivery of system wide initiatives and the broader People Strategy, including the six identified workstreams: integrated workforce planning; innovation and new ways of working; sustainable workforce supply; equality and inclusion; staff wellbeing and experience; and education, training and leadership development.	
Strategy Committee	The Strategy Committee is authorised by the Board to: • Provide assurance and oversight to the Integrated Care Board; and • Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee members. The Committee shall determine the membership and terms of reference of any such task and finish sub-	

Committee	Decisions and functions reserved to the Committee	Reference

	groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation but may not delegate any decisions to such groups.
	• Having oversight, assurance and providing constructive challenge to ensure that NHS Herts & West Essex ICB and partner organisations are delivering on its strategic priorities:
	  • Increasing healthy life expectancy and reduce inequality o Give every child the best start in life
	  • Improving Access to Health and Care Services o Increasing the number of citizens taking steps to improve their wellbeing
	  • Successfully delivering our financial plan each year
	• Consider the progress of the organisation in implementation of the Integrated Care Boards Medium Term Plan, and amend that plan as needed.
	• Advise the Integrated Care Board on the alignment of plans and strategies across the ICB.
	• Promoting the adoption of Population Health Management across the ICS and provide regular updates to the board on progress in this area.
	• Promote and facilitate the use of research and evidence generated by research.	

Health Care Partnership (HCP) Board – applicable to each HCP within the geographical area of HWE ICB	Each Health Care Partnership (HCP) Board within the geographical area of this ICB shall be responsible for transacting the HCP's core business and leading strategic thinking on behalf of the HCP. In discharging these key responsibilities the HCP Board will: **Core Business** • To take accountability for the development and delivery of the overall financial plan for the [specified HCP] within the specified delegated budgets of the HCP. • To scrutinise and approve recommendations proposed by the HCP Strategic Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee, or through whatever model of managing these responsibilities the HCP agrees. This will include investment and spending decisions within the specified delegated budgets of the HCP.	

Committee	Decisions and functions reserved to the Committee	Reference
	• To approve recommendations for activity/interventions arising from the HCP's Clinical Transformation workstreams, the enabling workstreams and the task and finish groups. • Receive updates from the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee (or equivalent) and to review the HCP's risk register • To assure and drive the performance and delivery of Integrated Neighbourhood Team transformation work in [the specified HCP]. **Strategic Leadership** • To participate in the development of strategy across the Integrated Care System • To take joint accountability for the development and implementation of plans to transform the delivery of health and care in [the specified HCP]. • To maintain oversight, understanding and alignment of individual organisation strategies and plans. • To bring together activity, finance, operations, and quality intelligence from NHS providers in order to drive whole-system planning and prioritisation. • To lead the resolution of strategic challenges, issues and risks between partners.	

Decisions and functions delegated to be exercised jointly

Committee/entity that will exercise the function/decision	Decisions and functions delegated by the Board	Legal power	Governing arrangements
ICB/Essex County Council	Better Care Fund funding as set out in and in accordance with: • Our final approved plan. • The national conditions (the "National Conditions") set out in the Better Care Fund Policy Framework for 2023-25 and further detailed in the Better Care fund Planning Requirements for 2023-25. • Satisfactory progress being made towards meeting the performance objectives specified in our Better Care Fund Plan. In respect of Better Care Fund funding – • The ICB and Council have entered into arrangements to established pooled budgets for the purpose of discharging the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD Reports on our area's progress and performance: • Will be provided to NHS England in accordance with relevant guidance and any requests made by NHS England and governmental departments. This includes quarterly reporting on the Better Care Fund overall and fortnightly reporting on use of the Additional Discharge Funding, as set out in the Planning Requirements document.		
ICB/Hertfordshire Council	Better Care Fund funding as set out in and in accordance with: • Our final approved plan. • The national conditions (the "National Conditions") set out in the Better Care Fund Policy Framework for 2023-25 and further detailed in the Better Care fund Planning Requirements for 2023-25.		

	• Satisfactory progress being made towards meeting the performance objectives specified in our Better Care Fund Plan. In respect of Better Care Fund funding – • The ICB and Council have entered into arrangements to established pooled budgets for the purpose of discharging the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD Reports on our area's progress and performance: • Will be provided to NHS England in accordance with relevant guidance and any requests made by NHS England and governmental departments. This includes quarterly reporting on the Better Care Fund overall and fortnightly reporting on use of the Additional Discharge Funding, as set out in the Planning Requirements document.		

Decisions and functions delegated by the Board to other statutory bodies

Body	Decisions and functions delegated by the Board	Legal power	Governing arrangements
Essex County Council	• s.75 – Partnership Agreement Relating to Specialist Healthcare Tasks - Essex Wide • s.75 – Partnership Agreement Relating to the Provision of Mediation and Disagreement Resolution Services for Children and Young People with Special Education Needs or Disabilities – Essex Wide • s.256 - Mental Health accommodation - Essex wide • s.256 – Street Triage - Essex wide • s.75 – Supported Employment Services, Essex wide • s.75 – Learning Disabilities services, Essex wide • Better Care Fund – and services falling within that	Section 75, section 65Z5	Delegation agreement, MOU, etc

Hertfordshire County Council	• s.75 – Agreement covering a number of services including Mental Health • s.256 – Agreement covers voluntary and community transport • MoU – Contribution towards costs of adult wright management Programme • Collaboration Agreement – for the provision of children and young people services in the QEII. • Alliance Agreement – for the provision of Stroke Services.		

Decisions and functions delegated by the Board to individual Board Members and employees

Board Member / employee	Decisions and functions delegated by the Board	Reference
Chair	**Regulations and Control**	
	• Authenticate use of the seal.	Standing Order 6
	• Suspend Standing Orders in conjunction with 2 other Board members.	Standing Order 6
	• In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the relevant Director, will provide a settled view which shall be final.	Standing Orders 5.1.1 Standing Orders 3.4
	• To call meetings of the Board and preside over Board meetings.	Standing Orders 4.1.2, 4.2.1
	• In conjunction with the Chief Executive (or relevant lead Director in the case of committees) and one other member, make an urgent decision on behalf of the Board/Committee.	Standing Order 4.9.5
	Appointments/Dismissal	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• Appoint the Chief Executive of the ICB subject to the approval of NHS England. • Approve the appointments of the Partner Members of the Board. • Approve the appointment of Executive Members of the Board. • Approve the appointment or re-appointment of Non-Executive Members of the Board. • Appoint the Vice Chair of the Board. • Approve appointment of members of any committee. • Suspend or terminate members of the Board, as approved by the Board.	Constitution 3.4.1 Constitution 2.2.1, 3.5.4, 3.6.5, 3.7.4 Constitution 2.1.5, 2.2.2, 3.8.2, 3.9.3, 3.10.3, 3.12.3 Constitution 3.11.2 Constitution 3.11.8 Constitution 4.6.6; Standing Orders 4.2.3 Constitution 3.13.3

Chief Executive (Deputy Chief Executive)	**Regulations and Control**
	• Propose amendments to the Constitution to be considered and approved by the ICB prior to making an application to vary the Constitution to NHS England.
	• Establish a procedure for the use of the seal and keep (or nominate a manager to keep) the seal secure.
	  • Authenticate use of the seal
	  • HWE ICB Signatory
	• Propose to the Board the adoption of the Executive structure to facilitate discharge of ICB business.
		Constitution 1.6.2, Standing Orders 2.1.3, 2.1.4
		Standing Orders 6.1.1, 6.1.3
		Constitution 3.5.4, 3.6.5, 3.7.4

Board Member / employee	Decisions and functions delegated by the Board	Reference
	<u>Appointments/Dismissal</u> • Subject to the approval of the ICB Chair, appoint the Partner Members of the Board. • Subject to the approval of the ICB Chair, appoint the Executive Members of the Board. • Subject to the recommendation of the selection panel, approve the appointment of the Non-Executive Members and their re-appointment (within the limit of terms of office) **<u>Statutory Functions / Duty</u>** • In accordance with section 252A of the 2006 Act (as amended) act as the Accountable Emergency Officer (AEO) and Gold Commander for responding to Emergency Planning Resilience and Response events and declared incidents. **<u>NHS England Delegated Specialised Commissioning</u>** • ICB Authorised Officer – for the Joint Commissioning Consortium. Responsibilities include those detailed in the Joint Commissioning Consortium Terms of Reference and cover the services as cited in Decisions and functions delegated to the Board by other organisations below. • ICB Authorised Officer – to oversee revisions to the supporting Delegation Agreement.	Constitution 3.8.2, 3.9.3, 3.10.3, 3.12.3 Constitution 3.11.2, 3.11.7

Board Member / employee	Decisions and functions delegated by the Board	Reference
Chief Financial Officer	**Regulations and Control**	
	• HWE ICB Signatory	Standing Order 6
	• Authenticate use of the seal.	Standing Orders 6.1.3
	• Develop systems and processes to comply with the requirements of the NHS Provider Selection Regime.	Constitution 7.3.2, 7.3.3
	• Establish processes to ensure compliance with all relevant procurement regulations.	Constitution 7.3.5
	Annual Reports and Accounts	Constitution 7.2.3
	• Preparation of the annual accounts and accounting tables within the Annual Report in accordance with relevant guidance and regulations, including those for funds held on trust.	
	• Arrange for annual accounts to be externally audited and published.	Constitution 1.4.7, 7.2.8
	Statutory Functions / Duty	
	• Ensure systems are in place to deliver the financial duties of the ICB (Sections 223GB, 223N, 223H and 223 J). Including establishing the annual budget and budget management processes.	Constitution 7.2.5 Constitution 7.4.2
	• Establish adequate arrangements to discharge ICB duties in relation to the Freedom of Information Act 2000 and Information Commissioner Office requirements.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• Develop the Capital Resource Use Plan for approval by the Board and report how the ICB has exercised its functions in accordance with the Plan within the Annual Report. **<u>Operational Responsibilities</u>** • To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation, and best practice: Financial Strategy; Financial Operations; Planning and Reporting; Estates; Purchase of Healthcare; Digital Technology; Data and System Technology. • To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Finance & Investment Committee. • To be the Senior Information Risk Owner (SIRO) for the ICB. • Maintain and refresh (where appropriate and subject to approval of the Board) the Schedule of Detailed Delegated Financial Limits. • Establish and maintain the financial framework of the ICB as defined within Standing Financial Instructions. • Respond to the annual management letter from External Audit preparing proposed actions for to present to the Board after review by the Audit Committee. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Medical Director	**<u>Regulations and Control</u>**	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• HWE ICB Signatory **<u>Operational Responsibilities</u>** • To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Development (Clinical and Professional Leadership, Primary Care and Primary Care Networks Development); Stewardship; Quality and Governance (Clinical and Professional Congress) and Medicines Optimisation. • To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Clinical & Professional Congress. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Director of Nursing	**<u>Regulations and Control</u>** • HWE ICB Signatory **<u>Strategy, Annual Operational Plan and Budgets</u>** • Develop and propose to the Board the ICB Quality Strategy. **<u>Statutory Functions / Duty</u>** • Ensure systems are in place to deliver improvement in quality of services (Section 14Z34) and report on the discharge of these duties within the Annual Report.	Constitution 1.4.7, 7.2.8, 7.4.1 Constitution 7.2.4

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• Establish and publish clear arrangements for dealing with complaints in accordance with the Complaints Regulations including publishing an annual complaints report. • EQIAs etc? **<u>Operational Responsibilities</u>** • To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Patient Safety; Patient Experience; Safeguarding and Continuing Health Care. • To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Quality & Safety Committee. • To act as the Caldicott Guardian and the Designated Safeguarding Lead. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Chief People Officer	**<u>Strategy, Annual Operational Plan and Budgets</u>** • Develop and present to the Board for approval, proposals for organisational development. **<u>Operational Responsibilities</u>** • To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Human Resources (ICB internal function); System Workforce.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Remuneration Committee. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Chief of Staff	**Regulations and Control** • Ensure processes are in place to comply with Local Authority Health Overview and Scrutiny Requirements. • Report urgent decisions to the Board for ratification. **Annual Reports and Accounts** • Preparation of the Annual Report in accordance with relevant guidance and regulations. **Statutory Functions / Duty** • In accordance with section 14Z30(2) of the 2006 Act establish systems and processes (defined within the Conflicts of Interest Policy) to manage conflicts of interest (including gifts and hospitality) and publish the registers of interest on the ICB website. • To ensure that key governance documentation (Constitution, Standing Orders, Governance Handbook, Register of Interests and other key documents and policies as appropriate) are considered annually, reviewed and updated as necessary and published on the ICB website.	Constitution 7.3.4 Standing Order 4.9 Constitution 7.4.1 Constitution 6.1.3, 6.1.4, 6.1.5, 6.3.1, 6.3.2, 6.3.7 Constitution 7.2.7, Standing Orders 2.1.2

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• Publish agenda's, papers and minutes for meetings held in public, including details about meeting dates, times and venues. • Ensure adequate arrangements are in place to govern Board and Committee meetings in accordance with the Constitution, Standing Orders and best practice, including the development of committee terms of reference. **<u>Operational Responsibilities</u>** • To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Audit Committee. • To have oversight of and ensure the correct functioning of the ICB and its Committees. • Ensure that non-compliance with Standing Orders are reported to the next formal meeting of the Board for action or ratification. • Establish a robust system for the management of risk (including defining the strategic aims and objectives; identify, evaluate and report on risks, establishment of a risk management policy). • Management the policy framework of the ICB ensuring that policies are reviewed, updated and approved in a cyclical manner. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	Constitution 7.2.2; Standing Orders 4.1.4, 4.3.3 Constitution 4.6.3, 4.6.6; Standing Orders 4.10, 4.11 Standing Orders 3.1.6
Director of Strategy	**<u>Strategy, Annual Operational Plan and Budgets</u>**	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• Develop and publish a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years.	Constitution 7.2.8
	• Develop the Integrated Care System Plan for approval by the Board reviewing, within the annual report, the extent to which the ICB has exercised its functions.	Constitution 7.2.8, 7.4.2
	Statutory Functions / Duties	
	• In accordance with section 14Z44 of the Act establish processes for public involvement and consultation in relation to commissioning arrangements and report on the discharge of these duties within the Annual Report; ensuring the ICB meets the ten principles set out by NHSE for working with people and communities.	Constitution 1.4.7, 7.2.8, 7.4.1, 9.1.1, 9.1.2, 9.1.3
	• In accordance with section 116B(1) of the Local Government and Public Involvement in Health Act 2007 ensure that due regard is given to assessments and strategies.	Constitution 1.4.7
	• Ensure systems are in place to reduce inequalities (Section 14Z35) and report on the discharge of these duties within the Annual Report.	Constitution 1.4.7, 7.2.8, 7.4.1
	Operational Responsibilities	
	• To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: ICB Strategy: Community Resilience and Mobilisation; ICP Development and Strategic Partnerships; System Development Plan; MSE Partners; Communications and Engagement.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Integrated Care Partnership. • Ensure the ICB discharges its responsibilities to lead the ICS Engagement Framework. • To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	Constitution 9.1.7
Director of Performance	**Statutory Functions / Duties** • In accordance with section 14Z38 of the Act establish arrangements for obtaining appropriate advice. • In accordance with section 14Z43 of the Act meet the duty to have regard to wider effect of decisions and report of the discharge of this duty within the Annual Report. • In accordance with section 116B(1) of the Local Government and Public Involvement in Health Act 2007 ensure that due regard is given to assessments and strategies. **Operational Responsibilities** • To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: System Performance Management and Oversight, Co-ordination/oversight of performance Improvement, Annual Business Cycle, Business Intelligence, Including PHM Analysis, Planned Care, Elective Care and Cancer, Digital Transformation.	Constitution 1.4.7 Constitution 1.4.7, 7.2.8, 7.4.1 Constitution 1.4.7

Board Member / employee	Decisions and functions delegated by the Board	Reference
	• To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Director of Operations	**<u>Statutory Functions / Duties</u>** • In accordance with section 14Z38 of the Act establish arrangements for obtaining appropriate advice. • In accordance with section 14Z43 of the Act meet the duty to have regard to wider effect of decisions and report of the discharge of this duty within the Annual Report. • In accordance with section 116B(1) of the Local Government and Public Involvement in Health Act 2007 ensure that due regard is given to assessments and strategies. **<u>Operational Responsibilities</u>** • To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Day-to-day system/place operational delivery, Co-ordination of Place Based Development and Leadership, Local Pathway design and implementation, EPRR, Urgent and Emergency Care, HBL ICT Shared Services.	Constitution 1.4.7 Constitution 1.4.7, 7.2.8, 7.4.1 Constitution 1.4.7
Audit Committee Chair	To act as the Conflicts of Interest Guardian.	Constitution 6.1.6
On Call Director	To fulfil the duties required as set out by the Emergency Planning Team for managing escalations, incidents and out of hours cover as set out within associated ICB Policies.	

Decisions and functions delegated to the Board by other organisations

Body making the delegation	Decisions and functions delegated to the Board	Reference
NHS England	In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England have delegated the exercise of Delegated Functions: For Primary Medical Services - to the ICB to commission a range of services for the people of the area as follows: • Decisions in relation to the commissioning, and management of Primary Medical Services. • Planning Primary Medical Services in the Area, including carrying out needs assessment. • Undertaking review of Primary Medical Services in respect of the Area. • Management of Delegated Funds in the Area. • Co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and • Such other ancillary activities that are necessary in order to exercise the Delegated Functions. Specific obligations also include: • Primary Medical Services Contract Management. • Enhanced Services. • Design of Local incentive Schemes. • Making decisions on discretionary payments or support. • Making decisions about commissioning urgent care for out of areas registered patients. • Transparency and Freedom of Information. • Planning the Provider Landscape. • Primary Care Networks. • Approving Primary medical Services Provider Mergers and Closures.	Delegation Agreement.

Body making the delegation	Decisions and functions delegated to the Board	Reference
	• Making decisions in relation to management of poorly performing Primary Medical Services Providers. • Premises Costs Directions Functions. • Maintaining the Performers List. • Procurement and New Contracts. • Complaints. • Commissioning ancillary support services. • Finance • Workforce For Primary and Secondary Dental Care Services - to the ICB to commission a range of services for the people of the area as follows: • Decisions in relation to the commissioning and management of Primary Dental Services; • Planning Primary Dental Services in the Area, including carrying out needs assessments; • Undertaking reviews of Primary Dental Services in the Area; • Management of the Delegated Funds in the Area; • Co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and • such other ancillary activities that are necessary in order to exercise the Delegated Functions. Specific Obligations – Primary Dental Services only: • Dental Services Contract Management. • Transparency and Freedom of Information. • Planning the Provider Landscape.	

Body making the delegation	Decisions and functions delegated to the Board	Reference
	• Finance. • Staffing and Workforce. • Integrated dentistry into communication at Primary Care Network level. • Making Decisions in relation to Management of Poorly Performing Dental Services Providers. • Maintaining the Performers List. • Procurement and New Contracts. • Complaints. • Commissioning Ancillary Support Services. For Primary Ophthalmic Services - to the ICB to commission a range of services for the people of the area as follows: • Decisions in relation to the management of Primary Ophthalmic Services; • Undertaking reviews of Primary Ophthalmic Services in the Area; • Management of the Delegated Funds in the Area; • Co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and • Such other ancillary activities that are necessary in order to exercise the Delegated Functions. Specific Obligations – Primary Ophthalmic Services: • Primary Ophthalmic Services Contract Management. • Transparency and Freedom of Information. • Maintaining the Performers List. • Finance. • Workforce.	

Body making the delegation	Decisions and functions delegated to the Board	Reference
	• Integrated optometry into communities at Primary Care Network Level. • Complaints. • Commissioning ancillary support services. For Pharmaceutical Services - to the ICB to commission a range of services for the people of the area as follows: • Delegated Pharmaceutical Functions – as cited in the NHS England to HWE ICB Delegation Agreement – with terms as referenced in March 2023. • Prescribed Support. • Local Pharmaceutical Services Schemes. • Barred Persons. • Other Services. • Payments. • Flu vaccinations. • Integration. • Integrating Pharmacy into Communities at Primary Care Network Level. • Complaints. • Commissioning ancillary support services. • Finance. • Workforce. Such arrangements as have been set out in the 'delegation agreement' and shall prevail as if written into the SORD.	

Body making the delegation	Decisions and functions delegated to the Board	Reference

Specialist Commissioning:

The following Specialised Services were delegated to the ICB on 1 April 2024.

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology (adults)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass (complex/high flow)

Body making the delegation	Decisions and functions delegated to the Board				Reference
		Adult specialist neurosciences services (continued)	58C	Neurosurgery LVHC national: transoral excision of dens	
			58D	Neurosurgery LVHC regional: anterior skull based tumours	
			58E	Neurosurgery LVHC regional: lateral skull based tumours	
			58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions	
			58G	Neurosurgery LVHC regional: deep brain stimulation	
			58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection	
			58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system	
			58J	Neurosurgery LVHC regional: epilepsy	
			58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's	
			58L	Neurosurgery LVHC local: anterior lumbar fusion	
			58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours	
			58N	Neurosurgery LVHC local: intraventricular tumours resection	
			58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)	
			58P	Neurosurgery LVHC local: thoracic discectomy	
			58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia	
			58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours	
			58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly	
	12	Adult specialist ophthalmology services	37C	Artificial Eye Service	
			37Z	Adult specialist ophthalmology services	
	13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)	
			34R	Orthopaedic revision (adults)	
	15	Adult specialist renal services	11B	Renal dialysis	
			11C	Access for renal dialysis	

Body making the delegation	Decisions and functions delegated to the Board			Reference
	16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
	17	Adult specialist vascular services	30Z	Adult specialist vascular services
	18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
			29Z	Adult thoracic surgery services: outpatients
	30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
			32D	Middle ear implantable hearing aids service
	35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
	36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
	40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
			08Z	Complex neuro-spinal surgery services (adults and children)
	54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
	58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
			04D	Complex urinary incontinence and genital prolapse
	58A	Specialist adult urological surgery services for men	41P	Penile implants
			41S	Surgical sperm removal
			41U	Urethral reconstruction
	59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
	61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
	62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
	63	Specialist pain management services for children	23Y	Specialist pain management services for children

Body making the delegation	Decisions and functions delegated to the Board			Reference
	64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
	65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
			18E	Specialist Bone and Joint Infection (adults)
	72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
	78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
	83	Paediatric cardiac services	23B	Paediatric cardiac services
	94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
			51R	Radiotherapy services (Children)
			01S	Stereotactic Radiosurgery / radiotherapy
	105	Specialist cancer services (adults)	01C	Chemotherapy
			01J	Anal cancer (adults)
			01K	Malignant mesothelioma (adults)
			01M	Head and neck cancer (adults)
			01N	Kidney, bladder and prostate cancer (adults)
			01Q	Rare brain and CNS cancer (adults)
			01U	Oesophageal and gastric cancer (adults)
			01V	Biliary tract cancer (adults)
			01W	Liver cancer (adults)
			01Y	Cancer Outpatients (adults)
			01Z	Testicular cancer (adults)
			04F	Gynaecological cancer (adults)
			19V	Pancreatic cancer (adults)
			24Y	Skin cancer (adults)
			19C	Biliary tract cancer surgery (adults)
			19M	Liver cancer surgery (adults)
			19Q	Pancreatic cancer surgery (adults)
			51A	Interventional oncology (adults)
			51B	Brachytherapy (adults)

Body making the delegation	Decisions and functions delegated to the Board				Reference
			51C	Molecular oncology (adults)	
			61M	Head and neck cancer surgery (adults)	
			61Q	Ophthalmic cancer surgery (adults)	
			61U	Oesophageal and gastric cancer surgery (adults)	
			61Z	Testicular cancer surgery (adults)	
			33C	Transanal endoscopic microsurgery (adults)	
			33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)	
	106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer	
			23A	Children's cancer	
	106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)	
			33B	Complex inflammatory bowel disease (adults)	
	107	Specialist dentistry services for children	23P	Specialist dentistry services for children	
	108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children	
	109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children	
	110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children	
	112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology	
	113	Specialist haematology services for children	23H	Specialist haematology services for children	
	115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta	
	118	Neonatal critical care services	NIC	Specialist neonatal care services	
	119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children	
			07Y	Paediatric neurorehabilitation	
			08J	Selective dorsal rhizotomy	

Body making the delegation	Decisions and functions delegated to the Board			Reference
	120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children	
	121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children	
	122	Paediatric critical care services	PIC	Specialist paediatric intensive care services	
	125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children	
	126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)	
	127	Specialist renal services for children	23S	Specialist renal services for children	
	128	Specialist respiratory services for children	23T	Specialist respiratory services for children	
	129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children	
	130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases	
	131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults	
			19P	Specialist services for complex pancreatic diseases in adults	
			19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults	
			19B	Specialist services for complex biliary diseases in adults	
	132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)	
			03Y	Specialist services for haemophilia and other related bleeding disorders (Children)	
	134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics (adults and children)	
	135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery	
	136	Specialist paediatric urology services	23Z	Specialist paediatric urology services	

Body making the delegation	Decisions and functions delegated to the Board				Reference
	139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children	
	139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	
	ACC	Adult Critical Care	ACC	Adult critical care	

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

APPENDIX 15

1. Appendix 1(Delegated limits)

Commitment of Healthcare, non-healthcare contracts and expenditure			
Committee	Role	Approval expenditure, business cases and contract award All expenditure must be authorised against known and agreed budget and cannot be exceeded All figures cited below include individual contracts or services where a perceived monetary value has been calculated – e.g., where a service is being offered to the ICB for free or at a reduced market rate. In such cases, and in support of full transparency a cost figure will be identified alongside an anticipated market value.	Authorisation for payment of prior approved expenditure
ICB Board / Governing Body		Unlimited	n/a
Strategic Finance and Commissioning Committee		**Approve** proposals on individual contracts or services of a capital or revenue nature amounting to, or likely to amount to £2.5m (or up to £5m if contract exceeds 12 months): **With delegated approval for the above sums to the ICBs Primary Care Commissioning Committee** in respect: • GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract). • Newly designed Local Enhanced Services and Directed Enhanced Services. • Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF). • Decision making on whether to establish new GP practices in an area, • Delegation of Pharmacy, Optometry and Dental Commissioning, Section 7A Public health functions and Health and Justice Commissioning – oversight of future model, governance and financial impacts. **Recommend** to the Board for approval all proposals on individual contracts or services of a capital or revenue nature amounting to,	**n/a**

		or likely to amount to over £2.5m (or £5m if contract exceeds 12 months.	
Remuneration Committee		up £100k, for clinical and non-clinical	**n/a**
Health Care Partnership/Place		**Approve** – • Authority to approve where the source of funds and its use is determined nationally • Proposals on individual contracts or services of a capital or revenue nature amount to, or likely to amount to £1m (or up to £2m if contract exceeds 12 months). **Recommend** to the Commissioning Committee for approval all proposals on individual contracts or services of a capital or revenue nature amount to, or likely to amount to £2.5, (or up to £5m if the contract exceeds 12 months)	
	CEO	up to £1000k	Unlimited
	CFO	up to £500k	Unlimited
	Deputy CFO	up to £50k	£29,999.999
	Other Directors	up to £100k	£ 999,999
	Deputy/Assistant/Associate Directors	up to £50k	£49,999
	Other budget holders*	Up to £25k	£24,999
	Senior Finance Manager	Up to £5k	£1,499,000
	Other Managers*		£4,999
	Continuing Health Care Placements (Operational leads)*	Approve care packages > £1.5K per week	£9,999
	Continuing Health Care Placements (Senior leads)*	Approve care packages < £2.5K per week	£24,999
	Continuing Health Care Placements (Assistant Director)	Approve care packages < £5K per week	£99,999
	Continuing Health Care Placements (Director Nursing)	Approve care packages > £5K per week	£ 999,999
	Financial Services (T10s) For urgent payments	up to £5k	£99.999

Tenders and quotations for non-clinical services			
	1 written quote with evidence to be obtained for contracts	£0 to £24,999	
	3 written quotes – Competitive invitation to quote supported by a specification and evaluation or the use of an appropriate framework	£25,000 to £216,446	
	Formal procedure in line with the Public Contract regulations	£213,447	
Tenders and quotations for clinical services			
	1 written quote with evidence to be obtained for contracts	Up to £24,999	
	3 written quotes – Competitive invitation to quote supported by a specification and evaluation or the use of an appropriate framework	£25,001 to £299,999	
	4 written quotes – Competitive invitation to quote supported by a specification and evaluation or the use of an appropriate framework	£300,000 to £663,539	
	Formal process in line with the Public Contract Regulations	£663,539 & above	

Procurement thresholds in line with Public Contract Regulations 2015 thresholds – note that all values are inclusive of VAT. The £25k threshold is the point at which we need to advertise on Contracts Finder, anything underneath that is outside of a formal process.
*Director confirmation will be sought by finance leads – of colleagues within their teams provided with delegated authority to approve sums to this level. A register will be held documenting these names and the same or relevant director will notify the finance team of any changes.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

East and North Hertfordshire Health Care Partnership Board

Terms of Reference_2024 v0.2

1. Constitution

1.1 The East and North Hertfordshire Health and Care Partnership Board ('the board') is established by the Hertfordshire and West Essex ICB to provide strategic leadership for the East and North Hertfordshire Health and Care Partnership ('the HCP').

1.2 These Terms of Reference (ToR) will be published on the ICB website and set out the membership, the remit, responsibilities and reporting arrangements of this Committee and may only be changed with the approval of the HCP Board.

2. Authority

2.1 The East and North Hertfordshire Health and Care Partnership ("the HCP") has the following vision: Working as one for healthier communities.

The role of the East and North Hertfordshire Health Care Partnership Board ("HCP Board") is to provide the multi-agency, system leadership to the HCP.

2.2 The HCP Board is authorised by the ICB Board to:

- Convene and support all partners across the HCP to work together to transform health and care delivery that achieves patient-centred improvements in health and care services
- Develop and deliver the HCP's delivery plan, including relevant national priorities/ targets.
- Utilise population health management approaches, to identify and develop evidence-based pathways and models of preventive and proactive care
- Drive a fundamentally different model of care and services that support people at or closer-to-home, ensuring avoiding requirement for more costly services that may also lead to poorer outcomes and experience
- Be accountable for balancing specified delegated budgets, and for the delivery of the relevant aspects ICBs strategy and priorities as agreed by the ICB Board.

2.3 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference of this Board.

3. Responsibilities and functions

3.1 The Board shall be responsible for transacting the HCP's core business and leading strategic thinking on behalf of the HCP. In discharging these key responsibilities the HCP Board will:

Core Business

- To take accountability for the development and delivery of the overall financial plan for East

and North Hertfordshire within the specified delegated budgets of the HCP.

- To scrutinise and approve recommendations proposed by the HCP Strategic Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee, or through whatever model of managing these responsibilities the HCP agrees. This will include investment and spending decisions within the specified delegated budgets of the HCP.
- To approve recommendations for activity/interventions arising from the HCP's Clinical Transformation workstreams, the enabling workstreams and the task and finish groups.
- Receive updates from the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Committee (or equivalent) and to review the HCP's risk register
- To assure and drive the performance and delivery of Integrated Neighbourhood Team transformation work in East and North Hertfordshire.

Strategic Leadership

- To participate in the development of strategy across the Integrated Care System
- To take joint accountability for the development and implementation of plans to transform the delivery of health and care in East and North Hertfordshire.
- To maintain oversight, understanding and alignment of individual organisation strategies and plans.
- To bring together activity, finance, operations, and quality intelligence from NHS providers in order to drive whole-system planning and prioritisation.
- To lead the resolution of strategic challenges, issues and risks between partners.

4. Composition and Quoracy

4.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	The Board will be chaired by the HCP Senior Responsible Officer. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.
Membership	The Board members shall be appointed by the HCP Board in accordance with the ICB Constitution. Membership shall comprise the following roles: • HCP Senior Responsible Officer(s) (Elliot Howard-Jones and Adam Sewell-Jones) • Non-Executive Member of the Integrated Care Board • Chief Finance Officer of the ICB (or Deputy) • ICB Medical Director or Director of Nursing (or Deputy) • ICB Partner Member (Primary Care GP) Members from partner organisations within the Health Care Partnership and East and North Hertfordshire HCP Place Director.

	Members of the HCP Board will operate with the individual delegated responsibility from their employing organisation to enable the Partnership to carry out its responsibilities and functions. In some circumstances this will necessitate decisions being taken through each organisation's specific governance processes. Named deputies are permitted to attend meetings where individuals above are unable to attend. When determining the membership of the Board, active consideration will be made to diversity and equality.
Attendees	Only members of the Board have the right to attend meetings, however all meetings of this Committee will also be attended by the following individuals who are not members of this Board: • SROs and programme lead(s) for transformation programmes • Specific project or programme leads from across the system • ICB Governance lead • Secretariat 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 particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.
Procedure for attendance	Where the HCP operates a HCP Strategic Finance and Commissioning Committee and its representative (who is not a member of this Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.
Meeting frequency and Quorum	The Board will meet a minimum of six times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The ICB Board or the HCP Senior Responsible Officer may ask the Board to convene further meetings to discuss particular issues on which they want the committee's advice. In accordance with the ICBs Standing Orders, this Board may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. **A quorum will be at least 50% of membership**, but for decisions to be taken on delegated matters, and in line with the ICBs constitution, that must include a minimum of three members of the ICB board or their deputies. If any member of the Board has been disqualified from participating in an

	item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Voting will be taken in according with the ICBs Standing Orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. On all matters not relating to responsibilities delegated by the ICB, all members have one vote, and a majority will be conclusive. On matters relating to ICB delegation, and where there is not a consensus opinion, only those members of the board who are also members of the Integrated Care board will be able to vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of this Board will hold the casting vote. The Chair can ask for an indicative vote of the whole board prior to initiating the sub-committee voting process but this is not binding on those members of the ICB board that will vote. The Chief of Staff of the Integrated Care Board, or their named representative, will determine whether an area is considered a delegated responsibility and therefore point 5.9 applies. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. The voting requirements set out in paras 5.7-5.11 apply.

5. Behaviours and Conduct

5.1 Benchmarking and Guidance

The Board will take proper account of National Agreements and appropriate benchmarking, for example Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

5.2 ICB Values

Members will be expected to conduct business in line with the ICB values and objectives.

Members of, and those attending, the HCP Board shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

5.3 Conflicts of Interest

The members of the Board must comply fully with the NHS England Guidance and ICB Standards of Business Conduct and Conflicts of Interest Policy.

The ICB reserves the right to ask members of the Board to provide assurance that they meet the criteria set out in the ICBs Fit and Proper Persons policy, before agreeing their appointment to the committee.

5.4 Equality Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

6. Accountability and Reporting

The Board is accountable to the ICB Board and shall report to the ICB Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

7. Secretariat, Administration and Review

The Board shall be supported with a secretariat function operated by the Integrated Care Board governance team, which will include ensuring that:

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the ICB Board.
Updates	The ICB Board is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Board will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1		HWE ICB Board	Annually	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

South West Hertfordshire Health Care Partnership Board

Terms of Reference_2024 v0.2

1. Constitution

1.1 The South West Hertfordshire Health and Care Partnership Board ('the board') is established by the Hertfordshire and West Essex ICB to provide strategic leadership for the South West Hertfordshire Health and Care Partnership ('the HCP').

1.2 These Terms of Reference (ToR) will be published on the ICB website and set out the membership, the remit, responsibilities and reporting arrangements of this Committee and may only be changed with the approval of the HCP Board.

2. Authority

2.1 The South West Hertfordshire Health and Care Partnership ("the HCP") has the following vision: Our vision is to be a 'single team' responsible for planning, improving and delivering population-based health and care services for the people of South-West Herts, delivered by via a locality working model.

The role of the South West Hertfordshire Health Care Partnership Board ("HCP Board") is to provide the multi-agency, system leadership to the HCP.

2.2 The HCP Board is authorised by the ICB Board to:

- Convene and support all partners across the HCP to work together to transform health and care delivery that achieves patient-centred improvements in health and care services
- Develop and deliver the HCP's delivery plan, including relevant national priorities/ targets.
- Utilise population health management approaches, to identify and develop evidence-based pathways and models of preventive and proactive care
- Drive a fundamentally different model of care and services that support people at or closer-to-home, ensuring avoiding requirement for more costly services that may also lead to poorer outcomes and experience
- Be accountable for balancing specified delegated budgets, and for the delivery of the relevant aspects ICBs strategy and priorities as agreed by the ICB Board.

2.3 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference of this Board.

3. Responsibilities and functions

3.1 The Board shall be responsible for transacting the HCP's core business and leading strategic thinking on behalf of the HCP. In discharging these key responsibilities the HCP Board will:

Core Business

- To take accountability for the development and delivery of the overall financial plan for South West Hertfordshire within the specified delegated budgets of the HCP.
- To scrutinise and approve recommendations proposed by the HCP Strategic Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee, or through whatever model of managing these responsibilities the HCP agrees. This will include investment and spending decisions within the specified delegated budgets of the HCP.
- To approve recommendations for activity/interventions arising from the HCP's Clinical Transformation workstreams, the enabling workstreams and the task and finish groups.
- Receive updates from the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee (or equivalent) and to review the HCP's risk register
- To assure and drive the performance and delivery of Integrated Neighbourhood Team transformation work in South West Hertfordshire.

Strategic Leadership

- To participate in the development of strategy across the Integrated Care System
- To take joint accountability for the development and implementation of plans to transform the delivery of health and care in South West Hertfordshire.
- To maintain oversight, understanding and alignment of individual organisation strategies and plans.
- To bring together activity, finance, operations, and quality intelligence from NHS providers in order to drive whole-system planning and prioritisation.
- To lead the resolution of strategic challenges, issues and risks between partners.

4. Composition and Quoracy

4.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	The Board will be chaired by the HCP Senior Responsible Officer. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.
Membership	The Board members shall be appointed by the HCP Board in accordance with the ICB Constitution. Membership shall comprise the following roles: • HCP Senior Responsible Officer (Matthew Coats) • Non-Executive Member of the Integrated Care Board • Chief Finance Officer of the ICB (or Deputy) • ICB Medical Director or Director of Nursing (or Deputy) • ICB Partner Member (Primary Care GP) Members from partner organisations within the Health Care Partnership, and South and West Hertfordshire HCP Place Director

	Members of the HCP Board will operate with the individual delegated responsibility from their employing organisation to enable the Partnership to carry out its responsibilities and functions. In some circumstances this will necessitate decisions being taken through each organisation's specific governance processes. Named deputies are permitted to attend meetings where individuals above are unable to attend. When determining the membership of the Committee, active consideration will be made to diversity and equality.
Attendees	Only members of the Board have the right to attend meetings, however all meetings of this Board will also be attended by the following individuals who are not members of this Board: • SROs and programme lead(s) for transformation programmes • Specific project or programme leads from across the system • ICB Governance lead • Secretariat 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 particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.
Procedure for attendance	Where the HCP operates a HCP Strategic Finance and Commissioning Committee and its representative (who is not a member of this Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.
Meeting frequency and Quorum	The Board will meet a minimum of six times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The ICB Board or the HCP Senior Responsible Officer may ask the Board to convene further meetings to discuss particular issues on which they want the committee's advice. In accordance with the ICBs Standing Orders, this Board may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. **A quorum will be at least 50% of membership**, but for decisions to be taken on delegated matters, and in line with the ICBs constitution, that must include a minimum of three members of the ICB board or their deputies.

	If any member of the Board has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Voting will be taken in according with the ICBs Standing Orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. On all matters not relating to responsibilities delegated by the ICB, all members have one vote, and a majority will be conclusive. On matters relating to ICB delegation, and where there is not a consensus opinion, only those members of the board who are also members of the Integrated Care board will be able to vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of this Committee will hold the casting vote. The Chair can ask for an indicative vote of the whole board prior to initiating the sub-committee voting process but this is not binding on those members of the ICB board that will vote. The Chief of Staff of the Integrated Care Board, or their named representative, will determine whether an area is considered a delegated responsibility and therefore point 5.9 applies. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. The voting requirements set out in paras 5.7-5.11 apply.

5. Behaviours and Conduct

5.1 Benchmarking and Guidance

The Board will take proper account of National Agreements and appropriate benchmarking, for example Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

5.2 ICB Values

Members will be expected to conduct business in line with the ICB values and objectives.

Members of, and those attending, the HCP Board shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

5.3 Conflicts of Interest

The members of the Board must comply fully with the NHS England Guidance and ICB Standards of Business Conduct and Conflicts of Interest Policy.

The ICB reserves the right to ask members of the committee to provide assurance that they meet the criteria set out in the ICBs Fit and Proper Persons policy, before agreeing their appointment to the committee.

5.4 Equality Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

6. Accountability and Reporting

The Board is accountable to the ICB Board and shall report to the ICB Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

7. Secretariat, Administration and Review

The Board shall be supported with a secretariat function operated by the Integrated Care Board governance team, which will include ensuring that:

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the ICB Board.
Updates	The ICB Board is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Board will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

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V1		HWE ICB Board	Annually	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

West Essex Health Care Partnership Board

Terms of Reference_2024 v0.2

1. Constitution

1.1 The West Essex Health and Care Partnership Board ('the board') is established by the Hertfordshire and West Essex ICB to provide strategic leadership for the West Essex Health and Care Partnership ('the HCP').

1.2 These Terms of Reference (ToR) will be published on the ICB website and set out the membership, the remit, responsibilities and reporting arrangements of this Committee and may only be changed with the approval of the HCP Board.

2. Authority

2.1 The West Essex Health and Care Partnership ("the HCP") has the following vision: "To help everyone in our area live long and healthy lives by supporting independence and providing seamless care".

The role of the West Essex Health Care Partnership Board ("HCP Board") is to provide the multi-agency, system leadership to the HCP.

2.2 The HCP Board is authorised by the ICB Board to:

- Convene and support all partners across the HCP to work together to transform health and care delivery that achieves patient-centred improvements in health and care services
- Develop and deliver the HCP's delivery plan, including relevant national priorities/ targets.
- Utilise population health management approaches, to identify and develop evidence-based pathways and models of preventive and proactive care
- Drive a fundamentally different model of care and services that support people at or closer-to-home, ensuring avoiding requirement for more costly services that may also lead to poorer outcomes and experience
- Be accountable for balancing specified delegated budgets, and for the delivery of the relevant aspects ICBs strategy and priorities as agreed by the ICB Board.

2.3 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference of this Board.

3. Responsibilities and functions

3.1 The Board shall be responsible for transacting the HCP's core business and leading strategic thinking on behalf of the HCP. In discharging these key responsibilities the HCP Board will:

Core Business

- To take accountability for the development and delivery of the overall financial plan for West Essex within the specified delegated budgets of the HCP.
- To scrutinise and approve recommendations proposed by the HCP Strategic Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee, or through whatever model of managing these responsibilities the HCP agrees. This will include investment and spending decisions within the specified delegated budgets of the HCP.
- To approve recommendations for activity/interventions arising from the HCP's Clinical Transformation workstreams, the enabling workstreams and the task and finish groups.
- Receive updates from the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee (or equivalent) and to review the HCP's risk register
- To assure and drive the performance and delivery of Integrated Neighbourhood Team transformation work in West Essex.

Strategic Leadership

- To participate in the development of strategy across the Integrated Care System
- To take joint accountability for the development and implementation of plans to transform the delivery of health and care in West Essex.
- To maintain oversight, understanding and alignment of individual organisation strategies and plans.
- To bring together activity, finance, operations, and quality intelligence from NHS providers in order to drive whole-system planning and prioritisation.
- To lead the resolution of strategic challenges, issues and risks between partners.

4. Composition and Quoracy

4.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	The Board will be chaired by the HCP Senior Responsible Officer. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.
Membership	The Board members shall be appointed by the HCP Board in accordance with the ICB Constitution. Membership shall comprise the following roles: • HCP Senior Responsible Officer (Lance McCarthy) • Non-Executive Member of the Integrated Care Board • Chief Finance Officer of the ICB (or Deputy) • ICB Medical Director or Director of Nursing (or Deputy) • ICB Partner Member (Primary Care GP) Members from partner organisations within the Health Care Partnership and West Essex HCP Place Director.

	Members of the HCP Board will operate with the individual delegated responsibility from their employing organisation to enable the Partnership to carry out its responsibilities and functions. In some circumstances this will necessitate decisions being taken through each organisation's specific governance processes. Named deputies are permitted to attend meetings where individuals above are unable to attend. When determining the membership of the Board, active consideration will be made to diversity and equality.
Attendees	Only members of the Board have the right to attend meetings, however all meetings of this Board will also be attended by the following individuals who are not members of this Board: • SROs and programme lead(s) for transformation programmes • Specific project or programme leads from across the system • ICB Governance lead • Secretariat 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 particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.
Procedure for attendance	Where the HCP operates a HCP Strategic Finance and Commissioning Committee and its representative (who is not a member of this Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.
Meeting frequency and Quorum	The Board will meet a minimum of six times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The ICB Board or the HCP Senior Responsible Officer may ask the Board to convene further meetings to discuss particular issues on which they want the committee's advice. In accordance with the ICBs Standing Orders, this Board may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. **A quorum will be at least 50% of membership**, but for decisions to be taken on delegated matters, and in line with the ICBs constitution, that must include a minimum of three members of the ICB board or their deputies. If any member of the Board has been disqualified from participating in an

	item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Voting will be taken in according with the ICBs Standing Orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. On all matters not relating to responsibilities delegated by the ICB, all members have one vote, and a majority will be conclusive. On matters relating to ICB delegation, and where there is not a consensus opinion, only those members of the board who are also members of the Integrated Care board will be able to vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of this Committee will hold the casting vote. The Chair can ask for an indicative vote of the whole board prior to initiating the sub-committee voting process but this is not binding on those members of the ICB board that will vote. The Chief of Staff of the Integrated Care Board, or their named representative, will determine whether an area is considered a delegated responsibility and therefore point 5.9 applies. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. The voting requirements set out in paras 5.7-5.11 apply.

5. Behaviours and Conduct

5.1 Benchmarking and Guidance

The Board will take proper account of National Agreements and appropriate benchmarking, for example Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

5.2 ICB Values

Members will be expected to conduct business in line with the ICB values and objectives.

Members of, and those attending, the HCP Board shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

5.3 Conflicts of Interest

The members of the Board must comply fully with the NHS England Guidance and ICB Standards of Business Conduct and Conflicts of Interest Policy.

The ICB reserves the right to ask members of the committee to provide assurance that they meet the criteria set out in the ICBs Fit and Proper Persons policy, before agreeing their appointment to the committee.

5.4 Equality Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

6. Accountability and Reporting

The Board is accountable to the ICB Board and shall report to the ICB Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

7. Secretariat, Administration and Review

The Board shall be supported with a secretariat function operated by the Integrated Care Board governance team, which will include ensuring that:

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the ICB Board.
Updates	The ICB Board is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Board will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1		HWE ICB Board	Annually	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire Mental Health, Learning Disability and Autism

Health and Care Partnership Board

Terms of Reference_2024 v0.2

1. Constitution

1.1 The Hertfordshire Mental Health, Learning Disability and Autism (MHLDA) Health and Care Partnership Board('the board') is established by the Hertfordshire and West Essex ICB to provide strategic leadership for the Hertfordshire MHLDA Health and Care Partnership ('the HCP').

1.2 These Terms of Reference (ToR) will be published on the ICB website and set out the membership, the remit, responsibilities and reporting arrangements of this Committee and may only be changed with the approval of the HCP Board.

2. Authority

2.1 The MHLDA Health and Care Partnership ("the HCP") has the following vision: Supporting people living with mental illness, learning disabilities and autism in Hertfordshire to live longer happier and healthier lives. The role of the MHLDA Health and Care Partnership Board ("HCP Board") is to provide the multi-agency, system leadership to the HCP.

2.2 The HCP Board is authorised by the ICB Board to:

- Convene and support all partners across the HCP to work together to transform health and care delivery that achieves person-centred improvements in health and care services.
- Develop and deliver the HCP's delivery plan, including relevant national priorities/ targets.
- Utilise population health management approaches, to identify and develop evidence-based pathways and models of preventive and proactive care.
- Drive a fundamentally different model of care and services that support people at or closer-to-home, ensuring avoiding requirement for more costly services that may also lead to poorer outcomes and experience.
- Be accountable for balancing specified delegated budgets, and for the delivery of the relevant aspects ICBs strategy and priorities as agreed by the ICB Board.

2.3 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference of this Committee.

3. Responsibilities and functions

3.1 The Board shall be responsible for transacting the HCP's core business and leading strategic thinking on behalf of the HCP. In discharging these key responsibilities the HCP Board will:

Core Business

- To take accountability for the development and delivery of the overall financial plan for MHLDA within the specified delegated budgets of the HCP. In practice this will require the MHLDA HCP Board to take accountability for the operation of the MHLDA schedule of the Section 75 agreement between HWE ICB and Hertfordshire County Council
- To scrutinise and approve recommendations proposed by the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Committee, or through whatever model of managing these responsibilities the HCP agrees. This will include investment and spending decisions related to the NHS elements of the pooled fund for MHLD within the Section 75 arrangements.
- To approve recommendations for activity/interventions arising from the HCP's sub-groups Clinical Transformation workstreams, the enabling workstreams and the task and finish groups.
- Receive updates from the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Committee (or equivalent) and to review the HCP's risk register

Strategic Leadership

- To participate in the development of strategy across the Integrated Care System
- To take joint accountability for the development and implementation of plans to transform the delivery of health and care for people with mental illness, learning disabilities and neurodivergent people.
- To maintain oversight, understanding and alignment of individual organisation strategies and plans.
- To bring together activity, finance, operations, and quality intelligence from NHS providers and wider system partners in order to drive whole-system planning and prioritisation.
- To lead the resolution of strategic challenges, issues and risks between partners.

4. Composition and Quoracy

4.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	The committee will be co-chaired by the HCP Senior Responsible Officers. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.
Membership	The Board members shall be appointed by the HCP Board. Membership shall comprise the following roles: • Hertfordshire Partnership University NHS Foundation Trust, Chief Executive Officer/ HCP Senior Responsible Officer (Karen Taylor) • Hertfordshire County Council, Director of Adult Care Services/ HCP Senior Responsible Officer/ Accountable Officer for Section 75

	arrangement (Chris Badger) • Non-Executive Member of the Integrated Care Board • Chief Finance Officer of the ICB (or Deputy) • ICB Medical Director or Director of Nursing (or Deputy) • ICB Partner Member (Primary Care) Members from partner organisations: • Hertfordshire and West Essex ICB, Director of Strategy and Deputy Chief Executive • Chair of South and West Hertfordshire Health and Care Partnership • Chair of East and North Hertfordshire Health and Care Partnership • Central London Community Healthcare NHS Trust, Divisional Director • West Hertfordshire Teaching Hospitals NHS Trust, Chief Executive • East and North Hertfordshire Hospitals Trust, Chief Executive • Hertfordshire Community NHS Trust, Chief Executive Officer • Hertfordshire County Council, Director of Public Health • Hertfordshire County Council, Director of Children's Services • Chair of Learning Disabilities and Autism Strategic Partnership Board • Chair of Crisis Care Partnership Board • Chair of Children and Young People Emotional and Mental Wellbeing Board • Chair of Primary and Community Mental Health Board • Chair of MHLDA HCP Clinical and Practice Advisory Committee • Chair of MHLDA VCFSE Alliance (in development) • HWE ICB MHLDA Clinical Leads • Carers in Hertfordshire, • Viewpoint, Chief Executive • Mind in Mid-Herts, Chief Executive • Hertfordshire Mind Network, Chief Executive Members of the HCP Board will operate with the individual delegated responsibility from their employing organisation to enable the Partnership to carry out its responsibilities and functions. In some circumstances this will necessitate decisions being taken through each organisation's specific governance processes. Named deputies are permitted to attend meetings where individuals above are unable to attend.
Attendees	Only members of the Board have the right to attend meetings, however all meetings of this Committee will also be attended by the following individuals who are not members of this Committee: • SROs and programme lead(s) for transformation programmes • Specific project or programme leads from across the system • ICB Governance lead/secretariat 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 particular

	matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist with its discussions on any particular matter including representatives from the Health and Wellbeing Board (s), Secondary and Community Providers.
Procedure for attendance	When an attendee of the HCP Strategic Finance and Commissioning (who is not a member of this Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.
Meeting frequency and Quorum	The committee will meet a minimum of six times a year and arrangements and notice for calling meetings are set out in the Standing Orders. https://www.healthierfuture.org.uk/sites/default/files/nhshwe-icb-constitution010722finalpending-approval-by-nhs-england.pdf Additional meetings may take place as required. The ICB Board or the HCP Senior Responsible Officer may ask the Board to convene further meetings to discuss particular issues on which they want the committee's advice. In accordance with the ICBs Standing Orders, this Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. A quorum will be at least 50% of membership, but for decisions to be taken on delegated matters, and in line with the ICBs constitution, that must include a minimum of three members of the ICB board or their deputies. If any member of the Board has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Voting will be taken in according with the ICBs Standing Orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. On all matters not relating to responsibilities delegated by the ICB, all members have one vote, and a majority will be conclusive. On matters relating to ICB delegation, and where there is not a consensus opinion, only those members of the board who are also members of the Integrated Care board will be able to vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of this Committee will hold the casting vote. The Chair can ask for an indicative vote of the whole board prior to initiating the sub-committee voting process but this is not binding on those members

of the ICB board that will vote.

The Chief of Staff of the Integrated Care Board, or their named representative, will determine whether an area is considered a delegated responsibility and therefore point 5.9 applies.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. The voting requirements set out in paras 5.7-5.11 apply.

5. Behaviours and Conduct

5.1 Benchmarking and Guidance

The Committee will take proper account of National Agreements and appropriate benchmarking, for example Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

5.2 ICB Values

Members will be expected to conduct business in line with the ICB values and objectives.

Members of, and those attending, the HCP Board shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

5.3 Conflicts of Interest

The members of the Committee must comply fully with the NHS England Guidance and ICB Standards of Business Conduct and Conflicts of Interest Policy.

The ICB reserves the right to ask members of the committee to provide assurance that they meet the criteria set out in the ICBs Fit and Proper Persons policy, before agreeing their appointment to the committee.

5.4 Equality Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

6. Accountability and Reporting

The Board is accountable to the ICB Board and shall report to the ICB Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

7. Secretariat, Administration and Review

The Board shall be supported with a secretariat function operated by the Integrated Care Board governance team, which will include ensuring that:

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
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Minute taking	Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the ICB Board.
Updates	The ICB Board is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Board will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

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Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care Board

System Transformation and Quality Improvement Committee

Terms of Reference v1.1

1. Constitution

1.1 The System Transformation and Quality Improvement Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive chaired committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2. Accountability and Delegated Authority

2.1 The System Transformation and Quality Improvement Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation set out in the Constitution as may be amended from time to time.

2.2 The Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

2.2 The Committee is authorised by the ICB to:

- Investigate any activity within these Terms of Reference;
- The Committee will drive improvement in performance and ensure oversight of the delivery of key performance standards by healthcare providers, performance of the system against the NHS Outcomes Framework https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022 and delivery against system Operational Plan This includes the performance review and management of system providers and health care partnerships.
- The committee will have a strong focus for identifying and driving improvement:
- Have oversight to monitor and drive improvements in performance at system, place, and organisation level within the ICS.
- Providing the oversight of the development and delivery of system delivery plans, working with organisations and Health Care Partnerships to agreeing objectives, indicators and quality and performance measures at system, place & individual organisational level.
- Linking where necessary with the ICB People Committee to focus on the system's performance against agreed outcome measures which includes NHS constitutional standards, CQC requirements, Operational Planning Guidance, and System and NHSE agreed transformation programmes.
- Provide specific oversight and seek assurance from organisations and Health Care Partnerships with regard to workforce delivery challenges impacting on performance

and, identify and seek assurance on any system wide workforce issues which are blockages to system wide performance improvement.

- Provide a forum to work with NHSE on any place based or individual organisations intervention undertaken as part of the national system oversight & assurance framework.
- Seek any information it requires from any member, officer or employee who are directed to co-operate with any request made by the Committee;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice; and
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and (SoRD) but may not delegate any decisions to such groups.
- Delegate tasks to such individual members, sub-committees, or individuals as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

3. Purpose of the Committee

3.1 The System Transformation and Quality Improvement Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out by NHS England and the National Quality Board and enshrined in the Health and Care Act 2022.

The Committee will have a duty to be mindful of all five ICB Strategic Objectives with a primary responsibility for, **Objective 2 Give every child the best start in life and Objective 3 Improve access to health and care services.**

3.2 The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality and performance governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

3.3 It is recognised that each provider has its own statutory responsibilities as individual statutory bodies in their own right, linked into CQC and NHSE. The Committee will however, drive system level initiatives and performance but in the most part this will be in the context of the system not at individual organisational level.

3.4 The Committee will play a key role in ensuring delivery of key national policy areas such as Long term Plan (LTP) requirements, Operating Plan, Fuller Recommendations, Primary Care contractual requirements and oversight of transformation with a view to continuously improve quality and enhance performance.

3.5 The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3.6 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference of the Committee.

4. Responsibilities of the Committee

4.1 The responsibilities of the System Transformation and Quality Improvement Committee will be authorised by the ICB Board.

It is expected that the Committee will:

4.2 Quality:

- Be assured that there are robust processes in place for the effective management of quality.
- Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern.
- Agree and submit to ICB put forward the key quality priorities that are included within the ICB strategy/ annual plan.
- Oversee and monitor delivery of the ICB key statutory requirements (e.g. Continuing Health Care) as applicable to quality.
- Review and monitor those risks on the Strategic and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner.
- Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health and Social Care (DHSC), NHS England (NHSE) and other regulatory bodies / external agencies (e.g. Care Quality Committee (CQC), National Institute for Health and Care Excellence (NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.
- Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation as applicable to quality and assure the ICB that these are disseminated and implemented across all sites.
- Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes.
- Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place.
- Receive assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded.
- Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and Prevention of Future Death (PFD) report).
- To be assured that service users are systematically and effectively involved as equal partners in quality activities.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control.

- Clinical or Quality related policies should come through the Quality committee for oversight, scrutiny and comment prior to approval and adoption by the ICB. Policy approval will be met through compliance with the ICBs Scheme of Reservation and Delegation.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.
- Have oversight of the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g. System Quality Groups, Infection Prevention and Control, Local Maternity and Neonatal System Partnership Board, Quality Patient Group etc).

4.3 Performance:

- The Terms of Reference sets out how Hertfordshire and West Essex ICB will work in partnership with the regional and national NHS England teams to provide effective, streamlined oversight for quality, performance, collective use of resources, and delivery of the 2024/25 Operational Planning requirements.
- These requirements include: Covid-19 restoration and recovery, a greater emphasis on population health management, and improving health inequalities, outcomes, and access.
- The Committee is the primary governance forum to oversee the Partnership's mutual accountability arrangements. Its primary function is to monitor system performance and provide assurance relating to quality, finance, workforce and operational performance against constitutional standards, national priorities, and local strategic plans.
- The TOR describe the scope, function, and ways of working for the Committee. They should be read in conjunction with the Hertfordshire and West Essex (HWE) Partnership Memorandum of Understanding.

4.4 Primary Care:

- Oversight of the delivery of national and local strategic plan for primary care and identify the key priority areas needing change.
- Enable system discussions integrating primary care into system transformation and enabling system wide discussions on impact of quality and performance standards across providers on primary care to support interface/end to end pathway.
- Set out the principles and methodology for transformation in the strategic delivery plan.
- Drive quality and reduce unwarranted variation in outcomes for patients in primary care across HWE through Health and Care Partnerships

5. Composition and Quoracy

5.1 This section sets out the meeting composition and quoracy arrangements:

Arrangement	Description of expectation
Chair and Vice Chair	The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of

	interest. If a Chair has a conflict of interest, then the co-chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.
Membership	The Committee members shall be appointed by the Board in accordance with the ICB Constitution. The Board will appoint no fewer than four members of the Committee including two who are Non-Executive Members of the Board. Other attendees of the Committee need not be members of the Board, but they may be. When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion. 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 particular matters. **Committee Members:** • ICB Non-Executive Member (Chair) • ICB Partner Member – Primary Medical Services ~~(Transformation)~~ (Vice Chair) • ICB Non-Executive Member x2 • ICB Director of Nursing • ICB Medical Director • ICB Director of Performance • ICB Director of Primary Care Transformation Other representatives: • Directors of Nursing aligned to each ~~Health Care Partnership~~ Organisation • Directors of Performance aligned to each ~~Health Care Partnership and/or~~ Organisation • Chairs of HCP equivalent committees • 1 x primary care representative • 1 x local authority lead from each local authority • 1 x Healthwatch (alternate between Essex and Hertfordshire) • 2 x Patient Safety Partners • ~~Safeguarding Lead for Children and Families~~ • System Quality Director
Attendees	Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee: • ~~ICB Quality Improvement and Patient Safety lead~~ • ~~ICB Nursing & Quality lead~~ • ~~Independent Chair for Safeguarding Board~~ • ICB Continuing Healthcare lead

	~~• ICB Primary Care Quality lead~~ ~~• Voluntary, Community, Faith and Social Enterprise (VCFSE) representative)~~ • Members of the Nursing and Quality, Performance and Primary Care Teams dependent on agenda e.g. Deputy Directors and Assistant Directors • Head of Community Resilience • ICB Quality committee governance lead • ICB Quality committee secretarial • Clinical Quality Director, NHS England • Specific project or programme leads from across the system.
Procedure for attendance	Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee. 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 particular matters.
Meeting frequency and Quorum	The Committee will meet every other month. Additional meetings may be convened on an exceptional basis and at the discretion of the Committee Chair. Arrangements and notice for calling meetings are set out in the Standing Orders. For a meeting to be quorate there will be a minimum of the **Chair or Vice Chair, plus at least the Director of Nursing or Medical Director, Director of Performance, and one provider representative, one Local Authority representative.** Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.
Decision making and voting	Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. Behaviours and Conduct

6.1 ICB values

Members will be expected to conduct business in line with the ICB values and objectives.

Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

6.2 Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

7. Accountability and Reporting

7.1 The Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a report on assurances received, escalating any concerns where necessary.

7.2 The Committee will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

7.3 The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

7.4 All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

8. Secretariat, Administration and Review

The Committee shall be supported with a secretariat function which will include ensuring that:

Distribution of papers	The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
Monitor attendance	Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
Maintain records	Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
Minute taking	Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
Support the Chair and Committee	The Chair is supported to prepare and deliver reports to the Board.

Updates	The Committee is updated on pertinent issues/ areas of interest/ policy developments. Action points are taken forward between meetings and progress against those actions is monitored.
Review	The Committee will review its effectiveness at least annually. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 26 April 2024	HWE ICB Board	Annually	n/a

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	NHS HWE ICB Board meeting held in Public				**Meeting Date:**	**24/05/2024**	
Report Title:	**Integrated reports for finance, performance, quality and workforce**				**Agenda Item:**	**08**	
Report Author(s):	Executive Team						
Report Presented by:	Alan Pond, Frances Shattock, Tania Marcus, Natalie Hammond, Michael Watson						
Report Signed off by:	Alan Pond, Frances Shattock, Tania Marcus, Natalie Hammond, Michael Watson						
Purpose:	**Approval / Decision**	☐	**Assurance**	☒	**Discussion**	☐	**Information** ☐
Which Strategic Objectives are relevant to this report **[Please list]**	• Increase healthy life expectancy, and reduce inequality • Give every child the best start in life • Improve access to health and care services • Increase the numbers of citizens taking steps to improve their wellbeing • Achieve a balanced financial position annually						
Key questions for the ICB Board / Committee:	Areas for discussion are identified in the summary section of the paper						
Report History:	N/A						
Executive Summary:	This report provides a summary of the quality, performance and finance reporting shared elsewhere on the agenda, whilst also providing an update on workforce across the ICS. **Board members should also review the more detailed reports in the for information section of the todays board agenda.**						
Recommendations:	The Board is asked to consider the report and the areas highlighted for discussion.						

Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
Implications / Impact:				
Patient Safety:	*N/A*			
Risk: *Link to Risk Register*	*N/A*			
Financial Implications:	*N/A*			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***		N/A	
	Quality Impact Assessment:		N/A	
	Data Protection Impact Assessment:		N/A	

1. Summary

This report is a summary of the Quality, Performance and finance reports that are elsewhere on the board agenda for information. It also includes the perspective of the workforce team on many of the issues raised.

In section two of today's report the executive team members involved in the production of the integrated report have highlighted the areas of most significant concern that they would like to escalate to the board for consideration, more information on these areas can be found in this report and in the quality, performance and finance reports before the board today.

2. Key issues highlighted

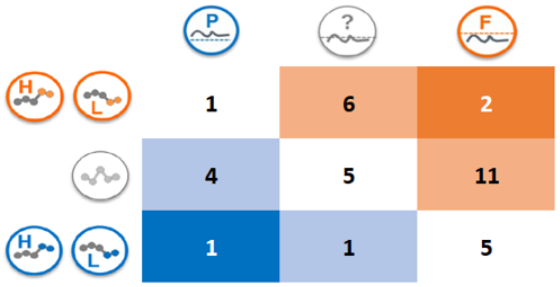
The executive team would like to bring the follow key areas to the Board's attention, which have an impact on quality and performance- and will need to be considered carefully as we deliver our plans in relation to finance and workforce:

Area of concern/ improvement	Current situation
System financial position 23/24	The system reported a year end breakeven position. Whilst this was due to a collaborative effort across the system and should be welcomed, it should also be noted that a number of measures taken to achieve that position were non-recurrent.
Planning for 24/25	The Integrated Care System enters 24/25 with an underlying deficit. Our most recent submission to NHSE projected a year end deficit of £44.9m. Further work is taking place to reduce the projected deficit and seek to reach a plan that achieves a breakeven position.
Urgent and Emergency Care Performance	4-hour ED achievement fell just short of the 76% national ambition, but was the highest the system has achieved since August 2021 against the backdrop of growth in attendences. Hours lost to ambulance handover reduced significantly, and the system achieved its year end trajectory.
Elective waiting times	The total elective waiting list reduced for the sixth consecutive month. 65- and 52-week backlogs continue to improve. Significant reduction in 78 and 65ww is due to a national change of reporting for community paediatric patients who are now reported in the community waiting list data.
Waiting time inequality for Children and Young People	Childrens community waiting lists remain high, with waiting times notably longer than in adult services. CAMHS caseloads have increased for three consecutive months.

3. Overview by area

Performance

Executive Summary – KPI Risk Summary



Highest Risk	Programme
RTT 78 Week Waits	Elective
Community Waits (Children)	Community

High Risk	Programme
% of on the day GP Appointments	Primary Care
% of <14 day GP Appointments	Primary Care
ED 4 Hour Standard	UEC
% in ED > 12 Hours	UEC
NHS 111 Calls Abandoned	UEC
Ambulance Response Times	UEC
4 Hour Stroke Unit	Stroke
Thrombolysed < 1 Hour	Stroke
CAMHS 28 Day Standard	Mental Health
Community MH - CYP Waits for 1st Appt	Mental Health
Community MH - Adult Waits for 2nd Appt	Mental Health
6 Week Waits	Diagnostics
62 Day Standard	Cancer
RTT 65 Week Waits	Elective
RTT 52 Week Waits	Elective
Autism Spectrum Disorder (ASD)	Community
CHC Assessments < 28 Days	Community

Lowest Risk	Programme
CHC Assessments in Acute	Community

Low Risk	Programme
Learning Disability (LD) Health Checks	Primary Care
90% Stroke Unit	Stroke
Adult Crisis 4 Hour	Mental Health
28 Day Faster Diagnosis	Cancer
Community Waits (Adults)	Community

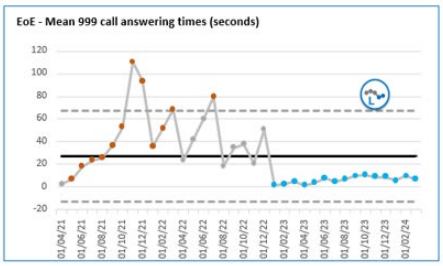
Variable Risk	Programme
Dementia Diagnosis	Primary Care
2 Hour UCR	UEC
No Criteria to Reside (NCTR)	UEC
Ambulance Handovers	UEC
Out of Area Bed Days	Mental Health
Adult 28 Day Standard	Mental Health
CYP Eating Disorders	Mental Health
Learning Disabilities - Time to 1st Assess.	Mental Health
31 Day Standard	Cancer
62 Day Backlog	Cancer
HPFT Early Memory Diagnosis (EMDASS)	Mental Health

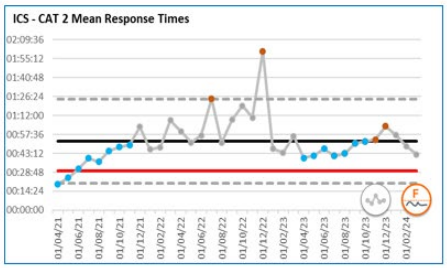
Moved to lower risk category | Moved to higher risk category | No change to risk category | New KPI added this month

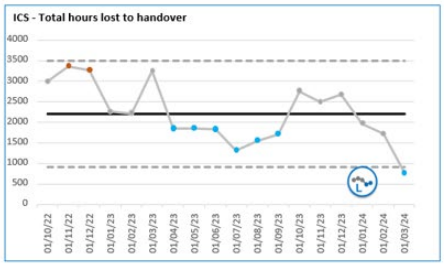
Narrative

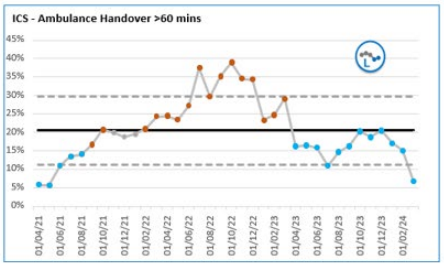
URGENT CARE, Slides 8-13	**4 Hour Performance**	**Region: HWE better than average**	**National: HWE worse than average**
• Hours lost to handover improved significantly to 771 hours in March, achieving the system recovery target • Performance against the 4-hour ED standard improved further to 74.8% in March. Whilst not achieving the 76% ambition, this was the best performance since August 21 • NHS 111 abandoned calls increased further in March to 28.3%. Latest data for April suggests significant improvement to <15% • Category 2 ambulance response times improved to 42 minutes in March, however HWE responses remain the highest in East of England			
PLANNED CARE, Slides 14-15	**18 Week RTT**	**Region: HWE better than average**	**National: HWE worse than average**
• The overall elective PTL continues to reduce and has fallen in each of the last 6 months • All HWE acute trusts continue to report 78-week breaches beyond the March 24 target date. There were c.60 x 78 week waits in the acute trusts' end of March position, with an additional 30 cases with ISPs • The 65 weeks backlog continues to slowly reduce. All trusts are forecasting to reach zero by end of September			
DIAGNOSTICS, Slide 16	**6 Week Waits**	**Region: HWE better than average**	**National: HWE worse than average**
• 6 week wait performance improved to 68.7%. All trusts saw improvement in February			
CANCER, Slides 18-19	**28 Day FDS / 31 Day / 62 Day**	**Region: HWE better than average**	**National: HWE better than average**
• 28 Day Faster Diagnosis Standard (FDS) performance continues to improve, achieving 81% in March against the 75% standard • Patients waiting >62 days continue to reduce. The HWE final 23/24 backlog was 398 against the target of 389 • 62-day performance betters the national and regional averages at 71.4%, but has been below the historic mean for the last 14 months; 31-day cancer performance narrowly missed the national standard at 95.9%			
MENTAL HEALTH, Slides 21-31	**Community MH (1st / 2nd Appts)**	**National: HWE better than average (Adult)**	**National: HWE better than average (CYP)**
• Mental Health (MH) out of area bed days increased in February, but the overall trend is one of improvement. Access to community MH services however remains challenged and high risk • Community adult MH waits for a 2nd contact continue to increase, but better the national average			
CHILDREN, Slides 27-29, 32-36	**Various**	**Community 18 Week %: HWE worse than national**	**Community MH 1st Appts: HWE better than national**
• The total number of children on community waiting lists remains very high. Longest waits increased slightly to 112 weeks, compared to 61 weeks for adults • Pressures are predominantly in Community Paediatrics, as well as therapies and Audiology services • Autism Spectrum Disorder (ASD) lists and waiting times remain high. Backlog funding ended in December 23. Without continuation of the backlog funding investments, ASD waiting lists will start to grow • CAMHS caseloads have increased for the last three months, and the 28-day access standard has not been achieved since 2021 • Children's waits for a Community MH 1st appointment are better than the national average. However median waits are 110 days, compared to 84 days for a 2nd contact in adult services			
COMMUNITY (Adults), Slides 37-38	**% <18 Weeks**	**National: HWE better than average**	**Adult waiting times better than CYP**
• % of adults waiting <18 weeks remains strong and betters the national average			
PRIMARY CARE & CHC, Slides 43-46	**Appointments <14 Days**	**National: HWE in line with national average**	
• Total number of GP appointments are variable but remain higher than pre-pandemic levels. Appointments in 2023 are highest since 2019 • The percentage of appointments seen on the same day and <14 days both have long-term decreasing trends • CHC assessments within 28 days remains high risk, with performance particularly challenged in South & West Hertfordshire			

UEC - Ambulance Response and Handover

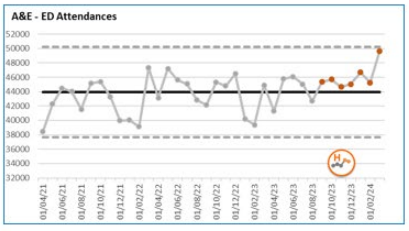


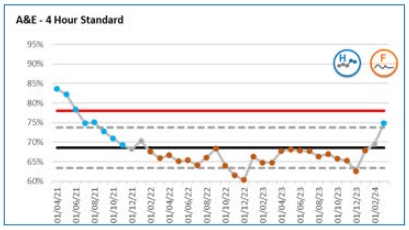


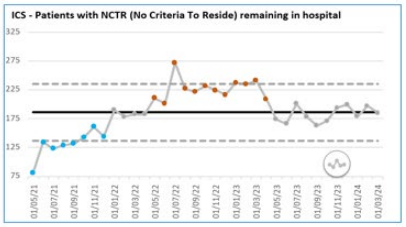


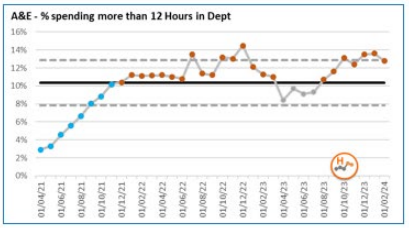


Urgent & Emergency Care (UEC)





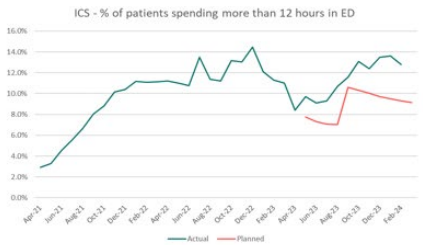




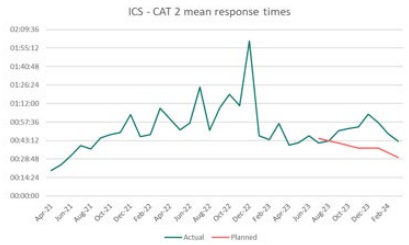
Urgent & Emergency Care (UEC) Improvement Trajectories

4 Hour Standard

% of Patients Spending > 12 Hours in ED

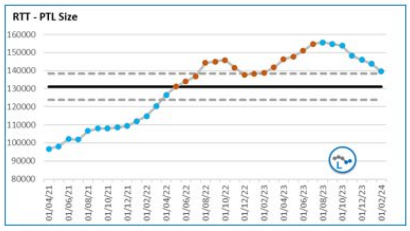


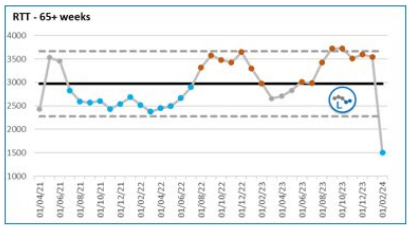
Ambulance Category 2 Mean Response Times

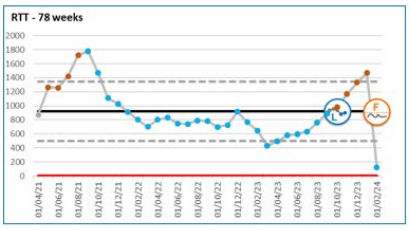


Hours Lost to Handover

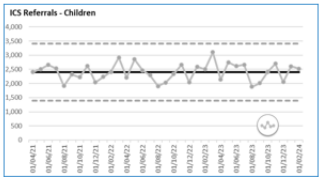
Planned Care – PTL Size and Long Waits

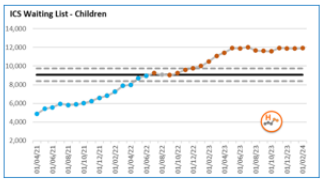


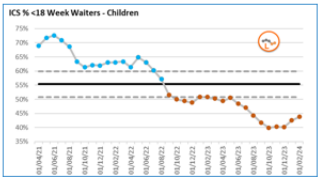


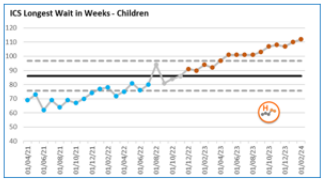


Community Waiting Times (Children)









		Referrals			Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Children	2604	2524	↓	11870	11919	↑	42.51%	43.82%	↑	110	112	↑	February

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	351	374	↑	1014	1015	↑	75.74%	82.07%	↑	50	51	↑	February
ENH	AJM/Millbrook	22	15	↓	125	118	↓	71.20%	72.03%	↑	34	36	↑	February
ENH	ENHT Community Paeds.	318	294	↓	5168	5295	↑	17.92%	17.58%	↓	110	112	↑	February
ENH	**All**	**691**	**683**	↓	**6307**	**6428**	↑	**28.27%**	**28.76%**	↑	**110**	**112**	↑	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	1342	1313	↓	4573	4464	↓	51.52%	54.75%	↑	82	73	↓	February
SWH	AJM/Millbrook	18	18	→	108	108	→	72.22%	71.30%	↓	31	35	↑	February
SWH	**All**	**1360**	**1331**	↓	**4681**	**4572**	↓	**52.00%**	**55.14%**	↑	**82**	**73**	↓	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT - Wheelchairs	23	15	↓	27	25	↓	100.00%	100.00%	→	16	17	↑	February
WE	HCRG / Virgin	530	495	↓	855	894	↑	93.80%	92.62%	↓	26	26	→	February
WE	**All**	**553**	**510**	↓	**882**	**919**	↑	**93.99%**	**92.82%**	↓	**26**	**26**	→	**February**

Performance v. 23/24 Operational Plans

		M11 Only					Year To Date				
POD	Description	Plan	Actual	Actual vs Plan %	Change	Performance	Plan	Actual	Actual vs Plan %	Change	Performance
EM13	Number of attendances at all type A&E departments	35,329	42,101	19.17%	6,772	↑	438,326	456,170	4.07%	17,844	↑
EM11a	Number of specific acute non-elective spells in the period with a length of stay of zero days	3,091	3,480	12.58%	389	↑	37,839	33,329	-11.92%	-4,510	↓
EM11b	Number of specific acute non-elective spells in the period with a length of stay of one or more days	6,026	6,457	7.15%	431	↑	67,993	73,851	8.62%	5,858	↑
EM10a	Elective day case spells	10,039	10,236	1.96%	197	↑	100,488	108,431	7.90%	7,943	↑
EM10b	Elective ordinary spells	1,247	886	-28.95%	-361	↓	12,800	9,830	-23.20%	-2,970	↓
EM32g	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance	43,694	41,911	-4.08%	-1,783	↓	474,957	462,403	-2.64%	-12,554	↓
EM32h	Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance	50,942	65,996	29.55%	15,054	↑	575,380	716,226	24.48%	140,846	↑
EB20	The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 65 weeks or more	1,775	1,508	-15.04%	-267	↓	25,887	34,575	33.56%	8,688	↑
	Operational planning modalities (provider)	36,393	33,735	-7.30%	-2,658	↓	393,765	380,199	-3.45%	-13,566	↓

ICB Issues and escalations

- YTD attendances, and non-elective spells with a length of stay of one of more days, are both higher than plan
- Non-elective spells with a zero-day length of stay are slightly below plan
- Elective inpatient activity is below plan. Elective activity in all areas has been impacted by Industrial Action
- The number of 65-week waits is above plan, however the target for zero 65ww breaches has been extended to end of September 2024

Quality

Key areas

Area	Position	Further info
Publication of Hertfordshire Special Education Needs and Disabilities (SEND) report		Local Partnership SEND Quality Assurance Framework undergoing formal sign off at Joint SEND Partnership and Assurance Board on 25th April 2024 and SEND Priority Executive on 2nd May 2024. Work is underway related to the development of joint quality assurance visits and provider self -assessment quality improvement toolkit.
Measles	N/A	Confirmed measles cases increased nationally and locally. Arrangements to reduce impact on local population and health and social care being put in place. The ICB, local NHS trusts, United Kingdom Health Security Agency and Herts County Council/Essex County Council collaborating with Incident Management Teams to put measures in place. An NHSE regional tabletop exercise at which the HWE ICS will be represented is taking place in May.
UPDATE: **East & North Herts NHS Trust Paediatric Child Hearing Impairment (PCHI) Service.**		Pathways reopened in April 2024 for 3-5 years and over 5 years. Hertfordshire Community Trust (HCT) continue to provide Auditory Brain Responses service. Regional team hosted by HWE ICB on behalf of East of England is fully recruited. Improvement work continues to be overseen by the ICB and NHSE via fortnightly oversight meetings , and steady improvements evidenced.
East and North Hertfordshire Trust (ENHT) X-ray backlog		Non-chest x-rays are now cleared. The Trust is working on radiology's demand

		and capacity to ensure that it matches the needs of the population and an improvement plan is in place.
The Lampard Inquiry		An Independent Statutory Inquiry into the deaths of mental health inpatients in Essex. The final Terms of Reference were published on 11th April 2024. The scope of the inquiry has been broadened and now also includes other key providers.

Reasons to be Proud

East and North Herts Trust (ENHT)

- The Admiral Nurse Caring Conversations video which has been shared with the Integrated Care Board, features outstanding work in dementia care, demonstrating multidisciplinary collaboration. Junior Doctors have shared their experiences and suggestions for improving communication with families where needs are complex.
- The vacancy rate for registered nurses is approximately 6%, with a target of 5% by April 2024, ranking the Trust in the top performing quartile nationally.

Hertfordshire Partnership Foundation Trust (HPFT)

- Colleagues from HPFT recently hosted a Quality Improvement webinar and highlighted how HPFT's Quality Improvement team are empowering staff, service users and carers to identify and implement innovative ideas to achieve better outcomes. Projects included;
- Equine Therapy was trialed at Warren Court, a HPFT medium secure unit for male service users with a complex trauma history. It was suggested by a service user who had benefitted from this treatment elsewhere and he helped to pull a project plan together to approach the Quality Improvement team
- Fishing for Health - Service users who took part in the pilot reported: "it taught me how to be patient and cope with disappointment and frustration." They described how "it was easier to talk about other things to do with my health when I was fishing." They also helped to facilitate the next cohort of service users taking part.

Hertfordshire Community Trust (HCT)

- In February 2024 HCT were delighted when two of their nurses, Catherine McCarevey (community staff nurse) and Mary Heffernan (clinical quality lead) were finalists for Heart Radio's 2024 Local NHS heroes award and were pleased to learn that Catherine went on to win. Both Catherine and Mary exemplify the compassionate and individual nursing care that HCT is so proud to deliver.

St Clares Hospice

- St Clare Hospice was named winner of the staff learning and development award at the Our Health Heroes Awards, delivered by Skills for Health. An expert panel of judges were impressed by St Clare's dedication to developing staff skills and improving services for patients and their families.
- The hospice ensures that all staff are equipped to address issues of end -of- life care through its end- of- life care webinar days, monthly masterclasses and students and professional placement programme. The Hospice helps professionals navigate sensitive conversations and decisions regarding resuscitation through training and care of the dying study afternoons.
- The hospice has also achieved Teaching Hospice Status with Cambridge University and is also a Centre for European Certificate in Essential Palliative Care. Hospice also runs biennial conferences, last one in 2023 and next due in 2025. From training volunteers on bereavement support to equipping shop staff with communication skills, the hospice understands the impact its work has on the entire community. www.skillsforhealth.org.uk/awards.

ICB - Patient Experience and Safety Quarter 4

ICB Area	Compliments	Complaints	PALS	Member of Parliament (MP)	General Practitioner (GP)	Whistleblowing	Serious Incidents	Never Events
East and North Herts.	2	31	121	23	89	0	6	0
South and West Herts.	0	33	154	18	53	4	19	0
West Essex.	0	13	102	11	66	2	4	0
Other.	4	17	189	3	2	0	3	0
Total.	6	94	566	55	210	4	32	0

ICB area	Key themes/ Risks	Improvement Actions and Mitigations
Herts and West Essex.	• Providers are transitioning from using the Serious Incident (SI) Framework 2015 to the new nation process for learning from incidents, the Patient Safety Incident Response Framework (PSIRF). • All Trusts have now transitioned to the new PSIRF and therefore numbers of SIs declared will significantly reduce. • Smaller and independent sector providers continue to transition to PSIRF. • National patient safety plan for primary care is anticipated in the coming months. Therefore, a small number of SIs from these providers will continue to be reported.	• Providers continue to use the Strategic Executive Information System to alert Commissioners to an incident where it is necessary to carry out a specific type of learning response, a Patient Safety Incident Investigation (PSII). • There is a national list of the types of incidents for which a PSII is required. In addition, each provider has identified local priority areas where PSIIs will be undertaken. • As PSIRF is implemented and embedded examples of learning will be shared with the Committee.

Infection Prevention and Control (IPC)

Area	Issue	Mitigating Action	Timescale
Measles.	Since 1st October 2023, the number of confirmed cases of measles in England has continued to rise. Although the outbreak in the West Midlands initially drove the increase in cases, in recent weeks there has been an increase in activity in London and across the United Kingdom.	• Fit testing sessions held for primary care. • Respiratory hoods, for staff regularly failing fit tests in primary care. Fit testing arrangements in place within all local trusts • Pop up immunisation clinics being held including traveller sites etc. • Collaboration between ICB, local NHS trusts, United Kingdom Health Security Agency and Herts County Council /Essex County Council to participate in healthcare or community case Incident Management Team. • HWE ICS Round Table event organised by ICB for 25th April to review learning from recent cases, review existing local arrangements and identify potential gaps and associated mitigation in local preparedness.	Ongoing.
Pertussis (whooping cough).	Pertussis activity exceptionally low in England (49 and 69 confirmed in 2021 and 2022 respectively) probably as result of work to control COVID-19. Increased to 858 in 2023 and continued rise to 1468 cases in England in January and February 24.	• Collaboration between ICB, local NHS trusts, United Kingdom Health Security Agency and Herts County Council/Essex County Council to participate in Incident Management Teams i.e. contact tracing • Communications to midwives to increase promotion and uptake of Diptheria – Tetanus- Pertussis in pregnant women • Communication to GPs to raise awareness of recent epidemiology. IPC link practitioner webinar held.	Ongoing.
C. difficile.	Nationally C. diff cases above pre-pandemic levels and rising. All 3 places, and acute trusts in HWE have counts above allocated ceilings. West Herts Teaching Hospital Trust (WHTHT)and South and West Herts place have numbers below last year.	• ICB /Trusts analysing C. diff and monitoring impact of activity. • Introduction of Multi- Disciplinary Team bedside C difficile reviews / ward rounds. • ICS Antimicrobial Stewardship Technical Working Group reviews antimicrobial prescribing data. Proportion of broad-spectrum antibiotics prescribed meets target. Total antibiotics prescribed in primary care and intravenous to oral switch need further work. • HWE ICS Antimicrobial Stewardship Strategy being produced.	Ongoing.

Finance

HWE ICS – Financial Report for Month 12 2023/24

Executive Summary

ICS Full Year Position – Month 12

In month 12, the HWE System reported a break-even full out-turn position. Whilst four organisations reported a surplus, PAH and WHHT reported deficit positions of £6.1m and £13.8m respectively.

The ICB finished the year ahead of plan by £4.6m. This was due to additional ERF being earned, together with several contracts reaching a full year position below that expected.

Planning 2024-25

The System submitted its final plan on 2nd May, with an overall position of £44.9m deficit. This included efficiency plans of 5% across all Trusts and the ICB's non-NHS spending. Conversations will continue with NHSE to identify the actions the system would need to take to break-even, with its next meeting 23rd May.

Capital

At month 12, the system reported an underspend against its operating capital allocation of £0.6m. The total capital allocation for Trusts for the year was £109.7m.
The ICB spent its full allocation of £3.1m in 2023-24.

In 2024-25, plans are in place for providers to spend the full allocation of £81m and the ICB to spend its allocation of £2.4m to support the GPIT rolling programme.

Planning 2024-25

The first planning submission for 2024-25 was made on 29th February.
The system report at a high level, rather than by organisation:

- Underlying exit rate out of 2023-24: **£146.1m deficit**
- Planning position for 2024-25**: £97m deficit**
- Efficiencies for 2024-25: **£130.4m**, equivalent to 4% for all organisations.

£m	Underlying Exit Run Rate 23/24	24/25 Plan	24/25 Efficiencies
ENHT	(25.6)	(12.6)	24.8
HCT	(7.8)	(4.7)	6.5
HPFT	(29.9)	(29.5)	17.2
PAH	(38.9)	(30.0)	16.4
WHTH	(29.5)	(24.9)	21.2
ICB	(14.5)	4.7	73.0
Total HWE	**(146.1)**	**(97.0)**	**159.1**
Intra- System Adjustment			(28.7)
Final System Position	**(146.1)**	**(97.0)**	**130.4**

Whilst the deficit is high, the HWE system did not report the worst position across the Region, with two other systems higher.
The position supports the MTFP output back in September 2023, which reported a deficit position in 2024-25 of between c£70m and c£130m deficit, depending on the exit run rate.

NHSE is running a series of rapid reviews across the region and the meeting for HWE will be held 20th March. This will be a deep dive into the reasons we find ourselves in the current unsustainable position and actions being taken to improve this.

Operational and Finance leads within the system have now met, to start to identify potential initiatives that could be taken forward to address the financial position. This will be an on-going piece of work.

Directors of Finance across the system are meeting with Chief Executive Officers this week to discuss options for addressing the deficit.

The next planning submission is due to be made 21st March, with a final planning submission due 2nd May.

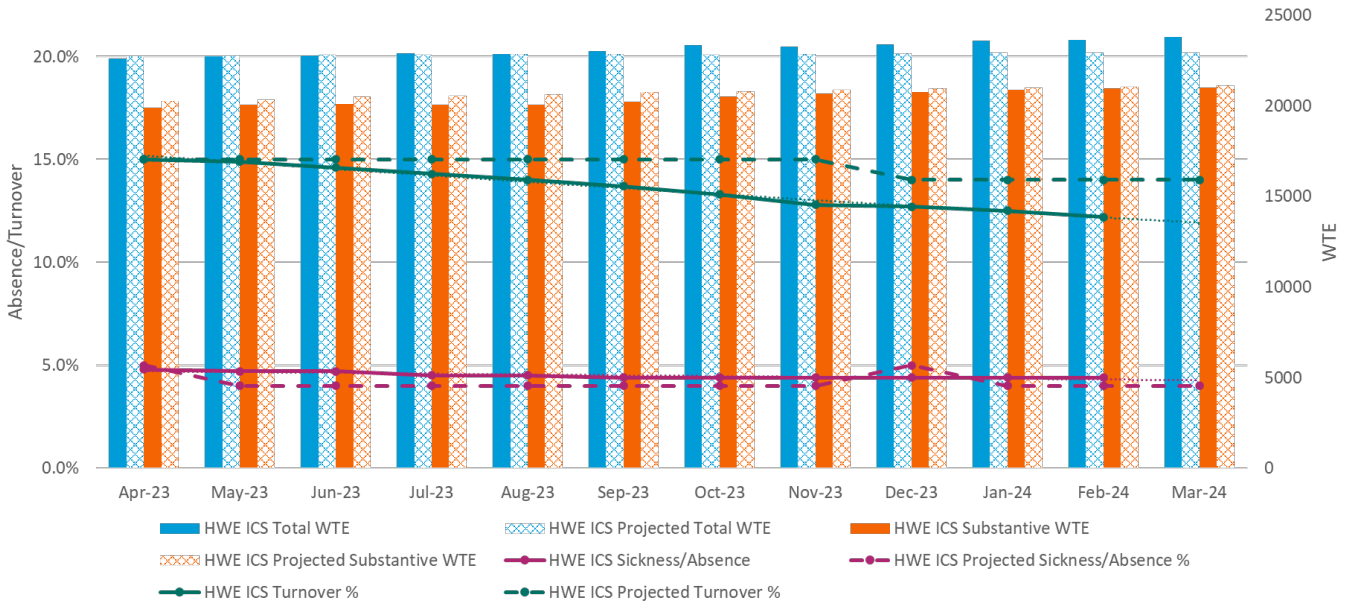
2024-25 HWE ICS Financial Plan

- The HWE ICS is submitted its 2024-25 financial plan on 2nd May 2024 with a System deficit of £44.9m. This is a £24.5m improvement on the flash submission of 18th April and a £36m improvement on the first submission made on 21st March. The deficit equates to <1.4% of income.
- Changes at HCT and HPFT included a reduction in the gap on external contracts of £5.6m. Whilst not resolved, and there is a risk to achievement - the ICB supports the Trusts.
- Trusts have identified a further £9m of efficiencies, productivity and Elective Recovery Fund opportunities.
- NHSE provided funding to cover additional depreciation cost and this has been updated since the last plan submission. This reduces the deficit by £6m.
- NHSE lodged £6m with the ICB at the end of 23/24 and has agreed the ICB can retain £4m.
- A deficit of £44.9m will not be acceptable to NHSE and we continue to develop a list of service reduction options that would need to be implemented to achieve breakeven.
- Furthermore, transformational changes need to be developed and delivered to secure a sustainable future and further details are set out in later slides.

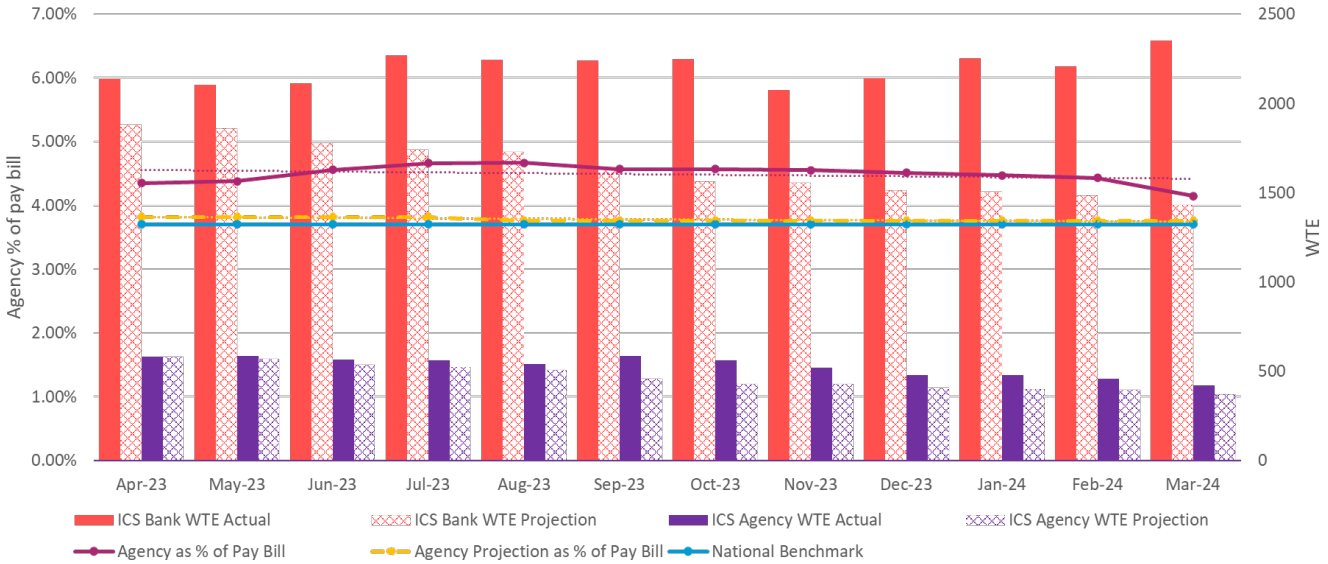
	2024-25 Plan Surplus / (Deficit) 21 March	2024-25 Plan Surplus / (Deficit) 18 April (Flash)	2024-25 Plan Surplus / (Deficit) 02 May Final
	£m	£m	£m
ENHT	(4.0)	(2.0)	0.0
HCT	(4.4)	(3.8)	(2.1)
HPFT	(25.1)	(23.1)	(15.4)
PAH	(27.9)	(27.4)	(25.4)
WHHT	(22.5)	(20.9)	(13.9)
ICB	3.1	7.8	11.8
Total System	**(80.9)**	**(69.4)**	**(44.9)**

WORKFORCE

2023/2024 Secondary Care Workforce Analysis



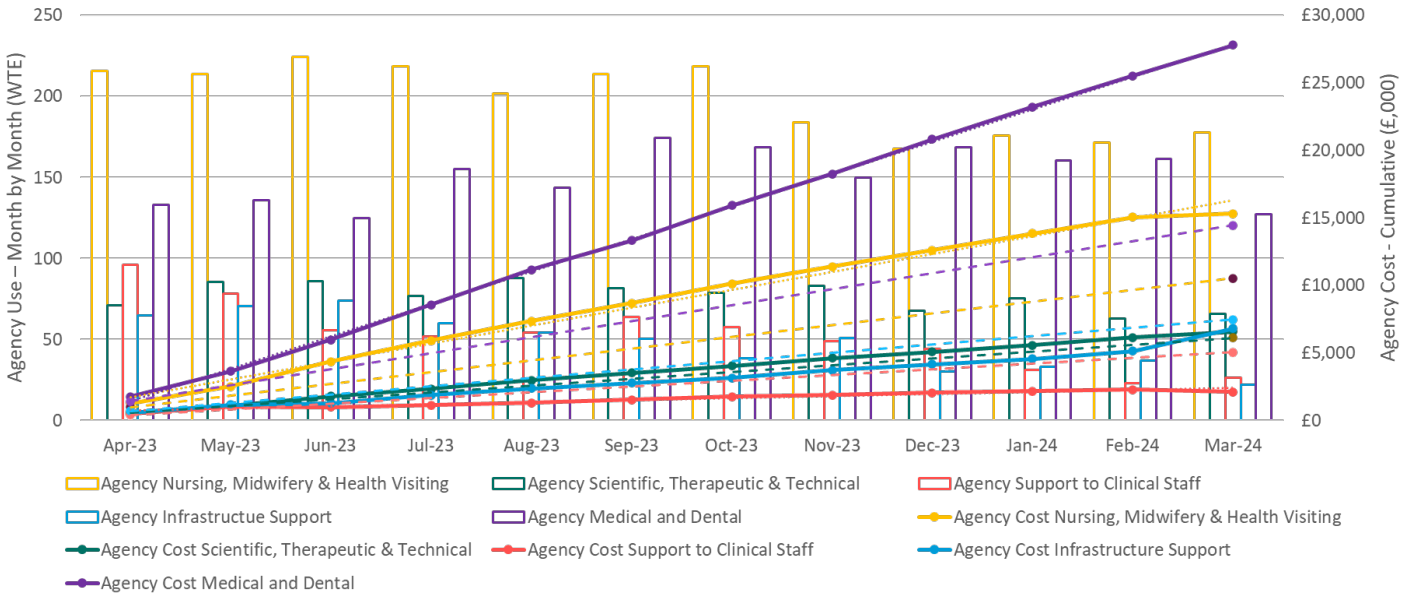
Throughout 2023/24 the system held a total WTE over and above its operational plan projection. This was predominantly through increased use of temporary staffing supporting key areas such as industrial action. The system came close to meeting its substantive staff requirements.



As highlighted above the system has struggled to meet its temporary staffing targets and specifically the agency as a percentage of pay-bill has been consistently above its target. Within the last quarter the system has made strong progress in reducing its agency usage and in month 12 saw a significant reduction in the

percentage of pay bill to the system. There has been a significant shift to use of bank staffing across the system.

Once again, we can see strong progress in relation to certain staff groups – giving a clear indication that organisations actions in relation to agency controls and reviews of staffing are starting to take effect.



OPERATIONAL PLAN SUMMARY:

- The system is forecasting an overall staff in post reduction of -572.3 wte / 2.4% of total workforce population.
- All staff areas are forecasting reduction: substantive, -148.8wte (0.6%), bank, -304.1wte (15%) and agency -119.4wte (25.3%).
- Hertfordshire Community Trust is the only organisation forecasting workforce growth relating to new service commissions and existing agreements of staff TUPE for services delivered within the system and wider region.
- Hertfordshire Partnership Foundation Trust are planning a shift from temporary staffing to substantive staffing, particularly to support the MH urgent care centre with nursing and support to clinical staff groups.
- Reductions in acute providers driven by pathology, whilst nursing and medical headcount remain stable with some small areas of growth, particularly at PAH to fill staffing gaps.
- The system is satisfied that acute workforce plans are sufficient to deliver activity forecast through the combination of some increase in nursing/medical alongside productivity opportunities in elective pathway.
- Providers have rigorous vacancy control processes in place, and the system is supporting further action to pause/stop senior executive recruitment as well as areas where shared services or a new approach could be considered.

- Numbers will be reviewed at the system's People Committee, Supply sub-committee, Temporary Staffing group, as well as system Performance Committee. In addition the system will submit the workforce tracker as part of being placed in triple lock going forwards.

SUBMISSION ANALYSIS:

The high-level overview of our submission is presented in the table below:

	March 2024 Outturn				March 2025 Projection				% Change			
	Total SIP WTE	Substantive SIP WTE	Bank SIP WTE	Agency SIP WTE	Total SIP WTE	Substantive SIP WTE	Bank SIP WTE	Agency SIP WTE	Total SIP WTE	Substantive SIP WTE	Bank SIP WTE	Agency SIP WTE
ENHT	6,829.5	6,187.2	558.7	83.6	6,504.5	5,990.9	439.6	74	-4.8%	-3.2%	-21.3%	-11.4%
HCT	2,214.2	2,066.5	101.5	46.1	2,281.7	2,150.5	91.4	39.7	3.0%	4.1%	-9.9%	-13.8%
HPFT	4,712.4	3,930.9	671.3	110	4,739	4,056.5	590.6	91.7	0.6%	3.2%	-12%	-16.6%
PAH	4,227.9	3,805.9	301.9	120.1	4,074.8	3,777.3	246.9	50.6	-3.6%	-0.8%	-18.2%	-57.8%
WHTH	5,674.5	5,173.1	390.4	111.1	5,486.5	5,039.7	351.2	95.5	-3.3%	-2.6%	-10%	-14%
HWE ICS	**23,658.7**	**21,163.7**	**2,023.9**	**471**	**23,086.4**	**21,014.9**	**1,719.8**	**351.6**	**-2.4%**	**-0.7%**	**-15%**	**-25.3%**

The plan forecasts for an overall system reduction in Whole Time Equivalents (WTE) of 2.4% (-572.3). The majority of the systems reductions relate to bank staff reducing by 15% (-304.1) and agency staffing by 25.3% (-119.4).

Key clinical staff groups including nursing and midwifery and medical and dental remain stable whereas other groups show a small reduction in substantive staff. Scientific, Technical and Therapy staff shows a slight reduction, predominantly from the change in pathology services.

	March 2024 Outturn			March 2025 Projection			% Change		
	Substantive SIP WTE	Bank SIP WTE	Agency SIP WTE	Substantive SIP WTE	Bank SIP WTE	Agency SIP WTE	Substantive SIP WTE	Bank SIP WTE	Agency SIP WTE
Nursing & Midwifery	6,343.9	600.6	181.3	6,394.6	498.6	146.8	0.7%	-16.9%	-19%
Sci. Technical & Therapy	2,751.9	96.2	66.6	2,696.8	87.8	43.6	-2.0%	-8.7%	-34.5%
Clinical Support	4,160.9	916	32.8	4,102.8	810.9	20.8	-1.3%	-11.4%	-36.5%
Infrastructure Support	5,314.6	279.2	68.7	5,191.7	207.8	55.6	-2.3%	-25.5%	-19%
Medical & Dental	2,560.1	131.8	121.4	2,595.7	114.5	84.6	1.3%	-13.1%	-30.3%

PROVIDER ANALYSIS

East and North Hertfordshire NHS Trust

- There is a funded increase of 28.30 substantive WTE at M7 relating to a funded business case for Vascular services, from M7, which shows in qualified nursing (22.00 WTE) and increases in Medical staffing.
- Within M10 there shows to be a -175.97 reduction in total staff relating to the TUPE of Pathology staff. This equates to -2.62% workforce reduction. The breakdown is shown within a total of -168.59 reduction in substantive staff, shown within STT (-59.94WTE), support to clinical staff (-92.17WTE).

Hertfordshire Community Trust

- There are immediate reductions in headcount at HCT from the removal of 39 WTE non=recurrent posts.
- There are then increases phased throughout the year for TUPE of existing services into HCT totalling 52 WTE with the transfer of Diabetic Eye Screening and Childhood immunisation services.
- Further increases of 21.6 WTE for funded business case of Community Dental Services and 32.5 WTE for Hospital at Home services phased from July 2024.

Hertfordshire Partnership Foundation NHS Trust

- HPFT's overall workforce growth is flat (0.6%), albeit the strategy relies on a transferral of staff from bank and agency to substantive – where there is a forecast increase of 120 WTE phased across the year.
- The most significant growth is within Nursing roles, increasing substantive staff by 46.06 WTE. M6 shows the most significant increase in staff of 19.50 wte. This will be undertaken through the creation of the Urgent Care Centre, the maternity mental health team to substantiate the increase.
- Support to clinical staff also grow their substantive (38.49 WTE), however this is mitigated by reductions of -19.9 in bank and -8.3 in agency usage, showing the organisation are investing in the future pipeline, mostly through apprenticeships as well as some trainee roles.

The Princess Alexandra Hospitals NHS Trust

- The PAH plan assumes recruitment into vacancies showing gradual reductions in use of bank and agency. The most significant reductions in temporary staffing are nursing and midwifery (-63 wte) and medical and dental (-33wte) which are phased across the year.
- There is a significant reduction of STT (-65.65 wte) and clinical support (-41.29 wte) roles in M12 relating to the TUPE of pathology staff.
- There is also an increasing reduction in infrastructure support (62 wte) from M10 to M12 as the Electronic Health Record Programme comes to an end.

West Hertfordshire Teaching Hospitals NHS Trust

- The overall changes for substantive staff in post are -124wte.
- For staff in post baselines assume 3% efficiencies reduction from M9 as a forecast outturn. Other key plan assumptions include known changes in 24/25 for the elective hub, pathology outsourcing of services contributed by staff groups STT (- 92.17WTE) and support to clinical staff (-82.17WTE), as well as a reduction in the oversupply of registered nurses as IR recruitment is paused while leavers reduce the headcount.
- Bank reductions are planned at 10%. Agency reductions are planned to align with the interim 3.2% of pay bill target.

The primary care submission forecasts no change over the course of 2024/25.

Primary Care Workforce	Year End (Mar-24) WTE	As At (Mar-25) WTE
Total Workforce	**4,019.03**	**4,019.03**
Total GPs	954.00	954.00
Total Nurses	322.00	322.00
Direct Patient Care (ARRS funded)	674.03	674.03
Direct Patient Care (not ARRS funded)	303.00	303.00
Other Admin/Non-Clinical	1,766.00	1,766.00

Additional Programme Highlights:

- A further analysis of the 2023 NHS Staff Survey has been provided to the system and is being shared with the People Committee, alongside additional system-based analysis to understand the core areas of progress that have been achieved, but also areas of work that can be focussed on as a system and that support the individual provider action plans.
- The programme continues to investigate ways and means in which the systems' workforce productivity and efficiencies can be measured going forwards. The system is continuing to link into national programme developments in understanding the results of the toolkit. Additionally, we are working with community providers across the system to replicate work undertaken by Hertfordshire Community Trust, but also identify a productivity 'currency' for the organisation and how to measure that on an ongoing basis.
- The system's Band 2/3 task and finish group continue to progress. Costings based on utilising a consistent approach has been shared with provider JSCC groups and the feedback is being worked through and further changes are being calculated. Revised proposals are being developed by providers to be shared across the system.
- Colleagues from across the system, including representatives from the University of Hertfordshire, recently met with regional colleagues to discuss the nationally proposed modelling and some of the challenges and opportunities there are within the system to achieve the ambitious clinical education expansion targets proposed as part of the long term workforce plan. The system is refining its approach to education development with a new provider group and is being supported by the Health and Care Academy to further develop and improve the pathway from Further Education Colleges to either employment or further study.
- Vacancy control – additional vacancy control measures have been put into place to support further workforce reductions. These include system assessment of all Band 9 and above vacancies. Additional vacancy control measures will be implemented through the triple lock process.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	NHS HWE ICB Board Meeting in Public		**Meeting Date:**	**24/05/2024**
Report Title:	**ICB Quality Escalation Report**		**Agenda Item:**	**09**
Report Author(s):	Multiple authors including relevant quality leads, collated by Shazia Butt, Assistant Director for Quality Assurance and Improvement, HWE ICB.			
Report Presented by:	Natalie Hammond, Director of Nursing and Quality			
Report Signed off by:	Natalie Hammond, Director of Nursing and Quality			
Purpose:	**Approval / Decision** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
Which Strategic Objectives are relevant to this report **[Please list]**	• Increase healthy life expectancy, and reduce inequality • Give every child the best start in life • Improve access to health and care services • Increase the numbers of citizens taking steps to improve their wellbeing			
Key questions for the ICB Board / Committee:	▪ Does the report provide sufficient information for the Board to be assured regarding the work undertaken to manage risks and drive forward needed quality improvements? Alongside this question, the Board is asked to note that work is ongoing to develop and refine the Quality Escalation Report and the Quality Dashboard.			
Report History:	The full report was presented and discussed at the ICB Quality Committee on 2nd May 2024. This version has been adapted to ensure appropriate for public discussion. At the Committee the Quality Escalation Report is presented alongside the quality dashboard that contains additional information relating to a number of key metrics and quality performance.			

<table>
<tr><td>Executive Summary:</td><td colspan="4">This paper provides a summary position relating to quality and safety across Hertfordshire and West Essex.

Areas included relate to sharing of best practice and learning from excellence as well as highlighting key areas of challenge and risk.

Areas of best practice include;

• ENHT outstanding work in dementia care and ranking in the top performing quartile nationally for registered nurse vacancy rates.
• HPFT quality improvement and innovative projects delivering improved outcomes.
• HCT staff recognition and award in Heart Radio’s 2024 Local NHS ‘Heroes’ award.
• St Clare’s Hospice wins ‘Health Heroes’ award.

Key challenges include;

• ENHT Paediatric child hearing impairment service, progression of ongoing work to support urgent improvements in several areas including estates, workforce, equipment and governance supporting oversight of the service.
• Multi Agency Improvement work continues following the SEND inspection report published in November 2023.
• Measles increases locally and nationally.
• Ophthalmology challenges across the system linked to waiting lists and timely care.
• Lampard Inquiry preparation continues including though the broadening of scope including via links with additional providers.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">The Board is asked to note the contents of the report.</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">Patient Safety is a driving principle and at the core of the Quality Report. The paper flags areas of good practice, identifies risks to patient safety and provides information about mitigation and actions to manage risks to</td></tr>
</table>

	patent safety.	
Risk: *Link to Risk Register*	The Nursing and Quality Team have been working to develop our risk register as well as consider our ICS system wide risks in common. As the risk register develops and the quality escalation report is refined the Board will be able to clearly identify the work being undertaken relating to the key risks throughout this report.	
Financial Implications:	*N/A*	
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Herts and West Essex Integrated Care Board (HWE ICB)

Quality Escalation Report
PUBLIC BOARD

May 2024

Hertfordshire and West Essex Integrated Care System

Report Contents

NHS Hertfordshire and West Essex Integrated Care Board

Executive Summary (1/2)

UPDATE TO PREVIOUS POSITION OR NEW. Area of Focus	Headlines	Slide Number	Position Since Previous Report
UPDATE: Publication of Hertfordshire Special Education Needs and Disabilities (SEND) report**.**	Local Partnership SEND Quality Assurance Framework undergoing formal sign off at Joint SEND Partnership and Assurance Board on 25th April 2024 and SEND Priority Executive on 2nd May 2024. Work is underway related to the development of joint quality assurance visits and provider self -assessment quality improvement toolkit.	Not applicable.	Significant ongoing assurances required.
UPDATE: East and North Hertfordshire Trust (ENHT) backlog of x-ray.	Non-chest x-rays are now cleared. The Trust is working on radiology's demand and capacity to ensure that it matches the needs of the population and an improvement plan is in place.	18	Consider closure as an escalated risk.
UPDATE: Measles.	Confirmed measles cases increased nationally and locally. Arrangements to reduce impact on local population and health and social care being put in place. The ICB, local NHS trusts, United Kingdom Health Security Agency and Herts County Council/Essex County Council collaborating with Incident Management Teams to put measures in place. An NHSE regional tabletop exercise at which the HWE ICS will be represented is taking place in May.	14	Further assurances required.
UPDATE: Lampard Inquiry.	The Lampard Inquiry: An Independent Statutory Inquiry into the deaths of mental health inpatients in Essex. The final Terms of Reference were published on 11th April 2024. The scope of the inquiry has been broadened and now also includes other key providers.	21	Ongoing process – with long-term assurances required.

Executive Summary (2/2)

UPDATE TO PREVIOUS POSITION OR NEW. Area of Focus	Headlines	Slide Number	Position since Previous Report
UPDATE: Ophthalmology at Princess Alexandra Hospital Trust (PAHT) and East and North Hertfordshire Trust (ENHT).	Ongoing ophthalmology improvement work is taking place across the system, addressing specific challenges at PAHT and ENHT where appropriate. System work includes focused work on pathways as well as out of hours service provision.	19	Ongoing assurances required.
UPDATE: ENHT Paediatric Child Hearing Impairment Service.	Pathways reopened in April 2024 for 3-5 years and over 5 years. Hertfordshire Community Trust (HCT) continue to provide Auditory Brain Responses service. Regional team hosted by HWE ICB on behalf of East of England is fully recruited. Improvement work continues to be overseen by the ICB and NHSE via fortnightly oversight meetings , and steady improvements evidenced.	18	Progress with further assurances required.
UPDATE: Mount Vernon Cancer Centre (MVCC) Gynaecology Outcomes.	Improvement plan and actions continue with regular NHS England oversight including pathways reviews and continued strengthening of governance.	20	Progress on improvement plan, regular oversight via NHS England/ HWE ICB.

Sharing Best Practice and Learning from Excellence

Reasons to be Proud

East and North Herts Trust (ENHT)

- The Admiral Nurse Caring Conversations video which has been shared with the Integrated Care Board, features outstanding work in dementia care, demonstrating multidisciplinary collaboration. Junior Doctors have shared their experiences and suggestions for improving communication with families where needs are complex.
- The vacancy rate for registered nurses is approximately 6%, with a target of 5% by April 2024, ranking the Trust in the top performing quartile nationally.

Hertfordshire Partnership Foundation Trust (HPFT)

- Colleagues from HPFT recently hosted a Quality Improvement webinar and highlighted how HPFT's Quality Improvement team are empowering staff, service users and carers to identify and implement innovative ideas to achieve better outcomes. Projects included;
- Equine Therapy was trialed at Warren Court, a HPFT medium secure unit for male service users with a complex trauma history. It was suggested by a service user who had benefitted from this treatment elsewhere and he helped to pull a project plan together to approach the Quality Improvement team
- Fishing for Health - Service users who took part in the pilot reported: "it taught me how to be patient and cope with disappointment and frustration." They described how "it was easier to talk about other things to do with my health when I was fishing." They also helped to facilitate the next cohort of service users taking part.

Hertfordshire Community Trust (HCT)

- In February 2024 HCT were delighted when two of their nurses, Catherine McCarevey (community staff nurse) and Mary Heffernan (clinical quality lead) were finalists for Heart Radio's 2024 Local NHS heroes award and were pleased to learn that Catherine went on to win. Both Catherine and Mary exemplify the compassionate and individual nursing care that HCT is so proud to deliver.

St Clares Hospice

- St Clare Hospice was named winner of the staff learning and development award at the Our Health Heroes Awards, delivered by Skills for Health. An expert panel of judges were impressed by St Clare's dedication to developing staff skills and improving services for patients and their families.
- The hospice ensures that all staff are equipped to address issues of end -of- life care through its end- of- life care webinar days, monthly masterclasses and students and professional placement programme. The Hospice helps professionals navigate sensitive conversations and decisions regarding resuscitation through training and care of the dying study afternoons.
- The hospice has also achieved Teaching Hospice Status with Cambridge University and is also a Centre for European Certificate in Essential Palliative Care. Hospice also runs biennial conferences, last one in 2023 and next due in 2025. From training volunteers on bereavement support to equipping shop staff with communication skills, the hospice understands the impact its work has on the entire community. **www.skillsforhealth.org.uk/awards.**

Key Priority Areas

ICB - Patient Experience and Safety Quarter 4

ICB Area	Compliments	Complaints	PALS	Member of Parliament (MP)	General Practitioner (GP)	Whistleblowing	Serious Incidents	Never Events
East and North Herts.	2	31	121	23	89	0	6	0
South and West Herts.	0	33	154	18	53	4	19	0
West Essex.	0	13	102	11	66	2	4	0
Other.	4	17	189	3	2	0	3	0
Total.	6	94	566	55	210	4	32	0

ICB area	Key themes/ Risks	Improvement Actions and Mitigations
Herts and West Essex.	• Providers are transitioning from using the Serious Incident (SI) Framework 2015 to the new nation process for learning from incidents, the Patient Safety Incident Response Framework (PSIRF). • All Trusts have now transitioned to the new PSIRF and therefore numbers of SIs declared will significantly reduce. • Smaller and independent sector providers continue to transition to PSIRF. • National patient safety plan for primary care is anticipated in the coming months. Therefore, a small number of SIs from these providers will continue to be reported.	• Providers continue to use the Strategic Executive Information System to alert Commissioners to an incident where it is necessary to carry out a specific type of learning response, a Patient Safety Incident Investigation (PSII). • There is a national list of the types of incidents for which a PSII is required. In addition, each provider has identified local priority areas where PSIIs will be undertaken. • As PSIRF is implemented and embedded examples of learning will be shared with the Committee.

National Patient Safety Strategy Implementation

Priority area	Current position	Status (for HWE ICB)
Just Culture.	• Ongoing work with HR within ICB (for example staff survey results) and working with providers regarding psychologically safe and just culture across system. Supported by PSIRF implementation	In progress.
Medical Examiner System for community deaths.	• On 15th April the Department of Health and Social Care announced that the statutory Medical Examiner requirements will come into effect from 9th September 2024. All 3 local Medical Examiner Offices continue to roll out scrutiny to community providers including primary care. Good progress continues to be made.	On track as an ICS. Delay in national IT system and commencement of statutory reforms, due April 2024.
Patient Safety Incident Response Framework (PSIRF).	• ICS system implementation ongoing; all main Trusts went live by January 2024. Several small providers have transitioned to PSIRF with work ongoing to support small providers to have a proportionate approach. System workshops continue to take place to support implementation and learning.	In progress. NHSE monthly reporting required.
Involving Patients in Patient Safety.	• First two Patient Safety Partners joined the ICB in February 2023 and now regularly attend Quality Committee and System Quality Group, with positive contribution. Currently working on ICB Patient Safety Partner Policy.	On track.
National Patient Safety Alerts.	• Robust processes within ICB and across main NHS Trusts to review and act upon alerts.	On track
Transition from National Reporting and Learning System to Learning from Patient Safety Events (LFPSE).	• All main providers either transitioned to LFPSE in line with September 2023 deadline, or ready to go, awaiting DATIX readiness. ICB developing plans for transition from STEIS to LFPSE. ICB planning roll out for primary care, awaiting national guidance (currently delayed).	On track
Patient safety education and training.	• Level 1 training made mandatory within ICB with good uptake (approximately 85%). Level 2 training made mandatory within ICB; work ongoing regarding data quality to monitor compliance.	On track
National Patient Safety Improvement Programmes.	• All programmes led by local Patient Safety Collaboratives, local providers (and ICB where appropriate) engaged in main programmes.	On track, await Patient Safety Collaborative update

Quality Improvement

Priority area	Current position	Status
Health Foundation Funding for QI Network.	• £20,000 was awarded by the Health Foundation to set up the HWE system Quality Improvement Network. Funding was awarded based on several key deliverables including a face-to-face improvement event, regular Network meetings including patient engagement, development of a dedicated internet page, tracking and monitoring outputs and improvements, and completion of mid-year report and final evaluation. • Current work focuses on developing a series of webinars as well as planning a face-to-face Quality Improvement event in June.	On track
Herts and West Essex Quality Improvement Network.	• Ongoing development of the system Quality Improvement Network, currently just under 100 members. • NHS Futures Platform dedicated page • Recent webinars include hosted sessions on innovation by East and North Herts Trust and Hertfordshire Partnership Foundation Trust. • Part time fixed term administrator commenced in post October 2023, in post until May 2024. • WhatsApp group implemented. • Ongoing work includes further development of the Network and setting up a forward planner mapping out future events and webinars.	On track
NHS Impact	• Baseline assessments have been completed for Trusts and ICB. ICB has undertaken analysis looking at system position based on submissions, this will be shared with the Quality Improvement Network. • Current work includes completion of the NHS Impact self-assessment by organizations across the system. A meeting is also planned with the National Director in the coming weeks to look at current progress as well as how NHS Impact can support the local system (these meetings are taking place with all systems).	In progress, on track
ICB Quality Improvement.	• Scoping work required to increase capability and capacity within the ICB and across system for smaller providers and primary care. • Ongoing work to implement the shift in approach from assurance to improvement across the ICB, and build improvement into 'business as usual' work • Work required to adopt and implement the NHS Impact 5 priorities (shared purpose and vision; building improved focused culture; leaders at every level understanding improvement; consistent use of improvement methods; embedding of improvement into management processes).	In progress, significant work required

Safeguarding - All Age (1/2)

Area	Risk	Mitigating Action
Herts and West Essex - Gaps in Safeguarding Adult provision and resource across primary care. Named General Practitioner (GPs) currently contracted to support safeguarding children.	• Inequity of service.	Service review is underway to address concerns and action plans in place to mitigate risks and address concerns. GP support for safeguarding adults is accessed via GP Practice Lead.
Hertfordshire Community Safety Partnership (HCSP) reported that there is a lack of Health referrals to Domestic Abuse and Violence Against Women and Girls services.	• Patients at risk of domestic abuse are not identified within Community Health Services.	• Safeguarding Team exploring/scoping solutions with partners on HWE gaps or inequity in provision of Independent Domestic Violence Advisors services in Hertfordshire. • Staff awareness and training and capacity focus. • Support for perpetrators and victims/survivors in place.
Reduction in available Sexual Abuse Referral Centre resource across East of England from 1st April 2024 for adults and children.	• Potential loss of forensic evidence due to time delay. • Lack of local provision and timely access to services. • Risk holistic health needs may not be met. Service inaccessible and restrictive.	• Regional NHS Leads working with Police and System Partners to address shortfall. • Escalated to the Safeguarding Partnership Boards across Hertfordshire and Essex as connected to Domestic Abuse and Violence Against Women and Girls agendas.
Commissioned Female Genital Mutilation service for Children/young people is limited.	• Lack of a commissioned pathway resulting in timely access for assessment	• Spot purchasing of specialist service available for women and girls currently negotiated with University College Hospital NHS Trust. • Work in progress to develop commissioning service level agreements with University College Hospital London. • Multi agency training plan being developed to support Mandatory Reporting. • Revised Female Genital Mutilation multi-agency pathway in progress.

Safeguarding - All Age (2/2)

Area	Risk	Mitigating Action
Non face to face General Practitioner (GP) consultation with Children.	• Children with safeguarding risks are not identified during virtual consultations.	• The primary care safeguarding team developed an action planning to progress consultation protocol for vulnerable children and those with complex needs. • The action plan will support training and guidance for primary care services.
Delays in coroner's inquest reports in excess of 18 months for unexpected child deaths.	• Delay in safeguarding responses during the child death review process.	• A thematic review is planned to identify similar cases and implement learning. • Identified cases are referred back to safeguarding panel for review and actions.
Concerns identified following the transfer of Child Health Information System to Herts Community Trust by NHS England there have been changes to service in West Essex.	• Fragmented process for the transfer of child health records in and out of area; potential for vulnerable children to become lost in the system. • There is no consistent process for the transfer of child health records across England.	• Met with NHS England Child Health Information System commissioners on 13th February 2024 confirmed transfer of clinical child health records responsibility of individual 0-19 provider. • Options appraisal / financial review to address shortfall being prepared by Essex County Council Commissioners. • Matter to be raised at the Southend, Essex and Thurrock (SET) Health Executive Forum as system risk.

Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR)

Area	Risk	Mitigating Action	Timescale
Herts and West Essex (HWE).	• No autism only reviews have been notified in West Essex and low numbers for Herts. A notification for an autistic person without a learning disability - deaths of autistic people have been eligible to be notified to LeDeR since January 2022.	• Proposed to include an Autism register in the Primary Care Enhanced Commissioning Framework. • Learning from Herts autism only reviews continues to be presented to LeDeR Leadership group for learning. • Collaborative work with All Age Autism Board to raise awareness of LeDeR with people who work with Autistic people. • Raising awareness of LeDeR to help Autistic people without Learning disability have deaths notified to LeDeR.	Oct 2024.
HWE.	• Learning Disability Annual Health Checks (AHC) are not always taken up by those who could benefit from them most. • Quality of AHCs can be variable • Uptake of AHCs 14-17 is lower than overall 14+.	• Awaiting report on outcomes of the AHC pilots in West Essex prioritising those who did not have health check in 2022/23 in 5 Primary Care Networks. • In Herts Health Equality Nurse for 'Hard to reach' is supporting practices engage patients not attending for AHCs. Positive outcomes include; supporting more practices to engage with Purple Star accreditation improving their practice in making reasonable adjustments and increasing access to health services; increased accuracy of GP registers; and identification of unmet need leading to improved wellbeing. • In Herts a new working group has been established focusing on uptake of AHCs of 14–17-year-old, improving quality of AHCs/ Health Action Plans.	May 2024. March 2025. 12-month project starting April 2024.
HWE.	• LeDeR reviews have highlighted that lack of flexibility of access to services can impact on outcomes. For example, lack of reasonable adjustments impacting on recognising early deterioration leading to delay in treatment.	• New Information Standard notice requiring action by all system partners to implement Reasonable Adjustment Digital Flag. • This has been highlighted to system partners via the Learning Disability and Autism Strategic Partnership Board. Actions progressing to identify a clear plan for the Information Technology infrastructure to enable this to be implemented.	March 2025.

Infection Prevention and Control (IPC)

Area	Issue	Mitigating Action	Timescale
Measles.	Since 1st October 2023, the number of confirmed cases of measles in England has continued to rise. Although the outbreak in the West Midlands initially drove the increase in cases, in recent weeks there has been an increase in activity in London and across the United Kingdom.	• Fit testing sessions held for primary care. • Respiratory hoods, for staff regularly failing fit tests in primary care. Fit testing arrangements in place within all local trusts • Pop up immunisation clinics being held including traveller sites etc. • Collaboration between ICB, local NHS trusts, United Kingdom Health Security Agency and Herts County Council /Essex County Council to participate in healthcare or community case Incident Management Team. • HWE ICS Round Table event organised by ICB for 25th April to review learning from recent cases, review existing local arrangements and identify potential gaps and associated mitigation in local preparedness.	Ongoing.
Pertussis (whooping cough).	Pertussis activity exceptionally low in England (49 and 69 confirmed in 2021 and 2022 respectively) probably as result of work to control COVID-19. Increased to 858 in 2023 and continued rise to 1468 cases in England in January and February 24.	• Collaboration between ICB, local NHS trusts, United Kingdom Health Security Agency and Herts County Council/Essex County Council to participate in Incident Management Teams i.e. contact tracing • Communications to midwives to increase promotion and uptake of Diptheria – Tetanus- Pertussis in pregnant women • Communication to GPs to raise awareness of recent epidemiology. IPC link practitioner webinar held.	Ongoing.
C. difficile.	Nationally C. diff cases above pre-pandemic levels and rising. All 3 places, and acute trusts in HWE have counts above allocated ceilings. West Herts Teaching Hospital Trust (WHTHT)and South and West Herts place have numbers below last year.	• ICB /Trusts analysing C. diff and monitoring impact of activity. • Introduction of Multi- Disciplinary Team bedside C difficile reviews / ward rounds. • ICS Antimicrobial Stewardship Technical Working Group reviews antimicrobial prescribing data. Proportion of broad-spectrum antibiotics prescribed meets target. Total antibiotics prescribed in primary care and intravenous to oral switch need further work. • HWE ICS Antimicrobial Stewardship Strategy being produced.	Ongoing.

Mental Health - Childrens

Area	Issues and Mitigating Actions
Herts Children and Young People Mental Health Services: Transforming Care.	• There are 10 inpatients currently (trajectory is for 4 inpatients). • Whilst numbers are gradually declining, there remain a high number of Transforming Care Children and Young People inpatients in Herts. • Multi-disciplinary meetings continue to consider most appropriate discharge option to meet their needs. Continued collaborative work via multi-agency approach to ensure needs assessment are holistic.
Herts Children and Young People Mental Health Services: Admissions / Discharge planning.	• There have been some delayed discharges for children and young people due to pressures across the health and social care sector. To support more robust partnership working and improve discharge planning, there will be a workshop for health and social care colleagues to understand each other pressures and agree working practices, including escalation protocols in May. Interim, commissioners continue to facilitate and support appropriate discharge and placements with health and social care. • Decline in number of children and young people who are admitted to ward after presenting in Emergency Departments. This has been attributed to 24/7 Children's Crisis Assessment and Treatment Team offer in both Herts acutes, who undertake a robust assessment on presentation.
Southend, Essex and Thurrock CAMHS Southend (SET CAMHS) Discharge from Tier 4.	• Commissioning team made aware of potential challenges in ongoing prescribing and administration of antipsychotic medication to young people discharged from Tier 4 inpatient settings. Meetings scheduled to define a solution. • To mitigate the impact on young people currently affected, solutions are being determined and management defined on a case-by-case basis.

ICB Risk		Issue	Mitigating Action	Timescale
Transforming Care Inpatient numbers increase – NHSE interest.	Herts	Target is 4. Currently 10 inpatient Transforming Care cohort.	As above.	Ongoing.

Maternity And Children

Issues and Overview	Mitigating Action
Autism Diagnosis Waiting Times Work ongoing across ICS to develop shared case for additional funding to address backlog and gaps in capacity, however the current financial position of the ICB remains challenging.	• Hertfordshire are undertaking transformation of their current provision which will result in greater alignment with the JADES model in West Essex. Health Care Resourcing Care Group continue to work on waiting well initiatives and developing a digital front door approach.
West Essex children's commissioners and wider partners are preparing for the Essex Special Educational Needs and Disabilities (SEND) inspection expected imminently. The last visit in May 2022 reviewed progress against the areas of significant weakness identified in the 2019 inspection. Improvements had been made and the joint written statement of action was lifted.	• Ongoing challenges remain which include Education Health and Care Plan and Autistic Spectrum Disorder waiting times, Educational Psychologist workforce, reports of over diagnosis and over medication and families not feeling improvements are being made. • ICB children's commissioning team and wider agencies continue to work together to improve services for children and young people with SEND.

Local Maternity Neonatal System – LMNS

Area of Focus	Issue and Mitigating Action
Midwifery Staffing.	Midwifery vacancy rates are improving, this is largely due to the number of newly qualified and international recruits in post. This however raises a potential risk around skill mix with additional consideration required surrounding acuity of patients and senior supervision to ensure patient safety is continually assessed and prioritised. Mitigations in place include: • Preceptorship programmes across the three Trusts. • Robust rota management to ensure rotas fulfil the required staffing numbers and include a safe skill mix. • Earlier release of rotas to enable forward planning for identified staffing shortages. • Daily safety huddles to identify any red flags and need for redeployment of staff to ensure adequate skill mix to maintain patient safety. • Continued support from regional workforce colleagues who share learning from wider system good practice which supports workforce growth and retention. • Recognise variance in 'headroom' across our system, ensuring that all midwifery staff have the adequate protected time for training and development.
Antenatal Education.	There is a risk relating to the inequity of antenatal educational offers across our system. Mitigations in place include: • Scoping to understand the current offer at each of the 3 Trusts and share any good practice opportunities currently in place. The aim being to support a consistent offer across our 3 sites • Reviewing consistent use of same company across all 3 acute trusts. • The LMNS including trust representatives form part of the antenatal education working group. The LMNS now has maternity input into the integrated offer for planning for parenthood which is led by the local authority, this will support richness and variety in the antenatal education offers available to our families. • Continue expansion of the Parenting and Pregnancy Circles Pilot model which will further support antenatal education.
Culture	• Culture continues to be a priority for maternity services nationally. • Within HWE, there have been recent significant changes to Senior Leadership Teams in all three of our trusts particularly involving the Director of Midwifery/ Head of Midwifery roles and trust governance teams. Within the LMNS, gaps in the programme Manager and Quality and Safety Lead roles have resulted in time investment required to build new relationships and support a communication stream to ensure information is shared in an open and transparent way.

Assurance and Oversight - Acute and Urgent Care (1/2)

Area	Risk	Mitigating Action	Timescale
East and North Herts Trust (ENHT) Bedford Renal Unit.	Temporary closure of the Bedford renal unit.	• System partner meetings held weekly. • On 15/04/2024 patients moved back to Bedford Renal unit post water testing and safety reviews. • During period of closure patients also supported by Milton Keynes and Northampton. • Duty of candour letters have been sent to all patients as appropriate and a helpline contact number also shared.	Completed
ENHT- Paediatric Audiology Services.	Risks due to a range of factors including robust governance, risk stratification, capacity with limitations around mutual aid.	• ENHT is working with the ICB and other stakeholders to make required improvements in paediatric audiology service. Regular meetings are held with ICB oversight and weekly Trust internal meetings. • Positive progress with recruitment including specialist clinical audiologist, however workforce remains challenged. • Quality and Safety, Environment and Equipment, Digital, Operational, Workforce, Communications workstreams progressing. • Limited mutual aid in place from Hertfordshire Community Trust and Cambridge University Hospital. • Over 3-5 years and over 5 years pathways re-opened April.	Ongoing.
ENHT X-Rays backlog.	Backlog of x-rays including chest and long bone identified following patient review.	• A robust process is in place to support reporting on a backlog of x – rays. • An external company has been outsourced to help reduce the backlog. • Round table learning event has taken place, improvement plan is in place. • Backlog of chest x-rays has been cleared.	Consider closure as an escalated risk.

Assurance and Oversight - Acute and Urgent Care (2/2)

Area	Risk	Mitigating Action	Timescale
Ophthalmology at East and North Hertfordshire NHS Trust (ENHT) and Princess Alexandra Hospital Trust (PAHT)	• Risks due to current pressures within ophthalmology services, with significant size of Patient Tracking Lists as well as some service areas requiring improvement.	• Recovery and improvement plans are in place at Trust level, with both Trusts engaging with the ICB and sharing learning across the system. • Improvement work ongoing related to the ENHT Patient Tracking List. • Ongoing work at Trust and system level to review pathways. • The Getting it right first time (GIRFT) team completed the planned visit of the PAH audiology department in December. The Trust is developing their action plan based on findings and have shared wider learning with system colleagues. • Operational support to PAH ophthalmology services has also been increased in terms of a dedicated operational team to drive the improvements forward.	Ongoing.
West Essex Ophthalmology Out of Hours.	• There are currently no formal arrangements for out of hours non-emergency patients, however emergency provision continues to be available at PAHT 24/7.	• Ophthalmology Out of Hours Provision – Integrated Care System (ICS) Ophthalmology Steering Group leading the Out of Hours workstream. Positive progress is ongoing. • All other measures as reported to previous committee.	Ongoing.
ENHT Mount Vernon Cancer Centre.	• Risk of increased patient mortality related to Ovarian 30-day Systemic Anti-Cancer Therapy.	• National Health Service England (NHSE) and Integrated Health Care Board (ICB) oversight in place, pathway design and biochemistry strengthened. • External gynaecology oncology peer support identified via University Central London Hospital. • Short term changes implemented for treat and transfer gynaecology patients. • Robust improvement plan in place.	Ongoing

Assurance and Oversight – Adult Mental Health

Area	Issue and Impact	Mitigating Action	Timescale
Herts and West Essex (HWE) NHSE Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme.	• This national programme required Mental Health Trusts to develop 3-year action plans to address the core key lines of enquiry set out within the programme to improve inpatient experience and quality. • Initial draft focuses on the system's two main Mental Health Trusts, Hertfordshire Partnership Foundation Trust (HPFT) and Essex Partnership University Trust (EPUT). • Programme priorities for the inpatient pathway: o Care that is personalised. o Admissions which are timely and purposeful o Hospital stays which are therapeutic. o Discharges that are timely and effective. o Care that is joined up across health and care system. o Services which actively identify and address inequalities. o Services which grow and develop the acute inpatient mental health workforce. o A pathway which is continuously improving.	• HPFT and EPUT have completed their initial self-assessments and provided detailed information. • 1st Draft ICB overview document submitted to NHSE (Regional team) at the end of March. • Collaborative working with EPUT and Pan-Essex ICBs to support aligned approach. • Following NHSE feedback the ICB strategic document will be finalised in partnership with HPFT and EPUT, approved through internal ICB Governance and published by the end of June 2024. • Once finalised and published, oversight of the plans, implementation, outcomes and impact will be monitored, and through ongoing review, where necessary plans will be refreshed and adjusted over time to achieve effective outcomes.	Ongoing
Essex	The Lampard Inquiry: An Independent Statutory Inquiry into the deaths of mental health inpatients in Essex. Final Terms of Reference were published on 11th April, with a broadened scope of enquiry. There is now a specific reference to role of commissioners - *interaction between the trusts and other public bodies, (including, but not limited to, commissioners, coroners, professional regulators and the Care Quality Commission).*	• The 3 Essex ICBs continue to work collaboratively in ensuring the necessary governance is in place to support actions or request for information from the inquiry team as its work progresses. • Briefings to the ICB Executive Team ongoing.	Ongoing

Assurance and Oversight - Community

Area	Issue and Impact	Mitigating Action	Timescale
Hertfordshire Community Trust (HCT); • Workforce • Waiting list backlog.	Challenges in Children Services - capacity and demand, particularly related to Community Paediatrics, Audiology and specialist services.	• Continuous recruitment and retention programme in place, Safer Staffing tool implemented to review caseload and complexity. • Programme of work across system to review current demand and capacity, focussing on two key parts; a) Clearance of the backlog for Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder diagnostics b) Developing wider biopsychosocial model of support with key stakeholders. • Joint Paediatric Audiology clinic pilot starting in February 2024 by HCT and West Hertfordshire Teaching Hospital Trust (WHTHT) to provide joint Consultant and diagnostic clinics creating efficiencies within the pathway.	Ongoing.

Assurance and Oversight - Care Homes and Home Care

Care Home

ICB Place	Outstanding	Good	Requires Improvement	Inadequate	Inspected and waiting publication	Total
EN	2	82	22	1	9	116
SW	8	90	26	3	7	134
WE	0	41	7	0	1	49
Total	**10**	**213**	**55**	**4**	**17**	**299**

Home Care

ICB Place	Outstanding	Good	Requires Improvement	Inadequate	No published Rating	Total
East North Herts	9	69	14	1	11	104
South & West Herts	4	35	6	1	3	49
West Essex	2	55	8	2	18	85
Total	15	159	28	4	32	238

Area	Issue	Mitigating Action	Timescale
Care Home. ICB.	• Home closures – 1 in process in East and North Hertfordshire - total 29 beds. • Home openings – 1 – 76 residential beds- South West place.	• Attendance at closure meetings for oversight and offer support. Link with Primary Care team supporting home openings.	Ongoing.
Care Home. ICB.	• Service Improvement Process and Quality Assurance Meetings for 3 homes across Hertfordshire. Process led by Herts County Council with governance arrangements in place.	• Joint visits with ICB Nursing and County Council colleagues. 6 weekly system-wide partner formal strategic management meetings, led by the County Council.	Ongoing.

Assurance and Oversight - Primary Medical Care

Primary Medical Care	ICB Place	Inadequate	Requires Improvement	Good	Outstanding	Awaiting publication	Total
	East North Herts (ENH)	0	4	44	0	0	48
	South and West Herts (SWH)	0	1	49	1	0	51
	West Essex (WE)	1	1	27	1	0	30

GP Practice	Issue	Mitigating Action	Timescale
West Essex.	1 practice has been rated as Inadequate and placed in special measures following an inspection in November 2023 (report published 28 March 2024).	• Support from ICB teams provided to practice to address highest risk issues • Meeting being arranged to discuss the outcome, understand practice plans to make required improvements • Undertake initial Contract/ Quality review	- Ongoing. - April 2024. - To be agreed at above meeting.
Herts and West Essex.	6 practices within Herts and West Essex (4 in ENH, 1 in WE and 1 in SWH) are currently rated as 'Requires Improvement' overall by the CQC.	• Support offered/provided by ICB Primary Care & Quality Teams to address the issues raised by the CQC. • Support from ICB specialist teams as required for example, Medicines, Infection Prevention Control, Safeguarding. • Action Plan monitoring /support offered.	Until next CQC inspection/ assessment. Note- due to changes in CQC assessment process timescales are currently unknown.
All Practices in Hertfordshire & West Essex.	There is a risk that there are practices yet to be identified as not meeting the required Quality standards. CQC are currently in a transitionary phase and will be commencing a new assessment process managed by new CQC teams. The new process will be unfamiliar to both ICB and practices.	• Resilience Index Tool within Place Risk and Information sharing meetings to enable timely support offer, if required and reduce potential risks. • Development of risk-based Contract/Quality review and visit programme with prioritisation process based on principles of revised Framework. • Review of ICB CQC support offer to reflect new CQC assessment framework.	Ongoing. April 24 – Pilot phase commenced Aug 24- Finalise Sept 24- Commence To Be Confirmed – when more information is available.

Acronyms

AHC	Annual Health Check
CAMHS	Child Adolescent & Mental Health Services
CLCH	Central London Community Healthcare NHS Trust
CQC	Care Quality Commission
ED	Emergency Department
ENHT	East and North Hertfordshire NHS Trust
EPUT	Essex Partnership University NHS Foundation Trust
GP	General Practitioner
HCRG	Health Care Resourcing Group
HCT	Hertfordshire Community NHS Trust
HPFT	Hertfordshire Partnership University NHS Foundation Trust
HWE	Hertfordshire West Essex
ICB	Integrated Care Board
ICS	Integrated Care System
IPC	Infection Prevention and Control
LeDeR	Learning Disability Mortality Review
LFPSE	Learning from Patient Safety Events
LMNS	Local Maternity and Neonatal System
MVCC	Mount Vernon Cancer Centre
NHS	National Health Service
NHSE	NHS England
NELFT	North East London NHS Foundation Trust
PAHT	Princess Alexandra Hospital NHS Trust
PERTUSSIS	Whooping Cough
PLACE	Patient-Led Assessments of the Care Environment
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
SEND	Special Education Needs and Disabilities
SET	Southend, Essex and Thurrock
SI	Serious Incident
UCLH	University College London Hospitals NHS Foundation Trust
WHTHT	West Hertfordshire Teaching Hospitals NHS Trust

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**24/05/2024**	
Report Title:	**HWE ICS Performance Report**				**Agenda Item:**	**10**	
Report Author(s):	• Stephen Fry, Head of Performance West Essex, Hertfordshire & West Essex ICB • John Humphrey, Head of Performance East and North Herts, Hertfordshire and West Essex ICB • Alison Studer, Head of Performance, South and West Herts, Hertfordshire & West Essex ICB						
Report Presented by:	Frances Shattock, Director of Performance and Delivery, Hertfordshire & West Essex ICB						
Report Signed off by:	Frances Shattock, Director of Performance and Delivery, Hertfordshire & West Essex ICB						
Purpose:	**Approval / Decision**	☐	**Assurance**	☒	**Discussion**	☒	**Information** ☒
Which Strategic Objectives are relevant to this report	▪ Improve access to health and care services ▪ Increase healthy life expectancy, and reduce inequality						
Key questions for the ICB Board / Committee:	▪ Are there any further actions the Board would recommend for assurance beyond those already being taken by the Performance Committee?						
Report History:	HWE ICB Performance Committee, 8th May 2024						
Executive Summary:	The ICS Performance Report provides an overview of the performance of services being delivered by the system against key standards and benchmarks. Issues are escalated by exception, with a focus on actions and next steps being taken to address. Since reporting to the March Board, significant improvement has been seen in a number of key areas: • 4-hour ED achievement fell just short of the 76% national ambition, but performance was the highest since August 21 • Hours lost to ambulance handover reduced significantly, and the system achieved its year end recovery trajectory • The total elective waiting list reduced for the sixth consecutive month, and 65 and 52-week backlogs continue to steadily improve						

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All HWE Trusts saw improvement to their 6-week diagnostics performance
Cancer performance continues to better regional and national averages

The 28-day cancer faster diagnosis standard was again met
The 62-day ambition of 70% for 24/25 was also achieved
The 31-day standard was missed by just 0.1%.

There remain however areas of significant performance risk and challenge as summarised below:

Elective recovery of 78 week waits was not achieved by the March 24 national objective. Alongside children’s community waits, and particularly Community Paediatrics, these are the highest areas of performance risk
Princess Alexandra Hospital (PAH) has been moved into Tier 2 of the national oversight and support infrastructure for cancer and elective (including diagnostics) recovery. Fortnightly tiering meetings are in place with the NHSE regional team
Category 2 ambulance response times are improving, however HWE performance remains the highest in the region
Mental Health (MH) out of area bed days increased in February, but the overall trend is one of improvement. Access to community MH services however remains challenged and high risk
Children’s community waiting lists (including for ASD) remain high, with waiting times notably longer than in adult services. CAMHS caseloads have increased for three consecutive months, and the number of children awaiting a 1st community MH appointment also continues to rise. Waiting times for community MH appointments are however notably better than the national average
GP appointments in 2023 were the highest recorded since 2019, and the percentage of appointments seen on the day, and with 14 days, both have long-term decreasing trends
Performance for CHC assessments remains high risk, with South & West Hertfordshire particularly challenged

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<tr><td>Recommendations</td><td>

To note Executive Summary highlights as reported to Performance Committee

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<tr><td colspan="3">None identified</td><td>☒</td></tr>
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Implications / Impact:		
Patient Safety:	Actions detailed by programme area to support timely patient flow through the system, reduce length of waits for treatment and mitigate risk to patient safety where performance is poor	
Risk: *Link to Risk Register*	*Linked to Performance Directorate Risk Register.* Datix Refs: • 608 Urgent & Emergency Care • 609 Mental Health • 610 Elective Recovery • 611 Diagnostics • 612 Cancer • 645 Community Waits (Children)	
Financial Implications:	N/A	
Impact Assessments:	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A

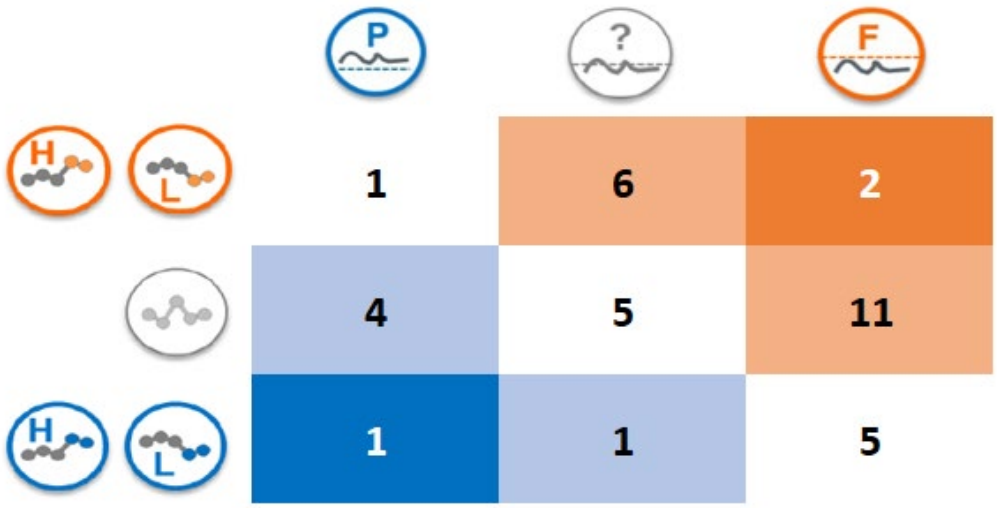
Hertfordshire and
West Essex Integrated
Care System

HWE ICS Performance Report

May 2024

Working together
for a healthier future

Executive Summary – KPI Risk Summary



Highest Risk	Programme
RTT 78 Week Waits	Elective
Community Waits (Children)	Community

High Risk	Programme
% of on the day GP Appointments	Primary Care
% of <14 day GP Appointments	Primary Care
ED 4 Hour Standard	UEC
% in ED > 12 Hours	UEC
NHS 111 Calls Abandoned	UEC
Ambulance Response Times	UEC
4 Hour Stroke Unit	Stroke
Thrombolysed < 1 Hour	Stroke
CAMHS 28 Day Standard	Mental Health
Community MH - CYP Waits for 1st Appt	Mental Health
Community MH - Adult Waits for 2nd Appt	Mental Health
6 Week Waits	Diagnostics
62 Day Standard	Cancer
RTT 65 Week Waits	Elective
RTT 52 Week Waits	Elective
Autism Spectrum Disorder (ASD)	Community
CHC Assessments < 28 Days	Community

Lowest Risk	Programme
CHC Assessments in Acute	Community

Low Risk	Programme
Learning Disability (LD) Health Checks	Primary Care
90% Stroke Unit	Stroke
Adult Crisis 4 Hour	Mental Health
28 Day Faster Diagnosis	Cancer
Community Waits (Adults)	Community

Variable Risk	Programme
Dementia Diagnosis	Primary Care
2 Hour UCR	UEC
No Criteria to Reside (NCTR)	UEC
Ambulance Handovers	UEC
Out of Area Bed Days	Mental Health
Adult 28 Day Standard	Mental Health
CYP Eating Disorders	Mental Health
Learning Disabilities - Time to 1st Assess.	Mental Health
31 Day Standard	Cancer
62 Day Backlog	Cancer
HPFT Early Memory Diagnosis (EMDASS)	Mental Health

Moved to lower risk category **Moved to higher risk category** **No change to risk category** **New KPI added this month**

Executive summary

URGENT CARE, Slides 8-13	**4 Hour Performance**	**Region: HWE better than average**	**National: HWE worse than average**

- Hours lost to handover improved significantly to 771 hours in March, achieving the system recovery target
- Performance against the 4-hour ED standard improved further to 74.8% in March. Whilst not achieving the 76% ambition, this was the best performance since August 21
- NHS 111 abandoned calls increased further in March to 28.3%. Latest data for April suggests significant improvement to <15%
- Category 2 ambulance response times improved to 42 minutes in March, however HWE responses remain the highest in East of England

PLANNED CARE, Slides 14-15	**18 Week RTT**	**Region: HWE better than average**	**National: HWE worse than average**

- The overall elective PTL continues to reduce and has fallen in each of the last 6 months
- All HWE acute trusts continue to report 78-week breaches beyond the March 24 target date. There were c.60 x 78 week waits in the acute trusts' end of March position, with an additional 30 cases with ISPs
- The 65 weeks backlog continues to slowly reduce. All trusts are forecasting to reach zero by end of September

DIAGNOSTICS, Slide 16	**6 Week Waits**	**Region: HWE better than average**	**National: HWE worse than average**

- 6 week wait performance improved to 68.7%. All trusts saw improvement in February

CANCER, Slides 18-19	**28 Day FDS / 31 Day / 62 Day**	**Region: HWE better than average**	**National: HWE better than average**

- 28 Day Faster Diagnosis Standard (FDS) performance continues to improve, achieving 81% in March against the 75% standard
- Patients waiting >62 days continue to reduce. The HWE final 23/24 backlog was 398 against the target of 389
- 62-day performance betters the national and regional averages at 71.4%, but has been below the historic mean for the last 14 months; 31-day cancer performance narrowly missed the national standard at 95.9%

MENTAL HEALTH, Slides 21-31	**Community MH (1st / 2nd Appts)**	**National: HWE better than average (Adult)**	**National: HWE better than average (CYP)**

- Mental Health (MH) out of area bed days increased in February, but the overall trend is one of improvement. Access to community MH services however remains challenged and high risk
- Community adult MH waits for a 2nd contact continue to increase, but better the national average

CHILDREN, Slides 27-29, 32-36	**Various**	**Community 18 Week %: HWE worse than national**	**Community MH 1st Appts: HWE better than national**

- The total number of children on community waiting lists remains very high. Longest waits increased slightly to 112 weeks, compared to 61 weeks for adults
- Pressures are predominantly in Community Paediatrics, as well as therapies and Audiology services
- Autism Spectrum Disorder (ASD) lists and waiting times remain high. Backlog funding ended in December 23. Without continuation of the backlog funding investments, ASD waiting lists will start to grow
- CAMHS caseloads have increased for the last three months, and the 28-day access standard has not been achieved since 2021
- Children's waits for a Community MH 1st appointment are better than the national average. However median waits are 110 days, compared to 84 days for a 2nd contact in adult services

COMMUNITY (Adults), Slides 37-38	**% <18 Weeks**	**National: HWE better than average**	**Adult waiting times better than CYP**

- % of adults waiting <18 weeks remains strong and betters the national average

PRIMARY CARE & CHC, Slides 43-46	**Appointments <14 Days**	**National: HWE in line with national average**

- Total number of GP appointments are variable but remain higher than pre-pandemic levels. Appointments in 2023 are highest since 2019
- The percentage of appointments seen on the same day and <14 days both have long-term decreasing trends
- CHC assessments within 28 days remains high risk, with performance particularly challenged in South & West Hertfordshire

Executive Summary – Performance Overview (1)

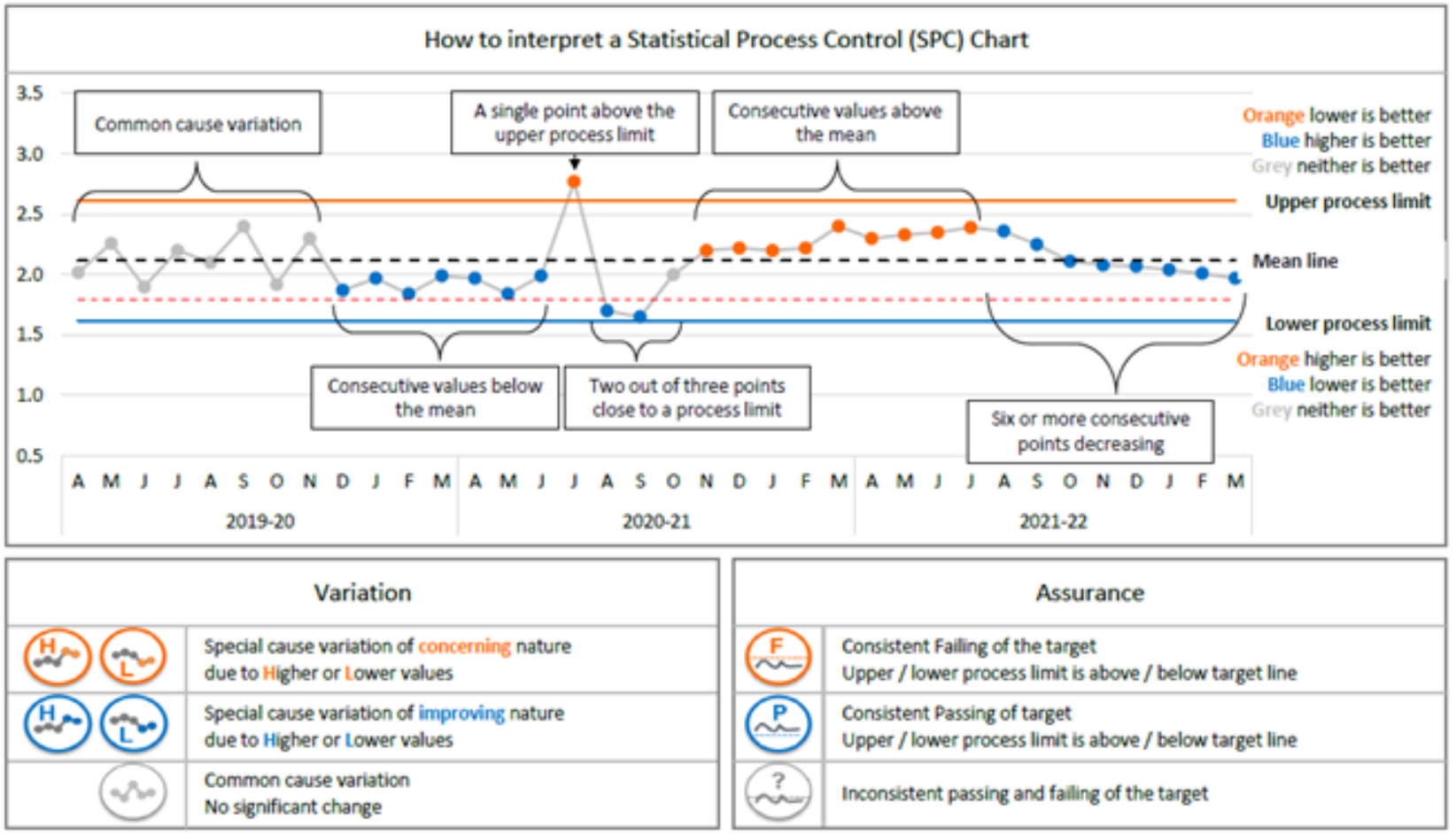
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
A&E - 4 Hour Standard	Mar 24	74.8%	76.0%	H	F	68.5%	63.3%	73.7%
A&E - % spending more than 12 Hours in Dept	Mar 24	9.1%	-			10.3%	7.6%	13.0%
A&E - ED Attendances	Mar 24	49630	-	H		43929	37672	50185
Trolley Waits	Mar 24	182	-	H		178	-39	395
2 Hour Community Response	Mar 24	76.7%	70.0%	L	P	82.2%	71.3%	93.1%
14 day LOS	Mar 24	26.5%	-	H		25.3%	22.0%	28.5%
Ambulance - Handover >60 Mins	Mar 24	447	-	L		983	566	1399
EEAST: Cat 1 - Mean (<7min)	Mar 24	00:08:59	00:07:00		F	00:09:29	00:08:01	00:10:58
EEAST: Cat 2 - Mean (<18 Mins)	Mar 24	00:42:29	00:15:00		F	00:52:33	00:20:29	01:24:37
CHC - Decision within 28 days	Feb 24	57.1%	80.0%		F	67.6%	49.8%	85.4%
CHC - Assessments in Acute	Feb 24	0.0%	0.0%	L	P	0.1%	-0.7%	0.9%
111 - Calls received by telephony system	Mar 24	49777	-			52840	31869	73811
111 - Calls answered within 60 seconds	Mar 24	21.7%	100.0%	L	F	46.9%	15.8%	78.0%

Executive Summary – Performance Overview (2)

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT - 18 Weeks	Feb 24	52.7%	92.0%			55.4%	52.5%	58.4%
RTT - 52 Week Waits	Feb 24	7288	-			8200	6655	9745
RTT - PTL Size	Feb 24	139524	-			131137	123919	138355
RTT - 78 weeks	Feb 24	124	-			922	496	1348
RTT - 65+ weeks	Feb 24	1508	-			2972	2276	3668
Cancer - 2 Week Wait Referrals	Feb 24	7327	-			7033	3358	10707
Cancer - 62 Day Standard	Feb 24	71.4%	85.0%			72.4%	63.4%	81.3%
Cancer - 62 Day Total Waiting	Mar 24	430	-			563	380	746
Cancer - 104 Day Total Waiting	Mar 24	163	-			157	108	206
Cancer - 28 Day Faster Diagnosis Standard	Feb 24	81.1%	75.0%			71.3%	61.8%	80.9%
Cancer - 31 Day Standard	Feb 24	95.9%	96.0%			95.1%	90.8%	99.4%
Diagnostics - 6 Week Wait	Feb 24	68.7%	99.0%			64.9%	57.0%	72.9%
Diagnostics - PTL Size	Feb 24	25855	-			25303	20321	30285
Primary Care - Attended Appointments	Jan 24	755633	-			658578	480546	836610
Primary Care - Routine Referrals	Feb 24	24870	-			24945	11727	38163
Primary Care - Urgent Referrals	Feb 24	5906	-			5471	2647	8296
Mental Health - Out of Area Bed Days	Feb 24	211	-			837	473	1200
Mental Health - Recorded >65s Dementia Diagnosis	Feb 24	64.4%	66.6%			62.4%	61.7%	63.1%
Mental Health - IAPT Entering Treatment	Feb 24	2586	-			2392	1310	3475
Early Intervention in Psychosis	Feb 24	90.6%	60.0%			81.6%	59.1%	104.1%

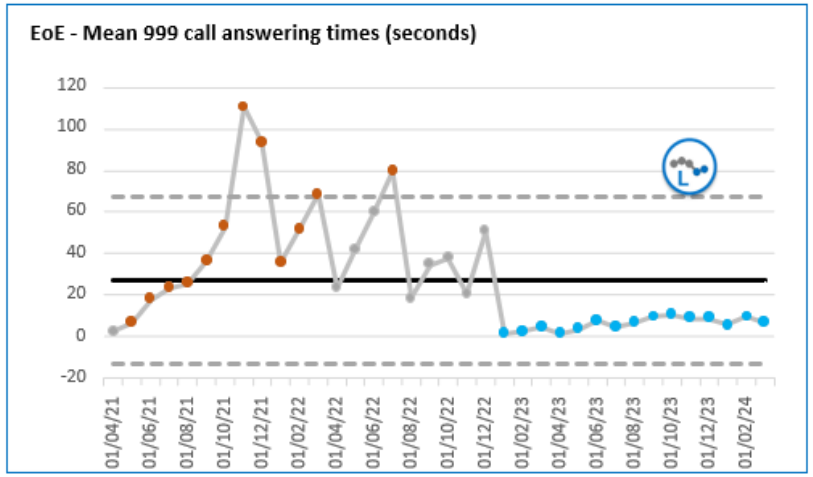
A Dashboard including Place and Trust based performance is included within Appendix A of this report

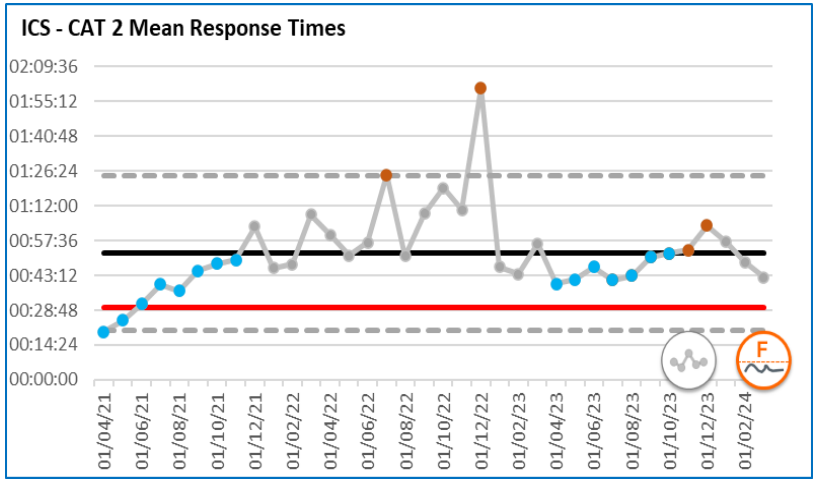
Statistical Process Control (SPC)

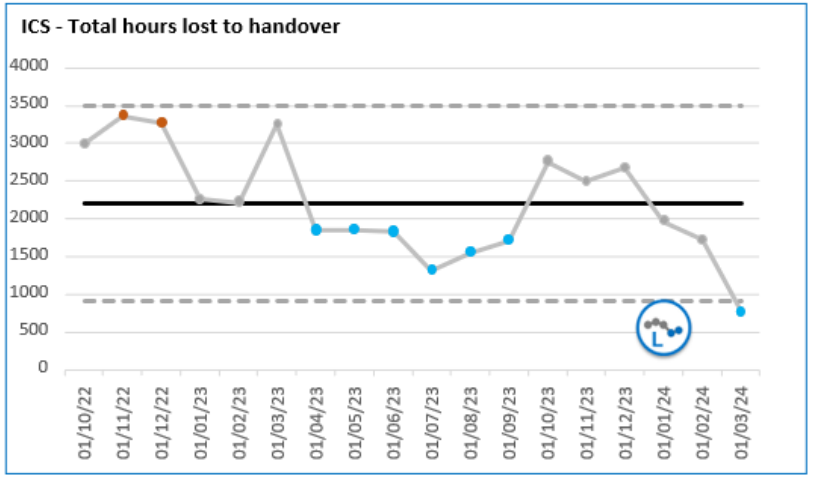


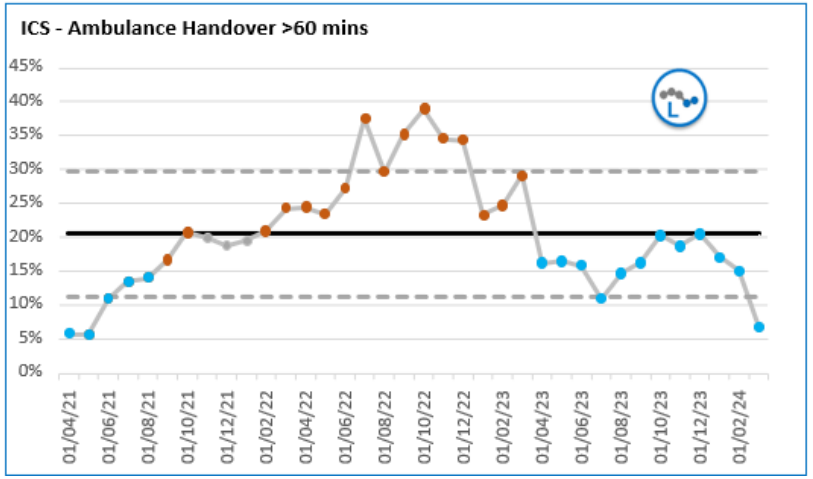
Performance by work programme

UEC - Ambulance Response and Handover

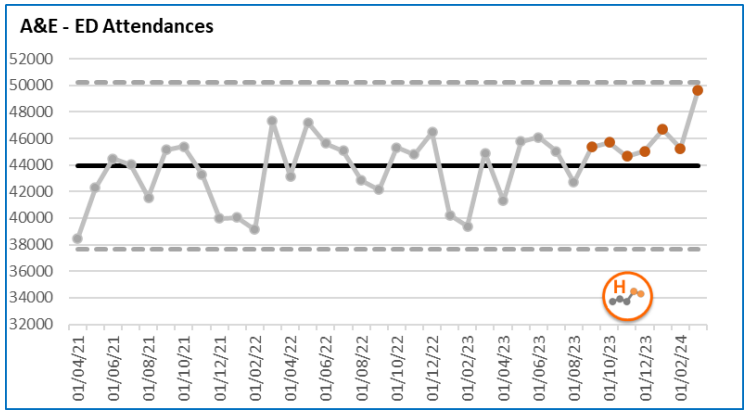




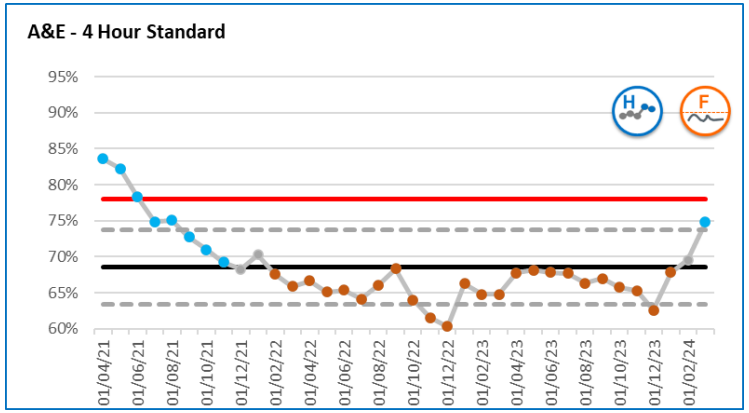




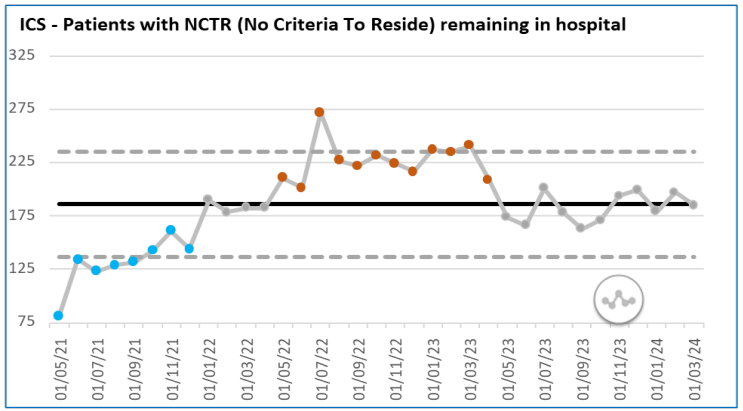
Urgent & Emergency Care (UEC)

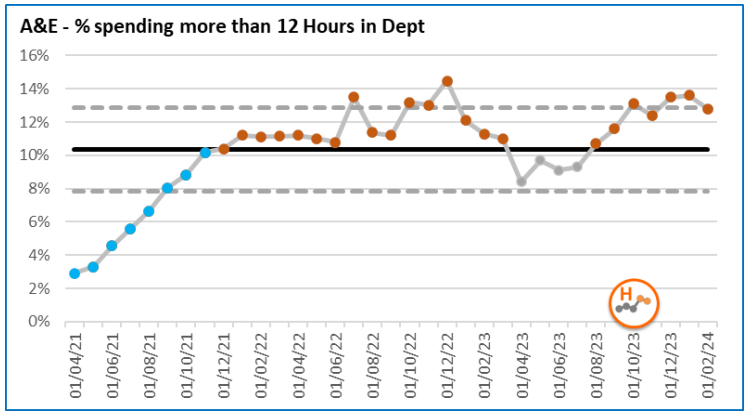


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
East And North Hertfordshire Place (ENHT and HUC)	15,23	16,65	17,78	17,60	16,81	18,38	18,41	17,50	16,21	15,98	15,93	19,13	17,01	19,00	18,00	18,23	17,11	16,63	17,83	17,42	17,78	15,77	15,35	17,58	15,95	18,22	18,13	17,59	16,63	17,70	17,93	17,65	17,76	17,93	17,92	19,73
West Hertfordshire Hospitals NHS Trust	13,20	14,41	15,17	15,22	13,94	14,97	15,20	14,52	13,42	13,53	13,02	15,53	14,73	15,63	15,63	15,14	14,83	14,13	15,54	15,55	16,66	14,11	13,70	15,73	14,75	16,02	16,07	15,89	14,86	15,96	15,77	15,93	16,15	16,59	15,64	17,28
West Essex Place (PAH and HCT)	10,03	11,22	11,53	11,21	10,79	11,78	11,75	11,28	10,33	10,50	10,16	12,61	11,39	12,57	12,00	11,68	10,89	11,37	11,96	11,80	12,01	10,33	10,31	11,58	10,58	11,52	11,88	11,54	11,20	11,68	12,00	11,08	11,12	12,16	11,67	12,60
ICS	38,47	42,29	44,48	44,03	41,54	45,14	45,37	43,30	39,97	40,03	39,12	47,28	43,13	47,21	45,64	45,06	42,84	42,14	45,33	44,78	46,46	40,22	39,37	44,90	41,29	45,77	46,09	45,03	42,70	45,34	45,70	44,66	45,04	46,69	45,24	49,63



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
East And North Hertfordshire Place (ENHT and HUC)	84.8%	85.9%	80.8%	77.5%	76.3%	72.8%	73.1%	72.2%	72.4%	73.2%	71.1%	70.9%	70.5%	70.9%	70.1%	67.5%	71.9%	70.7%	68.4%	64.8%	64.9%	69.3%	67.2%	67.6%	70.5%	69.5%	69.2%	70.0%	69.2%	70.8%	68.8%	66.7%	64.6%	70.2%	72.7%	76.2%
West Hertfordshire Hospitals NHS Trust	86.0%	83.0%	79.1%	73.9%	76.1%	77.6%	73.6%	70.5%	63.3%	65.7%	62.7%	58.8%	62.1%	58.2%	60.5%	63.2%	65.0%	70.2%	64.6%	60.2%	60.0%	68.4%	69.0%	68.1%	71.4%	74.1%	73.1%	71.3%	69.1%	69.9%	71.8%	71.4%	67.1%	69.5%	70.8%	78.2%
West Essex Place (PAH and HCT)	78.7%	75.8%	73.3%	72.0%	71.9%	66.4%	64.2%	63.0%	68.2%	71.6%	68.2%	66.9%	66.8%	64.9%	64.6%	60.2%	58.6%	62.7%	56.6%	58.6%	54.0%	58.6%	55.6%	55.9%	58.5%	57.6%	58.6%	59.1%	58.5%	57.1%	53.3%	54.2%	52.7%	61.8%	63.0%	67.9%
ICS	83.6%	82.2%	78.3%	74.9%	75.1%	72.7%	71.0%	69.2%	68.2%	70.3%	67.5%	65.9%	66.6%	65.1%	65.4%	64.1%	66.1%	68.4%	64.0%	61.5%	60.3%	66.2%	64.8%	64.8%	67.8%	68.2%	67.8%	67.7%	66.4%	67.0%	65.8%	65.3%	62.6%	67.8%	69.5%	74.8%

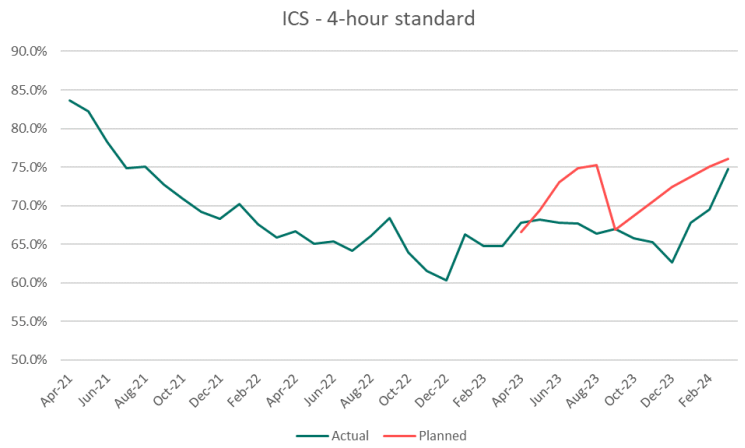




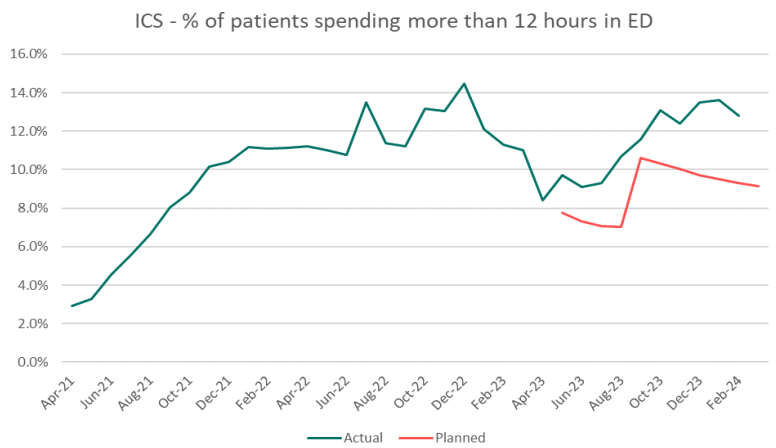
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
East And North Hertfordshire NHS Trust	2.8%	2.4%	4.7%	6.3%	8.6%	10.2%	11.8%	13.0%	12.8%	13.9%	14.1%	15.0%	14.8%	13.4%	13.9%	16.9%	12.3%	13.7%	15.7%	15.9%	15.7%	15.3%	16.3%	15.8%	12.7%	13.8%	13.2%	9.5%	12.7%	12.6%	13.0%	13.2%	15.1%	13.9%	13.9%
West Hertfordshire Hospitals NHS Trust	1.5%	2.4%	2.6%	3.2%	3.4%	3.1%	2.9%	5.4%	8.1%	7.9%	7.5%	6.1%	7.5%	8.6%	8.7%	9.4%	7.5%	6.7%	9.6%	9.9%	12.4%	10.9%	7.1%	5.6%	5.7%	4.6%	5.6%	8.3%	10.7%	8.7%	11.3%	12.3%	14.4%	14.7%	11.3%
The Princess Alexandra Hospital NHS Trust	4.2%	5.0%	5.9%	6.9%	7.2%	9.7%	10.9%	11.2%	9.8%	11.2%	10.9%	11.5%	10.7%	10.5%	9.5%	13.5%	13.8%	12.4%	13.8%	13.1%	15.2%	10.1%	9.8%	10.8%	6.5%	9.6%	7.8%	9.9%	9.0%	13.4%	15.0%	11.7%	11.2%	12.6%	13.1%
ICS	2.9%	3.3%	4.5%	5.6%	6.7%	8.1%	8.8%	10.2%	10.4%	11.2%	11.1%	11.1%	11.2%	11.0%	10.8%	13.5%	11.4%	11.2%	13.2%	13.0%	14.5%	12.1%	11.3%	11.0%	8.4%	9.7%	9.1%	9.5%	10.7%	11.6%	13.1%	12.4%	13.5%	13.6%	12.8%

Urgent & Emergency Care (UEC) Improvement Trajectories

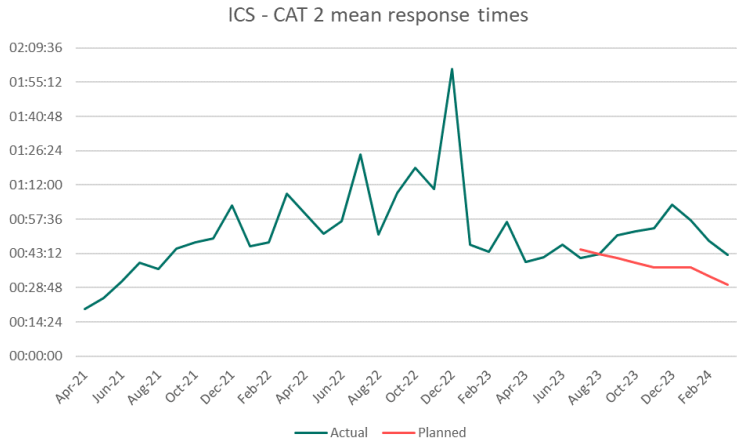
4 Hour Standard



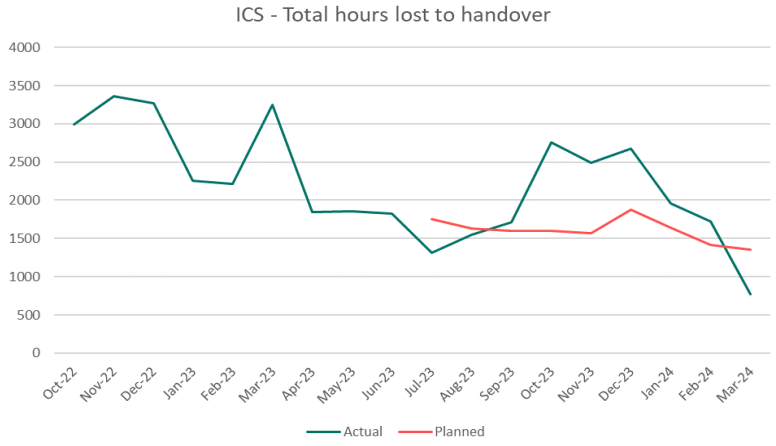
% of Patients Spending > 12 Hours in ED



Ambulance Category 2 Mean Response Times



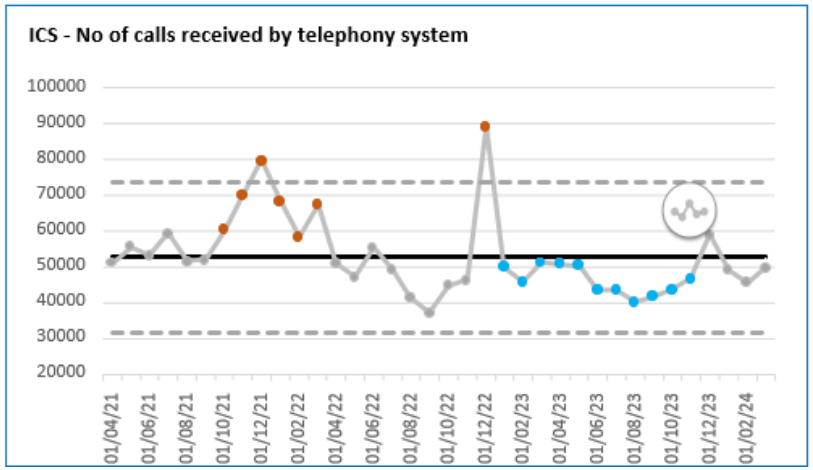
Hours Lost to Handover

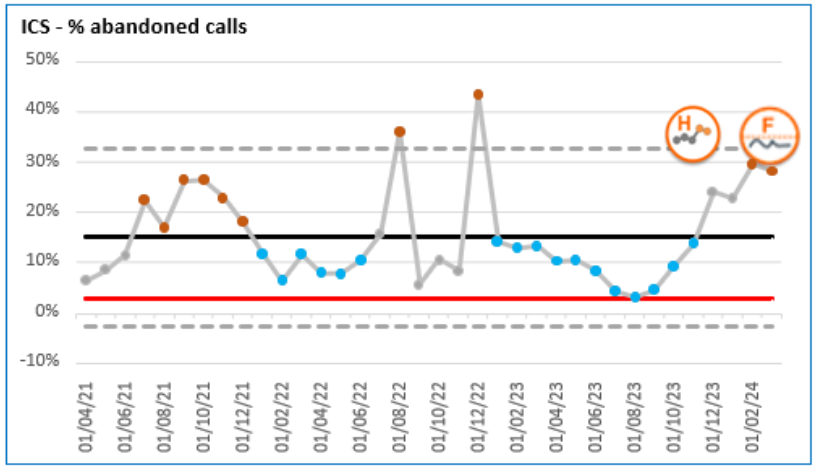


Urgent & Emergency Care (UEC)

ICB Area	What the charts tell us	Issues	Actions
ICB	• Performance against the 4-hour ED standard improved to 74.8% in March, which is the best performance since Aug-21. • This was achieved in-spite of Mar-24 having more ED attendances than any previous month in Hertfordshire and West Essex • There remains variation at a place level for performance against the 4-hour standard. However, the gaps have reduced: – SWH = 78.2% – ENH = 76.2% – WE = 67.9% • All three HWE acute trusts were in the top 20 trusts nationally for the improvement in 4-hour performance between Dec-23 and Mar-24 • 999 call answering times have remained low with an average of 7 seconds in March • The mean Category 2 ambulance response time was 42 mins in March. This is a considerable improvement compared to Dec-23 (63 mins), but remains adrift of the national 30-minute standard, and is consistently longer than other systems in the region • Hours lost to handover reduced to 771 hours in March; this is the best performance since Oct-22 and better than the target of 1351 hours for Mar-24 • Average patients per day with NCTR remaining in hospital improved to 185. This is slightly behind the March target of 178 hours	• Continued high demand and high acuity of patients requiring UEC services. ED attendances and ambulance conveyances across the health system in Q4 were 14% higher than they were in Q4 22/23. Mar-24 had the highest number of ED attendances ever in the HWE system • Increase in 111 call volumes during the winter months. However, 111 call volumes in Q4 were lower than during Q4 22/23. 111 call abandonment rates were higher in Q4 than they were in Q4 22/23 • Mental Health presentations at ED remain high, coupled with a shortage of beds / assessment space. Analysis suggests that mental health patients are more likely to wait >12 hours in ED • Hospital flow remains very challenging with high occupancy rates, especially at PAH where average bed occupancy in March was 97%	**System** • At the end of Dec-23, a series of protocols were introduced to help reduce handover times. These had a significant impact on reducing the hours lost to handover between December and March • Increased number of double staffed ambulances on evening / overnight shifts • C2 revalidation pilot has taken place and 37% of cases were stepped down from C2 **East and North Herts** • Interventions such as the new Lister UTC, expansion of SDEC and new ED nursing rotas, and launch of the MH UTC had a significant impact on ED performance during Q4 of 23/24 • Further upcoming interventions include: - Implement trusted assessor model to reduce 20 patient per day gap in medicine - August Junior Doctors roster implementation to give additional capacity in evenings - Extending hours of SDEC / UTC and opening of a Paediatric UTC - Robust and consistent use of plus one and reverse boarding in medicine (min of 5 per morning) **West Essex** • Falls car - working with EPUT to extend to end of 24/25 • Work continues with EPUT and ICB on MHRV for MH patients. Business case in discussion. WE vehicle expected live in September • Multi Agency Discharge Event (MADE) on w/c 25th March • EEAST / GP direct access to SDEC pathways - timeframe to be agreed • New IUATC phase 2 is now live • Additional senior decision maker in ED between 10pm and midnight • Golden patient SOP being finalised for April launch **South and West Herts** • Access-to-stack acceptance rates have been maintained since November workshop • Implementation of 45-minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • Additional assessment trolleys created in majors 2 • Workforce Business Cases going to TMC to support flow and time to initial assessment for nursing workforce, medical workforce, performance co-ordinators

NHS 111



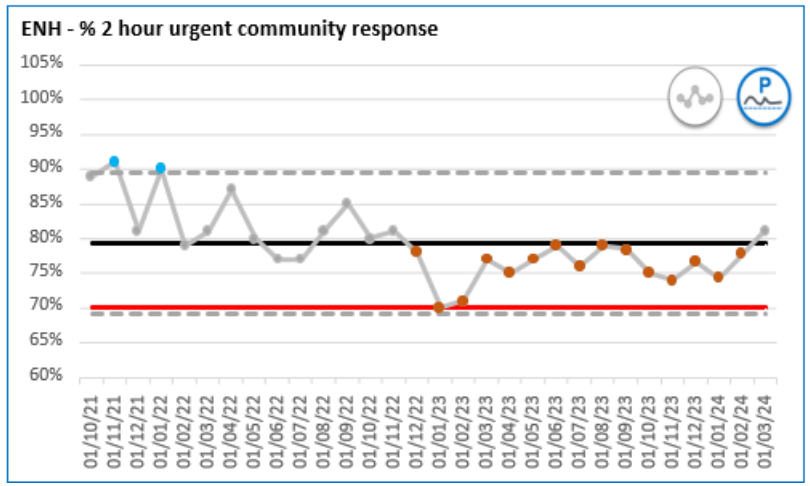


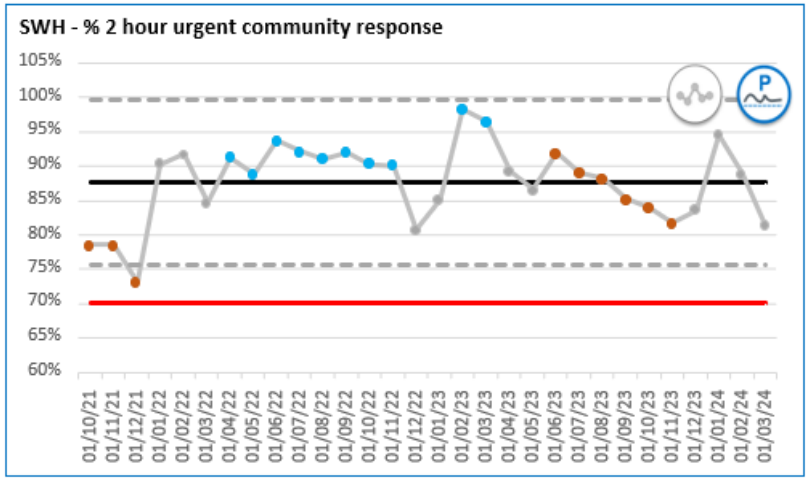
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Hertfordshire	40,961	44,295	42,714	47,283	41,153	41,252	48,102	59,032	67,426	58,723	50,284	58011	40,994	38,103	44,679	39,741	33,485	30,011	35,979	37,408	72,599	40,952	37,027	41370	40,906	40,641	35,309	35,339	32,701	34,068	35,313	37,481	48,145	39,466	36,872
West Essex	10,199	11,294	10,456	12,194	10,590	10,788	12,175	10,983	12,414	9,549	8,013	9377	9,904	9,165	10,642	9,452	8,020	7,255	8,861	9,121	16,414	9,145	8,739	9878	9,924	9,715	8,465	8,275	7,472	7,799	8,626	9,368	11,965	9,629	8,770
ICS	51,160	55,589	53,170	59,477	51,743	52,040	60,277	70,015	79,840	68,272	58,297	67,388	50,898	47,268	55,321	49,193	41,505	37,266	44,840	46,529	89,013	50,097	45,766	51,248	50,830	50,356	43,774	43,614	40,173	41,867	43,939	46,849	60,110	49,095	45,642

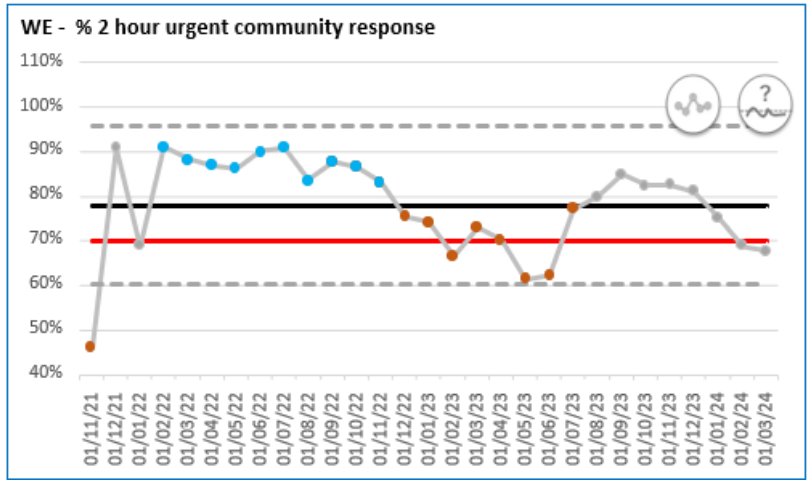
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Hertfordshire	6.1%	8.3%	11.2%	21.7%	16.4%	25.6%	25.7%	22.5%	18.0%	11.7%	6.5%	11.6%	7.8%	7.4%	10.3%	15.0%	35.5%	5.6%	10.5%	8.1%	42.7%	13.8%	12.7%	13.0%	10.2%	10.3%	8.2%	4.3%	3.3%	4.5%	9.6%	13.7%	24.3%	23.3%	29.8%
West Essex	7.1%	9.4%	12.4%	25.1%	19.2%	29.1%	29.0%	25.1%	19.0%	11.8%	6.3%	11.9%	8.5%	9.4%	11.8%	18.5%	38.5%	6.2%	11.8%	9.6%	46.2%	16.2%	13.7%	14.7%	10.9%	12.1%	8.7%	4.7%	3.3%	4.8%	8.6%	13.6%	23.5%	21.2%	28.2%
ICS	6.3%	8.5%	11.5%	22.4%	17.0%	26.3%	26.4%	23.0%	18.2%	11.7%	6.4%	11.6%	7.9%	7.8%	10.6%	15.7%	36.1%	5.7%	10.7%	8.4%	43.4%	14.3%	12.9%	13.4%	10.3%	10.6%	8.3%	4.3%	3.3%	4.6%	9.4%	13.7%	24.1%	22.9%	29.5%

ICB Area	What the charts tell us	Issues	Actions
HUC	• Call volumes have been consistently trending below the historic mean for the last year, other than a spike in December when more than 10,000 additional calls were received • Abandoned calls reached a yearly high of 29.5% in February • March showed a small improvement to 28.3% • Indicative data for April suggests considerable improvement to <15%	• Health Advisors need to hold calls until clinical advice has been given, leading to c.5% increase in call time • Recruitment issues; 21 WTE vacancies across HWE for Health Advisors • 25% of Health Advisors on probation requiring additional support • High number of early leavers, not finishing the training course • Activity levels higher than planned	• Abandonment rates under review with the ICB & NHSE. Ongoing investigation • Full week of recruitment assessment centres in February. 19 FTEs appointed across the next 3 months. Training courses to be live by May • NHSE National Resilience agreed for part of 24/25 - dedicated workforce to pick up an agreed % of HUC calls. NHSE employed remote staff • Continued staff support with MH and wellbeing • Calibre of new staff reviewed through assessments, separate to the interview process • Internal Action Plans in place to work through concerns and scrutinise performance • Clinical Navigator in place to support clinical staff • Cross-site working and pooling resources across HUC-Footprint (HAs and CAS)

UEC - Urgent 2 Hour Community Response (UCR)





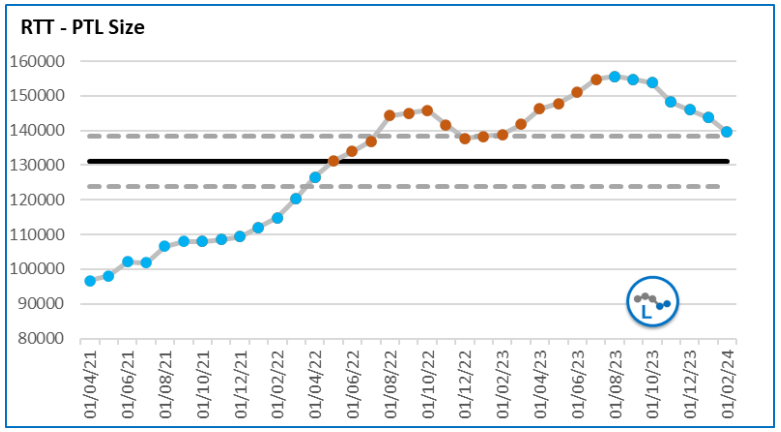


Activity	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
West Essex	466	376	348	472	430	489	375	413	464	357	374	497	455
East & North Herts	471	454	545	545	641	649	693	643	631	650	709	568	707
South & West Herts	136	203	222	196	232	159	175	180	158	157	213	212	209

ICB Issues, escalation and next steps

- West Essex performance dipped slightly below the 70% standard in February & March. This resulted from a lack of capacity within the EEAST RIS car in the Harlow and Epping localities
- Work continues in SWH to ensure recording practices are correct and to improve referrals to the service. CLCH Business Team have developed bespoke training material and guidelines to be rolled out in line with national guidance
- The system is working with the regional team to ensure consistency of reporting and capture of all UCR activity. We expect additional UCR activity for all Places in the next report

Planned Care – PTL Size and Long Waits



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
EAST AND NORTH HERTFORDSHIRE NHS TRUST	50312	50103	52368	51326	54504	54794	54200	53331	49521	48264	47103	49182	51259	52241	53993	55737	59979	58006	59917	60713	60999	60488	61406	61782	62296	62295	63245	63592	62958	63472	63258	61909	61208	59807	55116
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	25025	25842	27093	27823	28401	28438	28380	29017	32809	36110	40241	45085	49522	53146	54626	55530	57611	60326	59727	53831	49537	50343	50169	52995	56574	57933	60626	62689	64384	62966	63054	60236	58731	58220	58693
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	21297	22126	22654	22706	23706	24827	25359	26196	27081	27688	27444	26157	25780	25862	25287	25573	26759	26623	26237	27093	27172	27408	27247	27012	27372	27523	27137	28442	28312	28341	27426	26056	25991	25767	25715
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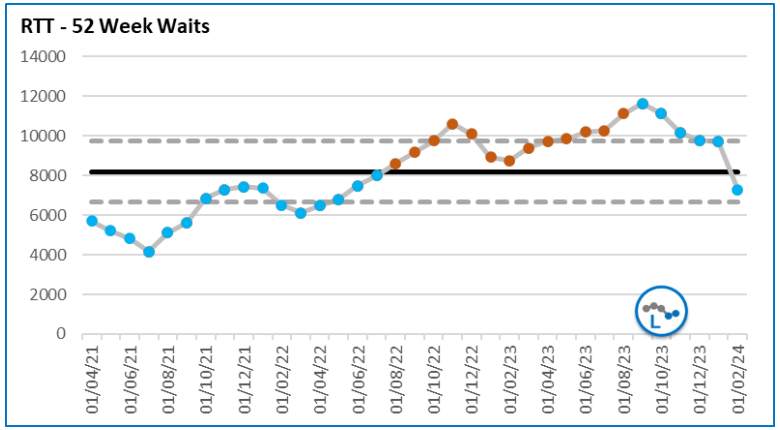

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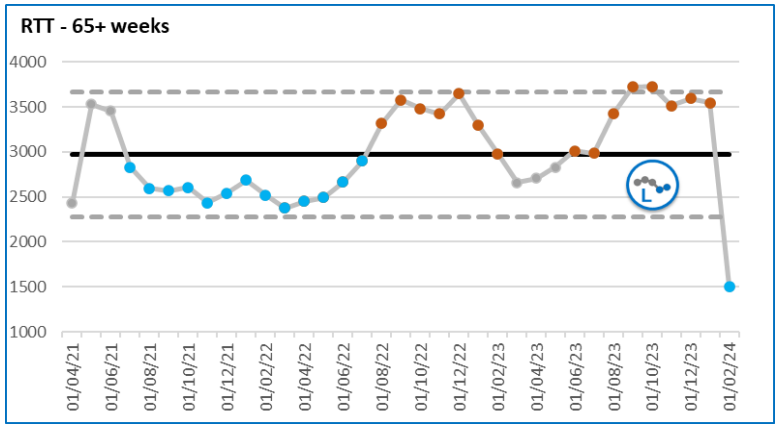
						2021	22											2022	23											2023	24				
Other	3740	3162	2782	2578	2447	2441	2394	2296	2321	3348	2853	2868	3033	2496	2412	2648	2532	2437	2533	2570	2728	2691	2641	2782	3133	3318	3109	3073	3122	2976	2829	2766	2607	2530	2412
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	1302	1249	1143	1269	1394	1536	2141	2321	2486	2613	2221	1737	1818	1674	1785	1911	1909	1898	1804	1721	1773	1850	1814	1870	1973	2098	2280	2376	2516	2557	2171	1965	1919	1941	1959
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	1462	1162	898	789	800	838	878	862	927	1006	1103	1059	1193	1431	1660	1783	2078	2587	3413	4172	3544	2681	2315	2729	2694	2439	2504	2440	2769	2982	3039	2488	2246	2407	2420
EAST AND NORTH HERTFORDSHIRE NHS TRUST	2936	2791	2785	2095	2910	3259	3818	4102	4016	3739	3194	3313	3473	3699	4027	4294	4628	4688	4527	4618	4778	4404	4618	4797	5064	5308	5400	5450	5831	6097	5912	5684	5612	5350	2909



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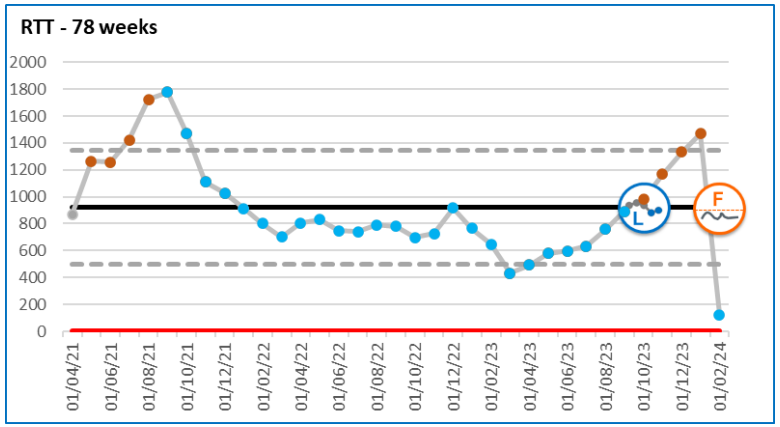
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	0	722	673	650	665	719	776	744	715	772	780	685	701	679	739	768	765	745	636	572	636	658	592	549	604	707	816	878	955	1018	840	756	830
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	1026	1007	783	578	477	431	399	351	390	437	461	413	459	480	499	480	566	680	719	767	831	819	607	548	495	504	524	455	569	636	621	466	434
EAST AND NORTH HERTFORDSHIRE NHS TRUST	1405	1799	1998	1601	1452	1417	1428	1338	1438	1475	1279	1278	1293	1334	1428	1653	1983	2150	2124	2081	2178	1816	1778	1562	1610	1621	1673	1650	1901	2068	2266	2293	2332



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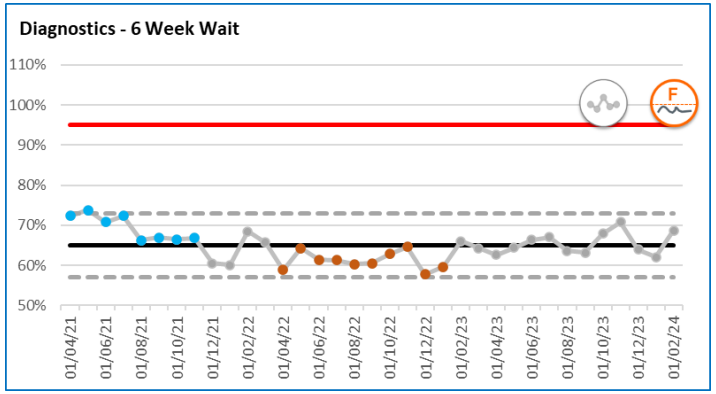
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	0	231	218	288	378	434	399	325	283	260	243	190	223	266	281	296	248	208	141	108	157	147	95	14	23	37	37	51	90	117	118	104	136	99	84
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	353	389	364	388	407	362	271	189	169	162	140	111	144	155	143	133	137	116	92	69	69	69	38	15	11	9	7	8	6	8	9	7	8	14	10
EAST AND NORTH HERTFORDSHIRE NHS TRUST	516	646	674	748	940	983	800	598	577	492	420	401	439	408	324	312	407	458	464	548	689	551	516	405	461	532	553	573	661	768	854	1058	1190	1357	30

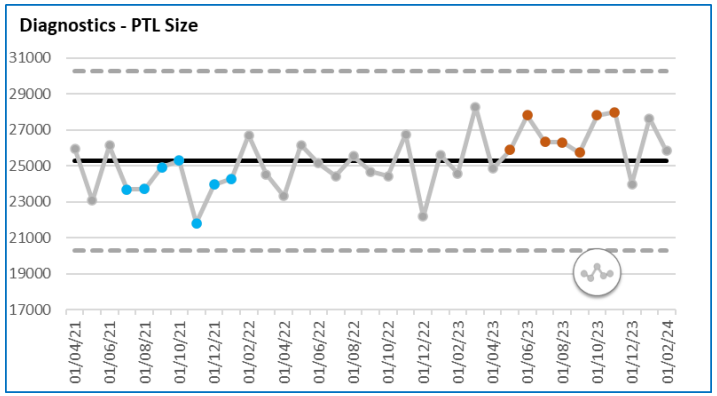
Community Paediatrics patients have been excluded from RTT reporting from February 2024 in line with national guidance
Waiting lists therefore show significant reductions

Planned Care – PTL Size and Long Waits

ICB Area	What the charts tell us	Issues	Actions
HWE	• Due to the change in national guidance, Community Paediatrics patients have been excluded from RTT reporting from February 2024. Waiting lists therefore show significant reductions in the latest data. These waits are included within the Community section of this report – see slide 35 • The overall PTL size remains high, although showing a decreasing trend over the last seven months • Excluding Community Paediatrics, February saw a slight increase in the number of patients waiting >78 weeks. This was mainly driven by PAH • Excluding Community Paediatrics, the number of patients waiting >65 weeks is beginning to reduce and has seen steady improvement over the last two months • Excluding Community Paediatrics, the number of patients waiting >52 weeks has decreased over the last three months, but remains an area of concern	• Trauma and Orthopaedics (T&O) remains the main specialty under pressure • Staffing remains a challenge, particularly in Anaesthetics • Latest data shows that PAH 78-week waits have reduced, although the ISP has taken 56 long waiting patients to their lists from PAH • There were 93 x 78-week breaches in the system's 2 end of year position (March data) • The latest 78ww April forecast (as of 21/4) is 91 for the system (ENHT 26 / WHTH 2 / PAH 22 / ISP 41)	• Princess Alexandra Hospital will be in Tier 2 of the national oversight and support infrastructure for Elective (including Diagnostics) recovery from the week commencing 29 April 2024. Fortnightly tiering meetings with the NHSE EOE regional team commence on 9th May **Management of waiting lists** • System focus on reducing number of patients waiting >78 weeks and >65 weeks, with regional and national oversight • Demand, capacity & recovery plans are in place to monitor 78 & 65 weeks • Weekly KLOEs in place with NHSE to track 104/78/65-week positions • Fortnightly performance meetings with each of the three acute Trusts are in place with NHSE support • Validation and robust PTL management in place • The 65ww target to zero breaches has been extended to September 2024 with each of the three trusts submitting plans to meet that target **Increasing capacity and improving productivity** • Pro-active identification of pressured specialties with mutual aid sought via local, regional & national processes • Outpatients has a full programme of work to increase productivity including PIFU (patient initiated follow up), reducing follow ups including discharging where appropriate, and increasing take up of advice & guidance • Maximising use of ISP capacity and WLIs where possible • Theatre Utilisation Programmes in place including an ICB wide programme • Anaesthetist recruitment

Planned Care – Diagnostics





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EAST AND NORTH HERTFORDSHIRE NHS TRUST	69.5%	69.6%	66.7%	70.5%	62.6%	63.0%	60.4%	61.0%	54.7%	50.9%	60.0%	54.9%	45.9%	53.0%	53.2%	50.3%	50.6%	50.0%	53.5%	56.9%	49.3%	54.5%	61.8%	58.1%	54.7%	58.2%	60.3%	60.4%	56.5%	57.2%	59.4%	62.5%	53.3%	49.2%	55.3%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	81.5%	83.5%	77.6%	77.6%	75.2%	73.8%	75.4%	71.6%	63.4%	67.5%	73.8%	72.5%	66.6%	67.6%	65.4%	67.8%	68.3%	70.7%	71.1%	69.9%	65.0%	62.0%	64.7%	63.1%	63.8%	65.8%	67.3%	69.5%	68.5%	70.8%	78.3%	83.3%	84.1%	85.2%	90.9%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	69.2%	71.9%	71.5%	70.6%	64.2%	67.3%	68.7%	72.9%	69.4%	71.8%	79.9%	82.0%	81.3%	86.9%	76.7%	78.8%	74.0%	71.4%	72.6%	74.2%	64.5%	65.7%	74.6%	76.4%	74.9%	73.5%	76.0%	75.9%	70.3%	65.8%	72.6%	73.1%	64.9%	65.3%	75.2%
ICS	72.3%	73.7%	70.7%	72.3%	66.2%	67.0%	66.5%	66.8%	60.5%	60.1%	68.4%	65.7%	58.9%	64.3%	61.4%	61.3%	60.3%	60.5%	62.9%	64.6%	57.7%	59.6%	66.0%	64.3%	62.6%	64.4%	66.4%	67.0%	63.6%	63.2%	67.9%	70.8%	63.9%	62.0%	68.7%

ICB Area	What the charts tell us	Issues	Actions

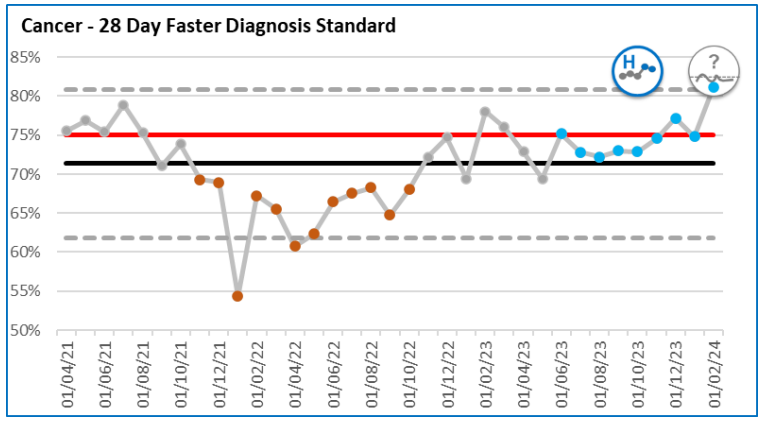
HWEICB	• 6-week wait performance across the ICS improved by 6.7% in February
	• PAH saw improvement of 9.9%; 6.1% at ENHT; 5.7% at WHTH
	• The overall PTL continues to fluctuate within expected common cause variation limits
		• Workforce remains the key area of concern across the ICS
		• Significant variation in Trust performance:
		  • ENHT – 55.3%
		  • WHTH – 90.9%
		  • PAH – 75.2%
		ENHT
		• Imaging remains the most significant risk to delivering 6-week wait performance
		• The number of people waiting over 6 weeks for imaging is 7,995 (MRI 2,764, CT 1,132, DEXA 1,296, US 2,803). This compares to 1,528 at PAH, and 85 at WHTH
		PAH
		• Non-Obstetric Ultrasound (NOUS), Echocardiography, Cystoscopy and Audiology are the key challenges at PAH
		WHTH
		• Audiology presents the greatest risk to 6 week wait performance
		• There has been a substantial improvement in all other modalities
			• Workforce lead for diagnostics in post and working with providers on the various projects
			• Recovery trajectories in place and overseen at Trust performance meetings and diagnostic programme
			ENHT
			• Seeking to outsource imaging to the independent sector and will look at mutual aid / levelling up
			• DEXA capacity will increase significantly over 24/25 after a robust demand & capacity exercise
			• New Cardiac CT Consultant capacity coming online
			PAH
			• PAH CDC is live for MRI, X-ray and Ultrasound Extended Access using insourcing and existing facilities
			• Audiology insourcing in place – significant improvement in > 6-week backlog
			• NOUS – Insourcing live from May
			• Discussions progressing for ISP Cystoscopy support
			• Echocardiography – new General Manager in post
			WHTH
			• Continued focus on DEXA – now showing an improving position
			• Plan to share learning on Echocardiography improvement across the ICS
			• Working on CDC and Endoscopy Unit mobilisation

Planned Care – Theatre Utilisation

Theatre Utilisation (w/e 7/04/24 unless otherwise stated)	ENHT	WHTH	PAH	ICB Total	Peer Average
Number of theatres	18	12	9	39	40
Number of cases*	336	231	129	696	603
Average cases per 4 hour session*	2.8	2.5	2	2.5	2.4
Utilisation - Capped	81.2%	74.9%	72.9%	77.2%	77.4%
Average late starts (Minutes)**	21	32	36	28	28
Average inter case downtime (Minutes)	15	14	16	15	16
Average early finish (Minutes)**	75	70	69	67	69
Average unplanned extensions (Minutes)**	29	75	62	55	47
% of emergency surgery conducted within elective lists*	1.5%	0.9%	0%	1.0%	1.0%
BADS day case (October-December 2023)	86.5%	77.2%	77.0%	81.4%	80.1%
Conversion from day case to inpatient (October-December 2023)	6%	11%	18%	10%	11%
* no national target					
** lists started late/finished early/extended time					

ICB Area	What the charts tell us	Issues	Actions
HWEICB	• Comparable performance v. peers for all aspects, excluding number of cases, and average unplanned extensions • Average cases per session for the ICB is slightly higher than peer average, although PAH are below average • Average early finishes are on a par with peer average, although much higher than the expected 15-30 minutes • BADS rate is lower than the 85% target	• Overall productivity has improved in March / April across all three providers. The main driver is average cases per 4-hour session • ENHT – although overall good performance, capped utilisation has yet to achieve the national target of 85% • PAH – consistently high conversion from day case to inpatient rate, alongside a low day case rate • WHTH - Capped utilisation rates and average cases per session have maintained improvement over the last 6 months	• Improvement programmes are discussed at the Theatre Utilisation Network Group • A series of reviews have taken place with Trusts through the GIRFT theatre programme team and improvements are underway as can be seen through the improved numbers • Active theatre improvement programmes at each of the acute providers • There will be a further GIRFT review visit in June 2024

Cancer



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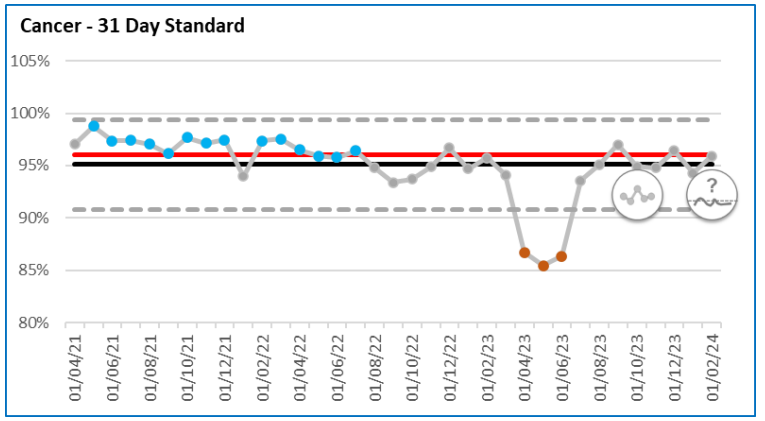
EAST AND NORTH HERTFORDSHIRE NHS TRUST	72.1%	75.6%	76.2%	76.7%	72.0%	71.8%	76.5%	74.8%	74.1%	64.2%	72.9%	74.6%	68.1%	64.2%	70.8%	71.8%	72.7%	69.7%	71.4%	71.7%	77.4%	65.8%	76.1%	72.9%	69.8%	69.3%	76.4%	75.9%	73.0%	74.1%	77.8%	78.2%	80.5%	76.1%	83.4%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	81.3%	79.8%	81.4%	82.1%	77.8%	77.2%	77.7%	71.9%	64.7%	47.0%	59.2%	54.6%	52.2%	58.3%	55.3%	60.6%	60.1%	57.8%	63.3%	71.6%	72.8%	70.1%	80.1%	78.7%	76.0%	68.0%	74.8%	68.6%	68.5%	69.8%	66.2%	68.7%	74.6%	74.1%	79.8%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	72.3%	74.6%	66.8%	77.1%	75.9%	62.9%	65.1%	60.6%	66.8%	50.9%	69.4%	69.3%	64.1%	65.9%	74.4%	72.2%	72.8%	68.4%	70.4%	73.6%	74.5%	72.1%	77.4%	76.6%	72.4%	71.2%	74.7%	74.5%	75.3%	75.7%	75.5%	77.9%	77.0%	74.5%	80.3%
ICS	75.6%	76.9%	75.4%	78.9%	75.3%	71.1%	73.8%	69.3%	68.9%	54.4%	67.3%	65.6%	60.9%	62.5%	66.3%	67.6%	68.2%	64.7%	68.0%	72.2%	74.8%	69.4%	78.1%	76.1%	72.9%	69.4%	75.2%	72.8%	72.2%	73.0%	72.9%	74.6%	77.2%	74.8%	81.1%



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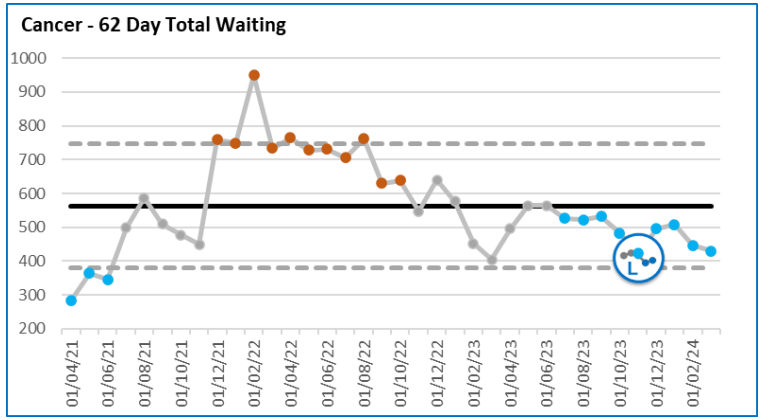
EAST AND NORTH HERTFORDSHIRE NHS TRUST	98.6%	98.8%	97.7%	98.4%	97.9%	97.4%	98.1%	98.2%	98.6%	96.9%	99.0%	98.6%	98.4%	97.6%	97.5%	97.1%	95.8%	93.2%	92.9%	95.5%	97.8%	95.8%	96.1%	93.0%	83.7%	80.5%	83.2%	93.8%	96.6%	97.0%	96.3%	95.9%	96.7%	96.8%	96.1%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	94.6%	97.8%	95.9%	95.9%	97.2%	95.5%	97.4%	92.9%	92.0%	85.1%	95.5%	96.2%	96.4%	96.4%	95.3%	95.9%	94.3%	95.3%	95.8%	94.8%	96.1%	92.6%	96.7%	99.5%	96.3%	99.0%	97.7%	94.1%	96.4%	99.0%	96.2%	94.4%	97.7%	88.1%	97.6%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	92.1%	100.0%	97.5%	93.3%	90.6%	88.9%	95.0%	97.2%	97.6%	85.9%	89.0%	92.7%	81.9%	82.9%	83.3%	92.9%	89.6%	90.4%	95.6%	90.7%	90.6%	91.0%	92.1%	92.9%	92.5%	95.3%	88.8%	91.3%	84.7%	91.3%	85.3%	88.8%	91.8%	87.4%	92.3%
ICS	97.1%	98.7%	97.3%	97.4%	97.1%	96.2%	97.7%	97.2%	97.5%	94.0%	97.4%	97.5%	96.5%	95.9%	95.8%	96.4%	94.8%	93.4%	93.7%	94.9%	96.7%	94.7%	95.7%	94.1%	86.7%	85.5%	86.3%	93.6%	95.1%	97.0%	94.9%	94.8%	96.4%	94.3%	95.9%



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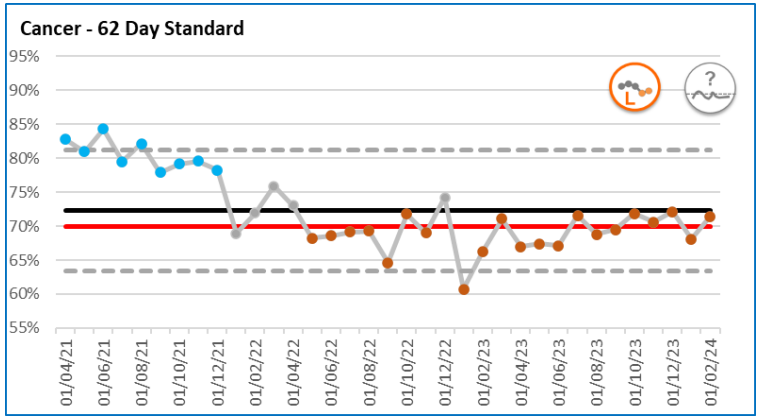
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	107	141	161	212	224	201	190	127	175	176	303	194	182	156	128	125	162	152	163	149	193	182	153	120	148	213	203	166	148	167	149	110	141	165	135	118
EAST AND NORTH HERTFORDSHIRE NHS TRUST	92	114	96	155	184	178	160	193	253	226	272	232	322	275	306	304	329	221	242	203	256	211	170	160	199	224	203	212	239	226	234	194	234	195	170	194



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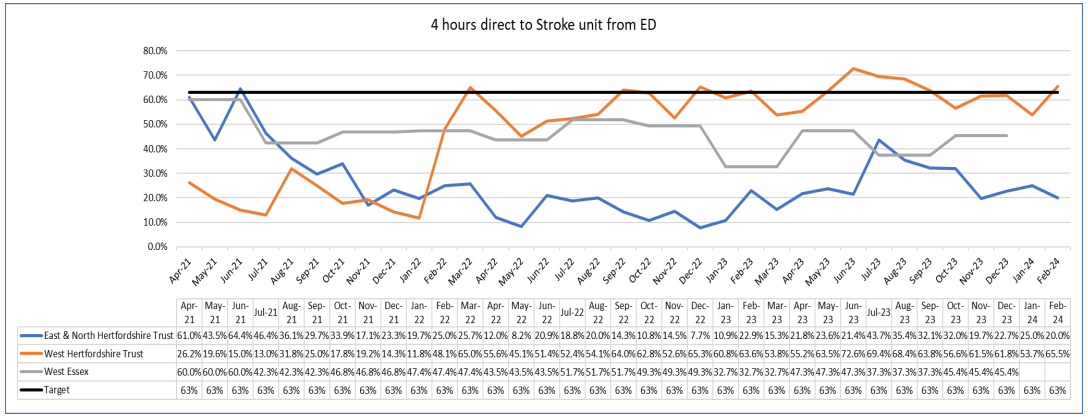
EAST AND NORTH HERTFORDSHIRE NHS TRUST	89.8%	87.2%	84.7%	88.9%	86.8%	88.2%	88.3%	88.1%	86.0%	80.4%	84.4%	86.1%	86.3%	79.1%	79.9%	85.4%	82.7%	79.3%	78.0%	78.8%	87.2%	77.5%	78.7%	85.7%	84.3%	82.1%	81.5%	82.7%	82.1%	78.6%	86.6%	86.3%	82.2%	86.1%	83.6%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	83.6%	74.5%	85.0%	79.9%	81.3%	71.5%	73.9%	75.4%	76.0%	58.7%	64.7%	72.1%	61.0%	64.6%	60.2%	61.8%	61.6%	59.9%	67.3%	63.7%	68.3%	54.6%	59.2%	61.1%	66.5%	60.2%	64.4%	69.7%	68.8%	75.3%	75.6%	75.5%	70.9%	62.6%	72.7%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	71.5%	78.6%	81.1%	61.4%	73.9%	67.5%	71.0%	68.7%	63.8%	57.4%	57.9%	64.9%	64.9%	51.8%	61.6%	52.3%	59.4%	44.8%	66.1%	58.0%	63.5%	46.9%	56.2%	57.7%	43.0%	48.8%	49.4%	56.4%	49.6%	48.3%	47.1%	40.9%	55.7%	44.2%	48.8%
ICS	82.8%	80.9%	84.3%	79.5%	82.2%	77.9%	79.2%	79.6%	78.3%	68.9%	71.9%	75.9%	73.0%	68.2%	68.6%	69.1%	69.3%	64.6%	71.8%	69.0%	74.2%	60.7%	66.2%	71.1%	66.9%	67.4%	67.1%	71.6%	68.8%	69.5%	71.8%	70.6%	72.1%	68.1%	71.4%

Cancer

ICB Area	What the charts tell us	Issues	Actions
ICB	• 28-day Faster Diagnosis Standard (FDS) performance has improved significantly over the last two months and is now at 81% • Each of the Trusts have surpassed the 75% FDS standard for the first time since prior to April 2021 • The 31-day 95% target was met collectively, although PAH was slightly below target at 92% • Performance against the 62-day standard remains below the national target, but is achieving the 70% standard expected in the 24/25 National Planning Guidance • The 62-day backlog decreased over the last two months, predominantly at WHTH and PAH	• There are no 62-day backlog targets for 24/25 • Oversight is focussed on achievement of the national FDS, 31 & 62-day standards **ENHT** • At the end of March, the 62-day backlog reached 194 patients vs a target of 134 patients • This is primarily due to late transfers (61 compared to an original plan of 25) • In addition, there have been patient choice delays on Skin and Urology pathways; PET CT delays; delays in negative results over Easter **WHTH** • 62-day backlog: At month end there were 118 (6.7%) pathways over 62 days, with a total PTL of 2,331 patients. The NHSE objective to have a backlog of no more than 6.4% • Increased referrals noted, but no subsequent increase in numbers of cancers diagnosed • Gynaecology and Urology account for 50% of the 62-day referral to first treatment breaches, both affected by capacity shortfalls, case complexity and patient availability **PAH** • 23/24 target for 62-day backlog clearance missed by 6 patients. Urology and Skin are the key services driving overall PTL and backlog pressures • Number of services referred on to tertiary providers, and delays in transfer times • Urology staffing, Cystoscopy capacity, and increase in prostate referrals • Urology is particularly challenged in both FDS and 62-day % performance	**ENHT** • Two-stop pathway for Urology service to be introduced from April with an MRI scan first • Head & Neck to increase one-stop service to eight slots per week • Haematology introducing triaging system to reduce blood test delays • Community breast pain clinic is reliant on continued funding • Continued Colonoscopy outsourcing to Pinehill **WHTH** • Review of Urgent Suspected Cancer referral forms; Gynae and Urology forms close to completion, however, launch delayed due to the complexity of changes required. All forms to be mandated going forward, which is expected to improve referral quality • Additional Gynaecology capacity is now in place and improvement is expected imminently • Additional photography clinics and triaging for Skin referrals - outsourcing in place for 6 months • Pilot project for radiology diagnostic post within LGI pathway – Endoscopy / surgery pathway. • Work to implement one stop diagnostic for Urology continues – operationalising planning and review of job plans (radiology) as key enablers • Breast pain pathway evaluation underway • Submission of transformation bids for the coming year to support continuation of current pilots and new projects • All patients who are treated after Day 62 will be subject to a Clinical Harm Review • Clinical review is requested by MDT trackers as they track patients. Escalated as necessary using new escalation process. Any patient found to have cancer will be subject to a clinical harm review after treatment **PAH** • Princess Alexandra Hospital will be in Tier 2 of the national oversight and support infrastructure for Cancer recovery from the week commencing 29 April 2024. Fortnightly tiering meetings with the NHSE EOE regional team commence on 9th May • Cancer Improvement Plans refreshed and agreed at tumour site level • Focussed work to drive more timely transfers to tertiary providers • Prostate CNS now in post. Return of consultant on restricted practice delayed • Discussions progressing for ISP Cystoscopy support • Additional weekend theatre sessions for Breast planned, subject to radioactive isotope support • Ongoing participation in the national GIRFT programme, with a particular focus on Urology • Participation in FDS Lower GI programme • System support and oversight in place, with Cancer Alliance & NHSE attendance

Stroke



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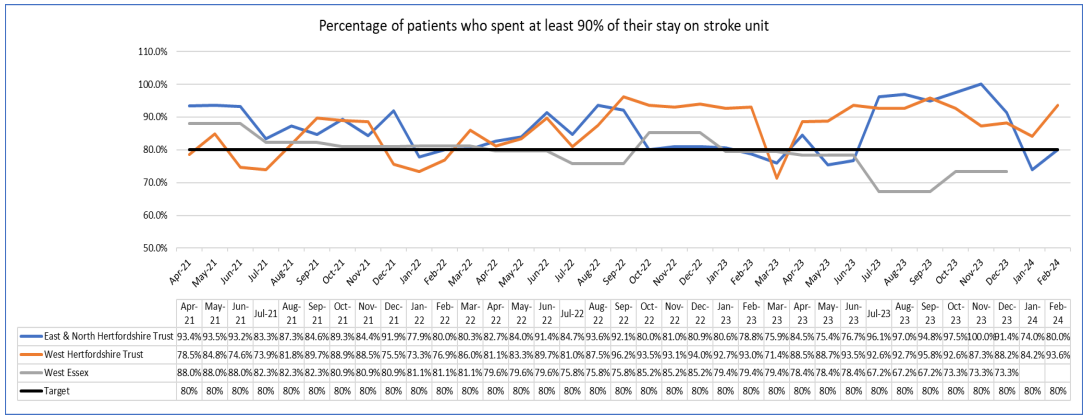
East & North Hertfordshire Trust	61.0%	43.5%	64.4%	46.4%	36.1%	29.7%	33.9%	17.1%	23.3%	19.7%	25.0%	25.7%	12.0%	8.2%	20.9%	18.8%	20.0%	14.3%	10.8%	14.5%	7.7%	10.9%	22.9%	15.3%	21.8%	23.6%	21.4%	43.7%	35.4%	32.1%	32.0%	19.7%	22.7%	25.0%	20.0%
West Hertfordshire Trust	26.2%	19.6%	15.0%	13.0%	31.8%	25.0%	17.8%	19.2%	14.3%	11.8%	48.1%	65.0%	55.6%	45.1%	51.4%	52.4%	54.1%	64.0%	62.8%	52.6%	65.3%	60.8%	63.6%	53.8%	55.2%	63.5%	72.6%	69.4%	68.4%	63.8%	56.6%	61.5%	61.8%	53.7%	65.5%
West Essex	60.0%	60.0%	60.0%	42.3%	42.3%	42.3%	46.8%	46.8%	46.8%	47.4%	47.4%	47.4%	47.4%	43.5%	43.5%	43.5%	51.7%	51.7%	51.7%	49.3%	49.3%	49.3%	32.7%	32.7%	32.7%	47.3%	47.3%	47.3%	37.3%	37.3%	37.3%	45.4%	45.4%	45.4%	
Target	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%



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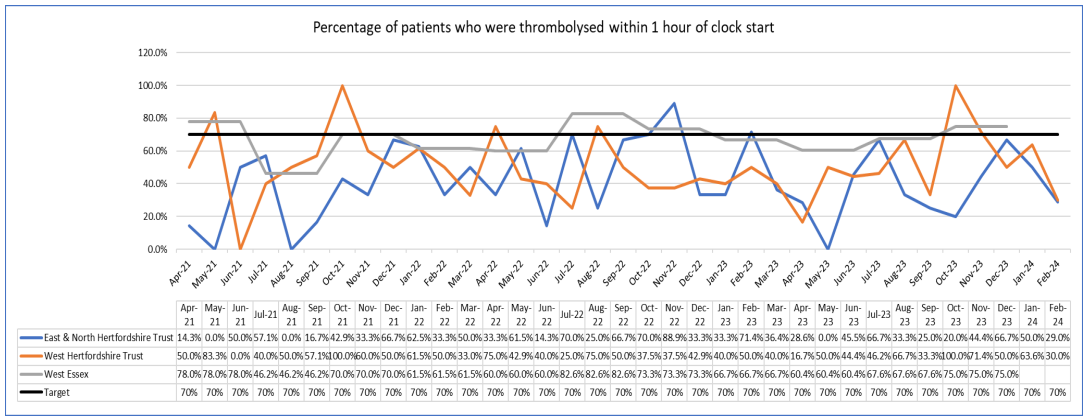
East & North Hertfordshire Trust	93.4%	93.5%	93.2%	83.3%	87.3%	84.6%	89.3%	84.4%	91.9%	77.9%	80.0%	80.3%	82.7%	84.0%	91.4%	84.7%	93.6%	92.1%	80.0%	81.0%	80.9%	80.6%	78.8%	75.9%	84.5%	75.4%	76.7%	96.1%	97.0%	94.8%	97.5%	100.0%	91.4%	74.0%	80.0%
West Hertfordshire Trust	78.5%	84.8%	74.6%	73.9%	81.8%	89.7%	88.9%	88.5%	75.5%	73.3%	76.9%	86.0%	81.1%	83.3%	89.7%	81.0%	87.5%	96.2%	93.5%	93.1%	94.0%	92.7%	93.0%	71.4%	88.5%	88.7%	93.5%	92.6%	92.7%	95.8%	92.6%	87.3%	88.2%	84.2%	93.6%
West Essex	88.0%	88.0%	88.0%	82.3%	82.3%	82.3%	80.9%	80.9%	80.9%	81.1%	81.1%	81.1%	79.6%	79.6%	79.6%	75.8%	75.8%	75.8%	85.2%	85.2%	85.2%	79.4%	79.4%	79.4%	78.4%	78.4%	78.4%	67.2%	67.2%	67.2%	73.3%	73.3%	73.3%		
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%



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East & North Hertfordshire Trust	14.3%	0.0%	50.0%	57.1%	0.0%	16.7%	42.9%	33.3%	66.7%	62.5%	33.3%	50.0%	33.3%	61.5%	14.3%	70.0%	25.0%	66.7%	70.0%	88.9%	33.3%	33.3%	71.4%	36.4%	28.6%	0.0%	45.5%	66.7%	33.3%	25.0%	20.0%	44.4%	66.7%	50.0%	29.0%
West Hertfordshire Trust	50.0%	83.3%	0.0%	40.0%	50.0%	57.1%	100.0%	60.0%	50.0%	61.5%	50.0%	33.0%	75.0%	42.9%	40.0%	25.0%	75.0%	50.0%	37.5%	37.5%	42.9%	40.0%	50.0%	40.0%	16.7%	50.0%	44.4%	46.2%	66.7%	33.3%	100.0%	71.4%	50.0%	63.6%	30.0%
West Essex	78.0%	78.0%	78.0%	46.2%	46.2%	46.2%	70.0%	70.0%	70.0%	61.5%	61.5%	61.5%	60.0%	60.0%	60.0%	82.6%	82.6%	82.6%	73.3%	73.3%	73.3%	66.7%	66.7%	66.7%	60.4%	60.4%	60.4%	67.6%	67.6%	67.6%	75.0%	75.0%	75.0%		
Target	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

ICB Issues and actions

West Essex

Barking, Havering and Redbridge Trust (BHRT) is the main provider of Stroke for WE patients, reported quarterly via SSNAP. The Trust's overall 23/24 Q3 SSNAP performance rating improved from D to C.

- Continued high demand for bed occupancy, with larger complex strokes requiring longer treatment plans
- TIA – Continued improvement following escalation of pathway delay issues. 26 days response now reduced to 8 days. Some ongoing issues due to shift fill and short notice cancellations
- EPUT - Staffing concerns due to 2 x WTE staff members leaving the service and 1 requesting to be re-deployed. Meeting being organised to review
- Catalyst Project – Vocational rehab, working age population affected by stroke to be provided with support
- SQUIRE ICSS – May LTC board to discuss supporting delivery of the ICSS. NHSE target of 75% of people who have a stroke will have access to the comprehensive care by 2027/28
- Local WE comms campaign to be initiated to notify the population that Princess Alexandra Hospital (PAH) does not have a HASU / ASU service, and that this will delay care if stroke patients present at PAH

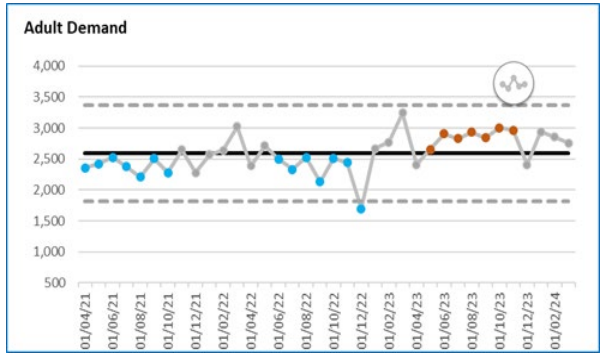
ENH

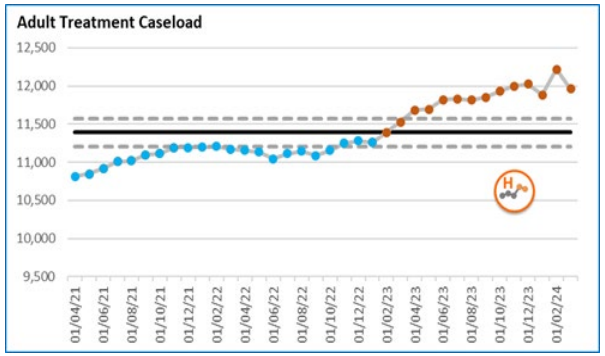
- The ENHT SSNAP performance rating for Q3 23/24 remained as a B rating. There is a risk to maintaining a B rating going forward due to therapies establishment and alignment with the new clinical guidelines
- The % of reaching a stroke unit within 4 hours increased to 36% in Mar-24. This is still notably below the target of 63%, but it is the best performance since Jul-23. The most significant delays tend to be for out-of-hours patients
- The % of patients spending >90% of their stay on a stroke unit dipped during January and February. However, in March, this figure was back up to 89%, meeting the target. Four ring-fenced stroke beds remain in place
- The % of patients thrombolysed within 1 hour of arrival met the target of 70%, but this standard is not consistently met
- Thrombolysis in Acute Stroke Collaborative (TASC) project underway to support improvement in Thrombolysis performance rate to 14%. Improved thrombolysis rates will support overall flow within the stroke wards, due to positive impact on simple discharges

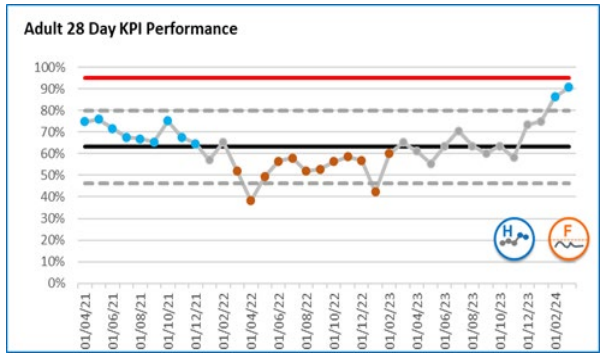
S&W Herts

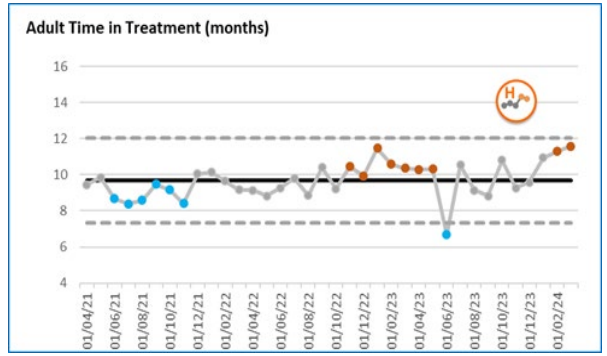
- WHTHT overall Q3 SSNAP rating has been maintained at an A rating
- Performance remains below the national standard (90%) for 4 hours direct to stroke unit from ED at 65%. This is similar to March 23 performance at 63.6%, and consistent with national performance. Wider system pressures such as late referrals, bed capacity constraints and patients admitted to another ward before the Stroke unit due to an unclear diagnosis are all issues which delay provision. Ring-fenced beds on HASU and a side room for thrombolysis have been maintained, and patients receive stroke consultant input for their care while waiting for admission to the stroke unit
- 94% of Stroke patients spent 90% of their time on stroke unit which is above the national target of 90%
- The % thrombolysed within 1 hour of clock start decreased to 30% (local standard 50%). WHTH are taking part in the EOE Ambulance Video Triage pilot (started Dec. 23). It is hoped that this will have a positive impact on patients' movement through ED and time to thrombolysis, but this is not as yet seen in the February data
- The rehab gym is no longer being utilised as a bed capacity surge area and assurance of maintaining going forward
- ESD, NETT and Community Stroke Service: ESD patients are now being seen within 1-2 weeks of referral. Additional resource has been allocated, aimed at reducing NETT and ESD waiting times

Mental Health – Adult Services



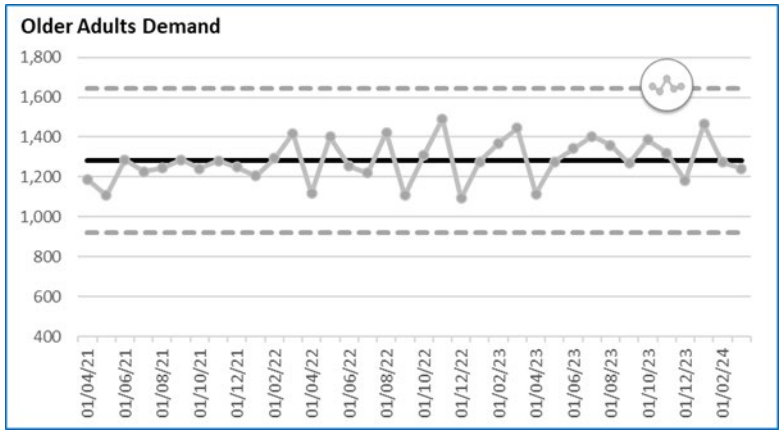


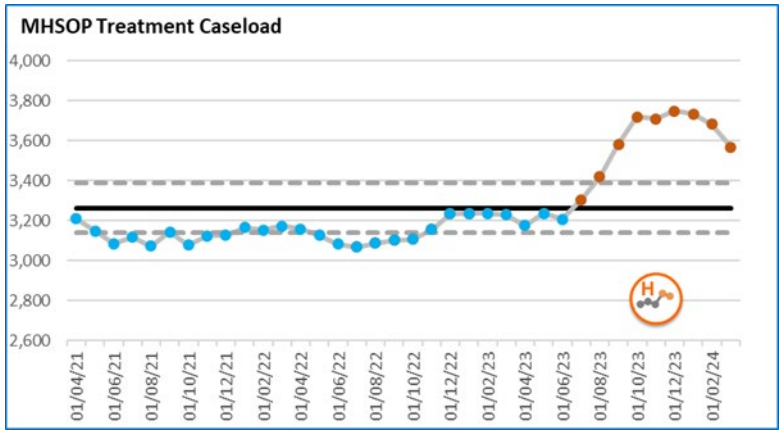


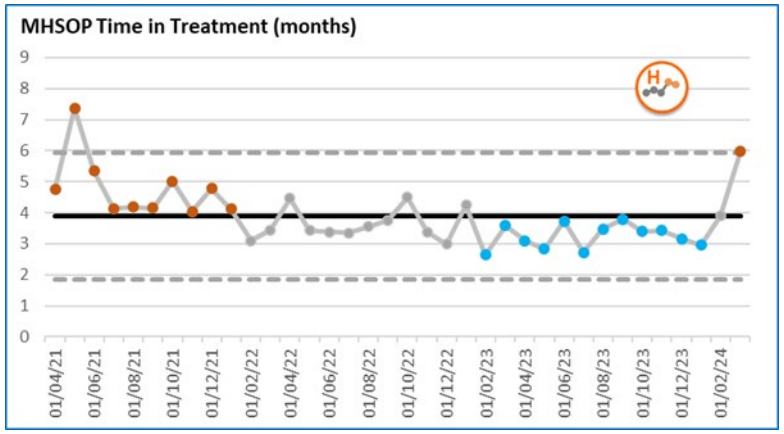


ICB Area	What the charts tell us	Issues	Actions
Adult Community Mental Health Services Herts & West Essex Herts data includes ADHD patients with the exception of the KPI. ADHD is excluded from the WE data	• Overall referral demand is stable, but remains high across the ICS • Demand in Herts fell slightly in February and March • Adult ADHD referrals have fallen by c.14% in February (compared to January) since letter to GPs requesting a hold on inappropriate new referrals • Community caseload increased slightly in February in Hertfordshire and stabilised in March. West Essex caseload was static • Initial assessments within 28 days of referral showed significant improvement as part of the Hertfordshire recovery work. The 95% target has been achieved in March • EPUT continue to meet the 28-day referral standard in West Essex • Overall time spent on treatment pathways has risen in February and March	• Hertfordshire recovered the 28-day target of 95% in March, in line with their recovery trajectory • Ongoing work with HPFT to split ADHD and SMI referrals. Separate service for West Essex as ADHD is not mental health • Working with HPFT to bring Voluntary Community, Faith and Social Enterprise (VCSFE) activity into the transformed community offer	• Additional assessments including out of hours clinics • Continued use of agency to improve capacity across Hertfordshire • Recruitment deep dive into areas most challenged with access • Additional admin. support to community MH teams • Hertfordshire demand and capacity review as part of the community transformation programme. ADHD review ongoing with commissioners to propose plan to address increased demand • Continued focus on triage to increase numbers signposted to more appropriate services from SPA, rather than post-assessment • Ongoing review of Care Coordination Centre (CCC) use in West Essex to enable access to right service first time and reduce delays in waits • Robust waiting list management and risk management protocols in place with daily and weekly reviews

Mental Health – Older Adults Services



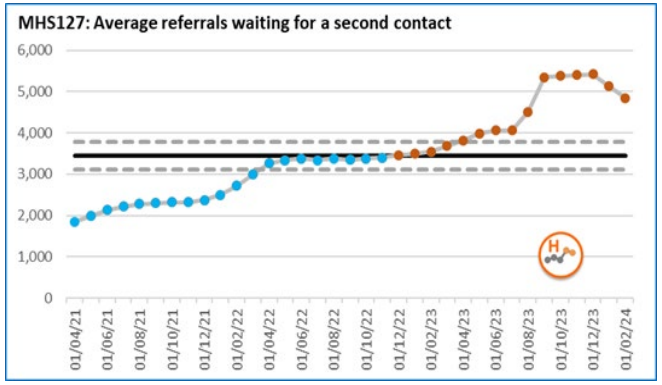


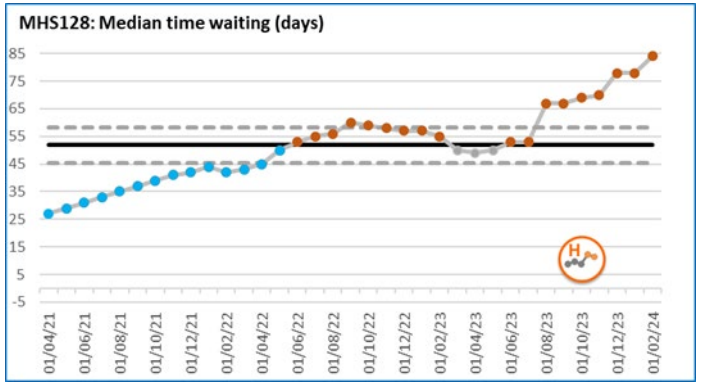


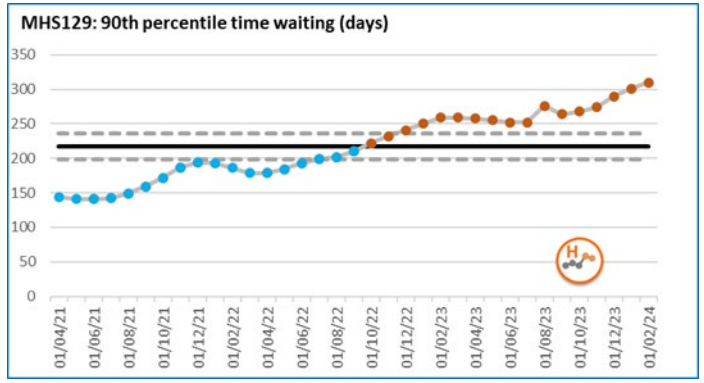
ICB Area	What the charts tell us	Issues	Actions
Older Adult Community Mental Health Services Herts & West Essex	• Demand is variable but remains within expected common cause variation limits • Rising caseload has stabilised, and is now reducing due to reductions in the EPUT WE caseload • March saw a sharp rise in time in treatment in Hertfordshire, but related to low numbers of patients discharged	• Recruitment continues to be an issue across the ICS • New waiting times from NHSE come into full effect at the end of Q4. This is expected to present an initial challenge for older adult services in Hertfordshire to meet the 28 days to intervention standard, as currently they are working to an 18 week wait to treatment standard • West Essex adult services are all age (18 plus) and currently achieving 28 days for older adults • Potential discrepancy between Hertfordshire & West Essex relative caseloads under investigation	• Robust workforce mobilisation plan in place for West Essex, including a positive recruitment pipeline projection. Currently working with the University of Essex • A joint deep dive into Hertfordshire older people services as part of the SDIP will be reviewing current service delivery and ensuring transformation is in line with adult community transformation plans • CQI project underway in Hertfordshire to prepare for introduction of full waiting time measures • Risk review and prioritisation for longest waiting service users • Reviewing older adults with SMI have a primary and community care offer

Mental Health – Community Waits

Adults and Older Adults – time still waiting for second contact



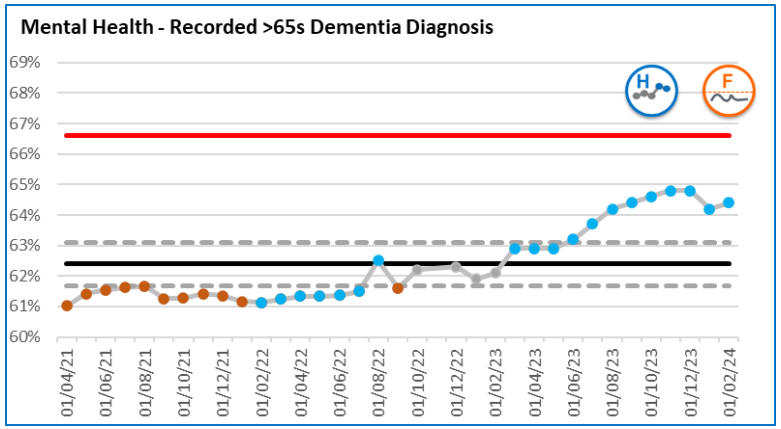


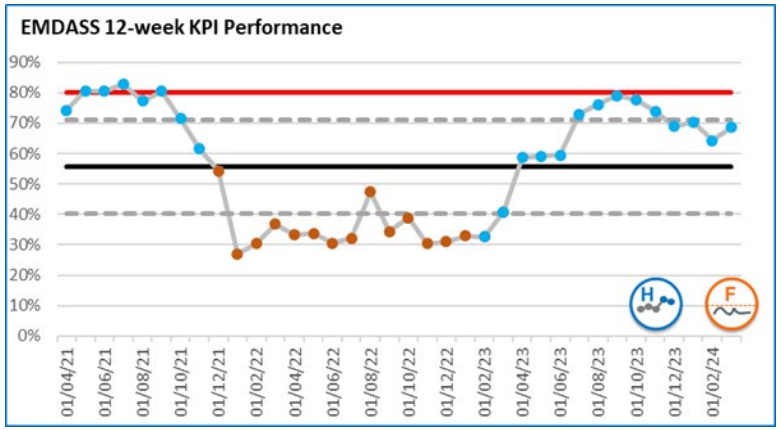


ICB Area	What the charts tell us	Issues	Actions

Hertfordshire & West Essex	• Median waiting times for a 2nd appointment increased further to 84 days
	• 84 days benchmarks well against the national average of 114 days, however there is a long-term trend of variation above the historic norm
	• Within the system there is variation of between 53 & 101 days:
	  • East & North Herts 53 days
	  • South & West Herts 101 days
	  • West Essex 78 days
	• 90th percentile waits increased further to 310 days
	• 310 days benchmarks well against the national average of 714 days, however again there is a long-term trend of variation above the historic norm
	• Within the system there is variation of between 237 & 382 days:
	  • East & North Herts 237 days
	  • South & West Herts 339 days
	  • West Essex 382 days
		• Datasets are not currently complete, and work is ongoing with ICBs and NHSE to finalise collections and reporting
		• The data flow from Primary care and VCSFE providers to MHSDS or the GP equivalent has not been worked through either locally, regionally or nationally
		• This relates to the transformed PCN areas that have ARRS workers and Enhanced Primary Care
		• The data collection from these new services is recorded locally on System one or EMIS
			• NHSE working with all ICBs to finalise the data
			• In Hertfordshire, a CQI project has been initiated to take forward the new waiting times and ensure that they are reflected in the design and processes of services. Awaiting the publication of SQL scripts to replicate this reporting internally
			• We are also working with NHSE and Voluntary Community, Faith and Social Enterprise (VCFSE) providers to look at the data flow from them to MHSDS, to include as part of the second contact information

Mental Health – Dementia Diagnosis in Primary Care & Herts EMDASS Service

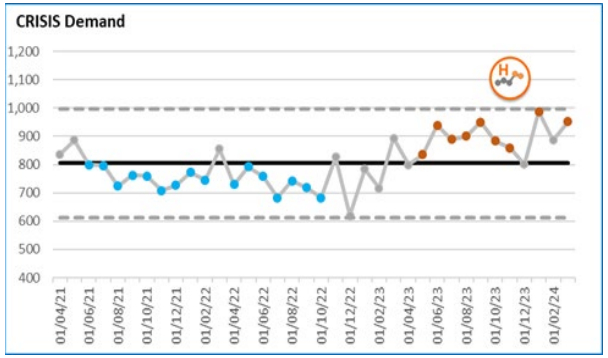


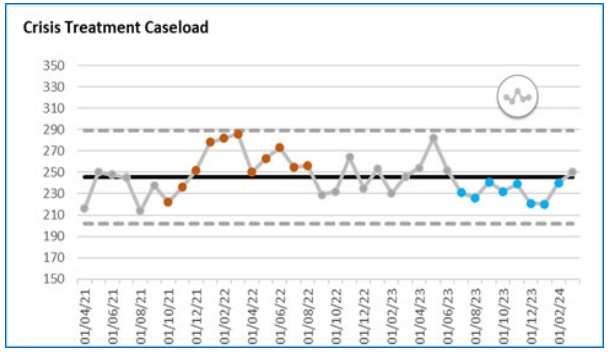


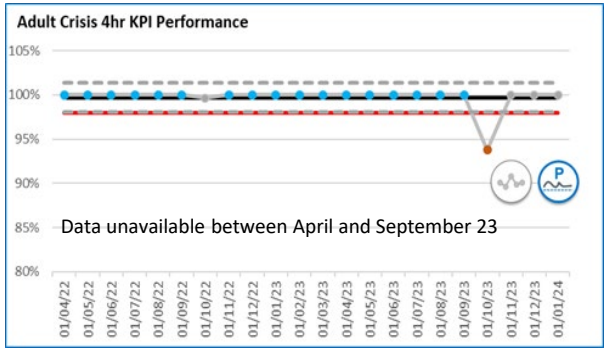
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
ENHCCH	59.4%	59.7%	60.2%	60.2%	60.2%	59.5%	59.3%	59.5%	59.2%	59.0%	58.8%	59.2%	59.2%	59.2%	59.0%	59.1%	60.9%	59.0%	59.8%	59.7%	59.6%	59.7%	60.5%	60.7%	60.7%	61.3%	61.8%	62.5%	63.0%	63.6%	63.8%	63.7%	62.7%	62.8%
HVCCG	59.2%	59.6%	59.6%	59.8%	60.0%	59.8%	60.1%	60.3%	60.6%	60.5%	60.6%	60.4%	60.6%	60.8%	60.7%	60.6%	61.2%	60.9%	61.3%	61.7%	61.3%	61.1%	61.4%	61.3%	61.3%	61.5%	61.9%	62.2%	62.2%	62.0%	62.1%	62.3%	61.9%	62.1%
WECCG	67.6%	68.0%	67.7%	67.7%	67.6%	67.3%	67.1%	67.0%	66.7%	66.4%	66.5%	66.6%	66.6%	66.5%	66.9%	67.6%	67.7%	67.6%	68.5%	68.3%	67.6%	68.3%	69.9%	69.9%	70.0%	69.8%	70.4%	70.9%	70.9%	71.5%	71.5%	71.5%	71.2%	71.2%
ICS	61.0%	61.4%	61.5%	61.6%	61.7%	61.3%	61.3%	61.4%	61.4%	61.2%	61.1%	61.2%	61.3%	61.3%	61.4%	61.5%	62.5%	61.6%	62.2%	62.3%	61.9%	62.1%	62.9%	62.9%	62.9%	63.2%	63.7%	64.2%	64.4%	64.6%	64.8%	64.8%	64.2%	64.4%

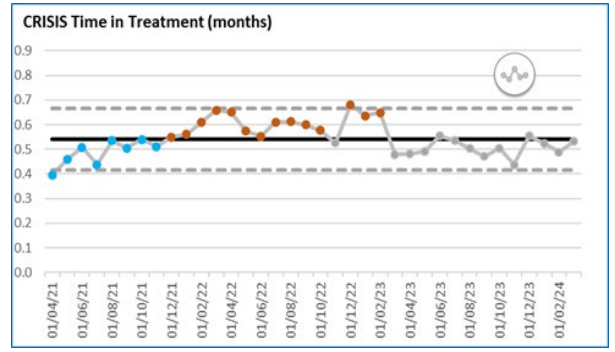
ICB Area	What the charts tell us	Issues	Actions
Dementia Diagnosis in Primary Care **Herts EMDASS Service**	• Dementia diagnosis rate across the ICB achieved 64.4% for February, below the national target of 66.7% • West Essex met the standard with 71.2% achieved • East and North Herts achieved 62.8% • South & West Herts achieved 62.1% • EMDASS service (Herts only) – the 80% target is not currently being met. Significant recovery programme has been underway, but demand for memory assessment remains very high • In 23/24 the EMDASS service saw c.230 patients per month, with c.160 of those patients seen in less than 12 weeks	• Estimated prevalence rate of people with dementia rises month on month. Constant growth and increasing demand, particularly in Hertfordshire • In Hertfordshire there is a significant waiting list for dementia diagnosis • Current EMDASS model of service may not be able to keep up with demand in future years re ageing population	• Diagnosis is a key focus of the Herts dementia strategy, with a subgroup progressing actions to improve diagnosis • Twice monthly meetings continue to monitor progress. Weekly performance report is produced • HPFT has tweaked its EMDASS pathway, bringing a Primary Care Nurse in house to increase capacity • Plan to increase number of assessments provided in Hertfordshire

Mental Health – Adult Crisis Services



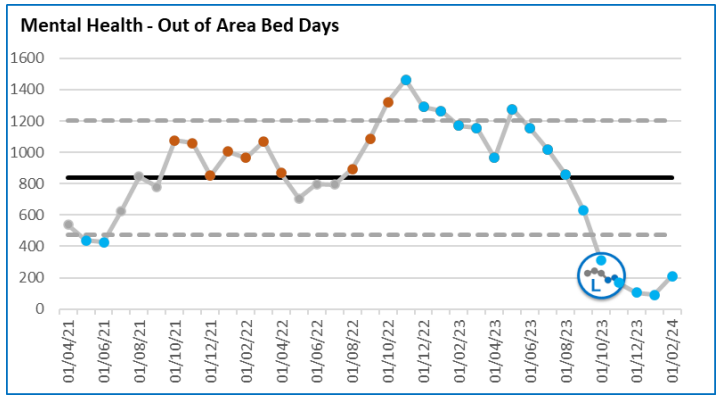






ICB Area	What the charts tell us	Issues	Actions
• Crisis Services – Adults and Older Adults • West Essex data is not included in the caseload chart as the service does not hold a caseload	• Crisis demand remains high. Referral numbers in all but one month in 23/24 have been above the historic mean • Caseload is variable but within expected common cause variation limits • Hertfordshire has re-modelled the way they record waiting times in line with the latest UEC guidance • 100% of people requiring a very urgent assessment were seen within 4 hours in February and March • The average time in treatment remains stable	• There is increased demand into the crisis service through supporting acutes with early discharges to manage bed pressures and flow issues • Recruitment to vacancies continues to be a significant issue across the ICS	• Ongoing focus on recruitment to vacancies and retention of existing staff • Review of community mental health caseloads to improve flow • ICB wide communications to be developed to promote 24/7 crisis lines (through NHS 111 for public and dedicated professionals' lines) • Wider communications re. crisis directory have been prepared as part of the winter planning and will be shared with system partners • ICB ongoing programme of engagement with ambulance and urgent care partners • Continue to identify delayed transfers of care on crisis caseload • Ongoing monitoring and MDT discussion to identify treatment pathway and discharge plans

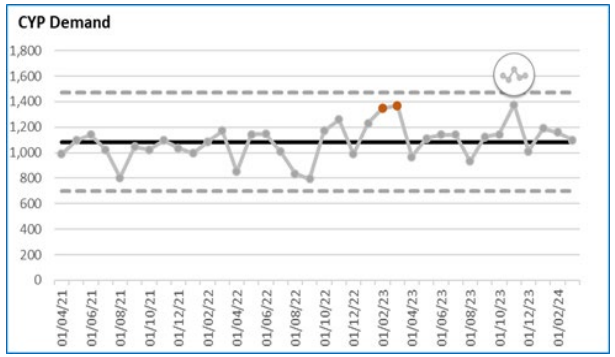
Mental Health – Out of Area (OOA) Bed Days

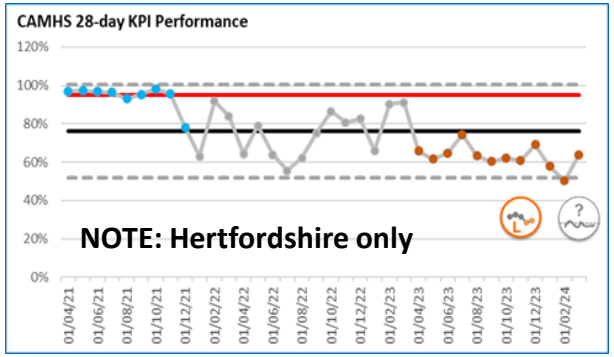


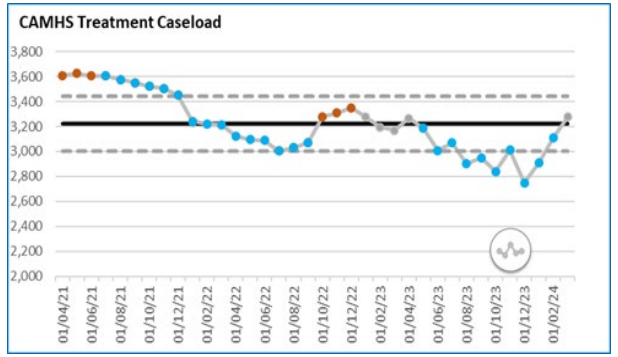
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Hertfordshire	452	337	336	574	834	759	936	745	674	779	830	987	767	691	775	757	817	1034	1177	1221	1080	1062	1003	966	650	980	938	863	632	430	171	25	11	36	172
Hertfordshire Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WECCG	86	102	90	51	12	22	140	314	177	225	134	83	100	16	21	38	76	55	145	242	209	203	166	191	316	296	216	153	224	200	143	144	95	54	39

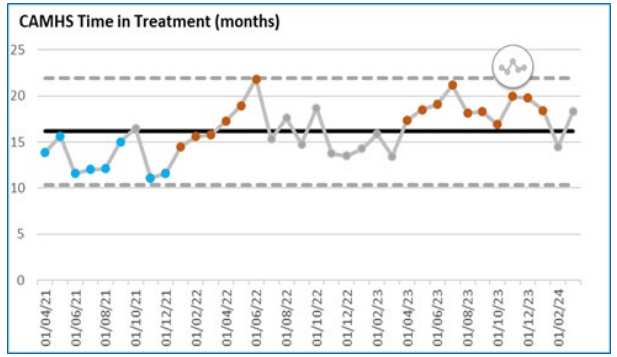
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Continued improvement in the number of Out of Area Bed Days • The 39 bed days February position was the lowest since July 22	• A national shortage of MH beds and increased pressures on service use of inappropriate OOA beds is very likely to continue	• Review of Essex bed stock and Essex wide risk share contract continues • Review of West Essex Community Rehab has seen an increase in discharges at place to support repatriation • Weekly system Delayed Transfer of Care (DTOC) calls and ongoing focus on 'time to care and purposeful admissions' • OOAP Elimination & Sustainability Impact System Group (Essex wide) to monitor the impact of the NHSE OOAP Action Plan • Continued engagement with national Getting It Right First Time (GIRFT) programme to identify areas of improvement
Herts	• Following a sustained period of improvement, Out of Area Bed Days rose from 36 to 172 days in February due to bed pressures	• Hertfordshire low number of beds per population – now supported by provision of additional block beds • A national shortage of MH beds, high occupancy rates and use of OOA beds is likely to continue • Challenges finding suitable placements for service users with complex needs who are clinically ready for discharge • Inpatient and Community recruitment • The closure of Aston Ward (with 20 beds) due to 'Water Safety Incident' has impacted the pressure on demands and recued the capacity	• Daily OOAP reviews / dedicated clinical ownership • Gatekeeping process and on call gatekeeping consultant • Consultant-led bed management meetings 3 per day, 5 days per week • COO sign-off for all out of area placements remains in place • Introduction of Enhanced Discharge Team, dedicated to supporting discharge • Review DTOCs and plan discharges with ongoing MADE type events • 10 additional block beds in place – a total of 42 remain in place • Enhanced community offers for rehab and assertive outreach • Introducing further alternatives to admission – Crisis House • Wider Executive led work at system level to support placement of longer term DTOCs • Bed management system being deployed in Hertfordshire and new arrangements in place to monitor demand and capacity • East Regional Mental Health, LD & Autism Inpatient Quality Transformation Group in place. Initial meeting Jan 24 to identify local priorities and actions

Mental Health – CAMHS Services





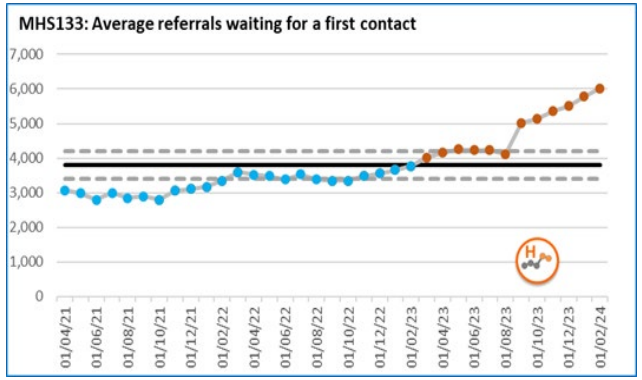


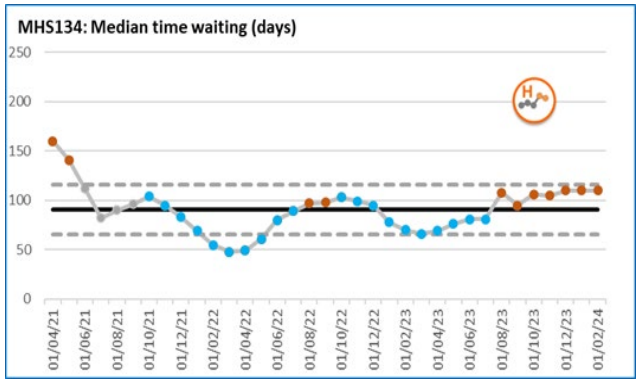


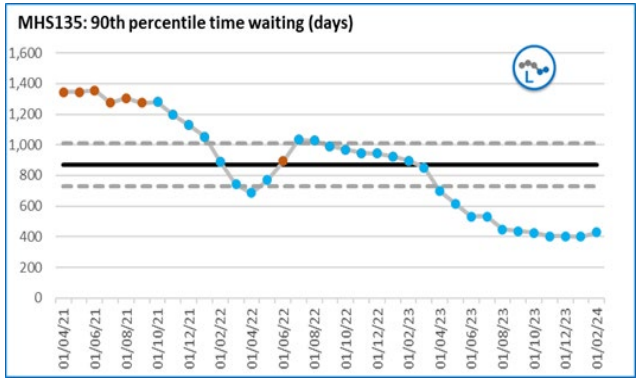
ICB Area	What the charts tell us	Issues	Actions
CAMHS Herts and West Essex. The CAMHS 28-day KPI Performance target relates to Herts only	**West Essex** • West Essex does not have a formal KPI for 28 days, but this is monitored at monthly provider meetings • Demand at SPA remains high, with seasonal downturn showing in December • CAMHS caseload remains on an improving trend through 23/24 **Herts** • Demand into the service remains stable • Caseloads have seen a steady increase since December • 28 days from referral to initial assessment remains below standard. 56% was achieved in March 24 • Time in treatment is variable but close to the historic mean	• Essex SPA and Eating Disorders (ED) services are undergoing changes to site location and management • Active issue regarding recruitment to vacancies across Herts and West Essex impacting on capacity and performance. Acquiring highly skilled CAMHS clinicians remains difficult. Non health support roles being used to bolster teams	• In Herts Community Quadrant teams an action plan is in place with weekly recovery meetings focusing on recruitment & review of resources across all teams • In Hertfordshire, the primary issues are in the West and East Teams. Both teams are being supported by the wider leadership team • NELFT Kent ED team providing support and supervision to Essex ED service • Ongoing focus on recruitment and retention in both HPFT & NELFT, including recruitment incentives in NELFT, and more recently exploring international recruitment • Successful recruitment to senior clinical posts in West Essex CAMHS • WE - New SPA team manager recruited and rolling advertisement for ED clinical lead • SPA Triage Tool improved to meet 5 day pass on to teams target in Hertfordshire • The Hertfordshire service had forecast recovery of the the 28-day KPI by end of Q4. However continuing vacancies have meant that the recovery prediction has moved to Q2/3 24/25. A revised recovery trajectory is in place

Mental Health – Community Waits

Children – time still waiting for a first contact



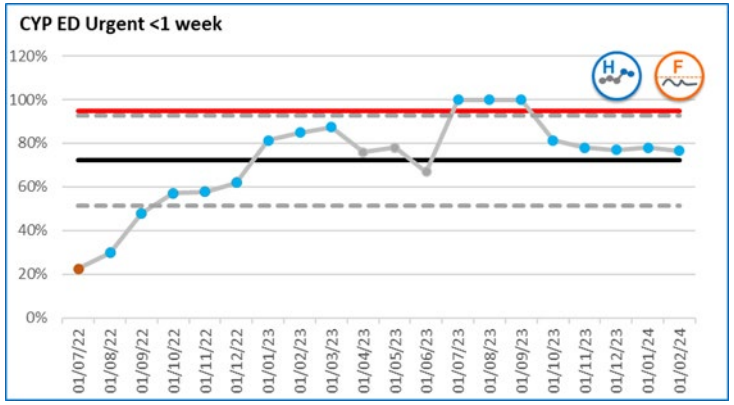


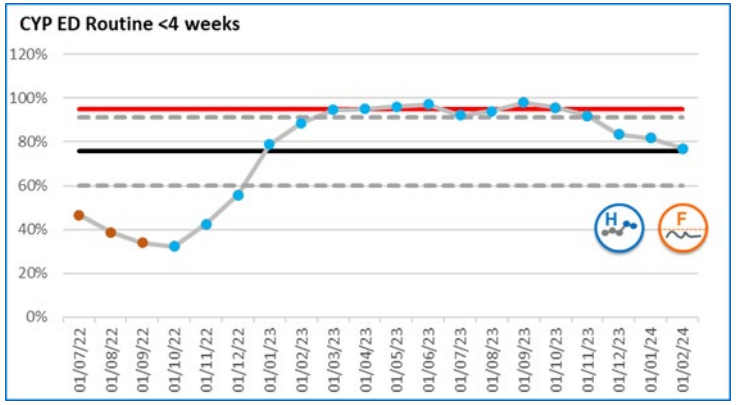


ICB Area	What the charts tell us	Issues	Actions

Hertfordshire & West Essex	• Median waiting times remain at 110 days and have been trending above the historic mean since August 23
	• 110 days benchmarks well against the national average of 198 days
	• Within the system there is variation of between 32 and 136 days:
	  • East & North Herts 32 days
	  • South & West Herts 136 days
	  • West Essex 52 days
	• 90th percentile waiting times are broadly unchanged at 428 days, and on a long-term trend of improvement
	• 428 days benchmarks well against the national average of 732 days
	• Within the system there is variation of between 312 & 428 days:
	  • East & North Herts 312 days
	  • South & West Herts 428 days
	  • West Essex 295 days
		The Hertfordshire data reflects the historically longer waiting times in the South and West of the County.
		
		The biggest impact on the Hertfordshire waiting list (long waiters) is Autism & ADHD backlogs / waiting lists for diagnostic pathways. NHSE to confirm if this will be included or excluded in the long-term. Currently it is included, which is masking the waiting times for core MH services.
			In Hertfordshire a CQI project has been initiated to take forward the new waiting times and ensure that they are reflected in the design and processes of services. Awaiting the publication of SQL scripts to replicate this reporting internally.
			
			GIRFT project to present some waiting times / flow data as part of CYPMHS, which excludes ASD/ADHD might provide a more accurate position on core MH waiting times and whether it has changed over the last few years.
			
			A local waiting time for each service is reported via provider dashboards, as well as the number of CYP waiting for assessment & treatment, and the average number of days waited to be seen per month. Where there are waiting lists, a recovery action plan is in place and closely monitored by commissioners.
			
			Commissioners, HPFT and now a HCT representative are linked into EOE waiting times standards group.
			
			HPFT have undertaken an initial cleansing exercise to remove any long waiters that are not true long waiters.

Mental Health – CYP Eating Disorders

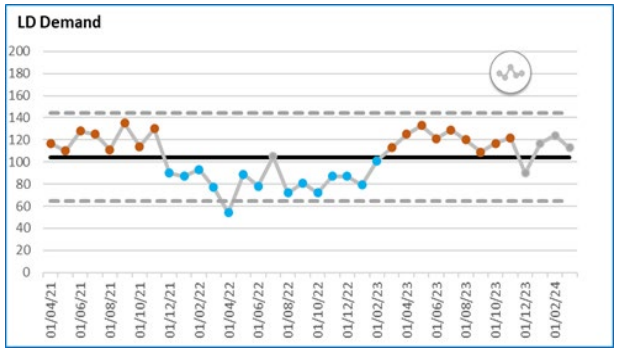


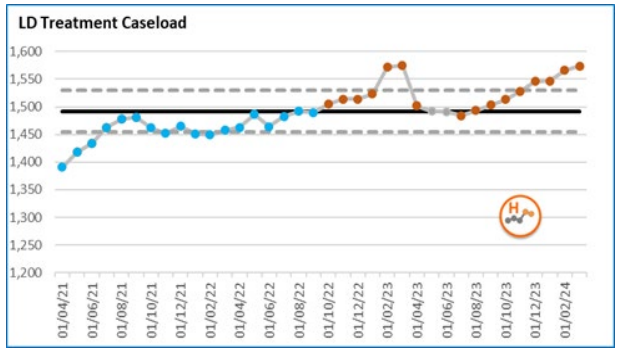


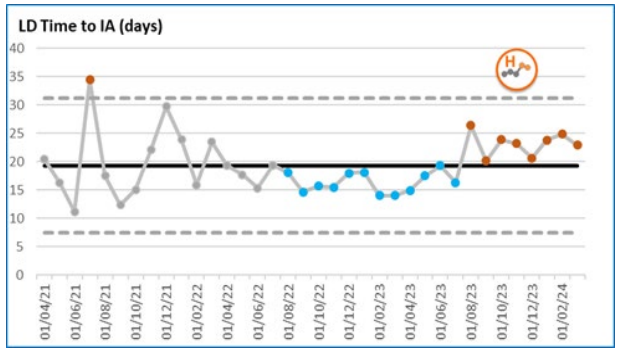
Description	Target		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
CYP ED Urgent <1 week	95%	Herts	12%	20%	43%	53%	54%	58%	80%	83%	86%	76%	78%	67%	100%	100%	100%	80%	77%	76%	77%	75%
		West Essex	92%	92%	92%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CYP ED Routine <4 weeks	95%	Herts	37%	30%	26%	25%	36%	49%	75%	86%	94%	95%	96%	97%	92%	94%	98%	96%	92%	83%	81%	76%
		West Essex	97%	97%	97%	96%	96%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	90%	90%	100%	100%

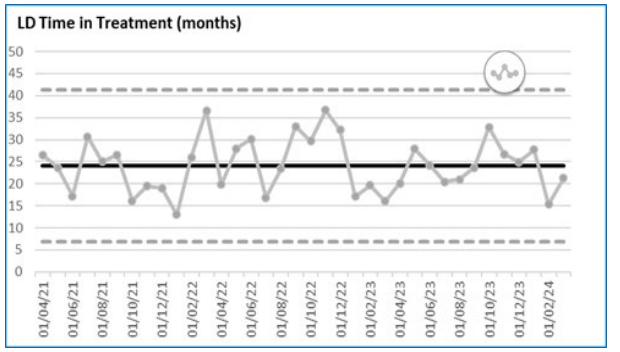
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Urgent 1 week standard consistently achieved in West Essex • Performance dropped to 90% in Q3 for routine referrals, but has returned to 100% compliance	• West Essex data from NELFT not currently flowing through MHSDS	• Commissioners working with NELFT and NHSE to secure more current data, as well as to flow data through the MHMDS
Herts	• The Eating Disorders Team had been performing consistently until a spike in referrals in Oct-Dec, coupled with an increase in vacancies • There are small numbers of urgent referrals, so each breach significantly impacts % achievement • Local reporting for March shows 100% for both standards	• The increase in referrals Oct-Dec is a seasonal and mirrors previous years • Overall annual referrals are broadly similar to 22/23 • Review of the ED service is currently in progress. Acuity and complexity tool shows CYP remain in service for a considerable amount of time and require input from a number of clinical resources. We have no baseline for acuity & complexity so cannot demonstrate the increase, but clinicians are flagging this as an issue	• The following actions are in place to improve access to the service: ○ Recruitment in progress and at pace ○ Strict adherence to inclusion criteria and service specification with non-ED diagnostic cases being signposted to relevant services ○ ED Consultation to referrers in place to support other services ○ Caseload and RAG rating review and equitable redistribution of caseload across workforce ○ Agreement for First Steps ED Service to manage a cohort of stabilised children and young people from the caseload ○ Work underway in Herts to ensure MHSDS reporting reflects local reporting.

Mental Health – Learning Disabilities Services









ICB Area	What the charts tell us	Issues	Actions
• Learning Disabilities Service • LD services are 18+ years and includes those with a learning disability who may have a diagnosis of Autism	• Overall referrals remain stable • Caseload continues to rise and has been consistently above the historic mean for the last 18 months • Time in treatment is subject to common cause variation • Within the services there is a wide range of treatment types with timeframes ranging from a few days to many years	• Lack of social care placement and housing in West Essex impacts on in-patient Length of Stay • Physical Health needs has a very clear area of focus for all MHLDA	• Service user and carer engagement and involvement programme continues aimed at improving care planning, service delivery and outcomes for LD service users across Herts and Essex • Ongoing review of Essex services with system partners across all ages to identify the wider impact for WE place • Work commenced on further development of the Adults Dynamic Support Register to increase support and access to services • Continuing work with commissioners to ensure that GPs are aware of and know how to refer directly into LD services • Inpatient flow is better, with some discharges in recent months and a reduction in length of stay • Opportunities for capturing feedback - ongoing partnership working • Continue progress on LD AHCs • Action plan approved for the new LeDeR three-year Essex plan • Overall LeDeR in Essex is performing better than both regional and national averages

Mental Health – Learning Disability (LD) Health Checks

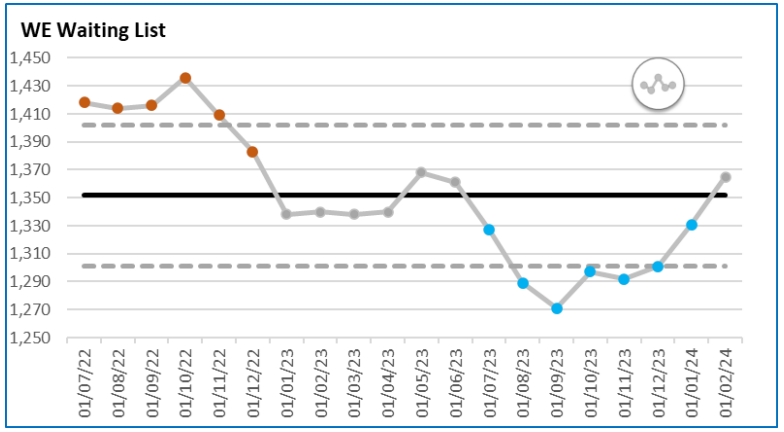
LD Health Checks February 2024	Total LD Register (age 14+)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks *	Comparison to February 2023
NHS Hertfordshire and West Essex ICB	**7,591**	**5,397**	**163**	**2,031**	**71.1%**	**67.8%**
East & North Hertfordshire	3,112	2,145	76	891	**68.9%**	**66.0%**
South & West Hertfordshire	3,342	2,501	53	788	**74.8%**	**71.3%**
West Essex	1,137	751	34	352	**66.1%**	**58.2%**

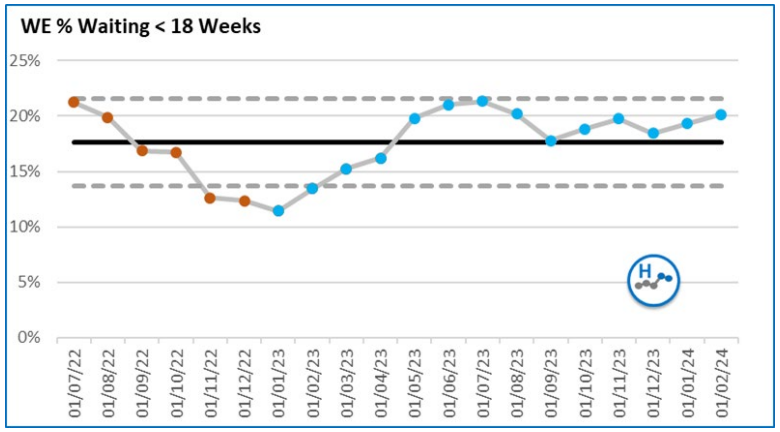
*** 75% Year End Target**

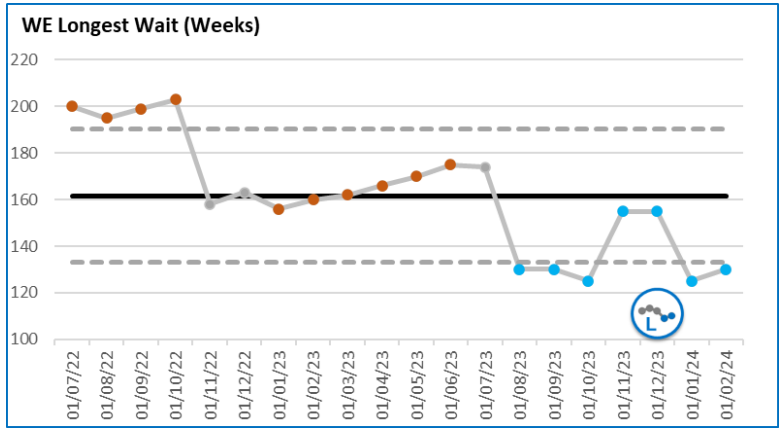
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• As of February 2024, the ICB is 3.3% ahead of its equivalent 2023 position. This is an improvement from a 1.2% lead in January • All three Places are also ahead of their equivalent 2023 positions	• It is challenging to forecast end of year performance against the 75% LD Health Checks standard, as a large proportion of health checks are carried out towards the end of the year, and particularly in Quarter 4 • The System is optimistic of once again achieving the 75% national standard	• Ongoing work between HWE Team and NHSE to cross check local data against national systems

Autism Spectrum Disorder (ASD) – West Essex

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	HCRG	Children	1331	1365	↑	19.31%	20.15%	↑	125	130	↑	February



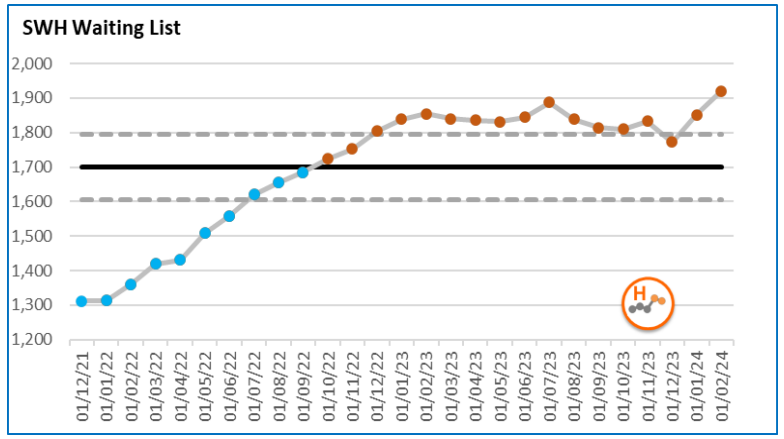


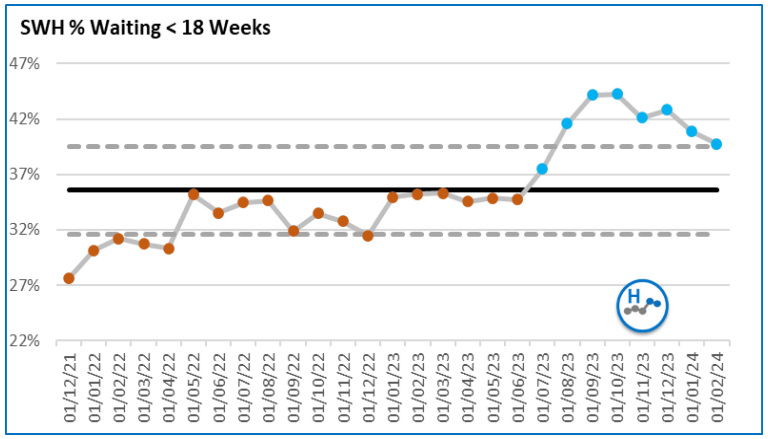


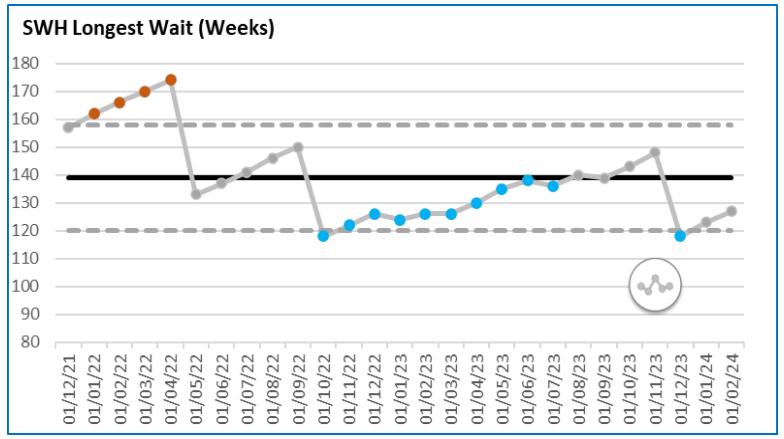
ICB Area	What the charts tell us	Issues	Actions
West Essex	• The ASD waiting list has increased for the last 3 months and is now exceeding the historic mean • The % of ASD waiters <18 weeks continues to fluctuate between 18-20% • The longest wait increased slightly to 130 weeks. There are 3 patients >125 weeks • 216 of the 1365 total waiting list are >104 weeks	• Average monthly referral rate for Q4 increased to 73, against commissioned capacity of 40 assessments per month • Demand and capacity analysis forecasts continued waiting list growth • Imminent CQC / Ofsted SEND Inspection for Essex. ASD waiting times and progress with improvement since last inspections in 2019 and 2022 expected to be highlighted • Inconsistencies in ICS and Essex datasets resulting in additional data collection and analysis for provider and commissioner	• Business case submitted to increase core capacity for sustainable delivery and address prescribing gap not supported due to available funding • 24/25 plans in discussion. Available funding will leave a capacity gap • 'Waiting well' workstream continues with local partners at place, led by HCRG, also linking in with Essex wide joint commissioning initiatives • Working with Hertfordshire partners on application of Neurodiversity Segmentation Model. This is similar to the West Essex JADES model already in place and requiring additional investment. Therefore, likely limited impact for West Essex

Autism Spectrum Disorder (ASD) – South & West Hertfordshire

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	Children	1852	1920	↑	40.87%	39.74%	↓	123	127	↑	February

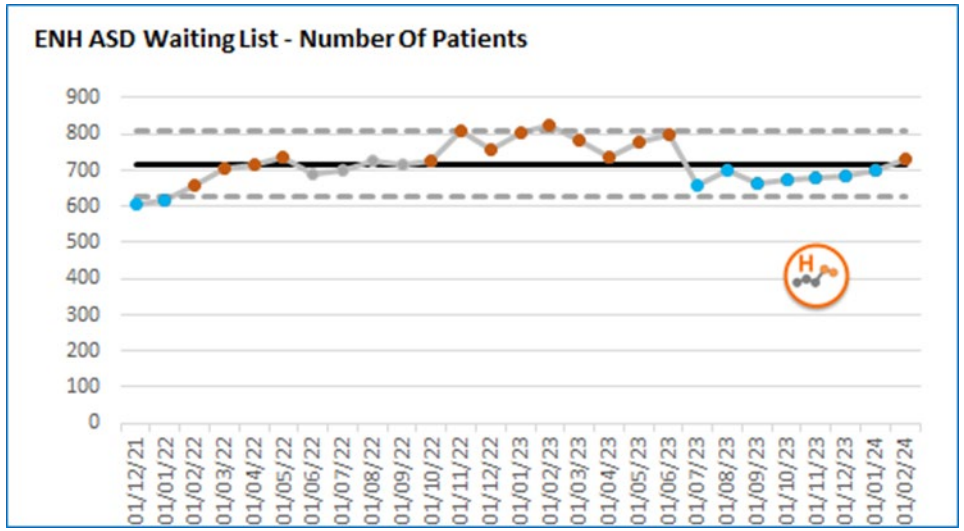






ICB Area	What the charts tell us	Issues	Actions
South & West Herts	• The overall waiting list remains consistently above the historic mean and increased to its highest level in February • The % of ASD waiters < 18 weeks remains above the historic mean, but has fallen by c.5% since October • The longest wait is now 127 weeks, up slightly in each of the last 2 months	• Capacity in existing services does not meet demand • Further increases in demand predicted • Funding for outsourcing additional diagnostic assessments to reduce the waiting list ended in December 2023. HCT continue to review the potential of extending this work, but it is dependent on funding	• Procurement process is progressing to outsource assessments for autism, ready to proceed subject to agreement of funding • Additional internal capacity and processes have been improved significantly • Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD. Funding has been agreed until March 2025 for the Neurodiversity Support Centre, and further funding has been agreed for 2024/25 for a framework of support for children and young people to understand their diagnosis and improve their mental wellbeing • Clinicians have agreed future best practice Neurodiversity Model for Hertfordshire. This has been signed off through HCT clinical governance and agreed by operational teams to inform the business case. Nearing completion to take though ICB and provider governance processes. The business case is scheduled to go to the ICB Strategic Finance and Commissioning Committee in July • Hertfordshire wide single point of referral for all ASD and ADHD is progressing well with providers working together to plan full implementation in August / September 24 • Expression of interest submitted for Partnership for Inclusion of Neurodiversity in schools (PINs programme) on behalf of Herts and West Essex ICB was successful. Planning for implementation is now in progress

Autism Spectrum Disorder (ASD) – East & North Hertfordshire

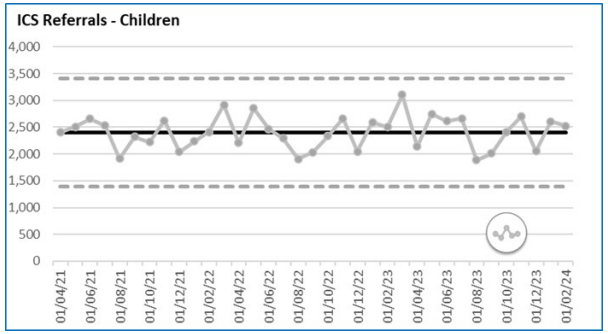


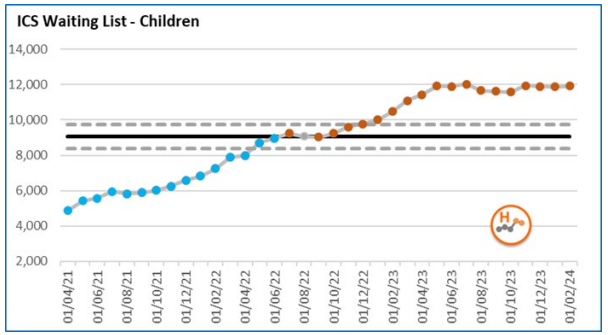
- In ENH patients have a first appointment with Community Paediatrics. If the clinician then considers that the patient requires an ASD assessment then they are added to the ASD waiting list
- Data is available on the waiting times for the first community paediatrics appointments and also for ASD assessments once a patient has been added to the ASD assessment waiting list. However, data is not available for both pathways combined
- The chart opposite shows the trend in the number of patients waiting for an ASD assessment once they have been referred by a community paediatrician
- The table below summarises how long patients on the ASD waiting list have been waiting (as of Dec-23):

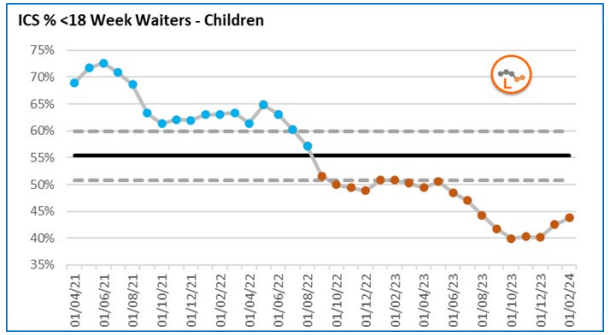
Waiting list bucket	Number of patients (Dec-23)	Number of patients (Feb-24)
<18 weeks	103	125
18 – 65 weeks	443	406
66 – 78 weeks	88	95
>78 weeks	86	103

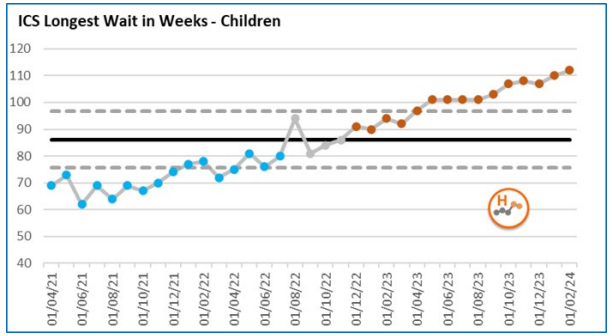
ICB Area	What the charts tell us	Issues	Actions
East & North Herts	• The ASD waiting list continues to fluctuate within the normal range of 600-800 patients • However, there have now been five months in a row where the overall waiting list has increased • The number of patients waiting >65 weeks has increased from 174 in December to 198 in February • The waiting list shown above does not include patients waiting for their first community paediatrics appointment, even if they have been referred by their GP as query ASD. It only shows patients who have been assessed by a community paediatrician and referred for a detailed ASD assessment	• Data not currently reportable on the same basis as the other two ICB Places • ENHT is currently subject to Tier 2 Oversight and Scrutiny meetings for Community Paediatrics with NHSE every 6 weeks because of increasing > 78-week waiters • Backlog funding ended December 2023. Without continuation of the backlog funding investments, ASD waiting lists will start to grow • Further increases in demand predicted	• Procurement process is progressing to outsource assessments for autism, ready to proceed subject to agreement of funding • Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD. Funding has been agreed until March 2025 for the Neurodiversity Support Centre, and further funding has been agreed for 2024/25 for a framework of support for children and young people to understand their diagnosis and improve their mental wellbeing • Clinicians have agreed future best practice Neurodiversity Model for Hertfordshire. This has been signed off through HCT clinical governance and agreed by operational teams to inform the business case. Nearing completion to take though ICB and provider governance processes. The business case is scheduled to go to the ICB Strategic Finance and Commissioning Committee in July • Hertfordshire wide single point of referral for all ASD and ADHD is progressing well with providers working together to plan full implementation in August / September 24 • Expression of interest submitted for Partnership for Inclusion of Neurodiversity in schools (PINs programme) on behalf of Herts and West Essex ICB was successful. Planning for implementation is now in progress

Community Waiting Times (Children)









		Referrals			Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Children	2604	2524	↓	11870	11919	↑	42.51%	43.82%	↑	110	112	↑	February

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	351	374	↑	1014	1015	↑	75.74%	82.07%	↑	50	51	↑	February
ENH	AJM/Millbrook	22	15	↓	125	118	↓	71.20%	72.03%	↑	34	36	↑	February
ENH	ENHT Community Paeds.	318	294	↓	5168	5295	↑	17.92%	17.58%	↓	110	112	↑	February
ENH	**All**	**691**	**683**	↓	**6307**	**6428**	↑	**28.27%**	**28.76%**	↑	**110**	**112**	↑	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	1342	1313	↓	4573	4464	↓	51.52%	54.75%	↑	82	73	↓	February
SWH	AJM/Millbrook	18	18	→	108	108	→	72.22%	71.30%	↓	31	35	↑	February
SWH	**All**	**1360**	**1331**	↓	**4681**	**4572**	↓	**52.00%**	**55.14%**	↑	**82**	**73**	↓	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT - Wheelchairs	23	15	↓	27	25	↓	100.00%	100.00%	→	16	17	↑	February
WE	HCRG / Virgin	530	495	↓	855	894	↑	93.80%	92.62%	↓	26	26	→	February
WE	**All**	**553**	**510**	↓	**882**	**919**	↑	**93.99%**	**92.82%**	↓	**26**	**26**	→	**February**

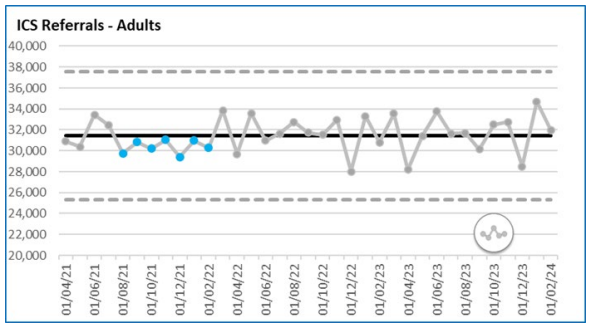
Hertfordshire and West Essex Integrated Care System

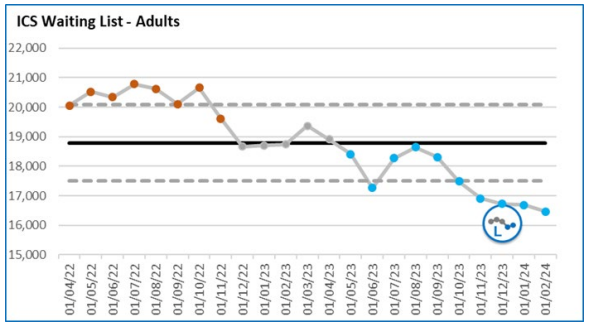
Community Waiting Times (Children)

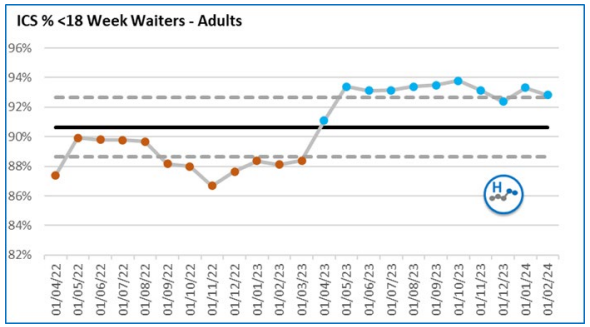
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18-week target for an overall view of waiting time performance.

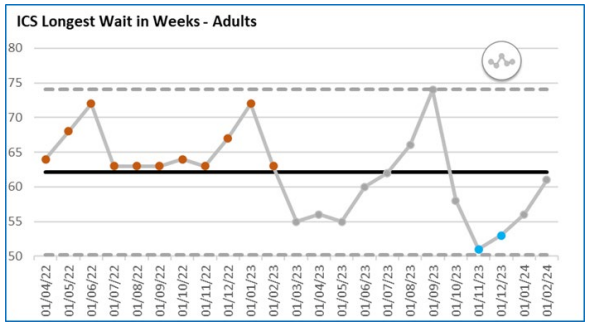
ICB Area	What the charts tell us	Issues	Actions
ICB	• Referrals continue to fluctuate within expected common cause variation limits • The total number of children on waiting lists remains very high, but has plateaued at c.12,000 • The % of children waiting less than 18 weeks remains of concern at c.44%, but has improved in each of the last 2 months. The national average is 51.8%, which is a deteriorating position • The longest waits are within the ENHT Community Paediatrics Service at 112 weeks. There are also long waits of up to 73 weeks within HCT services in South & West Hertfordshire • Consultant led 18-week RTT performance: SWH Community Paediatrics – 46.9% SWH Children's Audiology – 38.3% ENH Community Paediatrics – 17.6% WE Community Paediatrics – 98.6%	**Hertfordshire** • Referrals to HCT children's specialist services increased by 35% in 23/24, compared to 19/20, with most services seeing a marked increase in demand • Waiting times in the SWH HCT Community Paediatrics service are improving, with a decreasing number of long waiters. Service productivity shows clear improvement since 19/20, but referrals have increased by c.32% • There are continued waiting time pressures in Paediatric Audiology in SWH, but there has been improvement with a 31% decrease in total waiters since a high point in June. The service is also currently supporting ENHT newborn hearing pathways • Waiting times across Hertfordshire for children's therapies (OT, Speech & Language and Physiotherapy) remain under pressure **West Essex (WE)** • 18 week % is comparatively strong at 92.8%, but this is the 2nd lowest month recorded • The volumes on the Community Paediatrics waiting list continue to increase • Waits for first appointments have increased – ongoing demand and capacity challenge • Business case for additional funding remains unresolved	**Hertfordshire** • For HCT services the number of over 52-week waits has reduced from 605 in July, to 323 in March, and continues to improve in the most recent data • Focus on reducing DNA/NBI rates for children living in relatively more deprived neighbourhoods • Outsourcing in place in several services • Community Paediatrics in SWH is receiving non-recurrent additional investment to increase workforce capacity and introduce new specialist nursing posts. Recruitment remains a risk • Community Paediatrics also working with NHSE Elect to optimise waiting list management • Paediatric Audiology in SWH is focusing on higher priority appointments, especially follow ups, and signposting to interim advice whilst awaiting assessment. Demand and capacity analysis now completed to identify required staffing model to reduce the waiting list • Children's Therapies – increasing capacity through successful recruitment, waiting list initiatives and outsourcing. Pilot for self-booking in one locality has reduced NBI by over 50% • EHCP dashboard developed to improve waiting list management **Community paediatrics ENHT** • New clinical model agreed by all providers: HPFT, HCT and ENHT • Capacity model being populated with input parameters from the providers to support development of the business case. Target date for the business case is end Apr-24 • Single referral form expected to be in place by Sep-24 (but potentially earlier for some providers) • Target implementation date for the new model is Jan-25 • Providers have forecast investment levels to continue with outsourcing / backlog work in 24/25. Neurodiversity Directors Group to review / agree • ICB / HCC has agreed to expand the Neurodiversity Support Centre across Hertfordshire (staffed by experts by experience). Diagnosis not required to access the support • HCC local offer to be updated with consolidated support and patient signposting **West Essex (WE)** • Community Paediatrics Business Case: 23/24 requested investment has been rolled into year 2 of the 3-year investment plan. Process for 24/25 in year pressures remains unresolved • Admin exercise to review / discharge long waiters complete. Regular caseload review now BAU • Procurement planning initiated. Gap in current funding envelope. Investment will be required in order to procure a sustainable service going forward

Community Waiting Times (Adults)









		Referrals			Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Adults	34696	31992	↓	16686	16466	↓	93.31%	92.83%	↓	56	61	↑	February

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	9312	7882	↓	7432	7585	↑	91.04%	90.34%	↓	56	61	↑	February
ENH	AJM/Millbrook	132	82	↓	484	456	↓	73.55%	66.23%	↓	32	37	↑	February
ENH	**All**	**9444**	**7964**	↓	**7916**	**8041**	↑	**89.97%**	**88.97%**	↓	**56**	**61**	↑	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	CLCH	7738	7350	↓	1853	1621	↓	95.84%	97.47%	↑	38	42	↑	February
SWH	Connect	3652	3481	↓	3172	3135	↓	99.75%	99.74%	↓	34	34	→	February
SWH	HCT	989	977	↓	1036	1035	↓	89.77%	90.14%	↑	41	44	↑	February
SWH	AJM/Millbrook	123	120	↓	492	495	↑	76.22%	72.93%	↓	36	40	↑	February
SWH	**All**	**12502**	**11928**	↓	**6553**	**6286**	↓	**95.30%**	**95.47%**	↑	**41**	**44**	↑	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT	12650	11986	↓	2126	2037	↓	99.39%	99.61%	↑	25	23	↓	February
WE	EPUT - Wheelchairs	100	114	↑	91	102	↑	98.90%	100.00%	↑	21	17	↓	February
WE	**All**	**12750**	**12100**	↓	**2217**	**2139**	↓	**99.37%**	**99.63%**	↑	**25**	**23**	↓	**February**

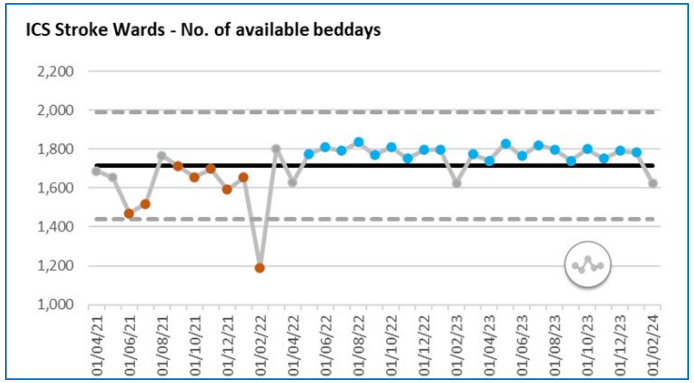
Hertfordshire and West Essex Integrated Care System

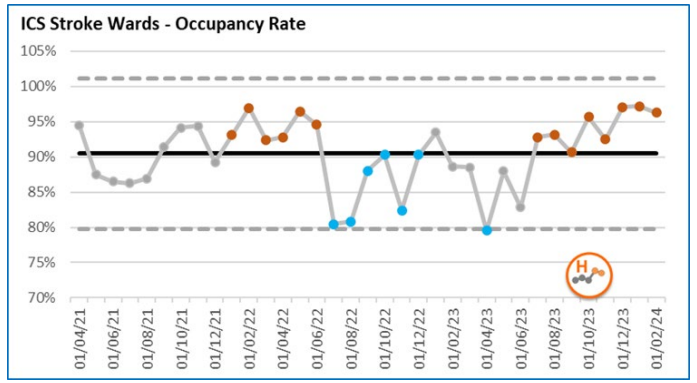
Community Waiting Times (Adults)

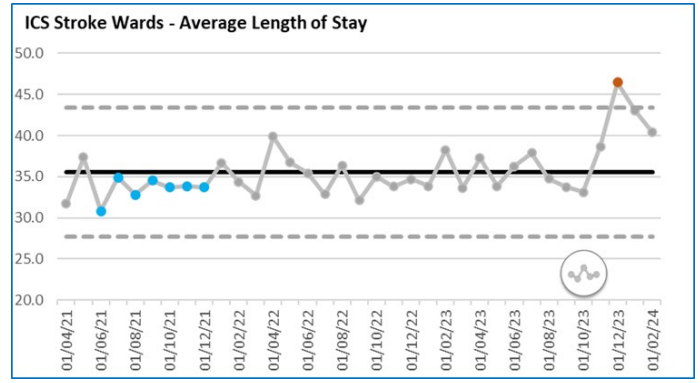
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Adult community services this include Skin Health (ENH), Respiratory (S&W), and Podiatric Surgery (WE). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18-week target for an overall view of waiting time performance. Full detail of commissioned services in HWE is contained within Appendix B.

ICB Area	What the charts tell us	Issues	Actions
ICB	• Referrals continue to fluctuate within expected common cause variation limits • The % of patients waiting less than 18 weeks continues to fluctuate at c.93%, compared to the national average of 83.5% • The total number of adults waiting on waiting lists decreased for the 6th consecutive month • Longest waits are within HCT services in East & North Hertfordshire – up for the 4th month to 61 weeks • Consultant led 18-week RTT performance: ENH Skin Health – 87.9% SWH Respiratory – 97.3% WE Podiatric Surgery – 100%	**East & North Hertfordshire (ENH)** • Referrals have increased by 15% compared to 19/20 and are also up compared to last year. Overall 'waiting within target' performance continues to be more favourable when compared to the pre-pandemic baseline **South & West Hertfordshire (SWH)** • MSK services previously delivered by Connect have been reprocured with Circle. There may be some interruption to data flows during mobilisation • Slight decrease in referrals at CLCH. The number of patients waiting continues to reduce, as does the number of patients waiting above 18 weeks. Respiratory service is now achieving 97% • Longest waiter remains within the Neuro Rehab service (ABI patient waiting for psychology input) • Now recruited to ABI Psychology post – start TBC • Lymphedema and Bladder and Bowel services now within agreed waiting times target **West Essex (WE)** • Pulmonary Rehab recruitment partially successful. Band 6 post remains unfilled • Small number of breaches in Leg Ulcer and Bladder & Bowel services	**East & North Hertfordshire (ENH)** • All waits are closely monitored and subject to robust internal governance • Service productivity analysis continues • Forecasting suggests a stable trend over the next 12 months, and that overall current waiting time performance will be maintained or slightly improved • MSK performance and overall waiting within target performance remains strong and now more favourable than pre-pandemic **South & West Hertfordshire (SWH)** • External provider continuing to support with PD and MS Nursing and ABI caseloads • External provider now also supporting with planned care therapy and NETT waits • Agree start date for substantive ABI Psychology starter • Recruit to PD post – funding secured • Divisional weekly waiting times group remains in place which also feeds into Trust group • Division specific recruitment plan underway, including developing videos to compliment adverts and targeting social media channels. A number of recruitment fairs held, with more being planned • Trajectories now in place for all services of concern. These are reviewed and monitored weekly **West Essex (WE)** • Pulmonary Rehab recovery trajectory agreed. Compliance with 8-week standard expected from June • Bladder & Bowel – temporary staffing in place to cover maternity leave. Recovery expected in May

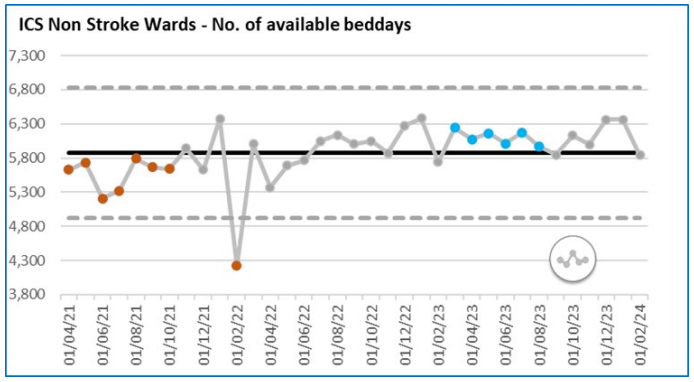
Community Beds (Stroke & Non-Stroke)

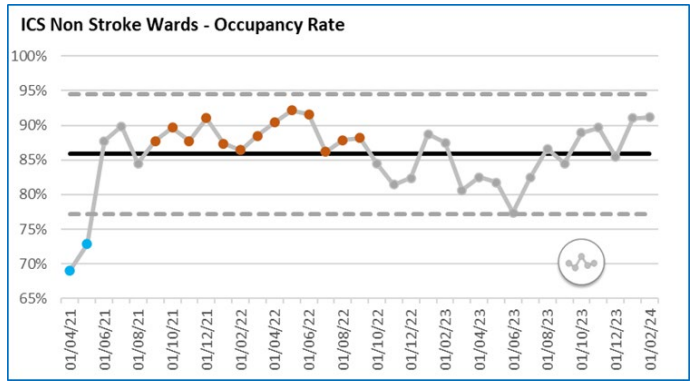


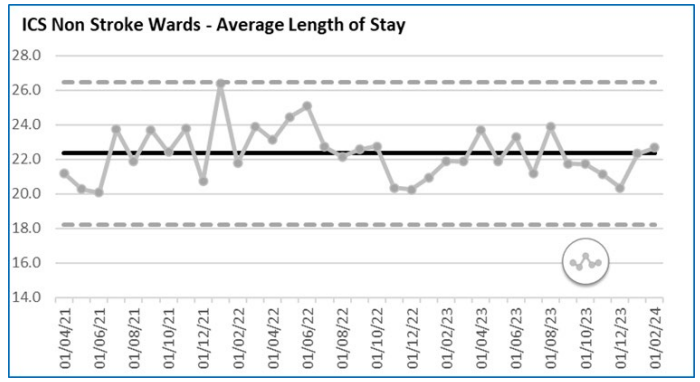




Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	744	672	↓	95.97%	91.37%	↓	39.6	32.4	↓	February
SWH	CLCH	605	561	↓	98.84%	100.00%	↑	48.4	33.5	↓	February
WE	EPUT	434	392	↓	97.09%	91.37%	↓	41.0	63.0	↑	February
ICS	**All**	**1783**	**1625**	↓	**97.20%**	**96.31%**	↓	**43.0**	**40.4**	↓	**February**





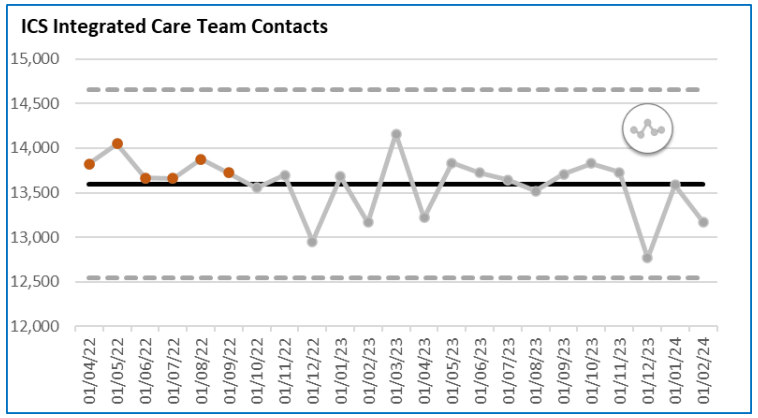


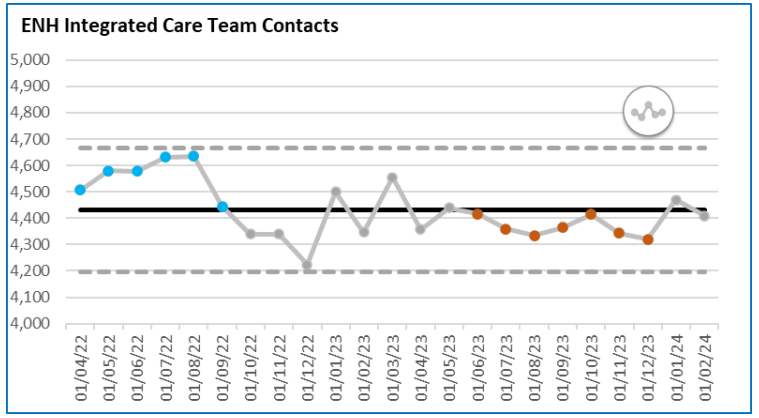
Non-Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	1767	1640	↓	87.83%	87.20%	↓	27.7	26.9	↓	February
SWH	CLCH	2330	2159	↓	89.18%	93.47%	↑	26.4	26.0	↓	February
WE	EPUT	2263	2044	↓	95.45%	91.93%	↓	14.5	15.9	↑	February
ICS	**All**	**6360**	**5843**	↓	**91.04%**	**91.17%**	↑	**22.3**	**22.7**	↑	**February**

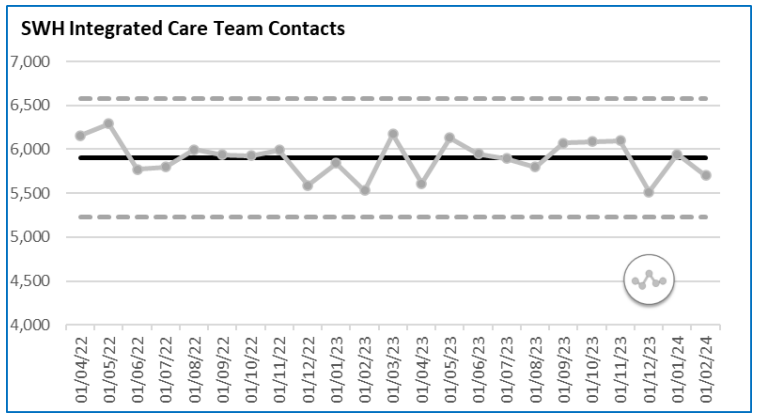
Community Beds (Stroke & Non-Stroke)

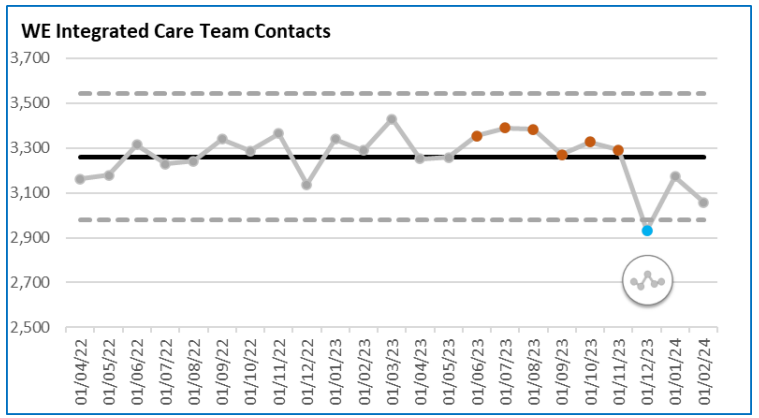
ICB Area	What the charts tell us	Issues	Actions
ICB	**Stroke Beds Days** • Available stroke bed days remain consistent. February numbers dipped due to the reduced number of days in the month • Overall stroke bed occupancy rates continue to trend above the historic mean, but have reduced in each of the last 2 months • Overall length of stay has reduced from the high seen in December, but continues to be impacted by a complex long stay patient at EPUT in West Essex **Non-Stroke Beds Days** • Available stroke bed days remain consistent. February numbers dipped due to the reduced number of days in the month • Overall occupancy rates across the system have been increasing through 23/24 but remain within common cause variation limits • Overall length of stay remains within common cause variation limits	**East & North Hertfordshire (ENH)** • Bed occupancy remains the highest at Danesbury with an average of 92% in 23/24. Herts & Essex and QVM have an average occupancy of 81% and 83% respectively • Average length of stay in 22/23 for Herts & Essex averaged 22 days, and 23 days at QVM. At Danesbury, there is now normal variation with an average of 32 days. Admissions into community hospitals show no significant change in trend at Herts and Essex and QVM • Danesbury has the least admissions with an average of 17 a month, with QVM averaging 19, and Herts & Essex averaging 31 **South & West Hertfordshire (SWH)** • Continued high occupancy rates across all beds due to supporting system flow and admitting higher acuity patients. Slight reduction in general rehab. beds • Slight reduction in average length of stay due to better management of No Criteria to Reside (NCTR) patients **West Essex (WE)** • Extended length of stay on stroke ward due to a complex patient. Extension to stay has been agreed with ICB commissioners	**East & North Hertfordshire (ENH)** • Comprehensive health inequalities metrics in place. Health inequalities analytics has allowed the Trust to compare waiting times and DNA rates for those living in relative deprivation versus those that do not, and critically to set targets to address discrepancies • New process regarding criteria to reside in place to support discharge **South & West Hertfordshire (SWH)** • Daily assurance calls remain in place with HCC with clear escalation process • In collaboration with system partners, action plan agreed to support flow and winter plan also drafted • In collaboration with system partners, SPOC review completed, and action plan agreed which is currently being worked through (most actions completed) • In partnership with social care colleagues, currently reviewing escalation plan **West Essex (WE)** • Daily escalation calls in place to support all delayed discharges • All extended stays are agreed with ICB commissioners

Integrated Care Teams (ICT)







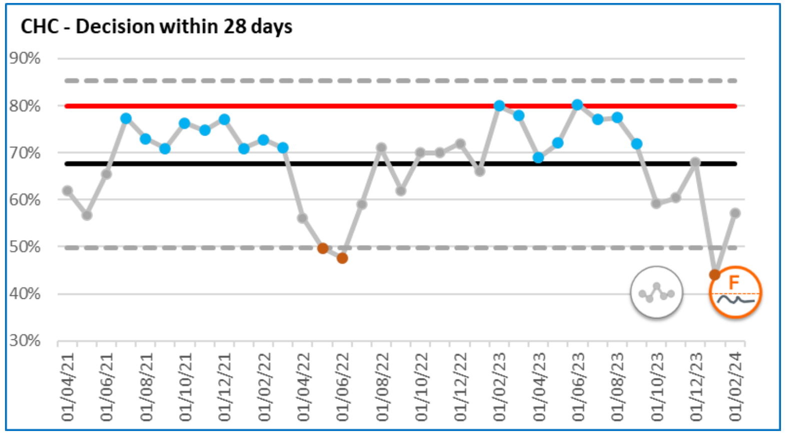


			Contacts (unique patients)			Contacts (unique patients) per 1000 population			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	4470	4409	↓	7.1	7.0	↓	February
SWH	CLCH	All	5944	5705	↓	8.7	8.3	↓	February
WE	EPUT	All	3172	3058	↓	9.6	9.2	↓	February
ICS	**All**	**All**	**13586**	**13172**	↓	**8.3**	**8.0**	↓	**February**

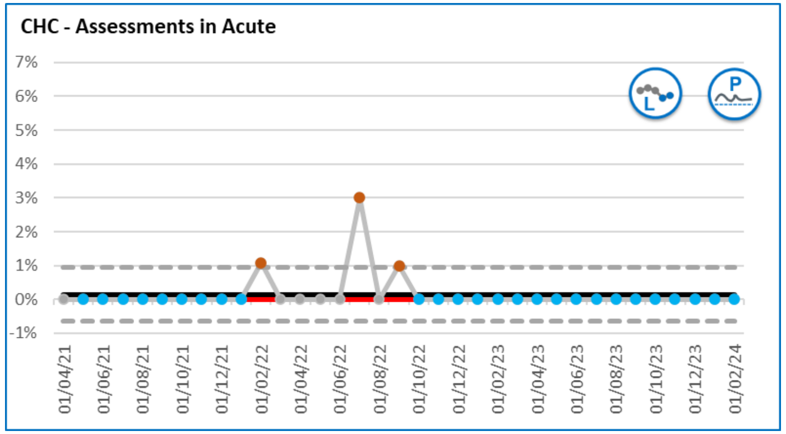
Integrated Care Teams (ICT)

ICB Area	What the charts tell us	Issues	Actions
ICB	• This section of the report has changed from this month to report on the number of unique patients in contact with the three HWE ICT Teams. Using this method removes the previous discrepancies seen due to provider internal recording and coding differences • Unique contacts in each place and at HWE System level are within expected common cause variation limits	**East & North Hertfordshire (ENH)** • Overall, referrals show a small increase compared to pre-pandemic, although the pattern differs at Locality level • Increasing patient complexity has driven an increase in caseload and first to follow up ratios • Service and staff are under growing pressure • Focus on increased deferral rates **South & West Hertfordshire (SWH)** • Slight reduction in referrals number in month. However, caseload numbers are largely unchanged **West Essex (WE)** • Since April 2021 ICTs have seen a reduction in referrals. Contacts per patient however have increased from 7.5% to 9.7% (c.30% increase), suggesting an increase in acuity of patients receiving care in the community	• Community services review underway across HWE to reduce variation and shift to reporting outcomes and impact, to compliment the activity driven data that exists **East & North Hertfordshire (ENH)** • Steering group in place chaired by HCT Chief Operating Officer • Various recruitment initiatives underway • A comprehensive support programme in place focused on workforce, wound care and diabetes management with the ICT • Additional activity support with locality cross team working to reduce deferrals **West Essex (WE)** • ICTs are focussing on proactive working within the Integrated Neighbourhood Teams, aligned to the 6 West Essex PCNs

Continuing Health Care (CHC)



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
East & North Hertfordshire	38.7%	23.3%	50.0%	58.3%	50.0%	66.7%	77.4%	70.4%	47.8%	52.6%	72.0%	69.0%	70.8%	74.2%	94.9%	86%	100%	83%	100%	70%	88%	83%	91%	87%	82.5%	86.5%	82.1%	75.6%	87.5%	82.9%	75.7%	77.1%	80.0%	50.0%	80.4%
South & West Herfordshire	47.2%	65.7%	74.4%	81.5%	80.4%	66.7%	61.1%	72.3%	85.7%	80.5%	71.2%	72.5%	47.2%	35.2%	23.4%	36%	41%	33%	50%	63%	58%	63%	72%	67%	50.0%	61.7%	73.6%	71.8%	69.7%	56.5%	36.4%	45.8%	47.5%	34.9%	35.4%
West Essex	100.0	87.0%	71.0%	83.0%	80.0%	88.0%	100.0	93.0%	92.3%	68.4%	80.0%	70.0%	88.9%	89.5%	85.0%	75%	100%	85%	89%	81%	78%	64%	87%	89%	91.7%	91.3%	87.9%	92.9%	83.9%	87.5%	92.6%	70.8%	92.9%	76.5%	84.6%
ICS	62.0%	56.8%	65.4%	77.3%	73.0%	71.0%	76.3%	74.8%	77.2%	70.9%	72.8%	71.0%	56.2%	49.7%	47.6%	59%	71%	62%	70%	70%	72%	66%	80%	78%	68.9%	72.1%	80.3%	77.1%	77.5%	71.9%	59.2%	60.4%	67.9%	44.0%	57.1%



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
East & North Hertfordshire	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	5%	0%	6%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
South & West Herfordshire	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	2%	0%	0%	0%	0%	3%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
West Essex	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
ICS	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	3%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

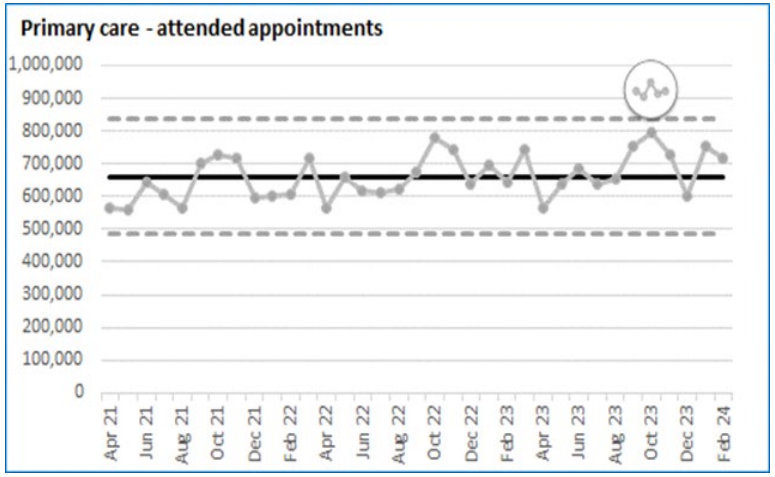
	What the charts tell us	Issues	Actions

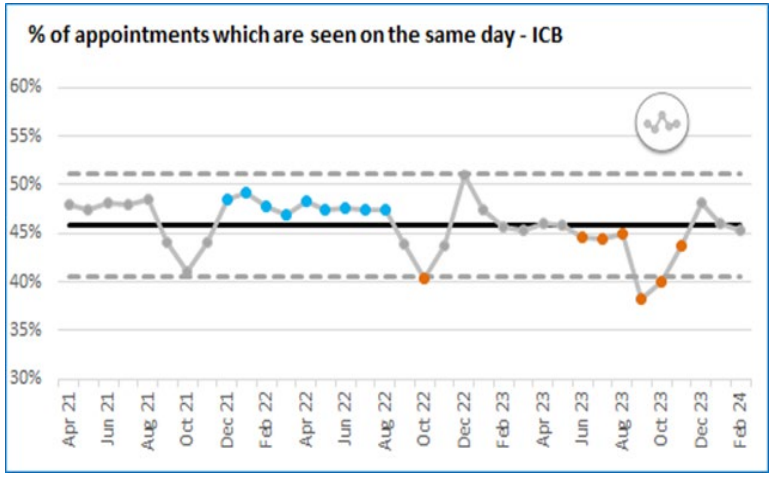
HWEICB	• The 28-day standard continues to present a significant challenge, most notably in South & West Hertfordshire
	• The 80% target was achieved in West Essex and East & North Herts in February; however, all Places will miss the target in March:
	  • Overall ICB – 43%
	  • West Essex – 76%
	  • ENH – 67%
	  • SWH – 24%
	• The assessments in an acute setting <15% standard continues to be routinely achieved
		• Workforce - new starters do not have CHC experience and require robust training and development
		• Recovery of the 28-day standard is forecast to take at least 6 months and has been agreed with NHSE
			• Weekly meetings are in place across all areas to monitor performance. Additional assurance meetings are being held with NHSE
			• A further comprehensive layer of management control and support has been implemented across the SWH service to significantly improve work allocation, daily analysis of completed work, case status and risk identification
			• The same process for all areas will be implemented moving forwards

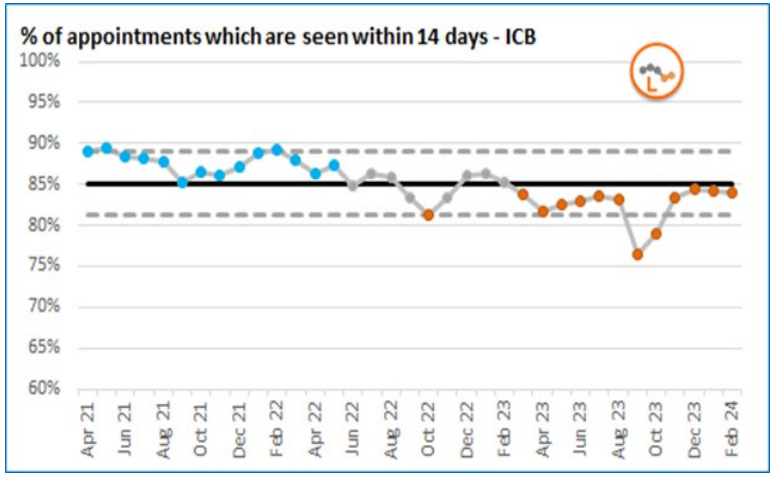
Primary Care – performance summary

Current Performance Period vs Prior Period								ICB	ENH	SWH	WE
Area	Indicator	Type	Prior Mth	Current	Change	Movement	Period	Rank (out of 42 ICBs)	Rank (out of 106 ICBs)		
Primary Care	S001a: Number of general practice appointments per 10,000 un-weighted patients	Monthly	4,468	4,227	(241)	↓	Feb-24				
	% of appointments which are seen on the same day	Monthly	46.0%	45.3%	(0.7%)	↓	Feb-24				
	% of appointments which are seen within 14 days	Monthly	84.2%	83.9%	(0.3%)	↓	Feb-24	23	92	33	35
	S074a: FTE doctors in General Practice per 10,000 weighted patients	Monthly	6.22	6.13	(0.09)	↓	May-23				
	S075a: Direct patient care staff in GP Practices and PCNs per 10,000 weighted patients	Quarterly	6.29	6.67	0.38	↑	Q4 23-24	35			
	S037a: Percentage of patients describing their overall experience of making a GP appointment as good	Annual	54.5%	52.4%	(2.1%)	↓	2023	32			
	S085a: Proportion of people with severe mental illness receiving a full annual physical health check and follow up interventions	Quarterly	68.7%	74.9%	6.2%	↑	Q1 23-24				
	S030a: Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check ICB	Monthly	42.6%	41.2%	(1.4%)	↓	Dec-23	38			
	S055a: Number of referrals to NHS digital weight management services per 100k head of population	Quarterly	24.7	37.9	13.2	↑	Q4 22-23				
	S050a: Cervical screening coverage - % females aged 25 - 64 attending screening within the target period	Quarterly	73.6%	73.8%	0.2%	↑	Q2 23/24	7	28	43	20
	S047a: Proportion of people over 65 receiving a seasonal flu vaccination	Seasonal	80.3%	80.7%	0.4%	↑	Feb-23	26	47	51	82
	S109a: Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	Annual	67.1%	72.5%	5.4%	↑	2022-23				
	S044a: Antibiotic items prescribed in primary care per STAR-PU (specific age-sex related prescribing unit)	Monthly	1.034	1.029	(0.005)	↓	Nov-23	28	56	19	76
	S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	8.54%	8.56%	0.02%	↑	Nov-23	34	83	84	70

Primary Care – key indicator trends







NOTE: %s in the above charts are based on appointments made, not requests received

What the charts tell us

- GP appointments remain within expected common cause variation limits
- The % of appointments which were seen on the same day returned to common cause variation following the dips seen in Sep-23 and Oct-23. Historically, those months are low due to flu vaccinations, which are not same day appointments
- The % of appointments which were seen within 14 days has been consistently below the mean for the last 12 months

Primary Care – narrative

ICB Area	Issues	Actions
ICB	• General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal • 23/24 contractual requirement for an offer of assessment, an appointment, or signposting to occur when the patient contacts the practice • National contract for 24/25 imposed without agreement from profession, with Industrial Action in Primary Care a possibility and added to the risk register	**Engagement with the National Access Recovery Plan** • All 34 PCNs have an agreed Access Improvement Plan (AIP) as outlined in the Primary Care Access Recovery Plan • Comms. to all practices noting AIP requirements by year end to be eligible for payment- assessment of achievement end of April • Some practices transitioning to Modern General Practice through demand / capacity analysis, use of cloud base telephony, enacting the National GP Improvement Programme (19 practices and 4 PCNs), roll out NHS app, online GP registration, development of GP and PCN websites and testing triage models • Transformation support funding - Indicative £13.5k per qualifying practice available for 23/24, and the same for 24/25. Place teams reviewed and approved submissions from practices • 28 sites identified for cloud base telephony. Delays in national procurement hub implementation may result in practices unable to deliver improvement in telephone access for 2023/24. Escalated to the regional team • Good progress on online access to GP records. Targeted work with practices to enable access by opting into (EMIS) or following self-enablement process (TPP) – proactive follow up of practices with low take up or high exclusion rates • Partnership working to increase self-referrals in high volume services: Physio, IAPT, Podiatry etc. • Support Level Framework (SLF) - Self assessment tool to support practice teams in understanding what they do well, what they might wish to do better, and where they might benefit from development support. Aim for all practices to have had a facilitated discussion using the SLF during the year • Comms. to support ICB and practice websites, media statements and patient comms re the Delivery Plan • Attendance at NHSE regional weekly drop-in sessions to escalate any issues or questions for clarification • GP contract for 24/25 - continued focus on access and reducing bureaucracy with light touch approach to Access Improvement Funding • Development of PC Dashboard to include further metrics to allow triangulation / narrative in the absence of plan / reporting requirement in national contract **Other** • Enhanced Commissioning Framework (ECF) reviewed and streamlined for 23/24, review for 24/25 to focus on outcomes and reducing bureaucracy • Trend analysis to identify practices with poor access via complaints and patient contacts • PCCC and Primary Care Board oversight of GPPS results. Action plan developed through the Access MDT Group • Initiatives for Primary Care Workforce to support recruitment and retention, supported by the HSE ICB Training Hub • Continued funding for spot booking hotels for health checks and MDT site visits agreed by PCCC at the February meeting • Daily review of OPEL reporting by practices and follow up by place Primary Care Teams with individual practices • Oversight of all Access plans as submitted and sharing of best practice across the ICB • Pharmacy First now live, work with Community Pharmacy leads and practices to promote service

Performance v. 23/24 Operational Plans

		M11 Only					Year To Date				
POD	Description	Plan	Actual	Actual vs Plan %	Change	Performance	Plan	Actual	Actual vs Plan %	Change	Performance
EM13	Number of attendances at all type A&E departments	35,329	42,101	19.17%	6,772	↑	438,326	456,170	4.07%	17,844	↑
EM11a	Number of specific acute non-elective spells in the period with a length of stay of zero days	3,091	3,480	12.58%	389	↑	37,839	33,329	-11.92%	-4,510	↓
EM11b	Number of specific acute non-elective spells in the period with a length of stay of one or more days	6,026	6,457	7.15%	431	↑	67,993	73,851	8.62%	5,858	↑
EM10a	Elective day case spells	10,039	10,236	1.96%	197	↑	100,488	108,431	7.90%	7,943	↑
EM10b	Elective ordinary spells	1,247	886	-28.95%	-361	↓	12,800	9,830	-23.20%	-2,970	↓
EM32g	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance	43,694	41,911	-4.08%	-1,783	↓	474,957	462,403	-2.64%	-12,554	↓
EM32h	Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance	50,942	65,996	29.55%	15,054	↑	575,380	716,226	24.48%	140,846	↑
EB20	The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 65 weeks or more	1,775	1,508	-15.04%	-267	↓	25,887	34,575	33.56%	8,688	↑
	Operational planning modalities (provider)	36,393	33,735	-7.30%	-2,658	↓	393,765	380,199	-3.45%	-13,566	↓

ICB Issues and escalations

- YTD attendances, and non-elective spells with a length of stay of one of more days, are both higher than plan
- Non-elective spells with a zero-day length of stay are slightly below plan
- Elective inpatient activity is below plan. Elective activity in all areas has been impacted by Industrial Action
- The number of 65-week waits is above plan, however the target for zero 65ww breaches has been extended to end of September 2024

Appendix A – Performance Dashboard

February 2024

Herts & West Essex ICB (Commissioner) / Provider

Area	Activity	Target	Latest published data	Data published	Trend *1	Variation	Assurance	NATIONAL position (ICB vs National)	REGIONAL position (ICB vs EoE Region)	ICB Ranking	ICB Aggregate Provider	Trend *1	ENHT	Trend *1	WHTHT	Trend *1	PAH	Trend *1
111	Calls answered < 60 seconds	95%	21.9%	February 24	✗ -61.64%		F	58.61% (Worse)	47.23% (Worse)	3rd lowest	21.9%	✗ -61.64%						
	Calls abandoned after 30 seconds	5%	29.5%	February 24	✗ 22.37%	H	?	9.31% (Worse)	15.78% (Worse)	1st lowest	29.50%	✗ 22.37%						
A&E	% Seen within 4 hours	76%	74.8%	March 24	✓ 7.086%	H	F	74.21% (Better)	75.52% (Worse)	20th highest	74.80%	✓ 7.09%	76.20%	✓ 4.59%	78.20%	✓ 9.46%	67.90%	✓ 7.22%
	12 Hour Breaches	0	182	March 24	✓ -71.98%		?	42,181 (0.43%)	2,913 (6.25%)	5th highest	182	✓ -71.98%	37	✓ -191.89%	44	✗ 13.64%	101	✓ -65.35%
Cancer	31 days	96%	94.1%	February 24	✓ 5.94%		?	91.11% (Better)	91.16% (Better)	14th highest	95.90%	✓ 1.67%	96.10%	✗ -0.73%	97.60%	✓ 9.73%	92.30%	✓ 5.31%
	62 days	85%	70.4%	February 24	✓ 6.29%		F	63.94% (Better)	63.17% (Better)	8th highest	71.40%	✓ 4.62%	83.60%	✗ -2.99%	72.70%	✓ 13.89%	48.80%	✓ 9.43%
	28 days Faster Diagnosis	75%	78.9%	February 24	✓ 6.81%	H	?	78.12% (Better)	75.21% (Better)	20th highest	81.10%	✓ 7.77%	83.40%	✓ 8.75%	79.80%	✓ 7.14%	80.30%	✓ 7.22%
RTT	Incomplete Pathways <18 weeks	92%	55.7%	February 24	✓ 2.87%	L	F	57.55% (Worse)	53.83% (Better)	14th lowest	52.70%	✓ 4.74%	54.20%	✓ 7.93%	51.40%	✓ 2.72%	52.70%	✓ 3.04%
	52+ weeks	0	9,225	February 24	✓ -26.08%	L	F	305,050 (3.02%)	50,086 (18.42%)	9th lowest	7,288	✓ -33.07%	2,909	✓ -83.91%	2,420	✗ 0.54%	1,959	✗ 0.92%
	65+ weeks	0	2,058	February 24	✓ -96.02%	L	F	75,004 (2.74%)	14,302 (14.39%)	13th lowest	1,508	✓ -135.08%	500	✓ -385.00%	353	✓ -13.88%	655	✓ -9.62%
	78+ weeks	0	124	February 24	✓ -4.84%		?	9,969 (1.24%)	2,110 (5.88%)	14th lowest	124	✓ -1085.48%	30	✓ -4423.33%	10	✓ -40.00%	84	✓ -17.86%
Diagnostics	6 week wait	5%	26.4%	February 24	✓ -21.59%		F	20.78% (Worse)	27.43% (Better)	9th lowest	31.30%	✓ -21.41%	44.70%	✓ -13.65%	9.10%	✓ -62.64%	24.80%	✓ -39.92%

Herts & West Essex ICB (Commissioner) / Sub-ICB

Area	Metric	Target	Latest published data	Data published	Trend *1	Variation	Assurance	National position (ICB vs National)	Regional position (ICB vs EoE Region)	ICB Ranking	ICS Aggregate Provider	Trend	East & North Herts	Trend *1	South & West Herts	Trend *1	West Essex	Trend *1
111	Calls answered < 60 seconds	95%	21.9%	February 24	✗ -61.64%		F	58.61% (Worse)	47.23% (Worse)	3rd lowest	N/A		22.33%			✗ -59.89%	20.00%	✗ -69.50%
	Calls abandoned after 30 seconds	5%	29.5%	February 24	✗ 22.37%	H	?	9.31% (Worse)	15.78% (Worse)	1st lowest			29.76%			✗ 21.70%	28.20%	✗ 24.82%
Mental Health	Dementia Diagnosis rate	66.6%	64.4%	February 24	✓ 0.20%	H	F	64.50% (Worse)	62.90% (Better)	22nd (middle)			62.85%	✓ 0.29%	62.12%	✓ 0.27%	71.20%	✗ -0.01%
	OOA placements	0	211	February 24	✗ 57.35%	L	F	n/a	n/a	n/a			172			✗ 79.07%	39	✓ -38.46%
CHC	% of eligibility decisions made within 28 days	80%	57.1%	February 24	✓ 22.94%		?	76.45% (Worse) *2	79.06% (Worse) *2	10th lowest *2			80.40%	✓ 37.81%	35.40%	✓ 1.41%	84.60%	✓ 9.57%
	% of assessments carried out in acute	15%	0.0%	February 24	— 0.00%	L	P	0.32% (Better) *2	0.29% (Better) *2	12th lowest *2			0%	— 0.00%	0%	— 0.00%	0%	— 0.00%

LEGEND On/above target | Below target | ✓ Improvement on previous month's performance | ✗ Decrease on previous month's performance | — No change on previous month's performance

Appendix B: HWE Adult Community Services

Elective & Specialist	E&NH	S&WH	West Essex
Cardiac Rehab	HCT/ENHT	CLCH	EPUT
Diabetes	HCT	HCT	EPUT
Continence services	HCT	CLCH	EPUT
Nutrition and Dietetic Service	HCT	HCT	EPUT
Speech and language therapy	HCT	CLCH	EPUT
Podiatry	HCT	CLCH	EPUT
Specialist palliative care	HCT	CLCH	EPUT
Heart failure service	-	CLCH	EPUT
Lymphoedema	HCT	CLCH	HCT
Tissue Viability	HCT	CLCH	EPUT
Leg Ulcer	HCT	CLCH (Herts one)	EPUT
Respiratory	HCT/ENHT	CLCH/WHHT	EPUT
MSK	HCT	Connect	EPUT
Chronic pain management	HCT	Connect	EPUT
Community Neuro/rehab	HCT	CLCH	PD/MS only
Pulmonary Rehab	HCT	CLCH	EPUT
Specialist Dentistry	HCT	HCT	-
Community Dermatology	HCT	-	GP Fed
Community ENT	-	Communitas	-
Community Gynaecology	-	The Gynaecology partnership	-
Long Covid	HCT	CLCH	EPUT
Diabetes eye screening	ENHT	HCT	Health intelligence Ltd
Sexual Health Services	CLCH	CLCH	Provide

Urgent & Emergency Services	E&NH	S&WH	West Essex
2 hour urgent response	HCT	CLCH	EPUT
Hospital at home/rapid response	HCT	CLCH	EPUT
Discharge to assess (at home)	HCT	CLCH	EPUT
Virtual ward/hospital	HCT	CLCH/WHHT	EPUT
Inpatient rehab beds	HCT	CLCH	EPUT
Inpatient stroke Neuro rehab beds	HCT	CLCH	EPUT
Respiratory services	HCT	CLCH	EPUT
Stroke (Early supported discharge)	HCT	CLCH	EPUT
Neuro ESD (NETT)	-	CLCH	-

Core community Services	E&NH	S&WH	West Essex
District Nursing	HCT	CLCH	EPUT
Community therapies (OT/PT)	HCT	CLCH	EPUT
Frailty clinics	HCT	CLCH	PAH
Enhanced health in care homes	HCT	CLCH	EPUT

Appendix B: HWE Children's Community Services

Children's Services within Hertfordshire and West Essex ICS are complex with a range of existing governance forums and a broad range of services provided primarily by NHS Trusts, but with a number of independent and 3rd sector organisations

Service	E&NH	S&WH	West Essex
ADHD	ENHT	HPFT	HCRG
Advocacy	KIDS	KIDS	Rethink / Open Door
Allergy	ENHT	WHHT	HCRG / PAH
ASD	ENHT	HCT	HCRG
Asthma Nurse specialist	n/a	HCT	To be established
Audiology	ENHT	HCT	PAH
Wellbeing Practitioners	HCT	HCT	HCRG
CHIS	HCT	HCT	Provide
Com. Nursing	ENHT	HCT	HCRG
Comm Paeds	ENHT	HCT	HCRG
Continence	n/a	HCT	HCRG
Continuing Care	ENHT	HCT	HCRG & Various Independent
CSAIS	EPUT (s/c HCT)	EPUT (s/c HCT)	EPUT
CYP Counselling	YCT, Youthtalk, Signpost, Rephael House & Safespace.	YCT, Youthtalk, Signpost, Rephael House & Safespace.	YCT
CYP Therapies	HCT	HCT	HCRG (SLT inclusive of dysphagia, PT inclusive of MSK)
Designated Medical Officer for SEND	ENHT	HCT	HCRG
Diabetes Nurse Specialist	ENHT	WHHT	PAH
Dietetics	HCT	HCT	HCRG / PAH
Eating Disorders	HPFT	HPFT	NELFT / BEAT
Epilepsy Nurse Specialist	ENHT	WHHT	PAH
Equipment	HCT	HCT	EPUT
Eye Care	ENHT	HCT/WHHT	PAH

Service	E&NH	S&WH	West Essex
Family Hubs/Children's Centres	Family Centre Services/Family Support Services/ HCT	Family Centre Services/Family Support Services/ HCT	HCRG
Health Visiting	HCT	HCT	HCRG
Hospice Care	Keech	Keech/Noah's Arc/ Rennie Grove	Haven House, EACH
Infant Mental Health	HCT	HCT	EPUT
LAC	HCT	HCT	HCRG
Lymphoedema	HCT	n/a	HCT
Mental Health Support Teams	HPFT/HCT	HPFT/HCT	West Essex Mind (mainstream) / HPFT (special schools)
Neuro-Rehab	Specialist commissioned	Specialist commissioned	Tadworth Children's Trust
Palliative Care Respite Service (EPIC)	Noah's Arc	Noah's Arc	Little Haven's
Palms	HCT	HCT	n/a
Parenting Support	HCC	HCC	Triple P (YCT from April)
Perinatal Mental Health	HPFT	HPFT	EPUT
School Nursing	HCT	HCT	HCRG
Sickle cell	HCT	HCT	PAH
Special care dentistry	HCT	HCT	PAH
Specialist CAMHS	ENHT	HPFT	NELFT
Specialist Healthcare Tasks	n/a	n/a	Provide
Specialist school nursing	ENHT	HCT	HCRG
Step 2 Service	JHCT	HCT	n/a
Therapeutic Health Based Coaching	n/a	n/a	NOW
Tier 4 CAMHS	HPFT	HPFT	EPUT
Transition coordinators	HCT	HCT	HCRG
Weight Management & other wellbeing services	Beezee Bodies	Henri/ Beezee Bodies	Provide

N.B. Virgin Care has now been transferred to HCRG Care Group

Appendix C: Glossary of acronyms (1 of 2)

A&E	Accident & Emergency
AAU	Ambulatory Assessment Unit
ADHD	Attention Deficit hyperactivity Disorder
AHC	Annual Health Check
ASD	Autism Spectrum Disorder
BAME	Black Asian & Minority Ethnic
BAU	Business As Usual
CAMHS	Children & Adolescent Mental Health Service
CCATT	Children Crisis Assessment & Treatment Team
CDC	Community Diagnostic Centre
CEO	Chief Executive Officer
CHC	Continuing Healthcare
CISS	Community Intensive Support Service
CLCH	Central London Community Healthcare NHS Trust
CMO	Chief Medical Officer
CPCS	Community Pharmacy Consultation Service
CQC	Care Quality Commission
CT	Computerised Tomography (scan)
CYP	Children & Young People
D2A	Discharge to Assess
DMAS	Digital Mutual Aid System
DQ	Data Quality
DST	Decision Support Tool
DSX	DSX Systems (Digital Health Solutions)
DWP	Department for Work & Pensions
EAU	Emergency Assessment Unit
ECAT	Emergency Clinical Advice and Triage
ECHO	Echocardiogram
ED	Emergency Department

EEAST	East of England Ambulance Service NHS Trust
EIP	Early Intervention in Psychosis
EMDASS	Early Memory Diagnosis and Support Service
EMIS	Supplier of GP Practice systems and software
ENHT	East & North Herts NHS Trust
EPR	Electronic Patient Record
EPUT	Essex Partnership University NHS Foundation Trust
F2F	Face-to-Face
FDS	Cancer 28 day Faster Diagnosis Standard
FHAU	Forest House Adelescent Unit
FNC	Funded Nursing Care
GIRFT	Getting It Right First Time
GP	General Practice
HALO	Hospital Ambulance Liaison Officer
HCA	HealthCare Assistant
HCT	Hertfordshire Community Trust
HEG	Hospital Efficiency Group
HPFT	Hertfordshire Partnership NHS Foundation Trust
HCRG	Health Care Resourcing Group
HUC	Hertfordshire Urgent Care
IAG	Inspection Action Group
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IPC	Infection prevention and control
IS	Independent Sector
IUC	Integrated Urgent Care
IUATC	Integrated Urgent Assessment and Treatment Centre

Appendix C: Glossary of acronyms (2 of 2)

IVR	Interactive Voice Response
JSPQ	Joint Service, Performance and Quality Review Meeting
LA	Local Authority
LAC	Look After Children (team)
LD	Learning Disability
LeDeR	Learning Disability Mortality Review Programme
LMNS	Local Maternity Neonatal System
LMS	Local Maternity System
LoS	Length of Stay
MDT	Multi Disciplinary Teams
MH	Mental Health
MHSOP	Mental Health Service for Older People
MOU	Memorandum Of Understanding
MRI	Magnetic Resonance Imaging
MSE	Mid & South Essex NHS Foundation Trust
NHSE	NHS England
NICE	The National Institute for Health & Care Excellence
NLMCTR	No Longer Meets Criteria To Reside
NOK	Next Of Kin
OHCP	One HealthCare Partnership
OOAP	Out of Area Placements
OPEL	Operational Pressures Escalation Levels
OT	Occupational Therapy
PAH / PAHT	The Princess Alexandra Hospital NHS Trust
PCN	Primary Care Network
PEoLC	Palliative & End of Life Care

PIFU	Patient Initiated Follow-Up
PMO	Project Management Office
PRISM	Primary Integrated Service for Mental Health
PTL	Patient Tracking List
RCA	Root Cause Analysis
REAP	Resource Escalation Action Plan
RESUS	Resuscitation
RTT	Referral to Treatment (18-week elective target)
SACH	St Albans City Hospital
SAFER	Tool to reduce patient flow delays on inpatient wards
SDEC	Same Day Emergency Care
SLT	Speech & Language Therapist
SMART	Surge Management and Resilience Toolset
SMI	Severe Mental Illness
SRG/LDB	System Resilience Group / Local Delivery Board
SSNAP	Sentinel Stroke National Audit Programme
SVCC	Single Virtual Call Centre
T&O	Trauma and Orthopaedic
TTA	Take Home Medication (To Take Away)
UEC	Urgent Emergency Care
US	Ultrasound Scan
UTC	Urgent Treatment Centre
WAF	Winter Access Fund
WGH	Watford General Hospital
WHHT	West Herts Hospital Trust
WW	Week Waits

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐				
	NHS HWE Board Meeting held in Public				**Meeting Date:**	**24/05/2024**		
Report Title:	**HWE Finance Report**				**Agenda Item:**	**11**		
Report Author(s):	Frances Barnes - Associate Director of ICS Finance Debbie Griggs – Deputy Chief Finance Officer							
Report Presented by:	Alan Pond, Chief Finance Officer, HWE ICB							
Report Signed off by:	Alan Pond, Chief Finance Officer							
Purpose:	**Approval / Decision**	☐	**Assurance**	☒	**Discussion**	☒	**Information**	☒
Which Strategic Objectives are relevant to this report **[Please list]**	▪ *Enhancing productivity and value for money* ▪ *Helping the NHS support broader social and economic development*							
Key questions for the ICB Board / Committee:	For discussion / noting							
Report History:	Finance and Investment committee 14th May 2024							
Executive Summary:	**ICS Full Year Position – Month 12** In month 12, the HWE System reported a break-even full out-turn position. Whilst four organisations reported a surplus, PAH and WHHT reported deficit positions of £6.1m and £13.8m respectively. The ICB finished the year ahead of plan by £4.6m. This was due to additional ERF being earned, together with several contracts reaching a full year position below that expected. **Planning 2024-25** The System submitted its final plan on 2nd May, with an overall position of £44.9m deficit. This included efficiency plans of 5% across all Trusts and the ICB's non-NHS spending. Conversations will continue with NHSE to identify the actions the system would need to take to break-even, with its next meeting 23rd May. **Capital**							

	At month 12, the system reported an underspend against its operating capital allocation of £0.6m. The total capital allocation for Trusts for the year was £109.7m. The ICB spent its full allocation of £3.1m in 2023-24. In 2024-25, plans are in place for providers to spend the full allocation of £81m and the ICB to spend its allocation of £2.4m to support the GPIT rolling programme.			
Recommendations:	The Board is requested to: • note the financial position of the HWE ICS System at the end of 2023-24 • note the planning position for the HWE ICS for 2024-25 • note the financial position of the ICB at the end of 2023-24 • note the planning position for the ICB for 2024-25			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
Implications / Impact:				
Patient Safety:	*n/a*			
Risk: *Link to Risk Register*	*n/a*			
Financial Implications:				
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***		n/a	
	Quality Impact Assessment:		n/a	
	Data Protection Impact Assessment:		n/a	

Hertfordshire and West Essex Integrated Care System

HWE ICB Board Meeting

Finance Report

24th May 2024

Working together
for a healthier future

HWE ICS – Financial Report for Month 12 2023/24

Executive Summary

ICS Full Year Position – Month 12

In month 12, the HWE System reported a break-even full out-turn position. Whilst four organisations reported a surplus, PAH and WHHT reported deficit positions of £6.1m and £13.8m respectively.

The ICB finished the year ahead of plan by £4.6m. This was due to additional ERF being earned, together with several contracts reaching a full year position below that expected.

Planning 2024-25

The System submitted its final plan on 2nd May, with an overall position of £44.9m deficit. This included efficiency plans of 5% across all Trusts and the ICB's non-NHS spending. Conversations will continue with NHSE to identify the actions the system would need to take to break-even, with its next meeting 23rd May.

Capital

At month 12, the system reported an underspend against its operating capital allocation of £0.6m. The total capital allocation for Trusts for the year was £109.7m.
The ICB spent its full allocation of £3.1m in 2023-24.

In 2024-25, plans are in place for providers to spend the full allocation of £81m and the ICB to spend its allocation of £2.4m to support the GPIT rolling programme.

The HWE System Position - Month 12

HWE ICS – Financial Report for Month 12 2023/24

Orgn '£'000	Annual Plan Reported	Original H2 Plan	Final Plan	Forecast Outturn Reported	Variance
ENHT	(2.5)	(0.7)	3.2	3.2	0.0
HCT	0.0	0.0	0.7	0.8	0.0
HPFT	(1.8)	(4.2)	2.0	2.0	0.0
PAH	(5.1)	(14.4)	(6.1)	(6.1)	(0.1)
WHHT	0.0	(18.0)	(9.3)	(13.8)	(4.5)
ICB	9.4	37.3	9.4	14.0	4.6
ICS	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.1**

The HWE system reported a break-even position at the end of the financial year 2023-24.

Whilst the system was in balance, not all organisations reported the same, with ENHT, HCT, HPFT and the ICB having surplus positions as shown above and PAH and WHHT reporting deficits.

Following the Half Two planning exercise and implementation of a financial recovery plan in November 2023, the surplus planned in the ICB was distributed across all organisations. Additional funding for industrial action December to February was received from NHSE (£6.8m) and distributed to Trusts.

WHHT experienced challenges in delivering its full financial recovery plan, with final pressures of £4.5m which it had signalled earlier in the month of March. It reported a final position of £13.8m deficit, being worse than plan by £4.5m.

The ICB position improved due to better-than-expected ERF performance, together with some contracts ending the year at a lower value than anticipated.

The small favourable variance of £0.04m across the system will be added to the historical surplus which will then be £17.1m.

HWE ICS ERF Performance in 2023/24

The table below shows the HWE ICS performance against the Elective Services Recovery target for 2023/24. The performance is based on Months 1 to 9 actuals with an estimate for performance for Quarter 4.

Following the final confirmation of Elective Services activity figures for 2023/24 in June 2024, there will be an adjustment to the 2024/25 target values to reflect any material differences of actual performance against the estimated position below.

	Baseline	Target %	Target	Actual	Financial Adj	Actual %		Apportion	Provider Total
2023/24 Year End Position								**A&G**	
The Princess Alexandra Hospital NHS Trust	£55,060,685	99.0%	£54,510,078	£53,950,790	-£559,288	98.0%		£543,658	-£15,630
West Hertfordshire Hospitals NHS Trust	£88,376,927	99.0%	£87,493,158	£92,302,343	£4,809,186	104.4%		£3,107,014	£7,916,199
East And North Hertfordshire NHS Trust	£85,824,697	110.0%	£94,407,166	£106,555,878	£12,148,712	124.2%		£2,480,758	£14,629,470
Independent Provider	£44,980,287	100.0%	£44,980,287	£51,969,656	£6,989,369	115.5%			£6,989,369
Non HWE Provider (API)	£119,671,304	103.6%	£124,038,788	£122,085,503	-£1,953,285	102.0%			-£1,953,285
Non HWE Provider (LVA)	£1,751,022	137.9%	£2,414,997	£2,100,347		119.9%			£0
Advice & Guidance				£6,131,430	£6,131,430			-£6,131,430	£0
NHSE Reconciliation				-£367,071	-£367,071				
TOTAL	**£395,664,922**	**103.1%**	**£407,844,475**	**£434,728,877**	**£27,199,053**	**109.9%**		**£0**	**£27,566,124**
Unallocated									£5,163,653
OVERALL ICB TOTAL	**£395,664,922**	**101.6%**	**£401,999,101**	**£434,728,877**	**£32,729,777**	**109.9%**			**£32,729,777**

The ICB Revenue Position – Month 12

HWE ICB 2023/24 Final Outturn Position

- The final year end outturn position for HWE ICB showed a surplus of £13.988m.
- The planned underspend of £9.4m was achieved at the financial year end. This achievement included providing non-recurrent HWE System support of £33.325m, allowing the System to remain in financial balance at the end of the financial year.
- The £14.5m underspend in Other Commissioned and Programme Services primarily relates to the Service Development Funding (SDF) slippage of £12.6m, which was identified as part of the H2 efficiencies.
- There are several areas of note within this position:
- Continuing Healthcare Services continues to experience increasing costs of packages of care. Work continues with delivering the efficiency schemes and these are closely monitored through a programme board
- Prescribing continues to experience significant increases in costs of drugs prescribed. Despite the delivery of the agreed efficiency schemes, these savings are being overshadowed by the cost increases being seen.

Expenditure Category	Annual Budget £'000	Outturn £'000	Variance £'000
Acute Services	1,724,739	1,725,455	(717)
Continuing Healthcare Services	171,138	175,159	(4,020)
Community Services	300,842	302,742	(1,900)
Mental Health Services	329,837	331,000	(1,162)
Delegated Primary Medical Services (GPs)	274,768	272,358	2,410
Delegated Pharmacy, Ophthalmology & Dental (POD)	135,689	135,349	340
ICB Primary Care Services	49,794	47,625	2,169
Prescribing	243,519	250,255	(6,736)
Corporate Services (Running Costs)	30,875	31,137	(262)
Other Commissioned and Programme Services	(18,732)	(33,198)	14,466
Industrial Action Funding	11,551	11,551	0
System Support	33,325	33,325	0
Current Forecast Outturn	**3,287,346**	**3,282,758**	**4,588**
Planned Underspend	9,400	0	9,400
Expected Position at Year End	**3,296,746**	**3,282,758**	**13,988**

The Capital Position - Month 12

System Capital Position Month 12

The HWE ICS received an operating capital allocation of £79.2m in 2023-24 as shown. The final outturn was £79.3m just £0.06m over allocation.

System CDEL Allocation	£'000
Capital Allocation	61,875
ENHT capital for LINACS	10,000
Additional Capital for 23/24	7,319
Total CDEL available	**79,194**

Orgn	FOT		
	Plan	Forecast	Variance
	£'000	£'000	£'000
ENHT	28,389	28,169	220
HCT	4,556	4,542	14
HPFT	10,299	10,328	(29)
PAH	14,297	14,571	(274)
WHHT	21,653	21,645	8
Total	**79,194**	**79,255**	**(61)**

	£000's
IFRS 16 Allocation	10,861
IFRS 16 Intra-Group Allocation	19,652
Total IFRS Allocation	**30,513**

IFRS16 Capital £000's	Plan	Actual	Variance
ENHT		2,104	
HCT		6,861	
HPFT		4,557	
PAH		15,734	
WHTH		639	
Total Providers	**30,513**	**29,895**	**618**

The system received an allocation to cover IFRS16 leases of £10.9m in November 2023. Following an exercise to identify the additional allocation required for Department of Health and Social Care (DHSC) group leases, a further £20m allocation was received in March 2024 – totalling £30.5m.

Final spend was £29.9m, being £0.6m underspent.

Overall, Trusts underspent their system operating capital allocation by £0.6m.

System Trusts invested £76.4m in national capital schemes.
There were lengthy discussions between NHSE and WHHT relating to the profile of its capital spend across years. WHHT brokered £10m of national capital with local capital, bringing forward its local capital plan. In 2024-25 it will use its local capital to top up expenditure in national schemes. This change in their capital profile related to CDC, pathology and endoscopy schemes.

£'000	FOT					
	ENHT	HCT	HPFT	PAH	WHHT	Total
National Capital	8,863	39	2,046	15,393	50,011	76,352

PAH also brokered local capital with national, to match the project time-scales for its CDC. Additionally, NHSE agreed to reprofile and move national capital into 2024-25 in line with the PAH New Hospital Programme (NHP) project plan.

ICB Capital Position Month 12

ICB Capital Allocation £'000	
GPIT	2,451
MH Capital Grants	647
Gigabit Allocation	23
Total	**3,121**

The ICB received a ring-fenced capital allocation of £3.1m, which was entirely spent.

Capital grants were awarded to the ICB to be spent with the MIND, after a successful bidding process with NHSE.
Additionally further capital was awarded to deliver the Gigabit work across BLMK and HWE. £23k represents the amount received for the ICB element of this work.

ICB IFRS16 Capital	£'000
Charter House	1,981
The Forum	258
IFRS 16 Total	**2,239**

The capital impact arising from IFRS16 leases in the ICB amounted to £2.2m, which was managed in NHSE centrally.

System Planning 2024-25

Comparison of HWE ICS 2024/25 Uplifts against National Assumptions

The National Growth Assumptions are shown in the light blue section. The direct comparison with the HWE ICS Growth Assumptions are shown in dark blue section. Following notification of the revised allocation values on 9 February 2024, these tables have been updated with the increase in the baseline growth of 1% and the reduction in the Convergence Factor of 20%.

The comparison shows that HWE is funded at 96.4% of the original national baseline growth uplift. The inflationary uplift of 1.9% and inflationary deflator of (1.1%) are required to remain at the same level as the national assumptions, therefore the funding available for growth moved to 3.25%, which is 95.6% of the national average growth uplift of 3.4%. The additional 1% increase in the baseline growth was nationally mandated to be applied against the increase in the Inflationary Uplift of 0.1%, against the increase in Capacity of 0.4%, with the balance to be applied against growth for both Continuing Healthcare and Prescribing.

The convergence factor for HWE is significantly higher at (1.088%), which is 123.6% of the national average convergence factor. As the purpose of convergence is to reduce the growth available and move the system towards Fair Shares of the national allocation, this reduces growth funding by 33.5%

National Baseline	3.20%	1.80%	-1.10%	2.50%	-1.10%	2.60%	2.10%	0.60%	3.10%	2.50%	5.50%	7.80%	1.60%	4.94%	2.10%
Spending Review 21						-0.30%	-0.30%		-0.30%		-0.30%	-0.30%	-0.30%		-0.30%
Additional Growth	1.00%	0.10%		0.90%	0.22%					0.90%	2.00%		2.00%		
Total	4.20%	1.90%	-1.10%	3.40%	-0.88%	2.30%	1.80%	0.60%	2.80%	3.40%	7.20%	7.50%	3.30%	4.94%	1.80%

	Base Growth	Inflationary Uplift	Inflationary Efficiency	Growth	Convergence	Ambulance Services	Acute Services	Capacity	Community Services	MHIS	CHC	FNC	Prescribing	BCF	Other Services
HWE Baseline Growth	3.06%	1.80%	-1.10%	2.36%	-1.36%	2.17%	1.70%	0.20%	2.64%	3.21%	4.91%	7.08%	3.12%	4.66%	1.70%
Additional Growth	0.99%	0.10%		0.89%	0.27%			0.40%		0.04%	2.00%		2.00%		
Total	4.05%	1.90%	-1.10%	3.25%	-1.09%	2.17%	1.70%	0.60%	2.64%	3.25%	6.91%	7.08%	5.12%	4.66%	1.70%

The specific categories of National Growth are shown in the right half of the table. There is a further reduction of the available growth through the application of the Spending Review 21 factor, which is (0.30%).

Where the National Guidance indicates a ring-fenced uplift (Capacity, MHIS, and BCF), the Spending Review 21 factor has not been applied. In addition, the Mental Health Investment Standard requires the level of investment to match the Baseline Growth of 4.05%.

Expected Allocations for HWE ICB for 2024/25

The total value of allocations which HWE ICB expects to receive in 2024/25 in shown in this table.

The Ambulance Capacity allocation (£6.93m) is a specific funding to be passed directly through to East of England Ambulance Services Trust (EEAST) and will uplift their contract value on a recurrent basis.

The Public Health baseline reset exercise funding (£2.496m) impacts only ENHT and WHTH and will be a recurrent passthrough change, which will be transacted through their respective contracts.

The Depreciation/Amortisation allocation (£12.682m) is a straight passthrough to the ICS Trusts, based on the values of depreciation charges that the Trusts are expecting to incur.

The Microsoft Licence reduction in funding (-£0.498m) affects HCT, HPFT and WHTH and will result in a reduction in their respective contract values.

HWE ICB Allocations	**£'000**
ICB Core Allocation	2,671,462
Delegated Primary Medical Care Services Allocation	272,628
Delegated Primary Care Allocation	142,404
Running Cost Allowance	25,265
Additional Discharge Allocation	12,179
Additional Physical and Virtual Bed Capacity	22,542
Ambulance Capacity	6,930
Learning disability and autism FTA	(153)
Allocation baseline reset (limited Public Health exercise)	2,496
Total ICB recurrent Allocation	**3,155,753**
Elective Recovery Funding	63,417
COVID-19 Testing	2,056
Service Development Fund (SDF)	58,348
Delegated Secondary Care Dental ERF	2,524
Charge Exempt Overseas Visitor (CEOV) and UK cross border adjustment	(1,392)
Depreciation/Amortisation - Additional Ringfenced Funding	12,682
Microsoft License Funding Transfer	(498)
Adult Long COVID	2,234
Total ICB Non-Recurrent Allocation	**139,371**
Total HWE ICB allocation	**3,295,124**

Use of ICB Resources

This table shows the planned deployment of the ICB's Core Allocation. It should be noted that this table does not indicate contract offers and only shows the ICB allocation, (excluding Primary Care Delegated Allocations and the ICB's Running Costs Allocation) and not spend and therefore does not reflect the significant financial planning gap for the ICB and Trusts.

ICB Allocation	%	ENHT	HCT	HPFT	PAH	WHHT	CLCH	EPUT - Comm	EPUT - MH	EEAST	Other NHS Trusts	ISP	ICB CHC	ICB Presc	ICB	Total
23/24 Contract Value		357,476	90,709	234,927	287,283	410,315	60,596	42,469	30,517	86,612	418,273	51,192	159,277	231,243	313,534	2,774,422
Less: ERF - Core		13,788	0	0	8,505	13,712	0	0	0	0	17,944	6,129	0	0	0	60,079
Less: Physical & Virtual Ward Capacity		2,050	4,414	0	0	2,466	0	4,091	0	0	0		0	0	1,000	14,021
Less: UEC Capacity		782	0	0	1,000	4,759	0	0	0	0	0		0	0	0	6,541
Less: COVID Testing		893	0	0	651	1,203	0	0	0	0	998		0	0	0	3,744
Less: Additional Inflationary Uplift		2,200	0	1,400	1,900	2,600	0	0	0	0	0	0	0	0	0	8,100
Less: SDF		0	1,351	10,900	0	0	1,780	670	0	0	0		0	0	33,684	48,385
Less: Other adjustments		0	1,232	11,676	0	0	0	0	0	0	0	0	0	0	1,227	14,135
2024/25 Baseline Contract Value		**337,762**	**83,711**	**210,951**	**275,227**	**385,576**	**58,816**	**37,708**	**30,517**	**86,612**	**399,331**	**45,063**	**159,277**	**231,243**	**277,623**	**2,619,417**
Inflation (net of efficiency)	1.70%	5,742	1,423	3,586	4,679	6,555	1,000	641	519	1,472	6,789	766	2,708	3,931	4,871	44,682
Efficiency	-1.10%	(3,715)	(921)	(2,320)	(3,027)	(4,241)	(647)	(415)	(336)	(953)	(4,393)	(496)	(1,752)	(2,544)	(3,054)	(28,814)
ERF - Core		13,871	0	0	8,556	13,794	0	0	0	0	18,052	6,166	0	0	2,978	63,417
Other Growth - Capacity	0.60%	2,027	0	0	1,651	2,313	0	0	0	520	2,396	0	0	0	0	8,907
Other Growth - Acute	1.70%	5,742	0	0	4,679	6,555	0	0	0	0	6,789	766	0	0	0	24,530
Other Growth - Community	2.64%	0	2,210	0	0	0	1,553	996	0	0	0	0	0	0	0	4,758
Other Growth - Mental Health	4.34%	0	0	9,155	0	0	0	0	1,324	0	0	0	0	0	0	10,480
Other Growth - Ambulance	2.17%	0	0	0	0	0	0	0	0	1,879	0	0	0	0	0	1,879
Other Growth - CHC	5.90%	0	0	0	0	0	0	0	0	0	0	0	9,397	0	0	9,397
Other Growth - Prescribing	2.23%	0	0	0	0	0	0	0	0	0	0	0	0	5,157	0	5,157
Other Growth - Other	1.70%	0	0	0	0	0	0	0	0	0	0	0	0	0	4,780	4,780
Convergence	-1.09%	(3,759)	(940)	(2,409)	(3,063)	(4,292)	(661)	(424)	(348)	(968)	(4,445)	(502)	(1,846)	(2,587)	(3,091)	(29,334)
Physical & Virtual Ward Capacity		2,050	4,414	0	0	2,466	0	4,091	0	0	0	0	0	0	1,000	14,021
UEC Capacity		782	0	0	1,000	4,759	0	0	0	0	0	0	0	0	1,979	8,520
COVID Testing		510	0	0	414	567	0	0	0	0	564	0	0	0	0	2,056
Additional Inflationary Uplift		0	0	0	0	0	0	0	0	0	0	0	3,304	4,796	0	8,100
Additional Discharge		0	0	0	0	0	0		0	0	0	0	0	0	12,179	12,179
Ambulance Capacity		0	0	0	0	0	0		0	6,930	0	0	0	0	0	6,930
SDF		0	1,351	10,900	0	0	0	0	0	0	0	0	0	0	46,097	58,348
CEOV		0	0	0	0	0	0	0	0	0	0	0	0	0	(1,392)	(1,392)
Health Inequalities		0	0	3,426	0	0	0	0	0	0	0	0	0	0	857	4,283
Long COVID		0	782	0	0	0	967	474	0	0	0	0	0	0	11	2,234
Learning disability and autism FTA		0	0	0	0	0	0	0	0	0	0	0	0	0	(153)	(153)
Microsoft Licences		0	(103)	(178)	0	(217)	0	0	0	0	0	0	0	0	0	(498)
Public Health baseline reset exercise		1,326	0	0	0	1,170	0	0	0	0	0	0	0	0	0	2,496
Depreciation/Amortisation		2,966	267	1,319	1,466	6,664	0	0	0	0	0	0	0	0	0	12,682
DEPLOYMENT OF CORE ALLOCATIONS		**361,011**	**91,248**	**233,289**	**290,116**	**414,052**	**60,061**	**42,598**	**31,676**	**95,492**	**425,083**	**51,764**	**171,088**	**239,996**	**344,827**	**2,852,303**

2024-25 HWE ICS Financial Plan

- The HWE ICS is submitted its 2024-25 financial plan on 2nd May 2024 with a System deficit of £44.9m. This is a £24.5m improvement on the flash submission of 18th April and a £36m improvement on the first submission made on 21st March. The deficit equates to <1.4% of income.
- Changes at HCT and HPFT included a reduction in the gap on external contracts of £5.6m. Whilst not resolved, and there is a risk to achievement - the ICB supports the Trusts.
- Trusts have identified a further £9m of efficiencies, productivity and Elective Recovery Fund opportunities.
- NHSE provided funding to cover additional depreciation cost and this has been updated since the last plan submission. This reduces the deficit by £6m.
- NHSE lodged £6m with the ICB at the end of 23/24 and has agreed the ICB can retain £4m.
- A deficit of £44.9m will not be acceptable to NHSE and we continue to develop a list of service reduction options that would need to be implemented to achieve breakeven. These are on slide 16.
- Furthermore, transformational changes need to be developed and delivered to secure a sustainable future and further details are set out in later slides.

	2024-25 Plan Surplus / (Deficit) 21 March	**2024-25 Plan Surplus / (Deficit) 18 April (Flash)**	**2024-25 Plan Surplus / (Deficit) 02 May Final**
	£m	**£m**	**£m**
ENHT	(4.0)	(2.0)	0.0
HCT	(4.4)	(3.8)	(2.1)
HPFT	(25.1)	(23.1)	(15.4)
PAH	(27.9)	(27.4)	(25.4)
WHHT	(22.5)	(20.9)	(13.9)
ICB	3.1	7.8	11.8
Total System	**(80.9)**	**(69.4)**	**(44.9)**

Difficult decisions under consideration to reduce deficit further

Scheme no.	Category	Scheme description	Estimated Potential benefit in 24/25 (£m)
1	Financial Plan	Phase delegated Dental recovery to £3m planned underspend (was £6m in 23/24)	3
2	Financial Plan	Withhold SDF funds that are not currently committed in contracts	3-5
3	Financial Plan	Further stretch in Trust CIP targets beyond current 5%	Each extra 1% is c£20m
4	Operational Plan	Model impact of not meeting selected community & MH targets	0-5
5	Operational Plan	Revisit additional planned UEC bed capacity	0-10
6	Operational Plan	Hold CYP ADHD activity at 23/24 level i.e. no growth and no waiting list clearance	0-5
7	Operational Plan	Phase expansion to talking therapies rollout requirement	0-5
8	Operational Plan	Phase roll-out of Mental Health Ambulances	0-3
9	Operational Plan	Pause implementation of dental and optometry screening	0-0.5
10	Prescribing	100% application of Biosimilar drug switches in Acute Trusts	0-1
11	Prescribing	Phase implementation of NICE Technology Appraisals (TAs)	0-5
12	Prescribing	Phase implemention of new NICE guideline changes	0-5

Scheme no.	Category	Scheme description	Estimated Potential benefit in 24/25 (£m)
13	De-commissioning	Reduce contributions to discretionary element of pooled Better Care Funds	0-5
14	De-commissioning	De-commissioning and consolidation of fragile services across Acute Trusts	0-5
15	De-commissioning	De-commissioning of services with low utilisation e.g. Long Covid services	1-2
16	De-commissioning	Increase thresholds for access to services and tighten POLCE guidelines	0-3
17	De-commissioning	Scope MH beds cap focussing on those with Court / MH Act detention requirements	0-3
18	De-commissioning	Review ICB contracts that end in 24/25 with a view to removing activity	0-3
19	De-commissioning	Review of Place based Local Enhanced Services (LES) with a view to reducing	0-1
20	De-commissioning	Pausing scheme for greater on the day access in S&W Herts (current in latter stages of procurement)	0.4
21	De-commissioning	Review VCFSE spend on crisis support and early help offers to re-purpose spend to support beds in HPFT	0-1
22	De-commissioning	Phase further expansion of ARRS roles in primary care	0-1
23	De-commissioning	Establishing a more restrictive pathway for access to Adult ADHD assessements including application of right to choose	0-3
24	De-commissioning	Further reductions in clinical locality leadership beyond running cost reduction requirement	0-1

*** All potential benefits are estimated and require detailed work up and profiling**

Next Steps 1 of 2

NHSE have held two further follow-up meetings to the initial Rapid Review meeting, with the objective of understanding the work being undertaken within the system to improve the planning position.

Whilst HWE has improved to a deficit of £44.9m, NHSE is clear that it needs to be working towards break-even.

NHSE has indicated that all systems planning for a deficit position will be moved into triple lock. Guidance around this has not yet been shared but it is expected that all investments above a threshold level (potentially £50k tbc) will need to be approved by NHSE.

It is unclear whether a further planning submission will be required for systems posting a deficit, however there will be a close-down meeting held by NHSE with HWE on 23rd April to review the plan and look at what else can be done to move to a break-even position.

The HWE Executive has approved (on 28th April), an extension to the double lock process in the ICB, facilitated by a panel which will be known as the Financial Scrutiny Panel, with a broader remit than the original panel. This panel will:

- Take any remaining decisions required to finalise the business planning process
- Be an additional point of approval for any proposed spend that does not have a source of funding
- Act as an additional level of approval for all requests to utilise new funding from external sources, to initiate new work
- Act as an additional level of approval for all proposed commissioning committee papers proposing spend.

The Financial Recovery Board will continue to run throughout 2024-25, offering review and challenge to all financial recovery actions. This will have attendance from members of the ICB Executive as well as Chief Finance Officers and other Operational Executives of System Trusts and be chaired by the Chief Executive Officer of the ICB.

There will be a more proactive approach to co-ordinating, monitoring and reporting the ICB efficiency programme, with an Executive Cost Improvement Plan (CIP) Director leading this work.

Next Steps 2 of 2

There are currently five financial recovery workstreams that are being developed, to create savings across the system, to improve the financial position in 2024-25 and beyond.

FRP work stream 1 – Improving productivity
Drive up productivity, reduce variation and create room for maximisation of elective recovery fund (ERF) income. This work stream will look at theatre optimisation, reducing length of stay, optimising outpatient procedures and utilisation of virtual ward.

FRP work stream 2 – Manage workforce growth and reduce agency spend
Improve the productivity of our workforce; employ fewer people more cost effectively through the development of the primary and community workforce. This work stream will look at skills mix, safer staffing ratios, job planning, agency staffing and vacancy controls.

FRP work stream 3 – Transformative approach to managing frail and elderly
Reduce frailty non-elective activity, develop and implement best practice models for managing care closer to home, maximise same day emergency care, increase advanced care planning and end of life management and optimise prescribing.

FRP work stream 4 - Transformative approach to managing growth and costs in Mental Health & Learning Disability & Autism Services
Implement a range of initiatives to manage growth and the use of premium contracted beds, maximise use of the new crisis centre, agree an approach to investing in the backlog clearance and managing bed flow.

FRP work stream 5 - Secure better value from contracts and increase efficiency
Continue to review all commissioned contracts, decision making processes around high-cost complex cases and clinical thresholds to improve outcomes. Identify best use of estate and excess estate for disposal. Look at opportunities for sharing back-office functions.

ICB Planning 2024-25

HWE ICB – Bridge showing movement from 2023/24 Outturn to 2024/25 Plan

The table to the right shows the movements from the 2023/24 Outturn to the Final 2024/25 Plan.

This shows the ICB exited 2023/24 with an underlying deficit position of £14.5m, which is largely driven by the continuing increases in costs and demand for both the Prescribing and Continuing Healthcare (CHC) services.

From a planning perspective, the incremental increases in income are expected to be spent at the same levels. The exception to this is the increase of funding for the recognised demand and price pressures in both Prescribing and CHC (£6.6m).

The HWE System has agreed to apply a 5% Efficiency Target. For the ICB, the nationally mandated efficiencies of Inflation Deflator (1.1%), Convergence (1.09%) and Spending Review reduction (0.3%) will be passed on to all NHS Providers. These efficiency requirements are shown within the netted Inflation and Growth income increases in the table. The Running Costs efficiency requirement equates to 20% of the total Running Costs Allocations (£4.5m)

Following additional instructions from NHS England, there have been two adjustments to the ICB plan: the benefit from the reduction in the contractual inflationary uplifts from 1.9% to 1.7% without the subsequent reduction in allocation and the confirmation that, of the £6m funding lodged with the ICB at the end of 2023/24, only £2m is required to be returned.

HWE ICB Bridge from 2023/24 Outturn to 2024/25 Plan

	£'000
HWE ICB 2023/24 Outturn	**13,988**
Adjusted for Non-Recurrent Items:	
Slippage on SDF schemes	(12,184)
Slippage on Delegated Dental Services	(5,372)
Release of Balance Sheet flexibilities	(5,889)
Efficiencies delivered non-recurrently	(5,000)
2023/24 Underlying Deficit	**(14,457)**
Incremental Increase in Income for 2024/25	
Net Inflationary Uplift	15,909
Growth less Convergence	19,172
Service Development Funding (SDF)	10,067
UEC and Capacity	9,008
Elective Recovery Services (ERF)	3,505
Primary Care Delegated Budgets	16,575
Running Costs Reduction	(4,475)
Other ICB Income	12,728
Total incremental increase in income	**82,489**
Incremental Increase in Spend for 2024/25	
Contractual increases for Inflation	(15,909)
Contractual increases for Growth	(19,172)
Service Development Funding (SDF)	(10,067)
UEC and Capacity	(9,008)
Elective Recovery Services (ERF)	(3,505)
Primary Care Delegated Budgets	(15,575)
Running Costs Reduction	4,475
CHC and Prescribing - demand/price increases	(6,589)
Other costs	(12,728)
Efficiency Target	24,165
Total incremental increase in spend	**(63,913)**
2024/25 Financial Plan	**4,119**
Subsequent Adjustments to Plan	
Reduction of 0.2% Inflationary Uplift	3,700
2023/24 Brokerage not required to be repaid	4,000
Finalised 2024/25 Financial Plan	**11,819**

HWE ICB - 2024/25 Financial Plan by Category of Spend

Initial Submission: The ICB submitted its first formal high-level plan on 29 February 2024, which showed a £14.5m deficit plan and included an efficiency programme of 3% and an underlying deficit exit rate from 2023/24 of £14.5m.

Interim Submission: The subsequent interim submission on 21 March 2024 improved the planned deficit position by £11.4m, showing a £3.1m surplus, which was predominantly achieved by increasing the efficiency target to 5%. HWE ICB has the highest level of efficiencies in the East of England Region. There was a late change in the inflationary uplift percentage, which was expected to improve the ICB's position and have a nil impact on the Trusts; this delivered a further £3.7m improvement, bringing the ICB to a planned surplus position of £6.8m.

Final Submission: The final submission on 2 May 2024 will show the ICB to be planning an underspend of £11.8m, which is a further improvement for the HWE System's financial position of £5m. This is due to an additional efficiency target applied to Primary Care Services of £1m and the agreement from NHSE that of the £6m of funding lodged with the ICB, only £2m will need to be returned.

HWE ICB Planned Budgets for 2024/25	2024/25 Financial Plan £'000
Acute Services	1,691,165
Mental Health Services	314,768
Community Services	313,694
Delegated GPs	272,628
Prescribing	239,211
Continuing Healthcare Services	169,746
Delegated POD	144,928
Primary Care Services - ICB Core	44,786
Running Costs	25,265
Other Commissioned and Programme Services	67,113
Reserves	0
TOTAL EXPENDITURE	3,283,305
Total Allocation	(3,295,124)
Financial position - Over/(Under)	(11,819)

Impact on Health and Care Partnerships – 2024/25 Financial Plans for the Trusts

Deficit shown by Health and Care Partnership (HCP):
This table takes the value of the deficit financial plans for each Trust within the ICS and allocates it to the relevant HCP based on the value of the three predecessor CCGs' contracts.

HWE are expected to reach a balanced position for the final Planning Submission on 2 May 2024, which will require a range of solutions to move the current deficit position of £44.9m **and** deliver the 5% efficiencies currently in each Trust and ICB's Financial Plans (c£155m).

Organisation	ENH HCP	SWH HCP	WE HCP	MH&LD HCP	TOTAL
	£m	£m	£m	£m	£m
ENHT	0.0	0.0	0.0		**0.0**
HCT	(1.7)	(0.3)	(0.0)		**(2.1)**
HPFT				(15.4)	**(15.4)**
PAH	(9.2)	(0.0)	(16.2)		**(25.4)**
WHTH	(0.2)	(13.7)			**(13.9)**
Total Deficit	**(11.1)**	**(14.1)**	**(16.2)**	**(15.4)**	**(56.7)**

Capital Planning 2024-25

Capital Plan 2024-25

The ICS has a capital allocation of £83.4m in 2024-25 excluding any capital for national schemes.

This is made up of system operating capital of £61.9m, which is the same value as 2023-24, without any growth or inflation being added.

The system will receive bonus capital for breaking even in 2023-24 of £3.7m, being less than the bonus capital received in 2023-24 (£7.3m). Additional requirements have been put into place for bonus capital in 2024-25, relating to UEC performance, which the system did not achieve. This additional requirement was not in place in the previous financial year and the system has therefore not benefitted to the same extent.

	2023-24 £'000	2024-25 £'000
Operating Capital Allocation	61,875	61,875
Bonus Allocation	7,319	3,654
Linac Allocation - ENHT	10,000	
IFRS16 Allocation	30,513	15,439
Total Provider Capital Allocation	**109,707**	**80,968**
ICB GPIT Allocation	2,451	2,448
MH Capital Grants	647	-
Ggigabit Pathway	23	-
Total System Capital	**112,828**	**83,416**

ENHT received an exceptional allocation of £10m in 2023-24 for LINAC replacement.

Capital relating to IFRS16 has been allocated to the HWE system of £15.4m. This compares with £30.5m that was made available in 2023-24. It should be noted the original allocation in 2023-24 was £10.9m with a further £19.7m coming late in the year, relating to intra-DHSC leases. Guidance around intra-DHSC leases is not yet available from NHSE for 2024-25. It has been made clear by NHSE that Systems should not assume any further capital.

The ICB has £2.4m of capital which will be spent to support GPIT. This is ring-fenced for the ICB and cannot be used by providers to support their capital programme.

This capital excludes national capital allocations and any capital grants that have been agreed by NHSE.

Currently there are MOUs in place for £53.7m of national schemes in PAH and WHHT. This relates to the community diagnostic centre, electronic health record, new hospital programme and diagnostic digital capability in PAH. WHHT will be investing in the elective care hub, community diagnostic centre, endoscopy unit and new hospital programme.
Further national capital may be made available in-year, but this is not yet confirmed.

Capital Plan 2024-25

The joint capital use resource plan is being finalised for publication. This describes how capital will support the System to deliver its priorities and benefits to patients and health care users.

It should provide transparency for local residents, patients, NHS work-force and other NHS stakeholders on how the system will achieve its strategic aims, whilst adhering to its financial duty to remain within its capital allocation and not overspend.

The plan will be published on the ICB's website and made available to NHSE and health and well-being boards.

The system is developing a capital prioritisation process, being led by the Chief Finance Officer of HPFT on behalf of the System Finance Directors. This will look at capital plans for the next 5 years and use a prioritisation approach to ensure the system invests in the right capital and estate to meet its strategic aims, maximises benefits for patients and health care users, whilst keeping its service delivery safe. This will move away from the current approach which mirrors the national allocation formula originally used by NHSE to allocate capital directly to Trusts. It will be more strategic in looking forward a number of years, with a pipeline of capital in place that will be constantly updated and reviewed.

The current financial year will act as a shadow year to test this prioritisation framework, with all Trusts working together to deliver an effective model.

Trusts are finalising their 5-year capital plans, and these will be shared with appropriate committees and boards.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

<table>
<tr><td rowspan="2">Meeting:</td><td colspan="2">Meeting in public</td><td>☒</td><td colspan="2">Meeting in private (confidential)</td><td>☐</td></tr>
<tr><td colspan="3">NHS HWE ICB Board meeting held in Public</td><td>Meeting Date:</td><td colspan="2">24/05/2024</td></tr>
<tr><td>Report Title:</td><td colspan="3">ICB Committee Summary Reports</td><td>Agenda Item:</td><td colspan="2">12</td></tr>
<tr><td>Report Author(s):</td><td colspan="6">Governance Leads, HWE ICB</td></tr>
<tr><td>Report Presented by:</td><td colspan="6">Committee Chairs / Executive Leads</td></tr>
<tr><td>Report Signed off by:</td><td colspan="6">Michael Watson, Chief of Staff</td></tr>
<tr><td>Purpose:</td><td>Approval / Decision</td><td>☐</td><td>Assurance</td><td>☐</td><td>Discussion</td><td>☐</td><td>Information</td><td>☒</td></tr>
<tr><td>Which Strategic Objectives are relevant to this report
[Please list]</td><td colspan="6">▪ Increase healthy life expectancy, and reduce inequality
▪ Give every child the best start in life
▪ Improve access to health and care services
▪ Increase the numbers of citizens taking steps to improve their wellbeing
▪ Achieve a balanced financial position annually</td></tr>
<tr><td>Key questions for the ICB Board / Committee:</td><td colspan="6">N/A</td></tr>
<tr><td>Report History:</td><td colspan="6">N/A</td></tr>
<tr><td>Executive Summary:</td><td colspan="6">Each ICB Sub-Committee has produced a summary document providing an update from the last meeting.
<table><tr><th>Committee</th><th>Date of meeting</th><th>Chair</th></tr><tr><td>People Committee</td><td>21 March</td><td>Ruth Bailey</td></tr><tr><td>Primary Care Board</td><td>28 March</td><td>Nicolas Small</td></tr><tr><td>Quality Committee</td><td>02 May</td><td>Thelma Stober</td></tr><tr><td>Commissioning Committee</td><td>16 May</td><td>Gurch Randhawa</td></tr><tr><td>Patient Engagement Forum</td><td>14 May</td><td>Alan Bellinger</td></tr></table></td></tr>
<tr><td>Recommendations:</td><td colspan="6">The Board is asked to note the contents of the report.</td></tr>
</table>

Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A			
Implications / Impact:				
Patient Safety:	*n/a*			
Risk: *Link to Risk Register*	*n/a*			
Financial Implications:	*n/a*			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***		N/A	
	Quality Impact Assessment:		N/A	
	Data Protection Impact Assessment:		N/A	

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document

NHS Hertfordshire and West Essex Integrated Care Board

People Board : 21st March 2024	
Signed off by Chair and Executive Lead:	**RB, TM**
Key items discussed: *(From agenda)*	• Workforce transformation report – operational planning update • Workforce risk and assurance report • Financial recovery and productivity tool • System and regional growth ambition (Long term training expansion) • Volunteering for health bid
Key points made / Decisions taken:	**Operational Plan –** March submission forecasts an overall **3%** reduction in system workforce against current staff in post over next 12 months; ENHT -5%, HCT -0%, HPFT +1%, PAH -4%, WHHT -3%. Bank and agency overall reduction of **-16%**; ENHT -18%, HCT -4%, HPFT -12%, PAH -30%, WHHT –11%. Working towards ambitions with a number of high impact actions. Further asks for the system to explore efficiency and productivity. Next regional and national review of the operational plan due on 2nd May. HRDs to discuss further monitoring to feed into regional and national assessments. Need to triangulate local authority and health reductions. Delivery to be tracked through regular Workfroce Transformation reports. **Workforce Risk and Board Assurance Framework Report -** 8 risks that are rated 12+, 2 risks rated at 16+. 2 highest rated risks relate to key staff shortages affecting capacity / product productivity and financial recovery. Health and Wellbeing risk will need further exploration re cessation of Here for You and potential impact on sickness absence. Good progress on re-banding risk (rated 12), further work relating to backpay aspect. Consideration of risk relating to CQC and integration of Health and Social Care. **Financial Recovery and Workforce Productivity Diagnostic Tool -** Tool used to understand differences in workforce establishment and productivity across acute settings aiming to; Benchmark variation in workforce vs cost weighted activity growth between 19/20 and 22/23, Self-assess where the workforce has been deployed (including national schemes and locally driven change), Use with quintiles data to identify top drivers of variation, e.g. sickness absence, retention, e-rostering/job-planning and identify key actions and opportunities to address unwarranted variation. Received positively by People Board. Tool only accounts for substantive workforce and some discrepancies exist in the data, staff breakdown is currently slightly crude, more detailed analysis is required but had been paused to prioritise operational planning. Agreed further work on data integrity, would like to extend the tool to community and mental health. Outputs will help identify key actions to feed into both individual Trust and wider system improvement plan. **System and Regional Growth Ambition -** 3 core pillars: Train, Retain and Reform with aspirational targets for 2031. Submission due at the end of July. EoE provide 8% of national training places, this should be 12% based on

	size/population. Need to increase domestic supply. Need to deliver on DOH priorities; clinical expansion, apprenticeships, medical expansion, retention, clinical reform, medical reform and productivity. National team provided 4 models for the system to consider utilising; population demand, current staffing, resource allocation and distribution model. Further discussion within the system between now and July to identify long term growth ambition, identify data needs and any areas for regional support. **Volunteering for Health bid** – CVS has submitted a bid for Volunteering for Health fund monies. 3 key outcomes are; increasing number of volunteers and demonstrate more effective use, develop a better understanding of barriers to volunteering and address health inequalities and improve life chances, provide a fully integrated offer wrapping around the needs of the beneficiary, not the bureaucratic needs of the Trust, Dept or Charity. CVS will understand outcome in May. Success will require the system to work together and agree protocols.
Forward plan issues:	Final operational plan to be discussed at next People Committee
Date of next meeting	16 May 2024

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

ICB Committee Summary Document

Primary Care Board – Thursday 28 March 2024	
Signed off by Chair and Executive Lead:	**Nicolas Small and Avni Shah**
Key items discussed: *(From agenda)*	• **Questions from the public** – none received. Noted the work taking place with the patient engagement forum and an upcoming meeting to discuss areas of work to be explored and opportunities through this. • **Directorate Highlight Report** - MMR vaccination: work was ongoing by general practices to identify cohorts where there is low uptake. Pop up/outreach clinics were being offered by our community providers Hertfordshire Community Trust (HCT) across HWE. All providers and partners within the system were considering the necessary steps in the event of an outbreak. • The deadline for applications to Assura for funding for PCN health inequality projects in partnership with the voluntary care sector was 15 March, applications would be reviewed by a panel. • The website review of all practices would be completed by the end of April by ICB; feedback is to be shared with practices to highlight areas for improvement. • National update on GP contract 2024/25 had been published recently. It was noted that the uplift was not in line with inflation and there was the possibility of industrial action. Advanced telephony continued to be rolled out. National data sets were being collected to understand demand activity (not just delivery). • Dental recovery plan: ongoing. The focus was on dental prevention particularly in deprived areas. New incentives within the contract had been created to attract those patients who had not been seen in the last two years. • Pharmacy First scheme had now launched. Inevitably there had been some teething issues and these were being addressed, eg some pharmacies were still waiting for equipment. • The National Referral to Treatment (RTT) Waiting List Review – GP Pilot in Stort Valley and Villages PCN had been delayed by one month. • **Primary Care Transformation integrated reports** SWH • The Hertsmere Minor Illness Hub project had been approved and was at the procurement stage - the go-live date was mid-May. • Advance Telephony - 12 practices were moving from analogue to digital during March/April. • Progress was being made on the ECF in the following areas:

	• End of life; identification of preferred place of death.
	• Diabetes – improvement in 8 care processes
	• Increase in referrals for weight management services and social prescribing.
	• Prevalence work on Hypertension across a number of practices
	
	ENH
	• Development of INT work on health and care partnerships with a focus on end of life, dementia. Meetings were planned with district and borough councils to further support INT links.
	• Example of good practice to highlight: Hitchin and Whitwell – a dedicated neurodiversity webinar took place on 14 March with excellent attendance of 120+ people, the team delivered a 30mins talk followed by a Q&A session.
	
	WE
	• 14 practices (out of 30) have now been accredited on the veteran friendly programme.
	• Development plan in place to increase 40+ health checks.
	• The (Harlow) integrated urgent care treatment centre was now in phase 2.
	• Example of good practice: the six INTs were at different stages of development but were all delivering proactive care linked to HCP place prioritise e.g. frailty and end of life.
	
	• **Primary Care workforce data – progress update**
	  • Workforce recruitment and retention was a key issue for everyone within the system with challenges noted across other sectors.
	  • Workforce was growing but not at the national target rate of 6%. There had been a decline in GP partners against a total population increase of 1.3%.
	  • Challenges include, estates, training new staff and recruitment of ARRs.
	  • The ICB is proactively working to support in areas such as, expansion of fellowships, new practice programme, GP trainee support programme, support meetings, expansion of PCN training teams and communications toolkit for practices on ARRS is about to be launched.
	
	• **Progress on Recommendations from the Healthwatch Commissioned Reports**
	  • Update report highlighting developments related to:
	  ○ Cloud based telephony; engagement events with carers had been held.
	  ○ Training needs had been identified.
	  ○ ICB staff were working with practice to review patient experience.
	  ○ Assessment of practice websites.
	  ○ Development of NHS app.
	  ○ Future reports for the coming year would include orthodontics.

	• **Year End report on the Patient Association Project**
	  ○ The project had provided the training/tools and support needed to establish Patient Participation Groups and ensure they met the needs of the patient population and the NHS effectively.
	  ○ The value of co-production within the wider community was well established and the Patient Association Project had helped establish links between primary care network leads and the wider community through buddy schemes, the Patient Engagement Forum and Advisory Board.
	  ○ Focus areas for the coming year include, promote awareness of PPGs, develop accessibility and inclusivity, support practice managers and improve communication channels.
	
	• **Update from the HWE Primary Care Citizen Representative**
	  ○ The Patient Engagement Forum (PEF) had been established in June 2023. This now had c20 members and included the three citizen representatives, patients, Healthwatch and ICB staff.
	  ○ The PEF acted as an advisory group to the Primary Care Board, posing questions and making suggestions – not all PC related but always health related.
	  ○ Each patient citizen worked with their own PPG, helping to arrange the many activities and events; e.g. LC had recently organised a webinar about Pharmacy First.
	  ○ The PEF had input/discussions on a diverse range of different topics in the last year and saw themselves as collaborative partners.
	  ○ Challenges around public perception and trust in the NHS were well publicised. Developing a wide network of patient groups to extend reach and diversity would only help improve this perception and create a free flow of information.
	  ○ Aim: Every GP practice to have a meaningful PPG and build a closer working relationship with ICB communications teams and ICB Youth Council.
	
	• **Primary Care Risk Register**
	• GP contract: threat of industrial action/risk to resilience and capacity. This also could apply to community pharmacy/optometry and dentistry as and when these contracts were reviewed.

Forward plan:	12 months since launch of Primary care Recovery Plan; Progress of primary care digital and show case the examples
Date of next meeting:	Thursday 23 May 2024

Hertfordshire and West Essex Integrated Care System

ICB Quality Committee Summary Document

NHS Hertfordshire and West Essex Integrated Care Board

Quality Committee – Thursday 02 May 2024	
Signed off by Chair and Executive Lead:	**T Stober / N Hammond**
Key items discussed: *(From agenda)*	• ICB Quality Committee Governance • ICB Quality Dashboard • ICB Quality Escalations Report (inc. National Patient Safety Strategy update) • Quality Accounts process and statements • Sensory Strategy • Focus area: Infection, Prevention and Control • SEND Quality Assurance & Improvement Framework • ICB Continuing Healthcare Report • ICB Risk Register (Nursing & Quality) and Strategic and Corporate Risk Register (Quality related) • Feedback from Patient Subgroup • Minutes/Summary from sub-groups
Key points made / Decisions taken:	• **ICB Quality Committee Governance** – committee noted a relatively low response rate to the annual committee effectiveness survey. However, the responses received are positive and provide feedback and suggestions for the new committee such as engagement through face to face sessions and focused report content. • System Transformation and Quality Improvement Committee Terms of Reference – for information. • Work plan – draft committee work plan – for information. **ICB Quality Dashboard** – the new dashboard will focus at System level and Place to provide an overview of Quality. • Focus areas include, CQC ratings for care home and home care and information relating to carer identification within Primary Care. • Future reports will combine quality and performance. • **ICB Quality Escalations Report (inc. National Patient Safety Strategy update)** • Hertfordshire SEND inspection has been completed, Essex to take place soon. • Focus areas include, paediatric audiology, measles roundtable event held in April, PSIRF, Pressure Ulcer, Venous Thrombosis, workforce and ophthalmology. • **ICB Continuing Healthcare Report -** Update report providing overview of the key work taking place across CHC team including challenges, current improvement work and risks with associated mitigations. Future report to include benchmarking information. • **ICB Risk Register (Nursing & Quality) and Strategic and Corporate Risk Register (Quality related)** • A reduction in numbers of risks with transfer of risks to relevant teams and will remain part of the quality oversight. • Regular meetings taking place to discuss ICB & system risks to ensure robust oversight and mitigations are in place.

	• **Quality Accounts process and statements** - Annual report depicting the quality of services provided by healthcare providers, enables providers to showcase how their organisation has overseen the quality of care and patient safety over the year. • The report highlights what is positive in terms of outcomes, but also to provide transparency in terms of areas and plans requiring improvement. • The committee agreed recommendations sign off of accounts. • **Sensory Strategy** – presentation led by the Sensory services team in HCC to address inequalities faced by residents with sensory needs. • The strategy aims to bring together all different groups involved in supporting residents with needs to address the short falls often experienced. The health action plan has been developed to identify areas for improvement and will be rolled out across Primary Care to gather a clearer picture of future needs. • Its aim is to review the quality assurance of health providers across Hertfordshire in relation to access to sensory services. • Improving access to interpreters, raising awareness, improvement of Low Vision Pathway and improving access to mental health services for deaf residents. • **Focus area: Infection, Prevention and Control** - Presentation provided a summary regarding the purpose and vision of the HWE ICS IPC 5-year strategy. Identifying eight priorities agreed by system partners and has been underway for 18 months. Developed in conjunction with the ICS Quality Strategy. The vision going forward is a more collaborative cohesive way of working to provide specialist care, to reduce the impact of health associated infections across the system, adopting and promoting a positive culture, reviewing learning and sharing findings. • **SEND Quality Assurance & Improvement Framework -** There are a number of streams of work, particularly in health, relating to children and young people, how their voices are heard and their lived experiences. Working through these via quality system, and strategy, along with quality visits to bring the voice of the child and young person and parents into the review and improvement work. • Committee requested to receive update reports on implementation, progress and risks/challenges. • **Feedback from Patient Subgroup** – Quality sub-committee renamed to Quality Patient Group. • The group are now better informed as members about which patient groups and other forums they are representing and are developing the purpose of the group. • They will look at what practical steps might be taken to form an influential and dynamic relationship between this Committee and the Quality Patient Group. • Future deep dives at Committees will include voice of the patients via the Quality Patient Group. • **Minutes/Summary from sub-groups - for information**
Board to note:	As above
Forward plan:	Next meeting to be held in person with a development session in the afternoon to be focused on the transition into the new System Transformation and Quality Improvement Committee. Deep Dive: Maternity
Date of next meeting	Thursday 04 July 2024

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

ICB Committee Summary Document - Public

Commissioning Committee – 16th May 2024	
Signed off by Chair and Executive Lead:	• **Gurch Randhawa** • **Elizabeth Disney**

Key items discussed:
(From agenda)
	• Minutes from 14th March 2024 noted with no amendments sought – approved.
	• Action Log – noted and discussed with updates received.
	• Governance Update – noted.
	  • Committee received and discussed the Effectiveness Survey for this Committee. The work forms part of an annual monitoring cycle and has been mirrored for all ICB Board sub-committees.
	  • Noted that survey was circulated to 18 Committee members and completed by 6 – one suggestion received concerned having time assigned at the end of the Committee to ensure it is completed.
	  • The Committee received the ICB Strategic Finance and Commissioning Committee Terms of Reference – document approved by Board when it sat in April 2024.Discussion surrounding mirroring committee in HCP's – flagged watch that the same conversations are not being had both at ICB and HCP.
	  • Committee received draft work plan for the ICB Strategic Finance and Commissioning Committee.
	• Outcome of ICB Business Planning Process 24/25 – paper received for information. By early next week an update will be shared with the Committee. Noted.
	• Service Review for Long Covid – approved.
	• Evidence Based Interventions, Clinical Policies & IFR.
	  • To approve the new policy/prescribing guidance and addition to formulary of Trans-Anal Irrigation Devices – approved.
	  • To approve the withdrawal of the Ultrasound guided injections policy – approved.
	  • To note that Dexcom G6 and G7 CGM devices now have the same cost and functionality so applications are being approved if the criteria for either are met. Noted.
	  • To note the Clinical Policies Group Dec 23 meeting minutes. Noted.
	  • To note the EBI and IFR team quarter 3 report. Noted.
	• Primary Care Commissioning Report – Committee updated on key areas. Noted potential conflicts by colleagues within the Committee. Committee not being approached for approval but noting.

Key points made / Decisions taken:	In addition to the above, discussion with feedback surrounding HWE ICBs current Governance Review and future structure of this meeting.
Committees to note:	Outcome of ICB Business Planning Process 24/25 – further updates to be received by the Committee prior to the start of HWE ICBs new Strategic Finance and Commissioning Committee.
Board to note:	As noted above.
Forward plan issues:	In support of continuity - for care to be taken in transition to the new Strategic Finance and Commissioning Committee, with ongoing matters.
Date of next meeting	11th July 2024 – sitting as the new Strategic Finance and Commissioning Committee.

Hertfordshire and West Essex Integrated Care System

ICB Meeting Notes and Actions

NHS Hertfordshire and West Essex Integrated Care Board

Patient Engagement Forum (PEF) – 14 May 2024		
Signed off by Chair and Lead:	**Patient Chair: Alan Bellinger / Michael Watson, Chief of Staff**	
Members and Attendees:	**Patient representatives** Joy Das, Citizen representative, Primary Care Transformation Group Kevin Minier – Vice Chair (shared South and West Herts Health and Care Partnership Co-production Board patient representative) Michael Carn (East and North Herts Community Assembly patient representative) Leighton Colegrave (ICB Primary Care Transformation Group Citizen representative, East and North Herts) Alan Bellinger- patient Chair (ICB Buddy Scheme patient representative) Fiona Corcoran (Deputy CEO Healthwatch Herts) Justin Jewitt (Patient Safety Partners and Quality Committee patient representative) Rita Dovey –– West Essex Carers network, PAH patient panel Andrew Smith – Herts service user representative, Viewpoint Sam Glover – CEO Healthwatch Essex Helen Clothier, Patient representative South and West Herts Leigh Hutchins, WHTH Patient Panel Meg Carter, Chair Quality patient group Paul Campion, Quality patient group Marianne Hiley (Citizen representative on ICB Primary Care Transformation Group, South and West Herts)	**Herts and West Essex Integrated Care Board staff** Michael Watson (Chief of Staff) Paul Burstow (ICB Chair) Lauren Oldershaw (Senior Communications and Engagement Officer) Heather Aylward (Engagement Manager) Louise Manders - Deputy Head of Communications and Engagement **Apologies** Martin Norman, John Wigley, Claire Uwins
Key items discussed: ***(From***	Main focus : discussion on questions posed to Paul Burstow in advance of the meeting: These covered: Q1 Patients at the Heart – principle 4 of the NHS Constitution	

agenda)	Q2 Acute Care: cancelled appointments, long waits and poor estate Q3 GP Variable Services: queue systems, triage processes, transactional relationships Q4 Mental Health – demand, SEND Q5 Continuous Improvement Q6 Social Care- - delayed hospital discharges, continuing healthcare waiting lists and long waits for social care **Updates from the PEF working Groups:** • **Primary Care** • **Mental health** • **Secondary care and community** • **Communications group** • **Networking task and finish group –** recently established PEF Facebook group which has 160 members, this to be used to communicate and hear the patient voice, in addition to the ICB's patient network of 700+.
Agreed Actions:	• PEF session to be organised around financial challenges. • Paul Burstow to discuss opportunities for Non Executive Directors to follow up on PEF questions • PEF question responses to contain relevant data. PEF to work with the Board for more detailed discussions. • Discussion with Avni Shah on how to ensure patients have easily available and transparent information on GP practice performance. • PEF to help promote ARRS roles • Inform PEF on the metrics and evaluation process for the SEND improvement plan. • Hospital discharge data to be shared with PEF • Paper to be developed on what PEF can do to provide support to patients when deciding on a GP practice. Scope to discuss. Democratic across the PEF, all having input into. To be drafted and all members to input.
Items for escalation / Committees / Board to note:	Board to note PEF activity and commitment to broadening their networks and bring the patient voice to discussions.
Date and time of next meeting:	Face to face meeting: 10 June • Building relationships with Trust patient panels • Taking forward the PEF TOR, building networks, questions to the Board

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	NHS HWE ICB Board meeting held in Public				**Meeting Date:**	**24/05/2024**	
Report Title:	**Hertfordshire and West Essex Medium Term Plan**				**Agenda Item:**	**13**	
Report Presented by:	Michael Watson, Chief of Staff						
Report Signed off by:	Jane Halpin, Chief Executive						
Purpose:	**Approval / Decision**	☐	**Assurance**	☒	**Discussion**	☒	**Information** ☒
Which Strategic Objectives are relevant to this report	• Increasing Healthy Life Expectancy and reduce inequality. • Give every child the best start in life. • Improving access to health and care services • Increasing the number of citizens taking steps to improve their health and wellbeing • Successfully deliver our financial plan each year						
Key questions for the ICB Board / Committee:	The Board is asked to agree the Hertfordshire and West Essex ICB Medium Term Plan.						
Report History:	The Board initially discussed the Medium-Term Plan at its board day in February. Work has subsequently taken place to develop the plan, in consultation with colleagues from within the ICB and across the Integrated Care System.						
Executive Summary:	Since its formation in July 2022 the Hertfordshire and West Essex Integrated Care Board has worked with system partners to develop a broad range of system wide plans and strategies that are making an impact- for example on Urgent & Emergency Care, our People Plan, our Primary Care Strategy and our Digital Strategy and Community Services Review. The Medium-Term Plan builds on this work, by exploring the key challenges facing the system for the remainder of this decade, and setting out our vision for overcoming them- focusing on achieving five ambitions that would deliver that vision and lead to a significant change in the way that we deliver health and care in Hertfordshire and West Essex. The Medium-Term Plan also confirms how we will we work with partners to achieve this. That shift will manifest itself in three ways:						

<table>
<tr><td></td><td colspan="4">A move from reactive acute care to preventative, anticipatory and community -based care
From a siloed and poorly coordinated model to continuous, integrated care
From a model based on providing care to one where active patients are engaged in self-management and collaborative care planning.</td></tr>
<tr><td>Recommendations</td><td colspan="4">To note Executive Summary highlights as reported to Performance Committee</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
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<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4"></td></tr>
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<tr><td colspan="2">Data Protection Impact Assessment:</td><td colspan="2">N/A</td></tr>
</table>

Overview

The Hertfordshire and West Essex Medium Term Plan will set the direction of the ICBs work for the remainder of this decade. It details our approach to meeting our immediate operation and financial challenges, whilst delivering a new approach which would see us move from :

- Reactive acute care to preventative, anticipatory and community-based care.
- A sometimes siloed and poorly coordinated model to continuous, integrated care.
- A model based on providing care to one where active patients are engaged in self-management and collaborative care planning.

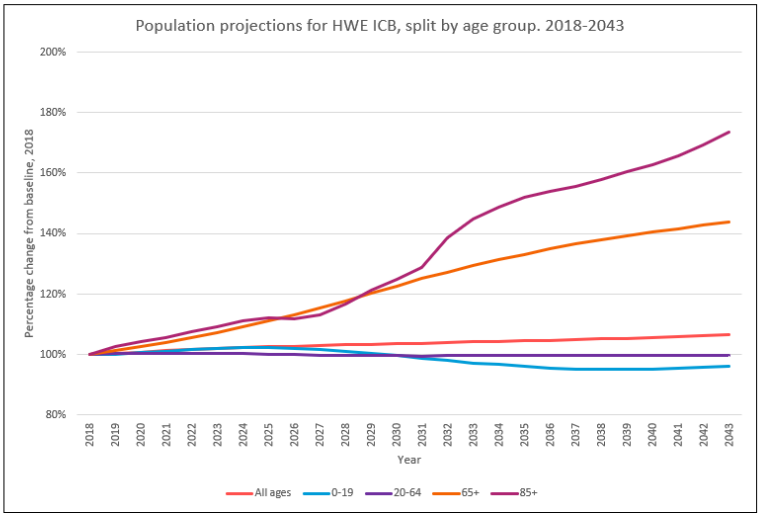
The plan sets out our approach to delivering this change and will guide our work in the years ahead. It also sets out our approach to partnership working within the system, which is critical to our success.

Our future challenge

There are four key challenges facing the Integrated Care System in the six years ahead. The first is the projected change in the demographics of our system. We will see a dramatic increase in our elderly population, with the associated challenges to health and care that increase will lead to.

Demographic Profile and Segmentation

- The population of the HWE ICB is expected to increase by 6% overall between 2018 and 2043.
- There will be significant differences in growth across age bands.
- Whilst there will be limited growth (or reductions) in children and working age adults, there will be significant growth in over 65 year olds and very significant growth in over 85 year olds.
- There is a sharp incline in the number of people aged over 85 years after 2030 as 'baby boomers' age.



The second is the areas of inequality that exist in our system, with the potential for the gap in health and other outcomes to increase in the years ahead.

Life Expectancy – Variation at local level

Better 95% Similar Worse 95%

	Indicator Name	Time period	England	East of England	HWE ICB	Broxbourne	Dacorum	East Hertfordshire	Epping Forest	Harlow	Hertsmere	North Hertfordshire	St Albans	Stevenage	Three Rivers	Uttlesford	Watford	Welwyn Hatfield
OF	Life expectancy at birth - (Male, 3 year range)	2018/20	**79.4**	**80.2**	**80.6**	79.6	81.1	81.6	80.4	78.6	79.5	81.1	81.8	79.5	81.2	82.6	79.3	80.6
OF	Life expectancy at birth - (Female, 3 year range)	2018/20	**83.1**	**83.8**	**84.1**	84.0	84.0	85.0	84.0	82.5	84.0	84.2	85.4	82.8	84.3	85.4	82.7	83.8
OF	Life expectancy at birth - (Male, 1 year range)	2021	**78.7**			79.5	80.5	80.8	80.1	78.4	81.3	80.9	82.1	80.2	81.2	83.6	78.7	80.3
OF	Life expectancy at birth - (Female, 1 year range)	2021	**82.8**			83.8	84.4	84.6	84.1	81.9	83.9	83.2	85.8	82.0	84.9	85.7	83.4	83.8

The third challenge is the need to improve patient experience and move from a model which is not aligned to modern day need. Finally, as discussed elsewhere on the agenda of today's meeting, the system continues to carry an underlying, recurrent, financial deficit, and will not be financially sustainable until this is resolved.

We will not overcome these challenges without a coordinated system wide effort which is focused on a clear vision of what we want to achieve, the radical shift in delivery of health and care required to achieve it, and the steps we will take to deliver it. Once approved the Medium-Term Plan will guide the work of the ICB in the years ahead- supporting and guiding decisions on how we set out priorities, use our resources and work with our partners.

Developing the plan

The principles that underpin the Medium-Term Plan were discussed at a board day in February of this year. Subsequent versions of the plan have been shared with the ICB Executive Team, and a wider group of ICB members of staff, the System CEO group, the Chair and other board members and the ICB directors of strategy group. Wherever possible feedback has been included.

Understanding the plan

The plan is broadly split into three parts:

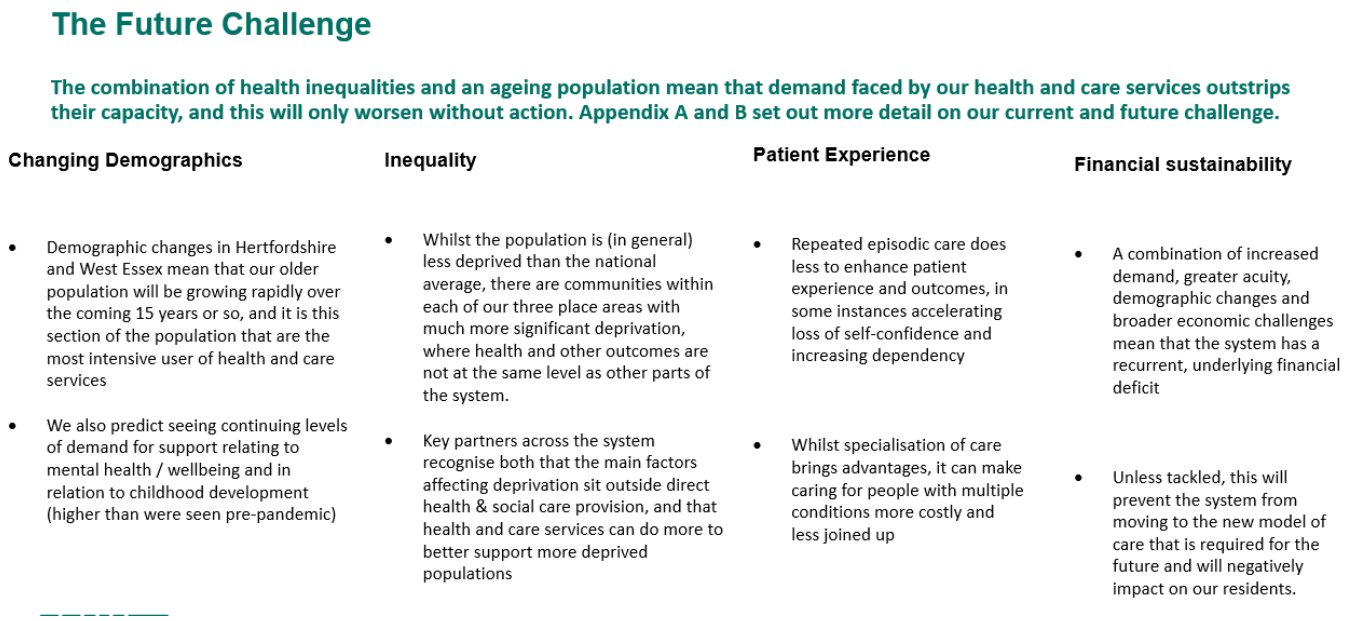
The Hertfordshire and West Essex Vision (Slide 2): This sets out in more detail the vision for Hertfordshire and West Essex that underpins our core mission - *Hertfordshire and West Essex ICB exists to work with others to build a future in which all of our residents can live better, healthier and longer lives*

The five medium-term 2030 ambitions that will support delivery of the vision (Slide 20-26): These will be delivered in a phased multi-year way, and the Medium-Term plan sets out the various pieces of work that will need to take place to achieve them. Work has already begun on all of the areas set out in the plan, and there is more detail on this in the many strategies and plans that have informed the creation of our Medium-Term Plan.

Our 2024-2026 priorities (slide 28): Although work has begun on all the areas that are set out in this plan, there are some that we need to prioritise now- this may be because there is an urgent need to improve performance for our residents (for example Urgent and Emergency Care, recovering our elective services and more support for those in mental health crisis), or because of the potential longer term benefits if we act now (A focus on CVD and hypertension) or because of the potential harm of not moving quickly (reducing backlogs in children's care).

Key elements of the plan

The Medium-Term Plan identifies the four challenges facing Hertfordshire and West Essex over the remainder of this decade, which without action will place huge constraints on our ability to deliver health and care effectively.



The plan recognises that we will need to change our approach if we are to overcome these challenges, by moving to a Hertfordshire and West Essex in which:

Hertfordshire and West Essex ICB exists to work with others to build a future in which all of our residents can live better, healthier and longer lives. Critical to this will be ensuring that:

- Our whole system delivers high quality, fully integrated care that can be accessed easily and quickly.
- No patient is treated in a hospital setting when it would have been possible for them to receive their treatment at home or in their community.
- The quality of care, experience and outcomes of all Hertfordshire and West Essex residents matches the experience and outcomes of those who live in our least deprived areas, with a focus on tackling unwarranted variation and health inequalities across and within our HCP areas
- Our system is proactive and as focused on interventions to prevent illness and reduce the risk of hospitalisation, as we are on the management of illness.
- We base our strategy and decisions on evidence and what's been proven to work- with strategy designed at a system level and implemented by each HCP in a way that is tailored to the needs of residents.
- We move to a sustainable financial position as a system which enables us to shift funds away from acute care and into prevention and care in home or community settings.

This vision will be achieved through a multiyear focus on achieving our five ambitions for the system, which are formed from our existing priorities:

The plan set outs more detail on our key areas of focus relating to each ambition, along with the main steps we will take to achieve it. The detail on delivery of each is contained in the strategies and plans that underpin the document.

By achieving these ambitions, we will be able to deliver the shifts in care critical to overcoming the four challenges and achieving our vision for the future.

Achieving the three shifts in care

The work that we will do to deliver our five ambitions will also support the 3 shifts required to our model of care to ensure we can meet the challenge of the changing demographics of our population:

Shift 1

From reactive acute care to preventive, anticipatory and community-based care:

- ✓ A focus on preventing Cardiovascular disease and hypertension;
- ✓ Implementing the outcome of our Community Services review;
- ✓ Expanding frailty support;
- ✓ Working with partners to reduce drug and alcohol dependency
- ✓ Successfully delivering our suicide prevention strategy

Shift 2

From a siloed and poorly coordinated model to continuous, integrated care:

- ✓ Targeted improvements in children's services
- ✓ Improving same day access to Urgent and Emergency Care
- ✓ Expanding MH crises support
- ✓ Utilising the opportunity presented by the New Hospital programme

Shift 3

From a model based on providing care to one where active patients are engaged in self-management and collaborative care planning:

- ✓ Data driven approaches to public health
- ✓ Being an active partner in the Integrated Care system as it works to reduce inequality

The Hertfordshire and West Essex Digital Strategy for 2022-2032 is a key enabler to these shifts in care.

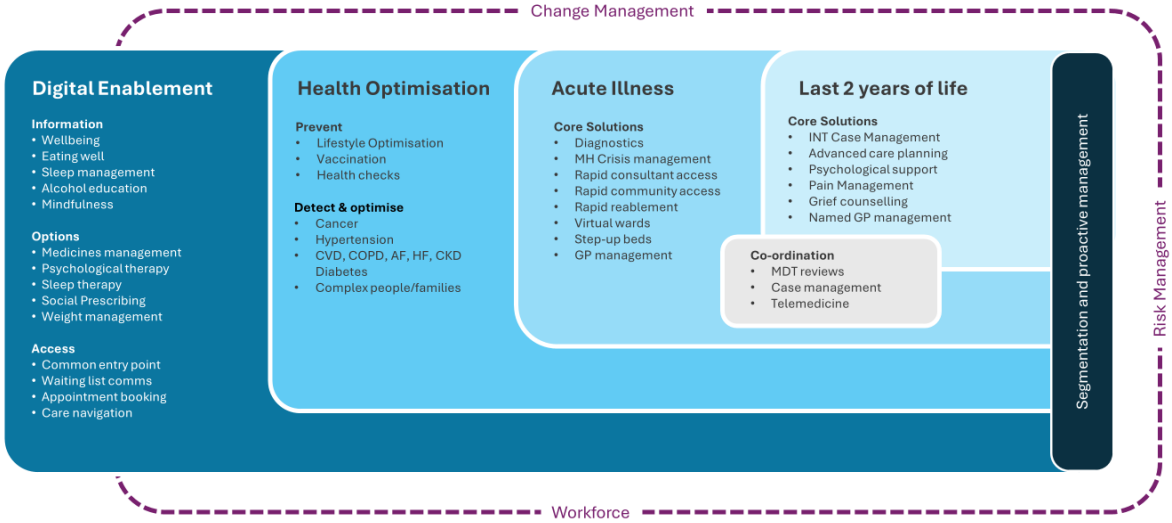
Community model

An integral part of delivering our Medium-Term Plan will be the implementation of the approach being developed across the East of England to 'Close the Care Gap'.

Closing the Care Gap

The Model

The vision for healthcare in EOE is one that is **readily accessible, seamlessly integrated, and inclusive to all members of our community**. A healthcare system that **is simple to use**, with services **available whenever they are needed**. Our priority is to **empower individuals by placing access to care directly in their hands**, offering user-friendly digital platforms and personalised support to navigate their healthcare journey with ease. Moreover, committed to **creating an environment our workforce finds joy and fulfilment** in their work, with opportunities **for professional growth, meaningful collaboration, and a shared sense of purpose** in delivering high-quality care. By **prioritising accessibility, inclusivity, and workforce satisfaction**, the aim is to create a healthcare system that not only meets the needs of our community but **also enriches the lives** of those who serve within it.



25-26 priorities

The plan also identifies the priorities that will be our key areas of focus over the next two years. They were developed by the system CEOs group and are based on an analysis of current need. Each has clearly defined success measures and will support our 6th key priority- delivering our financial plan.

Priority	Expected outcome	Success measures
Reduce inequality with a a focus on outcomes for CVD and hypertension	Reduce under 75 mortality from long term conditions	• 2% increase in hypertension QOF measures (March 2026) • Increase the % of patients with GP recorded hypertension whose last blood pressure was in taget to 77% • Increase the age of standardised prevalence of hypertension in the most deprived 20% of the population from 17.6% to 19% (March 2026)
Improve UEC through more anticipatory/ SDEC care	Reduce the rate of unplanned hospitalisations for chronic ambulatory care	• Decrease the rate of emergency admissions for falls within the community for people aged 65+ by 5% (March 2027) • Reduce the % of deaths with 3 or more emergency admissions in the last 90 days of life (all ages) from 6% to 5% across Herts and West Essex by March 2027
Better care for those in Mental Health crisis	Increase in the provision of early help to prevent mental illness and support the health and wellbeing of those with severe mential illness, learning disabilities or autism.	• Increasing our response to urgent referrals to Community Crises Services in 24/25 from 64% to 67%. • Reduce the use of out of area inappropriate beds for adults requiring a mental health inpatient stay across the ICS from 16 people to 4 people by March 2025. • 75% of inpatient discharges to have 72 hour follow up by March 2025.
Elective care recovery	Reduction in the numbers waiting for elective activity and diagnostics	• Reduce number of patients waiting more than 65 weeks for treatment, to 0 by 30th Sept 2024 • 85% of surgery across HWE is consistently undertaken as day case by March 2026 • Reduce the number of patients waiting more than 6 weeks for diagnostic services year on year and by March 2025 ensure that 95% of patients have their diagnostics within 6 weeks.
Childrens care backlog reductions	All children will have the best start and live a healthy life	• Reduction in wait for community paediatric services to 65 weeks by April 2026 • Reduction in ED attendance and admission rates for children and young people by 5% (2028)

Delivering the plan- changing our operating approach

Working with partners

Working with our partners to deliver our shared priorities

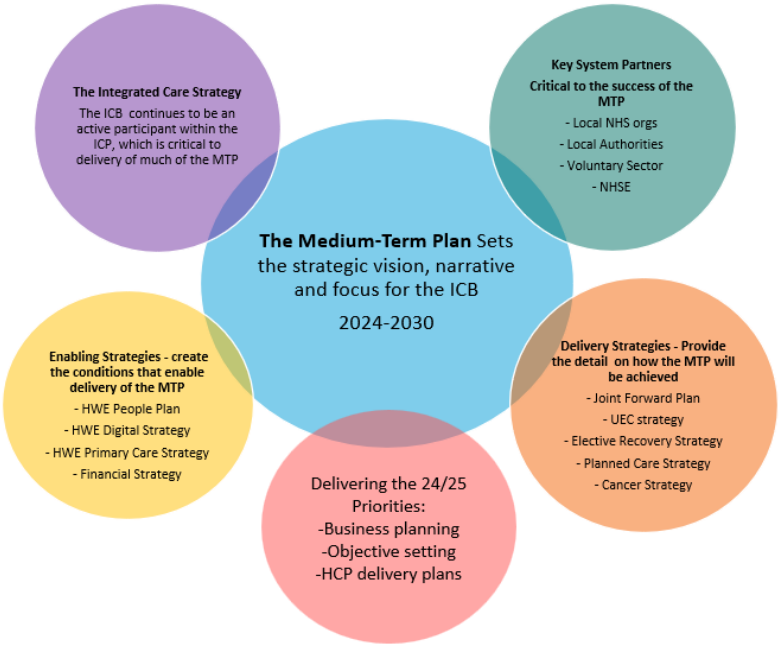
The Medium-Term Plan sets out the priorities and focus of the ICB, and our vision for Hertfordshire and West Essex in 2030.

In setting this plan we have ensured that all of our work will contribute to the delivery of the wider Integrated Care Strategy. The ICB and the Integrated Care Partnership are interdependent- we cannot deliver many of the aims of this plan without the ICP, and the ICP will not be as effective in achieving its priorities without the commitment of the ICB and the wider NHS. Our medium-term plan commits us to continuing to be full and active partners within the Integrated Care Partnership.

Our key non-NHS partners:

Partner	Our work together
Local Government	Our County, District and Borough colleagues are critical to the adoption of our new model care, and we will continue, and build on, our joint work on the delivery of social care, the prevention of illness, public health management and much more.
Health and Well Being Boards	The Joint Health and Wellbeing Strategies of both the Hertfordshire and Essex Health and Well Being Boards have informed this Medium-Term plan and we will continue to work closely with them as we build our delivery approach
Voluntary Sector, Faith and Social Enterprise Alliance	We are fortunate in Hertfordshire and West Essex to have a strong VCSFE alliance and we are one of only a small number of ICBs who have a representative of the sector as a full board member. The alliance is crucial to the delivery of the MTP and we look forward to continuing to work in partnership with them.

How it all fits together



Changing our operating model

Health and Care Partnerships have a critical role in the delivery of our Medium-Term Plan. A key principle set out in the plan is that decisions about health and care are best taken as closely as possible to those that it will impact. The plan also sets out the approach and options for further development of HCPs in the future.

Changing our governance

The Board will be aware that we have now concluded the review of our governance and are implementing the recommendations of that review. The creation of the strategy committee will enable the coordination of delivery of the plan.

In addition we will be changing our reporting to board to ensure it aligns to the Medium Term Plan, and aligning our future schedule of deep dives to highlight progress or issues relating to key areas of the plan.

The ICBs approach

The ICB has begun the process of changing its ways of working to ensure maximum focus on delivery of the Medium-Term Plan, including:

- Creating a new executive sub-group to ensure strategy alignment and monitor delivery.

- Using the five priorities to underpin business planning processes for 24/25
- All executive team members have objectives linked to delivery of the five priorities
- A revised approach to involving the ICBs senior leadership group in conversations around delivery of the Medium-Term Plan
- Early work taking place across our teams to align resource to the delivery of the plan.

Next steps

Once the board has approved the plan, the intention is to publish it formally in June. In terms of governance, the board will receive an update on progress towards implementation at each of its meetings, and each board sub-committee will discuss its role in implementation at their June/July meetings.

HCPs are finalising their delivery plans for 24/25 which are based on the five priorities, and the ICB will continue its progress on ensuring our approach is focused on delivery of the plan.

Hertfordshire and
West Essex Integrated
Care System

The Hertfordshire and West Essex ICB Medium Term Plan

Working together
for a healthier future

Introduction

The NHS is seeking to meet the dual challenge of unprecedented demand for our services and significant financial constraints. Hertfordshire and West Essex Integrated Care System is no different, and this means that for 2024/5, and each year that follows, we will need to focus on a clear set of priorities that will help us to meet both of those challenges.

In addition, we know that changes to the demographics of our population alongside an increase in the numbers of people living with multiple health conditions will further test both the services we provide and the budget which we have to provide them in the latter parts of this decade. Our system, which already has a higher proportion of over 85s than many others, will see a further steep incline in its older population over the next six years. This is cause for celebration, but it does mean that our services and approach will need to change to match the changing health and care needs of our residents.

Finally- we must not lose sight of the pockets of deprivation and health inequalities that exist in Hertfordshire and West Essex. Any plan that covers the remainder of this decade must demonstrate how the Integrated Care Board will level up people's experience and outcomes from health and care to match those in our least deprived communities.

Our Medium-Term plan describes our vision for Hertfordshire and West Essex and the key priorities and shifts in our care model we will need to focus on to achieve it. It doesn't describe everything we are and will do as a system but is designed to set out clearly the areas we will focus our efforts and investment on in coming years. It also describes the journey we will follow to build our operating model- which is based on the principle that decisions should be taken as closely as possible to our residents.

Some of our priorities will be achieved through our active participation in the Integrated Care Partnership. Others will be delivered in partnership with other NHS organisations, our district, borough and county council colleagues, other public sector organisations and with our partners in the voluntary, community, faith and social enterprise sector. The detail on delivery of those priorities is set out in other strategies and plans that are referenced throughout this document.

The Future Challenge

The combination of health inequalities and an ageing population mean that demand faced by our health and care services outstrips their capacity, and this will only worsen without action. Appendix A and B set out more detail on our current and future challenge.

Changing Demographics

- Demographic changes in Hertfordshire and West Essex mean that our older population will be growing rapidly over the coming 15 years or so, and it is this section of the population that are the most intensive user of health and care services
- We also predict seeing continuing levels of demand for support relating to mental health / wellbeing and in relation to childhood development (higher than were seen pre-pandemic)

Inequality

- Whilst the population is (in general) less deprived than the national average, there are communities within each of our three place areas with much more significant deprivation, where health and other outcomes are not at the same level as other parts of the system.
- Key partners across the system recognise both that the main factors affecting deprivation sit outside direct health & social care provision, and that health and care services can do more to better support more deprived populations

Patient Experience

- Repeated episodic care does less to enhance patient experience and outcomes, in some instances accelerating loss of self-confidence and increasing dependency
- Whilst specialisation of care brings advantages, it can make caring for people with multiple conditions more costly and less joined up

Financial sustainability

- A combination of increased demand, greater acuity, demographic changes and broader economic challenges mean that the system has a recurrent, underlying financial deficit
- Unless tackled, this will prevent the system from moving to the new model of care that is required for the future and will negatively impact on our residents.

Understanding our Medium-Term Plan

This medium-term plan will guide the work of the Hertfordshire and West Essex Integrated Care Board for the remainder of this decade. It is a response to the very urgent challenges we face now, and the demographic changes we will see over the next six years. It effectively has three key components:

The Hertfordshire and West Essex Vision (Slide xxx): This sets out in more detail the vision for Hertfordshire and West Essex that underpins our core mission - ***Hertfordshire and West Essex ICB exists to work with others to build a future in which all ~~of~~ our residents can live better, healthier and longer lives***

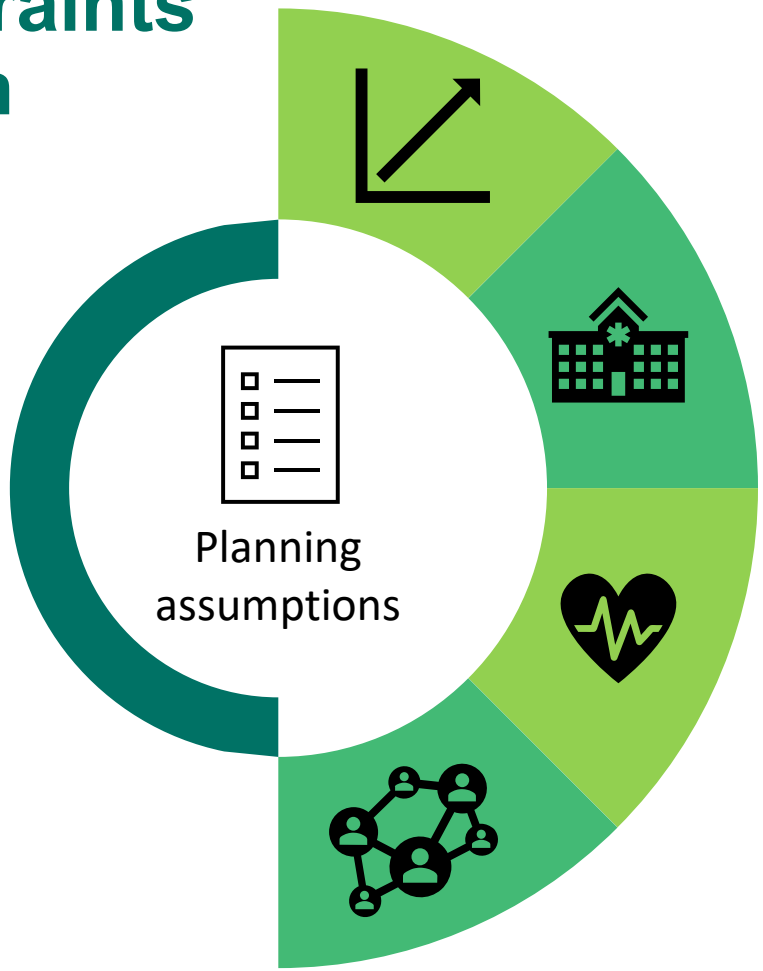
The five medium-term transformation objectives that will support delivery of the vision(Slide xxx): These objectives will be delivered in a phased multi-year way, and the Medium-Term plan sets out the various pieces of work that will need to take place to achieve them. Work has already begun on all ~~of~~ the areas set out in the plan, and there is more detail on this in the ~~many~~ strategies and plans that have informed the creation of our Medium-Term Plan.

Our 2024-2026 priorities (slide xxx): Although work has begun on all the areas that are set out in this plan, there are some that we need to prioritise now- this may be because there is an urgent need to improve performance for our residents (for example Urgent and Emergency Care, recovering our elective services and more support for those in mental health crisis), or because of the potential longer term benefits if we act now (A focus on CVD and hypertension) or because of the potential harm of not moving quickly (reducing backlogs in children's care).

The planning assumptions/constraints we are working with

We will set clear measures of success for all the areas identified for improvement in this plan.

Some will relate to the longer-term shift in population health we would like to see, with others acting as shorter-term markers of success.



C.25% of the (non-elective) patients admitted to our hospitals could be cared for at home if their needs were met earlier or differently.

The New Hospital programme presents an opportunity for the system to reset its current model of delivery but will mean that we have less beds across the system.

There is a system wide appetite to move towards proactive and preventative approaches that identify needs earlier and offers less intensive support to achieve better outcomes and enable people to live longer, healthier and happier lives.

A multi-partner whole system approach in areas of deprivation will improve residents' health and wellbeing and to some extent reduce hospital demand

Hertfordshire and West Essex Integrated Care System

About Hertfordshire and West Essex

Working together
for a healthier future

Snapshot of the Hertfordshire & West Essex ICS

Hertfordshire

Population: 1,198,800*

Hertfordshire Health & Wellbeing Board

Hertfordshire County Council

10 District and Borough Councils

3 Health and Care Partnerships

- **East & North Herts**
- **South & West Herts**
- **Mental Health Learning Disabilities & Autism**

2 Acute Hospital Trusts
4 Community, Mental Health & Ambulance Trusts
35 Primary Care Networks
Hertfordshire Healthwatch
Growth Board
Local Enterprise Partnership
One university

Combined population of 1.52m

West Essex

Population: 319,300*

Essex Health & Wellbeing Board

Essex County Council

3 District Councils

Health and Care Partnership

- **West Essex**

1 Acute Hospital Trust
2 Community, Mental Health and Ambulance Trusts
6 Primary Care Networks
Essex Healthwatch

VCSFE Alliance

* Source: Census 2021

Hertfordshire and West Essex Integrated Care System

Our vision for Hertfordshire and West Essex

Working together
for a healthier future

The Hertfordshire and West Essex Vision

Hertfordshire and West Essex ICB exists to work with others to build a future in which all ~~of~~ our residents can live better, healthier and longer lives. Critical to this will be ensuring that:

- **Our whole system delivers high quality, fully integrated care that can be accessed easily and quickly.**
- **No patient is treated in a hospital setting when it would have been possible for them to receive their treatment at home or in their community**
- **The quality of care, experience and outcomes of all Hertfordshire and West Essex residents matches the experience and outcomes of those who live in our least deprived areas, with a focus on tackling unwarranted variation and health inequalities across and within our HCP areas**
- **Our system is proactive and as focused on interventions to prevent illness and reduce the risk of hospitalisation, as we are on the management of illness.**
- **We base our strategy and decisions on evidence and what's been proven to work- with strategy designed at a system level and implemented by each HCP in a way that is tailored to the needs of residents.**
- **We move to a sustainable financial position as a system which enables us to shift funds away from acute care and into prevention and care in home or community settings.**

Achieving our vision

To achieve our vision, we will focus on five ambitions

- Increasing healthy life expectancy, and reduce inequality
- Giving every child the best start in life
- Improving access to health and care services
- Increasing the numbers of citizens taking steps to improve their wellbeing
- Successfully delivering our financial plan each year

Which will support 3 shifts in our model of care

- From reactive acute care to preventive, anticipatory & community-based care
- From a siloed and poorly coordinated model to continuous, integrated care
- From a model based on providing care to one where active patients are engaged in self-management and collaborative care planning

In our first year we will prioritise

- CVD and hypertension
- Reducing waiting times in targeted children services
- Reducing UEC demand by delivering more anticipatory/ same day care
- Provide better care to people in mental Health Crises
- Continue our elective care recovery

Hertfordshire and West Essex Integrated Care System

Achieving the three shifts in care

The work that we will do to deliver our five ambitions will also support the 3 shifts required to our model of care to ensure we can meet the challenge of the changing demographics of our population:

Shift 1

From reactive acute care to preventive, anticipatory and community-based care:

- ✓ A focus on preventing Cardiovascular disease and hypertension;
- ✓ Implementing the outcome of our Community Services review;
- ✓ Expanding frailty support;
- ✓ Working with partners to reduce drug and alcohol dependency
- ✓ Successfully delivering our suicide prevention strategy

Shift 2

From a siloed and poorly coordinated model to continuous, integrated care:

- ✓ Targeted improvements in children's services
- ✓ Improving same day access to Urgent and Emergency Care
- ✓ Expanding MH crises support
- ✓ Utilising the opportunity presented by the New Hospital programme

Shift 3

From a model based on providing care to one where active patients are engaged in self-management and collaborative care planning:

- ✓ Data driven approaches to public health
- ✓ Being an active partner in the Integrated Care system as it works to reduce inequality

The Hertfordshire and West Essex Digital Strategy for 2022-2032 is a key enabler to these shifts in care.

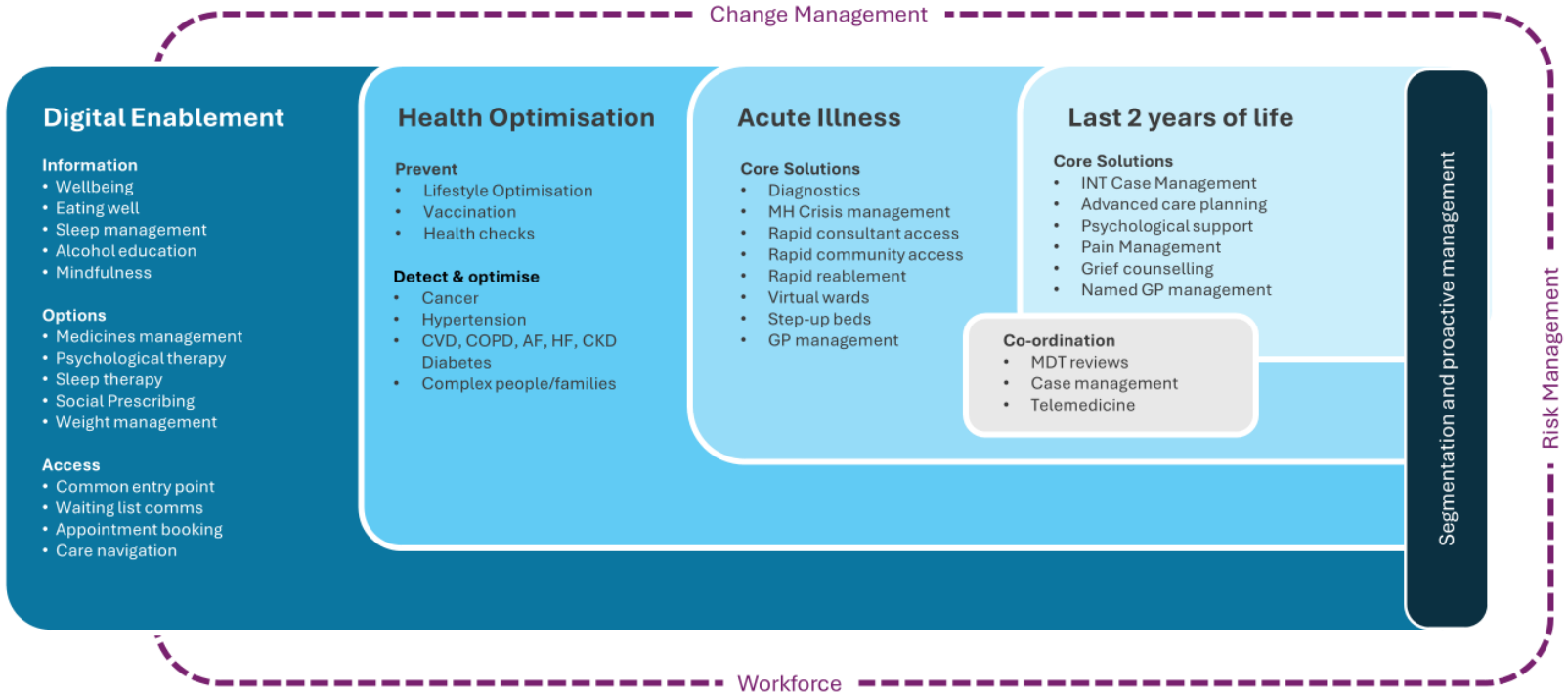
Hertfordshire and West Essex Integrated Care System

Changing our model of care- implementing the East of England Model as part of our Medium-Term Plan

Closing the Care Gap

The Model

The vision for healthcare in EOE is one that is **readily accessible, seamlessly integrated, and inclusive to all members of our community.** A healthcare system that **is simple to use**, with services **available whenever they are needed**. Our priority is to **empower individuals by placing access to care directly in their hands**, offering user-friendly digital platforms and personalised support to navigate their healthcare journey with ease. Moreover, committed to **creating an environment our workforce finds joy and fulfilment** in their work, with opportunities **for professional growth, meaningful collaboration, and a shared sense of purpose** in delivering high-quality care. By **prioritising accessibility, inclusivity, and workforce satisfaction**, the aim is to create a healthcare system that not only meets the needs of our community but **also enriches the lives** of those who serve within it.



We will continue to develop our approach to implementing this model in 24-25.

Hertfordshire and West Essex Integrated Care System

Hertfordshire and
West Essex Integrated
Care System

Our approach to delivery

Working together
for a healthier future

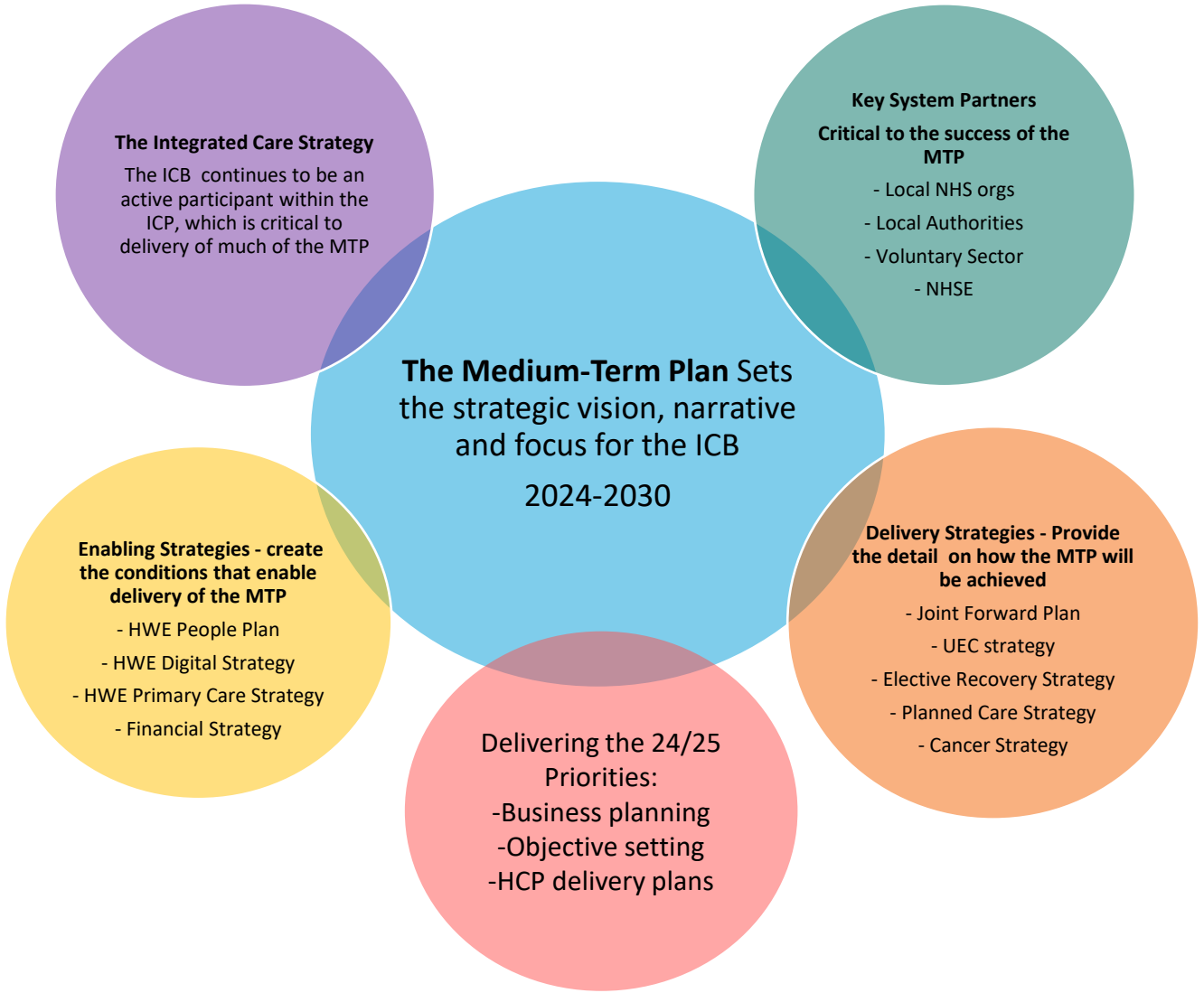
Working with our partners to deliver our shared priorities

The Medium-Term Plan sets out the priorities and focus of the ICB, and our vision for Hertfordshire and West Essex in 2030.

In setting this plan we have ensured that all of our work will contribute to the delivery of the wider Integrated Care Strategy. The ICB and the Integrated Care Partnership are interdependent- we cannot deliver many of the aims of this plan without the ICP, and the ICP will not be as effective in achieving its priorities without the commitment of the ICB and the wider NHS. Our medium-term plan commits us to continuing to be full and active partners within the Integrated Care Partnership.

Our key non-NHS partners:

Partner	Our work together
Local Government	Our County, District and Borough colleagues are critical to the adoption of our new model care, and we will continue, and build on, our joint work on the delivery of social care, the prevention of illness, public health management and much more.
Health and Well Being Boards	The Joint Health and Wellbeing Strategies of both the Hertfordshire and Essex Health and Well Being Boards have informed this Medium-Term plan and we will continue to work closely with them as we build our delivery approach
Voluntary Sector, Faith and Social Enterprise Alliance	We are fortunate in Hertfordshire and West Essex to have a strong VCSFE alliance and we are one of only a small number of ICBs who have a representative of the sector as a full board member. The alliance is crucial to the delivery of the MTP and we look forward to continuing to work in partnership with them.


The Integrated Care Strategy
The ICB continues to be an active participant within the ICP, which is critical to delivery of much of the MTP
Key System Partners
Critical to the success of the MTP
- Local NHS orgs
- Local Authorities
- Voluntary Sector
- NHSE
The Medium-Term Plan Sets the strategic vision, narrative and focus for the ICB
2024-2030
Enabling Strategies - create the conditions that enable delivery of the MTP
- HWE People Plan
- HWE Digital Strategy
- HWE Primary Care Strategy
- Financial Strategy
Delivery Strategies - Provide the detail on how the MTP will be achieved
- Joint Forward Plan
- UEC strategy
- Elective Recovery Strategy
- Planned Care Strategy
- Cancer Strategy
Delivering the 24/25 Priorities:
-Business planning
-Objective setting
-HCP delivery plans

Our key enabling strategies

In addition to the strategies that focus on delivery of our priorities directly, we have a number of enabling strategies that help to develop the right conditions for the delivery of the plan. They will be developed further over time to ensure full alignment with the medium term plan. These include:

Strategy	Overview
Hertfordshire and West Essex People Strategy 2023-2025	This strategy supports integrated workforce planning, innovation and new ways of working, a sustainable workforce supply, improved staff wellbeing, experience, and education, talent, and leadership development.
Hertfordshire and West Essex Digital Strategy	This strategy covering health service provision focuses on enabling our professionals to transform services to meet the needs of our residents. It will do this by providing the right digital capabilities, including technology and infrastructure. It is these capabilities that will enable those that provide care to work together to create the best outcomes for people living in Hertfordshire and west Essex. It will enable improved access for residents, patients, and service users to information about themselves and allow them to interact digitally with their clinical and care professionals when it is appropriate and convenient to do so.
Hertfordshire and West Essex Primary Care Strategic Delivery Plan 2023-2026	Our strategy to develop GP, community pharmacy, dentistry, and ophthalmology services across Hertfordshire and west Essex to benefit patients and communities over the next three years.

Our delivery architecture

Vision and objectives

Medium Term Plan

Integrated Care Strategy

Plan once, set clear expectations and outcomes, do things once where it makes sense to do so- for example data analysis

Enabling strategies- set the conditions needed for successful delivery

Digital strategy
People plan
Primary Care strategy
Financial plans

Delivery strategies- the plan for how we achieve the five MTP objectives

UEC strategy
Joint forward plan
Cancer strategy
End of Life strategy
Planned care strategy

Delivery- tailored locally when appropriate

HCPs -Delivery of agreed improvements, tailoring plans to local knowledge /circumstance, identify additional areas for improvement

Delivery in practice- UEC and same day urgent care example

Vision and objectives

Medium Term Plan- Aims to give everyone in Hertfordshire and West Essex access to Same Day Urgent Care as needed

Setting strategy and identifying what should be delivered once across the system

Relevant Enabling plans-

Digital strategy (supportive of improved pathways incl digital triage)
People plan (growing skills and capacity to support new pathways and models of care
Primary Care strategy (looks to simplify and enhance access for urgent primary care needs)
Financial plans- Implementing community service strategy

Guiding delivery strategy

UEC strategy- Sets out plan to move to an integrated 24/7 urgent care service, timely and appropriate access to diagnostics, integrated community pharmacies with UEC model, consistent, locally led pathways of care, greater treatment of patients through non admitted same day emergency care pathways

Delivery- tailored locally when appropriate

HCPs -Delivery of the agreed strategies through their annual delivery plans, tailoring plans to local knowledge /circumstance, identifying additional areas for improvement where approproiate

More detail around the delivery of the medium-term plan:

Strategy	Link *to be added*
Integrated Care Strategy	
Joint forward plan	
Primary Care Strategy	
UEC strategy	
HWE People Plan	
Elective recovery strategy	
Planned Care Strategy	
Cancer strategy	
Hertfordshire and West Essex Digital Strategy	

Hertfordshire and
West Essex Integrated
Care System

Our 2030 plan- delivering our five ambitions

Working together
for a healthier future

The priorities of the Integrated Care Board 2024-2030

Our mission

Better, healthier and longer lives for all

We will achieve this by

- **Improving physical and mental health across our population**
- **Tackling unequal access, experience and outcomes**
- **Enhancing productivity and value for money**
- **Ensuring the NHS supports broader social and economic development.**

Our 2030 ambitions are:

- Increasing healthy life expectancy, and reduce inequality
- Giving every child the best start in life
- Improving access to health and care services
- Increasing the numbers of citizens taking steps to improve their wellbeing
- Successfully delivering our financial plan each year

The ICB will deliver this by:

- Setting direction for the NHS in Hertfordshire and West Essex
- Allocating NHS resources fairly and effectively
- Supporting, equipping, and empowering our people
- Working with and pooling resources with our partners
- Enabling improvement and driving change, with a focus on quality
- Using data and evidence to generate insight and assess impact

Hertfordshire and West Essex Integrated Care System

Our approach to ensuring every child has the best start in life

What we will do:

We want to see improvements in the health of our children and young people, setting them up for their best future life. We will:

- tackle health inequalities and promote the prevention of ill health to ensure that all children receive high- quality care and are supported to live a healthy life both physically and emotionally.
- work together to ensure that children with long term conditions or complex care needs are supported to achieve their fullest potential.
- change the way we work together to provide care that is easy to access and integrated, which places the child or young person and their family at the heart of our planning.
- ensure that care is personalised and provided as close to home as possible, recognising the role of the community in children's lives supporting them to achieve their goals

Between 2024 and 2030 our focus will be on:

- Reducing waiting times in targeted children's services (ASHS / ASD system wide, community paediatrics, paediatric audiology), by building on current plans and redirecting resources.
- Improving services for children with Special Educational Needs and Disability (SEND) through our work with local government partners.
- Improving emergency pathways for children- as set out in our Urgent and Emergency Care Strategy
- Continuing our system journey of improvement in Maternity Services, with a focus on implementing the six elements of 'Saving Babies Lives' care bundle'
- Improve paediatric access to NHS dentistry

What our residents can expect:

- A reduction in the numbers of stillbirths and deaths in the first week of life
- Fewer 5-year-olds with tooth decay
- Reduced waiting lists for neurodiversity services
- Decreased waiting times across all community paediatric services
- Reduced emergency admissions for all children under 18.
- Increased utilisation of virtual wards and other approaches to support children to have hospital level care in their own home.

Our approach to increasing healthy life expectancy and reducing inequality

What we will do:

Through our work in the Integrated Care Partnership, with our communities and through own work:

- Reduce health inequalities to improve our resident's health and wellbeing
- Take positive action on the wider determinants of health, including housing, employment and the environment
- Ensure we adopt a data driven approach to prioritise work and approaches that will have the biggest public health impact

Between 2024 and 2030 our focus will be on:

- Continuing to play an active role in the work of the Integrated Care Partnership, supporting delivery of its priorities.
- Redeploy more of our resources on preventing and treating Cardiovascular disease, hypertension and Lipids
- Growing our Tobacco dependency reduction programme- to achieve a smoke free system
- Strengthening our work with system partners to reduce drug and alcohol dependency
- Working with local Governance and VCSFE colleagues to support healthy ageing
- Successfully delivering our suicide prevention strategy
- Taking targeted action across our HCPS to tailor approaches to delivering the above to local need

What our residents can expect:

- An increase in life expectancy across our system
- A lower rate of mortality from all cardiovascular disease
- An increase in the number of GP recorded hypertension patients with a blood pressure reading within the target range
- A fall in the rate of suicide across Hertfordshire and West Essex
- Targeted work to identify patients with hypertension in our most deprived communities

Our approach to improving access to Health and Care Services

What we will do:

We will ensure that residents of Hertfordshire and West Essex are able to get the help that they need, from the best place or health and care service, at the right time by:

- Developing ways of working that streamline care, providing a better experience for patients, carers and staff
- Working as a system to ensure we have the right model of care to support this
- Making it easier to connect people to the “best” service – rather than the “most obvious” service- ensuring the right people have access to care in the right place and at the right time.
- Continue to implement our Primary Care Strategic Delivery Plan for 23-26

Between 2024 and 2030 our focus will be on:

Ensuring system wide same day access to Urgent and Emergency Care

Expanding our MH crisis support / CAMHS services to ensure they meet present and future need

Continuing our work to recover elective care services

Delivering sustained improvement in cancer services

Ensuring we achieve the maximum benefit of new Community Diagnostic Centres and elective hubs for patients

Improving the experience of those at the end of life.

What our residents can expect

- Faster access and delivery of cancer services in line with the cancer standards
- Quicker access to diagnostic tests
- Shorter waits for planned care
- Easy and rapid access to same day or urgent care as needed
- Less emergency Hospital admissions for intentional self-harm across the system
- An enhanced response to urgent referrals to community crisis services
- A reduced uses of inappropriate out of areas placements for Mental Health patients

Our approach to increasing the number of residents taking steps to improve their wellbeing

What we will do

Our approach to ensuring that our residents are taking steps to improve their wellbeing is through our role as an active partner in the Integrated Care Partnership. The partnership is committed to:

- Develop a new physical activity offer for our residents.
- Support our residents in low-income households to have access to affordable healthy food and facilities to store and cook it.
- Support our residents most at risk of poor outcomes from being overweight including those with mental health conditions, physical disability or learning disability and autism.
- Support children and young people to have access to information, advice, and support to maintain a healthy weight and access to leisure activities in their communities, to support the importance of tackling childhood obesity

Between 2024 and 2030 our focus will be on:

- Working with our system partners to successfully deliver the relevant parts of the Integrated Care Strategy for the Hertfordshire and West Essex
- Tackling frailty, which is crucial given our future demographic changes as a system. We will deliver the changes we set out in our UEC strategy to achieve this- implementing improved clinical pathways, introducing an integrated acute frailty service, and strengthen our out of hospital care.

What our residents can expect:

- Fewer people admitted to hospital as a result of a fall.
- Access to physical activity offers
- A universal support offer for those looking to stop smoking
- Targeted support for those who are on low incomes
- More access to information that will help them stay healthy and improve their wellbeing.

Our approach to ensuring we are financially sustainable

What we will do:

We will use the resources available to us as best we can – to maximise the benefits for residents and staff, setting ourselves the twin challenge of being both more productive and efficient as a system. This will be guided by our medium-term financial plan.

Key to our financial sustainability, and the delivery of all of our objectives is our workforce. We will continue to implement the NHS Long term workforce plan alongside the Hertfordshire and West Essex People Plan.

With well-advanced and supported plans for large scale capital developments, we must use this once in a generation opportunity to invest wisely for today and for years to come.

- **Between 2024 and 2030 our focus will be on:**
- Using a data driven approach to improve the productivity of elective care pathways, focussing on our five high impact changes based on a 'Best in HWE Benchmark'.
- Making better use of workforce data and digital innovation to support workforce productivity and efficiency.
- Developing primary and community workforce to ensure more care takes place in the home / community.
- Implementing a new model of Out of Hours and Community Services which is underpinned by a new contractual framework focused on improving outcomes and tackling variation
- Focusing on those that are most likely to suffer deteriorating health leading to a need for urgent or emergency care, preventing where this is possible and ensuring same day access is integrated, easily accessible and safe
- Implementation of the ICS estates strategy.
- Developing a local workforce pipeline in line with workforce clinical expansion targets, support better retention of our workforce and reduce agency spend.
- Achieving financial balance annually (NHS)
- Designing and delivering a system wide agreed plan to maximise the benefits of the £2bn capital investment New Hospital Programme

What our Residents can expect:

- More care taking place at home or in the community
- For the system to maximise the productivity of our operating theatres and outpatients' services

- Develop a local workforce pipeline in line with workforce clinical expansion targets, support better retention of our workforce and reduce agency spend.
- A decrease in the amount of money we need to spend on urgent and emergency care
- A fall in our annual spend on agency staff to cover vacancies.

Hertfordshire and
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Priorities for 2024-2026

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2024-2026 transformation priorities

The Integrated Care Board has five key transformation priorities for the next two years. The delivery plans of our Health and Care Partnerships will set out our approach to achieving them. These transformation priorities will support delivery of our longer ambitions and assist in achieving our 6th priority for 24/25- delivering our financial plan.

Priority	Expected outcome	Success measures
Reduce inequality with a a focus on outcomes for CVD and hypertension	Reduce under 75 mortality from long term conditions	• 2% increase in hypertension QOF measures (March 2026) • Increase the % of patients with GP recorded hypertension whose last blood pressure was in taget to 77% • Increase the age of standardised prevalence of hypertension in the most deprived 20% of the population from 17.6% to 19% (March 2026)
Improve UEC through more anticipatory/ SDEC care	Reduce the rate of unplanned hospitalisations for chronic ambulatory care	• Decrease the rate of emergency admissions for falls within the community for people aged 65+ by 5% (March 2027) • Reduce the % of deaths with 3 or more emergency admissions in the last 90 days of life (all ages) from 6% to 5% across Herts and West Essex by March 2027
Better care for those in Mental Health crisis	Increase in the provision of early help to prevent mental illness and support the health and wellbeing of those with severe mential illness, learning disabilities or autism.	• Increasing our response to urgent referrals to Community Crises Services in 24/25 from 64% to 67%. • Reduce the use of out of area inappropriate beds for adults requiring a mental health inpatient stay across the ICS from 16 people to 4 people by March 2025. • 75% of inpatient discharges to have 72 hour follow up by March 2025.
Elective care recovery	Reduction in the numbers waiting for elective activity and diagnostics	• Reduce number of patients waiting more than 65 weeks for treatment, to 0 by 30th Sept 2024 • 85% of surgery across HWE is consistently undertaken as day case by March 2026 • Reduce the number of patients waiting more than 6 weeks for diagnostic services year on year and by March 2025 ensure that 95% of patients have their diagnostics within 6 weeks.
Childrens care backlog reductions	All children will have the best start and live a healthy life	• Reduction in wait for community paediatric services to 65 weeks by April 2026 • Reduction in ED attendance and admission rates for children and young people by 5% (2028)

Hertfordshire and
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Care System

Building our operating model- making decisions happen closer to our communities

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Starting in April 2024

In April 2024 our Health and Care Partnerships will become a more formal part of our system. This will mean that:

- The role and ways of working of the partnerships will be underpinned by an MOU and they will have a clearer place within the ICBs governance
- Financial, performance, quality and workforce data will be developed and aligned to support HCP decision making- this will be a priority for the ICB
- A provider CEO will take formal responsibility for the leadership of the HCP and developing and maintaining the relationships and ways of working critical to its success
- All of the work of the HCPs will be underpinned by a Population Health Management Approach underpinned by the new data platform.

Throughout 24/25 the main task of our HCPs will be to implement delivery plans around our five 24/25 transformation priorities and the delivery of our financial plan (see slide 10)

Our future operating approach

To support our vision of decisions about health and care being taken as close to the end user as possible, except where there is the benefit of our scale, our systems target operating model is one where:

The ICBs role will be:

- Coordinating strategic planning across the system
- Delivering the statutory functions of the ICB
- Taking decisions which have ramifications for the whole system- for example whole system service design or procurement
- Assurance around the performance of HCPs
- A focus on tackling inequalities- using Public Health Management data analysis and Evidence Based Interventions

The HCPs role will be:

- To be a key part of developing the system strategy
- To have responsibility for the delivery of the strategy within their HCP areas.
- To have the duty of oversight for finance, performance, quality and commissioning of services within their HCP
- To have fully devolved budgetary responsibility for their local population
- A focus on tackling inequalities-utilising their local understanding using PHM data to drive service redesign.

Achieving this approach

Our target operating model will require a significant shift in our current culture, operational approach and governance.

We recognise that given the different starting points of our HCP's, some will move faster than others towards achieving this target state.

There are several models by which we can achieve the empowerment of the HCPs we wish to create through this model. All of those models would see a shift of responsibility and accountability from the ICB to HCP partners.

Recently launched NHSE guidance has helped to clarify the process for delegation and has confirmed that ICBs can follow two models in delegation- a lead provider model and committee in common. The merits of both models will be considered in 24/25.

Irrespective of the final model agreed, HCP take on budgetary and contractual responsibility for the delivery of HCP duties within their HCP footprint. This would be underpinned by a partnership agreement between the ICB, the provider and the members of the Health and Care Partnership.

Hertfordshire and
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Appendix A: Our System in 2024

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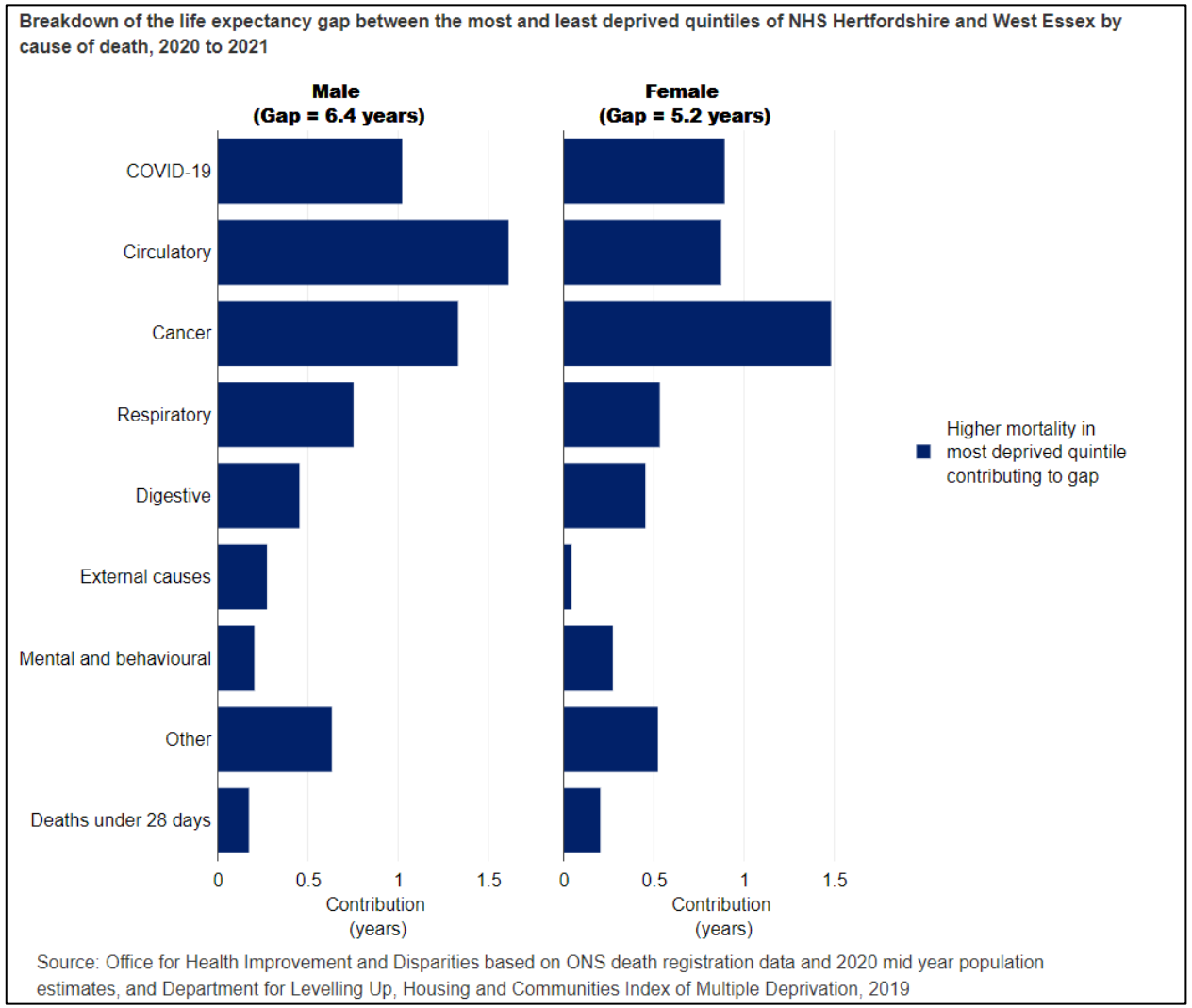
Life Expectancy Gap Between the Most and Least Deprived

OF	Life Expectancy Gap between most and least deprived			
	Male		Female	
	2017-19	2020/21	2017-19	2020/21
HWE	6.2	6.4	4.5	5.2
East of England	6.7	7.2	5	5.8
England	7.8	8.6	6.3	7.1

- The life expectancy gap between the least deprived and most deprived populations is 6.4 years for males and 5.2 years for females in HWE. The latest data shows an increase in the gap in line with what has been seen nationally and regionally. The gap remains smaller in HWE compared with the regional and national.
- This illustration on the right shows the breakdown of the causes that contribute to the life expectancy gap between people living in the most and least deprived areas of Hertfordshire and West Essex.
- This particular update shows the impact of Covid during 2020 to 2021.
- Data shows that Circulatory Disease and Cancer contribute the most to the life expectancy gap between the most and least deprived. These areas are identified within our clinical and strategic priorities of the ICB.

Segment Tool (phe.gov.uk)



Hertfordshire and West Essex Integrated Care System

Life Expectancy – Variation at local level

Better 95% Similar Worse 95%

	Indicator Name	Time period	England	East of England	HWE ICB	Broxbourne	Dacorum	East Hertfordshire	Epping Forest	Harlow	Hertsmere	North Hertfordshire	St Albans	Stevenage	Three Rivers	Uttlesford	Watford	Welwyn Hatfield
OF	**Life expectancy at birth - (Male, 3 year range)**	2018/20	**79.4**	**80.2**	**80.6**	79.6	81.1	81.6	80.4	78.6	79.5	81.1	81.8	79.5	81.2	82.6	79.3	80.6
OF	**Life expectancy at birth - (Female, 3 year range)**	2018/20	**83.1**	**83.8**	**84.1**	84.0	84.0	85.0	84.0	82.5	84.0	84.2	85.4	82.8	84.3	85.4	82.7	83.8
OF	**Life expectancy at birth - (Male, 1 year range)**	2021	**78.7**			79.5	80.5	80.8	80.1	78.4	81.3	80.9	82.1	80.2	81.2	83.6	78.7	80.3
OF	**Life expectancy at birth - (Female, 1 year range)**	2021	**82.8**			83.8	84.4	84.6	84.1	81.9	83.9	83.2	85.8	82.0	84.9	85.7	83.4	83.8

- Overall life expectancy and healthy life expectancy for the ICS masks variation within communities and HWE.
- HWE overall Life Expectancy is higher than regional and England. Urban areas experience lower average life expectancy for both males and females, with residents in Harlow experiencing the lowest average life expectancy for both males and females.
- The 2021 update for one year life expectancy shows an improved position for females in Harlow. This was previously categorised as significantly worse than the England value, however the latest data shows similar to England.

** Absolute trends will be updated later in the year as Fingertips methodology is updated to reflect the latest census*

Hertfordshire and West Essex Integrated Care System

Healthcare and premature mortality

* value suppressed for disclosure control due to small denominator

Better 95% | Similar | Worse 95%

	Indicator Name	Time period	England	Broxbourne	Dacorum	East Hertfordshire	Epping Forest	Harlow	Hertsmere	North Hertfordshire	St Albans	Stevenage	Three Rivers	Uttlesford	Watford	Welwyn Hatfield
	E01 - Infant mortality rate	2019 - 21	**3.9**	4.7	2.8	3.2	1.9	2.2	2.5	2.6	2.4	4.6	4.2	1.9	4.5	2.7
OF	E02 - Percentage of 5 year olds with experience of visually obvious dentinal decay	2021/22	**23.7**	24.6	11.4	9.2	23.2	28.6	14.9	7.2	10.2	11.6	11.0	*	16.6	17.4
OF	E03 - Under 75 mortality rate from causes considered preventable	2021	**183.2**	170.5	146.3	119.4	161.7	208.8	134.7	138.7	122.2	168.6	129.6	102.3	179.0	158.0
OF	E04a - Under 75 mortality rate from all cardiovascular diseases	2021	**76.0**	57.5	63.5	65.0	62.4	89.5	57.8	67.0	48.4	59.4	40.3	44.4	64.2	56.2
OF	E04b - Under 75 mortality rate from cardiovascular diseases considered preventable	2021	**30.2**	24.4	23.6	24.8	23.5	36.0	20.0	27.6	19.5	26.1	15.9	16.6	24.9	20.9
	E05a - Under 75 mortality rate from cancer	2021	**121.5**	126.9	108.7	98.4	103.3	133.5	112.3	103.9	81.8	115.6	87.1	87.2	121.2	108.5
	E05b - Under 75 mortality rate from cancer considered preventable	2021	**50.1**	45.7	42.5	28.1	45.3	54.5	46.2	31.6	35.7	47.9	35.0	33.4	52.5	52.7

- Premature mortality by different conditions for the ICS remains similar or better than the England position.
- Cardiovascular premature mortality trend is marginally worse for England but has remained similar for Hertfordshire and West Essex.
- Areas with higher levels of deprivation in general experience poorer outcomes within the ICS. As previously observed Broxbourne, Harlow, Stevenage, Watford and Welwyn Hatfield have similar outcomes and are similar in terms of demographic features.

Healthcare and premature mortality

* value suppressed for disclosure control due to small denominator

Better 95% | Similar | Worse 95%

	Indicator Name	Time period	England	Broxbourne	Dacorum	East Hertfordshire	Epping Forest	Harlow	Hertsmere	North Hertfordshire	St Albans	Stevenage	Three Rivers	Uttlesford	Watford	Welwyn Hatfield
	E06a - Under 75 mortality rate from liver disease	2021	**21.2**	13.1	14.0	12.5	9.8	19.1	11.6	16.0	11.4	20.8	23.0	*	16.4	21.2
	E06b - Under 75 mortality rate from liver disease considered preventable	2021	**18.9**	*	11.9	10.4	8.2	*	*	11.9	10.0	18.1	21.7	*	14.0	15.1
OF	E07a - Under 75 mortality rate from respiratory disease	2021	**26.5**	24.6	19.4	13.7	16.5	*	22.1	19.6	14.7	27.8	20.2	*	21.6	29.8
OF	E07b - Under 75 mortality rate from respiratory disease considered preventable	2021	**15.6**	12.6	11.8	10.1	8.2	*	13.1	11.9	9.3	20.0	*	*	*	17.2
	E08 - Mortality rate from a range of specified communicable diseases, including influenza	2021	**9.4**	*	13.1	7.9	7.1	*	10.9	9.0	6.4	*	13.6	*	*	11.5
	E10 - Suicide rate	2019 - 21	**10.4**	6.1	8.4	8.8	8.7	10.0	11.5	6.5	8.3	9.0	6.9	10.3	4.4	7.7

- Further indicators for Premature mortality by different conditions shows the ICS is similar or better than the England position.
- Latest suicide data shows an improvement in rates in Harlow.

Healthcare and premature mortality

* value suppressed for disclosure control due to small denominator

Better 95% | Similar | Worse 95%

	Indicator Name	Time period	England	Broxbourne	Dacorum	East Hertfordshire	Epping Forest	Harlow	Hertsmere	North Hertfordshire	St Albans	Stevenage	Three Rivers	Uttlesford	Watford	Welwyn Hatfield
OF	E11 - Emergency readmissions within 30 days of discharge from hospital	2020/21	**15.5**	13.9	14.1	14.8	15.7	15.9	13.4	15.2	13.2	15.8	13.8	13.8	13.7	14.0
OF	E13 - Hip fractures in people aged 65 and over	2021/22	**551.2**	488	505	559	555	540	551	555	510	638	533	567	557	536
OF	E13 - Hip fractures in people aged 65 to 79	2021/22	**235.7**	191	229	217	184	208	276	183	217	216	246	196	250	241
OF	E13 - Hip fractures in people aged 80 and over	2021/22	**1466**	1349	1307	1550	1631	1503	1348	1636	1360	1863	1365	1645	1449	1389
	E14 - Winter mortality index	Aug 2020 - Jul 2021	**36.2**	47.8	31.6	22.8	62.2	53.4	35.0	69.1	52.5	53.0	48.9	49.2	52.7	65.6
	E14 - Winter mortality index (age 85 plus)	Aug 2020 - Jul 2021	**42.8**	45.9	39.1	35.2	59.8	52.0	34.4	89.8	50.9	71.8	52.7	36.8	72.8	81.3
	E15 - Estimated dementia diagnosis rate (aged 65 and over)	2022	**62**	50.8	56.4	51.5	78.3	52.3	66.4	65.5	55.8	73.7	55.1	61.0	75.8	56.3
	E15 - Estimated dementia diagnosis rate (aged 65 and over)	2023	**63.0**	54.6	60.0	52.2	80.6	55.1	67.2	67.5	56.6	74.6	52.3	62.4	76.3	57.7

- In general the majority of indicators are similar or better than the England rate.
- A small number of indicators are statistically worse than the national average in some districts within the ICS for Winter Mortality.
- Post covid the estimated dementia diagnosis rate has opportunity for improvement in 7 districts within the ICS.

- The latest % Winter mortality index covers the period of the Covid pandemic. The data shows Epping Forest, North Hertfordshire and Welwyn Hatfield with significantly higher number of deaths than the national.

Hertfordshire and West Essex Integrated Care System

Appendix B: Our system in the future

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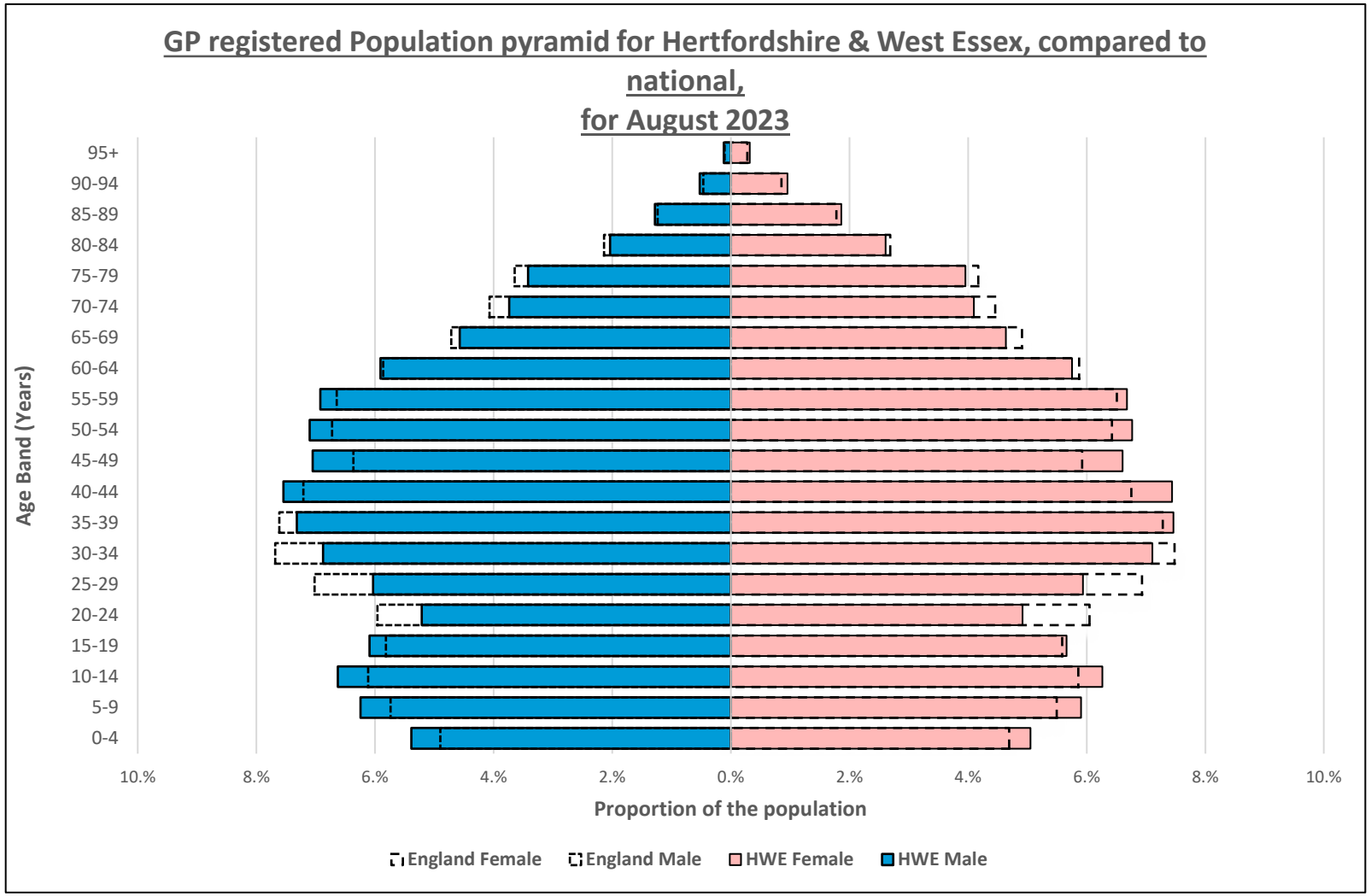
Demographic Profile and Segmentation

- Compared to the national average, the HWE ICS has a higher proportion of the population aged over 85 years, and a higher proportion aged under 20 years.
- Younger adults (20-34 years) make up a smaller proportion of the population, whilst older working age adults make up a greater proportion of the population.
- The registered population in HWE ICS has increased by 1.33% in the last 12 months, compared to a 1.35% increase nationally.

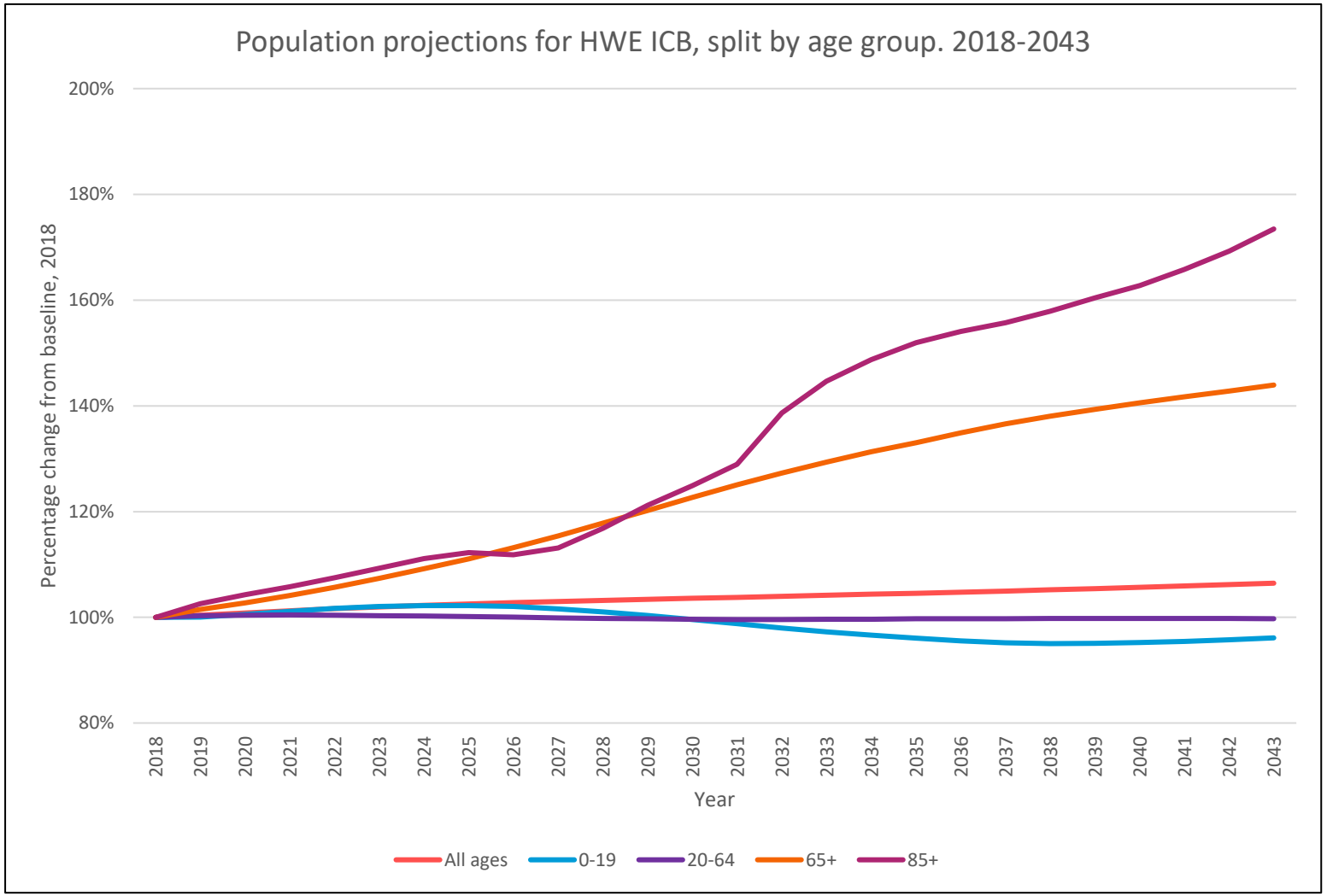
Source: Patients registered at a GP Practice Dashboard - August 2023



Hertfordshire and West Essex Integrated Care System

Demographic Profile and Segmentation

- The population of the HWE ICB is expected to increase by 6% overall between 2018 and 2043.
- There will be significant differences in growth across age bands.
- Whilst there will be limited growth (or reductions) in children and working age adults, there will be significant growth in over 65 year olds and very significant growth in over 85 year olds.
- There is a sharp incline in the number of people aged over 85 years after 2030 as ‘baby boomers’ age.



Hertfordshire and West Essex Integrated Care System

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Questions to the Board

Public Engagement Forum:

Continuity of Care – Many patients, especially those with a complicated medical condition, appreciate **continuity of care**, and being treated holistically.

Question:

What is the ICB's position on ensuring continuity of care across primary, community, hospital and mental health providers? And is there any assurance you can give that there is sufficient capacity and skills in care services to support this aspiration?

NB recently published research shows continuity of care is beneficial to both the patient and the GP, but in order to achieve this a patient will have to wait 18% longer to see their GP (https://www.cam.ac.uk/research/news/having-a-regular-doctor-can-significantly-reduce-gp-workload-study-finds).

Response:

The ICB is responsible for the development and delivery of healthcare in partnership with NHS providers, Local Government partners and the wider VSFSE sector. The organisation seeks to deliver the national NHS mandate for all of its population as well as addressing local inequalities and variations within the local patch. These plans are set out in the Joint Forward Plan and annual system operating delivery plans, progress on which is reported to this Board and the ICB sub-committees with our wider achievements set out in the annual report. We are also developing a medium-term plan to focus on the local system transformation priorities the delivery of which over time will support the wider improved health and wellbeing of our population.

In terms of how we ensure we have the skills and capability to deliver this work, this is a key element of the delivery plan overseen by the People Committee and frequently reported back to this Board.

Question:

Outpatient Waiting List – What is the total size of the waiting list this month? How does that compare to last month, and to the same month last year? What initiatives are working, in each of the 3 hospitals, and need to be accelerated?

Response:

Thank you for your question in relation to initiatives for outpatients. It will probably make things clearer if we recognise that there are three different times of outpatients; those where the consultant is seeing the patient for the first time, after referral, known as “firsts”. The second type is “follow-ups” and the third type is “procedures”, and these are hopefully self-explanatory.

At present there are three main focus areas. The first is increasing the number of “firsts” so that patients who have been assessed by their GP get seen by the appropriate specialists. In this regard we have been providing about 70,000 more first outpatient appointments compared to the pre-pandemic year, but we are doing a lot of work to ensure departments are operating as efficiently as possible, such as comparing rates of patients who ‘do not attend’ their appointment and trying to reduce this.

The second is to try to and avoid unnecessary referrals. There are many cases where a brief correspondence or conversation between the general practice and the specialist may give patients the answers they need very quickly. This is known as ‘advice and guidance’ and we have commissioned this across the whole of the Hertfordshire and West Essex Geography. To add to this we are also looking at appropriate community alternatives.

The third focus is to streamline the use of follow-ups. National guidance is that the ratio of firsts and procedures to follow ups should favour firsts and procedures as much as possible. In this respect, we do have the most favourable ratio in the East of England, but we plan on improving this by several additional percentage points through the year. We are doing this by looking at ICS wide implementation of tried and tested protocols which are working well in this region, but have also had presenters from other hospitals such as the Norfolk and Norwich, Maidstone and Tunbridge Wells and East Suffolk and North Essex Foundation Trust.

Additionally, PIFU (patient initiated follow up) is a focus of the ICB and providers, which is of real benefit to patients and something that is being rolled out within different specialties in the system. PIFU is when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances. It can be used with patients with long or short term conditions in a broad range of specialties including dermatology and rheumatology.

Overall, there is an increase in the waiting list for outpatients however, concurrently there is an improvement in the number of patients waiting 104, 78 and 65 weeks, which is in line with the national requirement and the operational planning guidance to reduce this cohort of patients. Each cohort improved over 2023/24 and the end of April 2024 showed the number of breaches had decreased to 1x 104 week wait (in the independent sector), 83x 78 week waits (43 of whom were in the independent sector) and 1,278x 65 week waits which has a target of zero breaches by end of September 2024, for which there is a robust plan in place.

Appendix 1 – data included.

Question:

Acute Hospitals – are there any plans for acute hospitals to be able to use e-Prescribing, particularly for medications prescribed by A&E, UC and same day emergency centres?

Response:

Are there any plans for acute hospitals to be able to use e-Prescribing, particularly for medications prescribed by A&E, UC and same day emergency centres?		
	HWE ICS Acute Trust	**Response**
1	East and North Hertfordshire Trust (ENHT)	*ENH currently has full e-prescribing across its inpatient wards which will be implemented within ED by May 2025 when the New EPR is deployed.* *There are no current plans to use the Electronic prescriptions Service (EPS) for Outpatients.*
2	West Hertfordshire Teaching Hospital (WHTH)	*We are in the process of writing a business case to try and obtain the funding that would support e prescribing in the community for outpatients. We are including same day emergency services in the scope should the business case be approved.*
3	Princess Alexandra Hospitals (PAH)	*ePrescribing is already live from our inpatients wards, SDEC and ED (JAC)*

Top 5 Patient Concerns – The PEF terms of reference now commit us to provide the Top 5 patient concerns at every other ICB Board Meeting and to request the Board to note this information.
Will the board consider using this regular patient feedback to inform future decisions?

We are grateful to the Patient Engagement Forum for their work to develop this information and will include it in our Integrated Report to the future board meetings.

Questions from the public

Question:

The new NICE Guideline for Stroke Rehab. was published on the 18th October 2023. Can the implementation plan for the new Guideline be shared?

Response:

There is not a formal implementation plan that can be shared, however the ICB and all our provider organisations are aware of the new NICE Guidelines and are working on how they can meet the new guidance, primarily within their current specification and workforce allocation. Work is focussing on sharing good practice and innovation, such as group therapy, telerehabilitation and skill mixing of staff, to meet the increased rehabilitation requirement. Delivery of stroke rehabilitation at scale is currently being tested with the introduction of the H&WE ICB Stroke Vocational Rehabilitation service and learning from this will influence delivery in accordance with the new guidance. Work is ongoing to develop our Integrated Stroke Services across the ICS and the new NICE guidance will be considered alongside the ICSS specification.

Question:

How will the delivery and outcome of the implementation be reported and monitored?

Response:

It is expected that delivery and outcomes will be reported through our stroke governance meetings; our place based stroke boards and our Stroke Senior Advisory Group meetings. The type of rehabilitation and intensity of therapy will continue to be monitored as part of SSNAP which is routinely monitored by our ICB Stoke Team.

Question:

** (in relation to the announced plans for development at Hemel Hempstead Hospital and the ICB involvement in them).*

In November, it was announced that a new Health Campus for Hemel Hempstead was being discussed. At present, West Hertfordshire Teaching Hospitals Trust has responsibility for Hemel Hempstead Hospital. But the November announcement on the Campus said that ' The most likely way forwards is for the ICB to lead on the development of the project, working closely with DBC [Dacorum Borough Council] and local NHS partners.'

Does that mean that all hospital services for Dacorum Borough will be the direct lead responsibility of the ICB in future? What continuing role in the Borough of Dacorum will West Herts Hospitals Trust retain? What arrangements will be put in place to ensure some local oversight of these developments?

Response:

Dacorum Borough Council, West Hertfordshire Teaching Hospital Trust and HWE ICB are working in partnership to explore the opportunity for a new health campus in Hemel Hempstead, that could allow a range of local health services to be provided from a single, convenient and easily accessible site. One of the options being considered is land owned by DBC and hence there are three parties to the project. All projects require clear overall leadership, and it has been decided amongst the parties that HWE ICB will lead on the project. Each organisation will adhere to its process and governance within an overarching project governance framework.

The current arrangement where HWE ICB commissions healthcare services and WHTH provides relevant healthcare services will remain in any new development, and therefore WHTH will continue to be responsible for delivering their services day-to-day.

Question:

Have there been any newly identified or continuing areas of concern for 2024 within HWE that require more ethnic representation in Mental Health service delivery? What have been the most challenging areas requiring solutions?

Response:

In 2023, the Trust commenced implementation of the Patient Carer and Race Equality Framework (PCREF) with a focus on improving access, experiences, and outcomes for ethnically diverse communities.

Upon preliminary data analysis, it became evident that individuals identifying as Black/Black British were disproportionately represented in our Inpatient Units and crisis services, while those of Asian/Asian British descent were notably underrepresented across all services. In response, we proactively initiated an Outreach Programme in partnership with the voluntary sector, aimed at building trust, reducing stigma, and facilitating early access to preventive services to reduce Mental Health Act detentions.

Since the inception of this programme, the impact has been tangible, evidenced by a remarkable 300% increase in people from BAME backgrounds accessing Talking Therapies in Watford. Leveraging DIALOG to assess outcomes, early indications point to significant improvement in the mental health of BAME service users. Nevertheless, persistent social determinants such as employment, accommodation, relationships, and personal safety continue to pose significant challenges for this demographic. Are there any conclusions as to why this is the case – as this has impact on those communities accessing those services

and therefore what work is being done towards this. Is there additional service delivery to help combat this.

While strides have been made, the imperative for continuous improvement remains paramount, with a commitment to ensuring that the voices and experiences of service users drive continuous improvements. Furthermore, we recognise the need to expand our outreach efforts to communities yet to be fully engaged, including Gypsy, Traveller and Roma communities (GTR), Chinese, Japanese, alongside sustained collaboration with those already within our sphere of engagement.

In parallel, the Trust's workforce reflects good levels of diversity, with 38% comprised of Black and Minority Ethnic (BAME) staff. Whilst our recent staff survey identified improvements in the equality of experience between White and BAME staff, there remains a difference. The Trust recently co-produced and launched our Belonging and Inclusion Strategy which commits to ensuring that all our people have an equally great experience of being part of HPFT and to further developing a diverse workforce. Our Workforce Race Equality Scheme (WRES) and Belonging and Inclusion Strategy set out the actions we are taking to ensure we achieve equality, a sense of belonging and inclusion for all our staff.

Question:
What perinatal checks are there for fathers before and after childbirth e.g. mental and physical wellbeing

Response:

As a 'women's service' there are no formalised physical or mental wellbeing checks for fathers. During the very first booking appointment, in line with NICE guidance (NG 201 AN Care), the woman is asked 'about her medical history, obstetric history, family history (of both biological parents). It also asks for her family & home situation, available support network and any health or other issues affecting her partner or family members that may be significant for her health and wellbeing'. This will be recorded at each Trust in line with their individual documentation.

Postnatally, at the community midwives first home visit, the woman is asked how the family are doing as part of holistic care but this does not include a mandated, specific question about fathers health, which is in line with national guidance.

At any point in the pregnancy or the postnatal period a midwife may enquire after the fathers physical or mental health on an individual basis, as part of personalised care and in line with safeguarding responsibilities regarding any issue that may impact the health and well-being of mothers and babies. A significant issue relating to fathers' physical or mental health may prompt an information sharing form to be completed and shared with other professionals if

additional family support could be beneficial. If a referral to social care is deemed necessary in order to access additional support or for safety reasons then this would also be made.

At the three Trusts across the system, partners are now welcomed 24/7 to stay with their partners and baby's in response to service user feedback as we recognise the vital role that fathers/partners play as part of the family unit.

Support for fathers is provided by our partners. For example, the Hertfordshire Family Centre Service have recently launched an inclusive workshop 'becoming Dad', for new and expectant fathers. This is to help them connect with and understand their baby's needs and to promote positive mental health. The Family Service can also provide targeted support through one to one sessions or via parenting groups concerning parental wellbeing, to help parents understand the importance of their own wellbeing and how this impacts their children.

Hertfordshire County Council have a 'support for dads' page on their website which sign posts 'dads' to advice, guidance and support. This includes where to go for Paternal mental health support. Posters have been produced to promote this resource and links to online information are provided via websites and hospital specific sites and applications.

Question:
And what is the ethnic minority breakdown for those accessing these services?

Response:

Maternity services capture all women's and partners ethnicity data at the start of pregnancy for screening purposes. A recent quality improvement project has ensured that paternal ethnicity on all neonatal records is equally robust. If midwives encounter fathers with poor mental health, they may sign post them to their GP or other support services, who are best placed to provide the further breakdown of the ethnicity data for men accessing additional support.

All women accessing perinatal mental health support in Hertfordshire are given a self assessment and signposting document for their partners, which can help them self identify a need for support and tells them how to access NHS mental health support. As will not be via a dedicated service for fathers, ethnicity and access figures for fathers are not available.

In Essex, a peer support organisation will be subcontracted this summer to provide a screening support call for fathers, which will be offered via the women. This latter service will be able to record ethnicity of fathers accessing services.

Hertfordshire Public Health Nursing have recently piloted a fathers emotional wellbeing assessment, focusing on the feasibility of undertaking emotional health screening for fathers. Due to the success of this pilot, universal screening and signposting will roll out for all fathers/partners this summer and will record ethnicity of fathers who are subsequently signposted to access additional support. This will be possible because this service will be separate to the mother's care, therefore not subject to the confidentiality, consent and data

protection restrictions that impact the recording of the fathers' data within maternity and women's perinatal mental health services.

We appreciate the query around the ability to request the ethnicity of fathers accessing perinatal mental health services. As supporting the mental health of fathers is an agenda that has only recently gained momentum, local services are still in their infancy therefore provision and reach will naturally expand over the coming years in line with need. As the impact of these will be key to their sustainability, recording data that supports the evaluation and uptake of services, such as ethnicity, will be essential.