NHS HWE ICB Board meeting

Held in Public

Friday 22 March 2024

Latton Hall

Latton Bush Conference Centre

Harlow

CM18 7BL

11:30 - 15:00

NHS
Hertfordshire and West Essex
Integrated Care Board

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: 26 January 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	Chief Executive Officer
12:00	7. Governance Report	Approval	Chief of Staff
12:15	8. Integrated reports for finance, performance, quality and workforce	Assurance	ICB Executive Team
	Lunch break 12:30 - 13:00		
	Exception reports		
13:00	9. Quality Escalation Report	Assurance	Director of Nursing
	10. Performance Report	Assurance	Director of Performance
	11. HWE Finance Report	Assurance	Chief Finance Officer
	12. Committee summary reports	Assurance	Committee Chair's
	Part Two - System, Leadership and Strategy		
13:05	13. Green Plan, progress and future roadmap	Approval	Sustainability Programme Manager
13:20	14. HWE Joint Forward Plan - Refresh Update	Approval	Director of Strategy
13:35	15. HWE ICS Urgent and Emergency Care Strategy	Approval	Director of Operations
13:45	16. Deep Dive: Review of winter and innovation in demand management	Assurance	Director of Operations
14:40	17. Questions from the Patient Engagement Forum and public	Assurance	ICB Executive Team

14:50	18. What would service users, patients, carers and staff take away from our discussions today?	All
15:00	Close of meeting	Chair
	Date of next meeting: Friday 24 May 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:**	**22/03/2024**
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	

Herts and West Essex ICB Board 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	Foreame			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	
			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	To be declared as appropriate
			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	
Stober	Thelma	Non-Executive Member, NHS HWE ICB	Patient , Surgery Berkhamsted	-	-	√	-	-	2018	Current	HWE Conflict of interest Policy . NHS England » Managing conflicts of interest in the NHS and Best practice in corporate governance
			Patient, RNOH Stanmore			√			2005		
			Patient, Stoke Mandeville Hospital			√			2010		
			Employee of Local Government Association	√	-	-	-	-	2013	Current	
			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	-	-	-	-	-	-	-	-
Watson	Michael	Chief of Staff, NHS HWE ICB	Nil	-	-	-	-	-	-	-	-
Webb	Matthew	Hertfordshire & West Essex ICS Transition Director	Partner is employed by AGEM CSU as a Programme Director	-	-	√	-	√	10.01.22	Continuing	
			Daughter is an employee of Central & North West London NHS Trust	-	-	√	-	√	Dec-20	Continuing	
Wightman	Lucy	Partner Member, Local Authority	Member of international Advisory Panel for Academic Health Solutions	√					Apr-22	Present	Exclusion from related/conflicted agenda items/papers
			Board Member for Northamptonshire Sport		√				Apr-22	Present	Exclusion from related/conflicted agenda items/papers
			Member of Reform Health Council						Sep-22		Exclusion from related/conflicted agenda items/papers
			Board Member for Intelligent Health & Sport England Advisory Board		√				Aug-22	Present	Exclusion from related/conflicted agenda items/papers
			Student at Anglia Ruskin University		√				Jan-23	Present	Exclusion from related/conflicted agenda items/papers

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 26 January 2024**			
Time:	**11:30 – 15:10**			
Venue:	**The Fielder Centre, Hatfield and remotely 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
Catherine Dugmore (CD)	Non-Executive Member	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)	Medial Director	Herts and West Essex ICB
Lance McCarthy (LM)	Partner Member (NHS Acute Trust)	Herts and West Essex ICB
Owen Mapley (OM)	Partner Member (Local Authority, HCC)	Herts and West Essex ICB
Prag Moodley (PM)	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
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:		
Alan Bellinger (AB)	Chair, Patient Engagement Forum	Herts and West Essex ICB
Rosie Connolly (RC)	Deputy Director Quality Improvement and Patient Safety	Herts and West Essex ICB
Sharn Elton (SE)	Place Director, East and North Herts	Herts and West Essex ICB

David Evans (DE)	Executive Director, Strategy and Partnerships	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)	Chief People Officer	Herts and West Essex ICB
Margaret-Mary Devaney (MD)	Director of Quality and Patient Safety Specialist	East and North Herts Trust
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
Matt Webb (MWe)	Place Director, South West Herts	Herts and West Essex ICB
Tracey Norris (TN)	Meeting Clerk	HFL Education
Via Microsoft Teams:		
Natalie Hammond (NH)	Director of Nursing and Quality	Herts and West Essex ICB
Ian Perry (IP)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Lucy Wightman (LW)	Partner Member (Local Authority ECC)	Herts and West Essex ICB

ICB/01/24	**Welcome, apologies and housekeeping**
1.1	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).
1.2	Apologies for absence had been received from: • Joanna Marovitch • Nick Moberly • Karen Taylor (represented by David Evans) • Toni Coles Members joining on Teams were: • Ian Perry • Natalie Hammond • Lucy Wightman
ICB/02/24	**Declarations of interest**
2.1	The Chair invited members to update any declarations relating to matters on the agenda and reminded them of their responsibility to update their declarations: • None declared. 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/03/24	**Minutes of the previous meeting**
3.1	**The minutes of the previous meeting held on Friday 24 November 2023 were approved as an accurate record.**
ICB/04/25	**Action Tracker**
4.1	The following update was provided: • ICB.83.4/23: Report on system providers' response to learnings from Countess of Chester hospital: See quality report for update. Item closed. • ICB.98.9/23: Overview into SEND services for Children and Young People: creation of improvement action plan and oversight board which will report at committee level. Item closed.
4.2	**The Board noted the updates to the action tracker.**
ICB/05/24	**Chair's update report**
5.1	The Chair's update (pages 24-27 of the document pack) was noted.
5.2	There were no questions or comments arising.
05.3	**The Board noted the Chair's update**
ICB/06/24	**Chief Executive Officer's report**
6.1	Jane Halpin (JH) referred to her update (see pages 28-52 of the document pack) drawing the board's attention to the following: • Industrial action: the possibility of action by junior doctors and consultants remained a risk. In a recent ballot, consultants had not accepted the latest pay offer. Work was ongoing to mitigate the impact of potential industrial action on the delivery of services. • A national critical incident had been announced in response to the West Midlands measles outbreak. Vaccination rates in HWE were c92% overall and work was ongoing across the ICS to identify pockets of low take up and mitigate the spread of the disease which was highly contagious. • Positive feedback had been received from the "getting it right first time" review.

6.2	Questions and comments were invited: • HCC were liaising with Public Health and system partners to get comms out to all communities where the take-up of the measles (MMR) vaccination was low.
6.3	**The Board noted the CEO's report**
ICB/07/24	**Governance Report**
7.1	Michael Watson referred to the report (see pages 53-64 of the document pack) drawing the board's attention to: • The Governance Report would now be a standing agenda item. • The Governance review recommendations that have been amended since they were last received by the board- in particular the creation of the strategy committee. • Further review and discussion would be possible at February's development session. • Final terms of reference will be submitted to the Board for approval in March.

7.2	Proposed changes to the ICB Governance Structure:
	• Board members welcomed the opportunity of further discussion and greater clarity on the role and responsibilities of the merged committees and HCPs.
	• Areas for further consideration included:
	  ○ Agenda mapping for the merged committees to ensure smooth transition.
	  ○ Strategic planning would remain the responsibility of the Board, with implementation of strategy delegated to the strategy group.
	  ○ Continuous review of the level of detail and information shared at each committee so that all system partners were able to continue to contribute.
	  ○ Opportunities to reduce duplication of discussion.
	The proposals were AGREED in principle.

8.3	**Proposed amendments to the Constitution: APPROVED.**

8.4	Board Assurance Framework
	• Risks have not materially changed since the last iteration.
	• Risks around SEN provision would be reviewed, and MW would provide an update in a future paper.
	• Next steps included:
	  ○ Development and mitigation of system risks.
	  ○ Identification of medium term and longer-term system risks and mitigation timeline.
	  ○ Horizon scanning to be completed in Board development session.

8.5	**The Board approved in principle the changes to the governance structure, approved the amendments to the constitution and noted the board assurance framework**
ICB/09/24	**Integrated report for finance, performance, quality and workforce**
9.1	MW introduced this agenda item (see pages 65-83 of the document pack) and invited each of the area leads to present their highlight report before opening for questions.
9.2	**Finance overview:** Alan Pond (AP) summarised the financial position: • The system wide deficit as at Month 8 was £36.5m, this was an improvement of £8.9m on the month 7 position. • NHSE have announced the capital that will be released to the system to cover International Financial Reporting Standard 16, which will impact all organisations holding lease agreements. At this stage the funding allocated falls short of the HWE requirement by £21.1m
9.3	**Performance overview:** Frances Shattock (FS) provided the following update: • Highest risks: ED 4hr standard and ED admittances. • Successes: Reduction in hours lost in ambulance handovers and marginal improvements in elective long waiters. • Industrial action in December and January would negatively impact most metrics.

	• Waiting time for children/young people in community/mental health services remained high with children/young people waiting longer than adults. • Cancer: 28-day faster diagnosis performance remained broadly flat for the last four months but was better than national average. The number of patients waiting >62 days had reduced significantly between September and November. Performance against the 62-day standard remains below target (but above regional and national average).
9.4	**Workforce overview:** Tania Marcus (TM) provided the following update: • Some reduction in staff turnover has been recorded. • Bank and agency staff levels remained above projections but there have been reductions at some of the acute providers as medical posts have been recruited and health care assistants have been taken on permanently (from bank). • Domestic recruitment has been prioritised (above international) with a focus on the clinical education pipeline (NB University of Hertfordshire and apprentice schemes). • National directive to re-band healthcare assistants from Band 2 to Band 3 will impact budgets for PC and social care partners as this was expected to be backdated to August 2021. • The new diagnostic productivity tool has been used by two acute providers (part of the pilot). Feedback had been given to NHSE and TM hoped that modifications would be made to enable the tool to be improved and to be utilised in MH and community settings.
9.5	**Quality overview;** Rosie Connolly (RC) provided the following update: • *c-diff* – some improvement with only ENHT currently above the regional rate. • Audiology: challenges remained at ENHT and for complex pathways although some progress had been made with recruitment. • Ophthalmology: The team were working with all three trusts to ensure a consistent approach in each place re provision. Learnings from "Getting it right first time" visit to PAHT would be shared.
9.6	Questions and comments were invited: • Recruitment outreach events included visits to schools, NHS careers events in Hatfield and Harlow, promotional videos in shopping centres as well as liaison with Hertfordshire University and colleges re future skills needs. • An outpatient deep dive at the Performance Committee had highlighted the volume of appointments offered each year and ways in which patient experience could be improved, NB greater collaboration/communication between primary and secondary care. • Waiting lists, waiting well initiatives and list prioritisation measures were discussed. In-depth analysis was conducted at provider and committee level, but it was agreed that the Board should have increased sight of this complex picture in the executive summary given its importance and high profile for citizens and the impact of growing waiting times on the wider system (ie primary care). Metrics on clearance times would be welcome. • Pathway improvements were being developed to address the increased demand for MH services for young people. The roll-out of mental health support teams in schools would begin to mitigate some demand.
9.7	**The Board noted the integrated reports for finance, workforce, quality and performance**
ICB/10/24	**Aligning needs of the HWE population and interventions for improved outcomes**
10.1	Rachel Joyce (RJ) presented this agenda item (see pages 84-145 of the document pack) drawing the Board's attention to: • The projected significant rise in the population of the >85yr age group. • High rates of emergency admissions of children. • Low levels of school readiness NB FSM cohort. • Increasing rates of smoking and obesity. • High rates of suicide. • Variations in life expectancy. • High rates of falls and fractures and admission rates in the last year of life.

	• Examples of programmes to respond to population health needs included frailty, young people, and long-term conditions. • Data packs would be shared with PCNs.
10.2	Questions and comments were invited: • Board members noted the rich data in this report and welcomed the increasing ability to integrate data across all partners (LA, public health and social care) and improve the identification of issues/cohorts and interventions. • Programmes of work had been re-prioritised in response to population health need; it was clear that the data was driving commissioning decisions, eg UTC at PAHT. • Preventive and lifestyle workstreams were key to supporting the ageing population as well as taking a holistic view of the frailty cohort (co-morbidity). • Links between productivity/financial planning and workforce CPD could eventually all be linked to population health need. • Transformation in the primary care ECF and medical workforce (eg ARRs) would further support this. • Population health management data should be used not just as a description of need but as a tool to identify cohorts who will benefit from intervention, supported by clear communication. INTs would be key in developing this. • Quantitative measures of the impact of interventions were welcomed, eg reduction in the number of unnecessary diagnostic procedures following introduction of UTC. • Future deep dive: frailty.
10.3	**The Board noted the report and recommended the sharing of the paper and the population health need data with Healthwatch, ICPs, HCPs and other partner organisations.**
ICB/11/24	**Quality Escalation Report**
11.1	See pages 146-188 of the document pack
11.3	**The Board noted the Quality Report**
ICB/12/24	**Performance Report**
12.1	See pages 189-243 of the document pack.
12.3	**The Board noted the Performance Report**
ICB/13/24	**ICB Finance Report**
13.1	See pages 244-261 of the document pack.
13.2	**The Board noted the ICB Finance Report**
ICB/14/24	**Committee Summary Reports**
14.1	See pages 262-274 of the document pack.
14.2	**The Board noted the Committee Summary Reports**
ICB/15/24	**Deep dive: Patient Safety**
15.1	Natalie Hammond (NH), Rosie Connolly (RC) and Margaret Mary Devaney (MMD) presented this agenda item (see pages 275-290 of the document pack) drawing the Boards attention to: • The strategy, background, and context to the improvements in patient safety culture. • Serious incident reporting would be replaced by PSIRF framework with focus on oversight and learning from events rather than the number of events. The transition to the PSIRF (experience and learnings) at ENHT was shared. • The roll out of medical examiners and the creation of patient safety partners: 88% of general practices have engaged with the medical examiners service (100% compliance

	was required by April 2024). Opportunities for learning identified by MEs (from care and community cases) would be shared with the ICB. • The national patient safety plan had been delayed but was expected later in the Spring; this would have implications for all primary care providers and comms on this had already been shared with PC. • Extensive governance systems were in place to support patient safety throughout the system with clear routes into the ICB and Regional.
15.2	Questions and comments were invited: • The enthusiasm and engagement of the system in this area was noted. • Suggestions for wider areas for review re patient safety included medication and frailty de-conditioning (9% of non-elective admissions related to medication issues). • Governance was linked to the system oversight group. • Webinars and training sessions for staff would regularly be held to share "you said....we did...." feedback; this work was further supported by the Freedom to Speak Up Guardians. • Changes to pathways as a result of learnings to avoid future harm demonstrated the impact and value of PSIRF across the system. • The value from using patient safety partners in pathway design and the need for clear terms of reference for new committee structure re patient safety responsibilities was highlighted.
15.3	**The Board noted the patient safety presentation.**
ICB/16/24	**Patient Engagement Forum Report**
16.1	Alan Bellinger (AB) presented this agenda item (see pages 291-305 of the document pack) drawing the Board's attention to: • The PEF had been created to ensure that patient voice could be heard. • AB had been appointed Chair of the PEF in September 2023 and there were now 17 members. • Wider networks would be built up overtime through PPG contacts and networks. • The PEF saw itself as a collaborative partner rather than a critical friend.
16.2	Questions and comments were invited: • Technical support from the ICB to create a platform/database and collaboration from practice managers would be welcomed. The possibility of including the voluntary sector in this wider network creation was raised. • Learnings from MH/autism patient groups and their contributions to pathway design within HPFT were shared. • Patient engagement was a two-way process; supporting the co-production of new pathways and providing feedback. • Diversity within the PEF was crucial to inclusion.
16.3	**The Board noted the Patient Engagement Forum Report and presentation.**
ICB/17/24	**Questions from the public**
17.1	See appendix 1.
ICB/18/24	**What would service users, patients, carers and staff take away from our discussion today?**
18.1	The following observations were made: • Focus and appetite on learning and responding to patient experience. • Importance of workforce and people across the system was evident in all discussions.
Date of next meeting: Friday 22 March 2024	
The meeting closed at 15:10.	

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:**	**22/03/2024**
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

Chairs Report to the Integrated Care Board

Chairs Report

I would like to begin by welcoming all members of the board to our second meeting of the year. Today's agenda is representative of where I think we currently are as a system- with discussions focused on the challenges of the next few years- our financial and operational plan for 24/25, Urgent and Emergency Care, and the further delegation of responsibilities mixed with some of the changes we need to make the meet the challenges of the future- the recommendations of our community services review, our Green plan for the system and preparations of our Medium Term Financial and Operational plan.

I suspect that this will be a theme of the next few months, and I am very conscious of how difficult it can be to devote time to planning for the future when the here and now operational pressures on the NHS are so challenging. Thank you to all ICB staff, and staff from across the system both for their work to care and support our residents now, and their work in planning to ensure we can sustainably deliver that care not just today but in the future.

Preparing for 2030

At our Board Day last month, we discussed our medium term financial and operational plan, and I am grateful to all for their contribution. Getting this plan right is critical for our system. Its critical now because we already know what needs to change to improve care for our residents- a shift to more operationally integrated and proactive care which has empowered patients and their carers at its centre, and a move away from acute care to care at home or in the community wherever possible. Its critical for the future as we seek to meet the challenges of a population that is living longer but not always healthier lives. The NHS contribution to supporting our residents to age well is to make the shift from reactive care to ways of organising ourselves to deliver more anticipatory care.

There is much work to be done between now and May, when the plan comes to the Board for final consideration- and I know, and I am keen that, all board members can contribute to its development.

Governance Review and Health Care Partnerships (HCPs)

A further element of ensuring that we are prepared as a system to meet our present and future challenges is ensuring that our governance breaks down siloed thinking, enables effective decisions and acts as an enabler of different ways of working. We are also changing the ICBs governance to create the conditions in which our placed based and MHLDA HCPs can drive the transformation in health and care our residents need.

After much discussion, I believe that we have reached the right place in terms of the recommendations of our governance review- and in today's governance report we receive

an update on implementation of the review's recommendations over the coming months. I look forward to working with you all to make the new arrangements a success.

Look ahead to 24/25

As I mention above- in planning for the future must never lose sight of the need to continue to deliver for the residents of Hertfordshire and West Essex now. I know that many staff across the system are presently engaged in planning for next year, and we will be discussing that at various points today. In line with the wider NHS context our operating and financial position remains very challenging and there will be difficult decisions that will need to be made- and the board will play an essential role in that process. These challenges were underscored by the NHSE national leadership at an in-person event for Trust and ICB Chairs in February which I attended with many of our Trust Chairs.

I am grateful to Board members for their feedback and support in approving the ICSs approach to redistributing the ICBs 2023/24 underspend amongst our Trust partners. Because urgent decision was made under our standing orders this is reported in the Governance Report for formal ratification.

Changes to the board

I am sad to say that both of our local government partner members- Lucy Wightman (Essex County Council) and Owen Mapley (Essex County Council) will be leaving their organisations to move on to exciting new opportunities, which means that they will also be leaving our board. I want to thank them both for their work as part of the Integrated Care Board since it was formed in July 2022. Their dedication to ensuring that the voice of Local Government is at the heart of our deliberations has been invaluable, as has the value-based approach to ensuring we constantly strive to deliver integrated services for our residents that they have both continuously demonstrated.

Integrated Care Partnership

In February I attended a development session of the ICP. The ICP remains critical to delivering the change we need to make as a system to meet the challenges of the future. In particular, we will only be able to tackle inequalities that exist within our system through the broader spectrum of partners that the Integrated Care Partnership provides. I think in the coming months we will see changes to the way that the ICP choses to conduct its work- and the ICB looks forward to being a fully active partner in its future development.

Hertfordshire Growth Board

In January I attended the Hertfordshire Growth Board on behalf of the ICB. Over the past year the Board has been reviewing its priorities and has adopted a mission-based approach to its future growth strategy. I am sure colleagues will welcome the inclusion of a health-based mission in the strategy, recognising the important role of place-making to healthy communities and in particular the role that local plans and planning must play. It also gave me the opportunity to talk about the investment the ICB has made in building a team to work with our thirteen District and Borough Councils both at the plan writing stage and when planning applications are being considered.

Equality, Diversity, and Inclusion

In February the board also held a session to consider issues relating to Equality, Diversity, and Inclusion within the ICB and across the system. This is an area where many across the board are already playing a key leadership role- either through their role on the board or within their host organisations. I have written to all members of the Board setting out our next steps so that we continue to strengthen our shared leadership role by agreeing EDI objectives for each board member.

Steve Palmer- Chair of Healthwatch Hertfordshire

Many of you will have heard the sad news that Steve Palmer, the Chair of Healthwatch Hertfordshire between 2017 and 2023, passed away recently. Steve held many roles across our system serving as a councillor in Watford and as a social housing Finance Director as well as the Healthwatch Chair. His passion to improve health and care for the residents of Hertfordshire will have been clear to everyone and I would like to take this opportunity to pay tribute to Steve's service on behalf of the board.

The Rt Hon Paul Burstow

Chair

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:**	**22/03/2024**
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. The Board is asked to approve the updates made to the ICB Governance Handbook.			
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

Our financial position

Today's financial report, which is the last the board will receive this financial year, confirms that we remain on trajectory to successfully deliver our financial plan and achieve a balanced year-end financial position. The hard work that has taken place across the system to ensure that this is the case cannot be underestimated- and my thanks go to everyone involved.

Planning for 24/25 and beyond

Whilst the successful delivery of our financial plan this year is to be welcomed, In my board report I highlighted what a challenging year 24/25 would be for the system, with financial constraints that are greater than those we have faced in 23/24.

We are currently developing our financial and operational plans for 24/25- and the scale of the challenge means that it is inevitable that we will be required to make some difficult decisions. Crucial to achieving our plans will be our focus on five key priority areas for the year ahead:

- A focus on CVD and hypertension
- Improve UEC through more anticipatory/ same day emergency care
- Better care for those in Mental Health crisis
- Elective care recovery
- Childrens care backlog reductions

Success across these five areas will support delivery of our operational and financial priorities. More broadly, we know we also need to look to the future and create a plan to achieve our system priorities whilst also meeting the demand caused by the anticipated demographic changes that we will see across Hertfordshire and West Essex in the coming years. We will receive an update on the development of the Medium-Term Plan at todays meeting- and whilst the priorities above represent the year one focus of that plan, it will also set out the longer priorities and shifts in our model of care required.

Winter-operational performance

In my report to the board in January I also thanked staff across the system for their hard work over the winter period. This year, in addition to the usual demand pressures over the winter period, our teams also had to manage several rounds of Industrial Action.

Todays 'deep-dive' will focus on our approach to winter, our performance over the period and the lessons we have learnt. At today's board we will also be considering the systems Urgent and Emergency Care strategy- which seeks to incorporate that learning and build upon the huge strides that have been made to our system approach in this area over recent years.

Staff Survey

Board members will have seen that the staff survey results for NHS organisations were published earlier this month. We are continuing to analyse the results and will share a more detailed analysis with the board in the coming weeks. The ICBs results stayed largely stable- and we remain in the top 10 of ICBs for the question of whether staff would recommend us as a good place to work, with the

7th highest score in this area. Whilst this is to be welcomed, the staff survey does give us a clear sense of where we need to improve as an organisation- and the executive team is currently developing our action plan in response to the survey. In terms of system staff survey results I would like to particularly highlight PAH- who have seen a good improvement in many scores which is indicative of the work that the organisation has been doing to improve staff experience.

Health and Care Partnerships

The next phase in the evolution of our Health and Care Partnerships will begin next month. A key principle of our Medium Term Financial Plan will be to ensure that decisions are taken as closely to residents as possible, except for where there is clear benefit to doing something at scale. Over time our HCPs will develop further to support that, but in their first year they will crucial to delivering the priorities I set out earlier in my report, and have developed delivery plans to do so.

Careers event for Community and young people

I wanted to draw the boards attention to this event, which is referenced later in this report. It was held at the start of February in partnership with the University of Hertfordshire, with schools in attendance from across the system. It was an opportunity for young people to meet healthcare professionals from across the sector and to find out more about a variety of roles.

Pharmacy first

The Board will be familiar with the National Pharmacy First initiative in which pharmacists offer an advanced service and act as the first point of treatment for several common conditions. I am delighted that 98.5% of community pharmacies in our system are now offering this service.

New website- live from April

I also wanted to make the board aware that the ICB will soon be launching its new website and staff intranet. We created our current website prior to the ICBs creation and now have a much greater understanding of what is needed to support our communities. We have also managed to reduce costs associated with the website as a contribution to our wider running cost reduction work. I would be grateful for feedback from the board once the website goes live.

Thank you for your ongoing support for the work of the Integrated Care Board.

Dr Jane Halpin

CEO

Appendix 1: Key Updates

Contents:

1. Better Care Fund
2. Primary Care Transformation
3. Operations
4. Place based updates:
   4.1 East and North Herts
   4.2 South West Herts
   4.3 West Essex
5. Herts Mental Health, Learning Disabilities and Autism Health and Care Partnership
6. Community Provider update
7. Medical Directorate update
8. VCFSE Alliance
9. Local Authority – Herts County Council
10. Local Authority – Essex County Council
11. Workforce update

1. Better Care Fund:

The ICB, is a partner in two statutorily required Better Care Funds (BCF), one in Essex and the other in Hertfordshire, which are overseen by the relevant Health & Well Being Board. The BCF is the only mandatory national policy to facilitate the integration of health, social care and housing funding.

In West Essex day to day decisions on the BCF are overseen by a officers from across the ICB and the LA. A monthly meeting of this group reviews progress against planned schemes. The BCF has supported local schemes including:

- Bridging
- Impartial Assessor
- Primary Care Aligned Community Teams / Care Co-ordination Centre development
- Loughton, Buckhurst Hill & Chigwell care home hub

This year the BCF also included the Discharge Fund. West Essex adopted a similar approach to the wider BCF in managing this fund, with the local allocation overseen by officers from across the ICB and Local Authority. It has supported a number of programmes that have helped accelerate discharges such as:

- Discharge to Assess Wrap around service
- Ward led Enablement
- Transfer of Care Hub support
- Assistive Tech
- GP wrap around service
- Ticket Home

The ICB and Local Authority submit a joint quarterly report covering the Health & Well Being Board footprint to NHS England outlining performance against the BCF metrics and spend. In addition, monthly reporting on capacity and demand and the discharge fund schemes has also been required this year.

The most recent Essex Q3 report showed we are on track for avoidable admissions, discharge and falls. Local data also suggests progress on residential care admissions.

2. Primary Care Transformation update:

Good progress has been made across all areas outlined in the strategic delivery plan. Detailed progress report discussed at the January Primary Care Board and accessible via ICB website under Primary Care Board papers in Public. Some of the key highlights include:

- **Progress on development of Integrated Neighbourhood Working** – Each place is actively discussing the approach to integrated neighbourhood working and agreeing the cohort of patients who would benefit a multidisciplinary (MDT) delivery as highlighted in the refreshed Population Health Management packs at Primary Care Network (PCN) level.

To date, all 6 PCNs in west Essex, 4 of out 12 PCNs in East and North; 2 PCNs in Dacorum, and locality level approach in Watford and Three Rivers and Hertsmere are all embarking on implementation agreeing the cohort of focus and agreeing the interventions to be implemented through the MDT working. One of the key lessons is being clearer of what data is collated which support ongoing evaluation.

- **Primary Care Access Recovery Plan (PCARP)** – Whilst good progress being made on all areas of the recovery plan, to improve patient experience with the 8am rush to contact practices, significant progress made on the implementation of Cloud Based Telephony (CBT) in practices. To date:
  a) 62 GP practices are now live with this facility. This is only as ICB was supportive to prioritise through primary care delivery plan during 2023/24 through local and some national funding.

  b) 26 GP practices identified as national priority for upgrade from analogue telephony system have all been approved and progressing toward implementation. Aim for these to be implemented by end of June 2024.

  c) 6 practices will be upgraded from low level cloud systems to an advanced telephony system through national programme.

  d) 18 practices are being offered a free upgrade by their telephone system under the national framework to enhance their functionality to advanced CBT version.

  e) That leaves 17 GP practices across HWE with no upgrade path yet in place. As discussed at Primary Care Board and Primary care Commissioning Committee this is a priority to support the modern general practice programme and primary care recovery hence to identify local non-recurrent transformation funds.

  Note: ongoing telephony costs are managed by the practice.

In addition, Board to note from October 2024, nationally data will be extracted from these telephony providers to provide data on proposed 8 metrics which will support to have a better understanding of demands on general practice across each system.

call volumes	wait time before call abandoned
calls abandoned	call backs requested
time taken to answer calls	call backs made
missed call volumes	average call length time

- **Pharmacy First – National Scheme**

As of 21st February 2024, approximately 98.5% of HWE community pharmacies have opted in to provide Pharmacy First. With clinical leadership provided via our appointed community pharmacy PCN clinical leads with oversight from our ICB Community Pharmacy Integration lead, teams have developed resources adapted for use which can be tailored for clinical and non-clinical workforce and signposting resources for patients too. Awaiting national update on the digital solution to integrate this service with general practice.

- **Enhanced Commissioning Framework (ECF) 2024/25**

Detailed discussion at the last Primary Care Board on the development of the Enhanced Commissioning Framework for 2024/25. This builds on the success to date. The aim of the scheme is to commission a consistent approach across all practices, improve outcomes and reduce variation.

The ECF framework for 2024/25 consists of three components including compliance and engagement, clinical transformation and transactional.

Clinical transformation areas for 2024/25 include Frailty, End of Life Care, Mental Health in particular severe mental illness, Learning Disabilities and focus on three long term conditions – Chronic Obstructive Pulmonary Disease, Cardiovascular Disease and Diabetes which are all in line with the ICB priorities. For each area it sets out evidence-based interventions with a view to improve outcomes and reduce inequality. All of these will support place as they look to pull together delivery plan against agreed priority areas.

- **Dental Recovery Plan**

On 7 February 2024, NHSE published their joint plan with the Department of Health and Social Care on the recovery and reform of NHS Dentistry Faster, simpler and fairer: our plan to recover and reform NHS dentistry - GOV.UK (www.gov.uk)
The plan outlines changes that aim to support:

- Prevention of poor oral health; this will remain with Local Authorities to initiate Oral Health Programmes. This will build on the progress to date and how this is targeted where there is a greatest need as identified in both Hertfordshire and Essex Joint Services Needs Assessment for oral health.
- Increase access and delivery of activity:
  - New Patient Premium/Tariff will be introduced for patients who have been unable to access care in the past 2 years; This is to incentivise contractors to take on new patients in a planned way.
  - Increase of the minimum Unit of Dental Activity (UDA) value from £23 to £28 – this will take effect from 1 April 2024 and will be applied nationally across contractors if below £28

- Offer of a “Golden Hello” – funding for up to 240 posts across England where recruitment is challenging on the proviso that the dentist commits to stay in post for a full 3 years. Awaiting further details on this and how this may benefit us locally.
- Ambition to introduce Dental Vans to support rural and/or under-served areas and to support hard-to-reach communities – this is not applicable to Hertfordshire and west Essex.

Teams are working through the detail of this plan and how this is built into the dental work plan for 2024/25.

- **Temporomandibular Joint (TMJ) Disorders Pathway across East of England**

Secondary care dental workstream have reviewed the current pathway and flow of patients with Temporomandibular Joint (TMJ) Disorders. Currently HWE registered population with complex TMJ who require specialist input are referred to either Oxford, Nottingham or London. Primary Care Commissioning Committee considered and approved the proposal from East of England secondary care dental clinical network to commission a tertiary centre Bedfordshire Hospital for all our local population during 2024/25. The pathway will remain the same with referrals into tertiary centre via our Individual Funding Request (IFR) team.

- **Vaccinations and approach to rise in infections:**

COVID and Flu Vaccination Update

- Covid vaccinations ended 31st January. Uptake across the ICB for eligible cohorts 55.7% (slightly lower than EoE Region 58.3%)
- Uptake for flu vaccinations - 75.5% for 65 and over and 45.2% for at risk patients aged 6 months - 64 years. The campaign will continue until the end of March.
- Spring 2024 programme for Covid vaccinations has been announced and will commence with care homes and housebound on 15th April, with other eligible cohorts able to book from 22nd April 2024.

Measles Mumps Rubella (MMR)

- Whilst not declared as an incident, with the risk is cases of measles there is an enhanced focus on MMR vaccination uptake across all age groups
- Working in the system, targeted communications to 21 GP practices identified with lower than national uptake on 1st and 2 doses of MMR.
- Hertfordshire Community Trust (HCT) have been commissioned to deliver targeted pop-up clinics during the February half term week which led to 225 MMR vaccinations given plus 119 other childhood immunisations.
- National campaign commenced to increase measles vaccination uptake.
- HCT to start the call and recall pilot for children missing MMR vaccination from April 2024.
- With the rise in MMR infections, primary care leads working with infection prevention control have commissioned train the trainer approach to the use of FFP3 personal protective equipment (PPE) which is essential if there was a local outbreak. In addition, protocols developed as to how GP practices can access respiratory hoods if they require via PCN or neighboring PCN.

3. Operations:

Key successes:

- System leaders workshop agreed outline for HCP operating model changes from 1 April.
- Improvement in key UEC metrics seen in January, including a reduction in ambulance handover delays.
- Significant work on development of virtual ward models for ongoing implementation through 24/25 – pending support and decision from Commissioning Committee.
- Finalisation of ICS UEC Strategy for presentation to ICB Board.

Upcoming opportunities, key events and challenges:

- System wide director workshop to determine the recovery and priority areas to achieve financial balance in 24/25 – outline plan to be presented to system CEOs on 14 March.
- Intensive work during next few weeks on aligning performance, operational, clinical and financial aspects of delivery for 24/25, including support to HCP development to clarify their delivery role.

4. Place-based Updates:

4.1 East and North Herts:

Key successes in the last 2 months:

Further workshops have been held in Welwyn Garden City and Broxbourne and Hoddesdon PCNs respectively regarding Integrated Neighbourhood Team (INT) development; attention is now shifting to Stevenage PCNs and Hitchin and Whitwell PCN respectively. The Clinical and Professional Transformation Group (CPTG) has held focused sessions on diabetes, chronic kidney disease, and frailty as part of the review of our priorities for 2024/25. The Integrated Heart Failure Service is fully recruited too, and the service commences in Broxbourne on the 4th of March. The evaluation of the pilot for Managing Heart Failure @ Home is complete and shows an improvement in patient experience. Additional inputs to support a reduction in non-elective activity are being developed as part of the outcome of the evaluation. Our proposals for greater involvement of borough and district councils continue to be developed. This work is being led by Richard Cassidy, CEO East Herts District Council and builds on the ICS report recommendations. We jointly co-ordinated the NHS-local government workshop which was held on the 5th of March which focused on health, growth, and planning. Proposals for expanding patient involvement across the partnership are being developed via the Community Assembly. We continue to develop our place-based performance reporting in support of the emerging governance for Health and Care Partnerships. The Strategic Planning Group has been established and is agreeing a place-wide approach to prioritisation, with frailty now agreed by the partnership as our top delivery priority. Finally, our latest executive survey suggests a growing confidence in trust, accountability, and benefits delivery.

Upcoming opportunities, key events, and challenges:

Continued collaboration with local government, particularly borough and district councils present opportunities for the partnership. Analysis continues to be provided by the ICB's PHM team to develop datasets for the INT model in conjunction with local transformation teams. The Partnership Board will be considering proposals regarding the future 'form' of the HCP following recent Health and Care Partnership development discussions.

Challenges include forming mechanisms that enable joint re-allocation and/or investment into population-based priorities in support of increasing financial pressures.

Appendix A: latest executive survey results January 2024

Question	March 2021	October 2021	April 2022	March 2023	January 2024	Change
To what extent do you think our partnership is focussed on a shared goal?	2.7 (15)	3 (14)	2.8 (19)	3 (16)	2.9 (8)	0.1 ↓
To what extent do you think our partnership is built on trusting relationships?	2.2 (15)	2.8 (13)	2.8 (19)	2.9 (16)	3.1 (7)	0.2 ↑
To what extent do you think our partnership is clearly owned by committed partners?	2.1 (15)	3.1 (13)	2.7 (21)	3.1 (14)	3 (7)	0.1 ↓
To what extent do you think our partnership has clear, measurable expectations?	1.8 (15)	2 (13)	1.8 (23)	2.7 (15)	2.3 (7)	0.4 ↓
To what extent do you think our partnership enables risks to be effectively managed?	2.1 (15)	2.2 (13)	1.9 (22)	2.6 (16)	2.7 (6)	0.1 ↑
To what extent do you think our partnership enables 'benefits' to be shared amongst our partners?	1.5 (15)	1.7 (15)	2 (23)	2.5 (15)	3 (7)	0.5 ↑
To what extent do you think our partnership is robust enough on accountability?	1.8 (14)	1.9 (15)	2 (23)	2.4 (15)	2.7 (7)	0.3 ↑

4.2 South and West Herts:

Key successes since the last meeting:

- Following SWH HCP board approval for a minor illness bookable service for Hertsmere patients; the ICB has approved the spend from primary care transformation funding for 2024/25 and 2025/26. This service will offer, in total, 60 appointments per day (Mon-Fri) for Hertsmere patients with same day minor illness presentations. Patients will be booked into the ANP led service by GP practices and NHS 111; and once the service is established, there is the potential for A&E redirection and community pharmacy direct booking as well. It is anticipated that during the next financial year, this model will be used as a proof of concept of positive A&E channel shift.
- The SWH HCP continues to work collaboratively with the ICB and other HCPs to develop a clear and consistent, joined-up approach to working within the ICS environment and in a way that supports any future delegation of responsibilities from the ICB. In doing this the HCP has set out a proposed approach to governance and leadership and this includes an approach to building readiness for taking on delegated budgets in April 2025.
- Discovery 'baselining work' is under way in order to develop a shared understanding of the current clinical and care operating model across the SWH HCP. This will enable the HCP to

make informed, evidence-based decisions about where to prioritise development and resource, as we further develop our localities, embedding truly integrated working. This will enable the HCP to ensure all available resource can be utilised to best effect for local people.
- The HCP has chosen to prioritise frailty and falls for HCP-wide transformation delivery during 2024/25 and detailed delivery plans in support of this are currently being finalised.

Upcoming opportunities, key events and challenges:

- The HCP continues to develop its governance structure to ensure that the HCP can discharge its responsibilities whilst enabling joined up and coherent working with the ICB. This includes developing Terms of Reference and establishing an HCP Finance & Commissioning Committee and an HCP Quality and Performance Committee from 1st April.
- The HCP will develop a comprehensive frailty and falls transformation programme that will support the HCP to deliver the ICB's frailty strategy to provide a proactive, person-centred, integrated approach to frailty that empowers people living with frailty to remain as independent for as long as possible and maximises their quality of life.
- Procurement are supporting the ICB and the SWH place team to progress the commissioning of the minor illness bookable service for Hertsmere patients using the 'Most Suitable Provider Process' within the new provider selection regime regulations, as per the Primary Care Commissioning Committee's recommendation. It is anticipated that the service will commence during April 2024.

4.3 West Essex:

Key successes in the last 2 months:

Focus continues on delivery of our proactive care model: First stage evaluation is underway with North Uttlesford as the wayfinding INT. The initial focus was on the Advanced Disease and Complexity segment of our population and as part of planning for next year we are scoping the opportunity to improve outcomes for our population in the End of Life, Dementia and Severe Frailty segment. There continues to be a lot of interest in the west Essex INT model, particularly around our approach to measuring impact. The team presented on the model to Essex partners this month at the Essex Health and Wellbeing Board and as a follow up to this, have been invited to meet with the Director General for Adult Social Care from the Department of Health and Social Care on their visit to Essex County Council on 23 February.

Prioritising improving discharge and flow: The CCC is currently mobilising the Transfer of Care Hub (TOCH) function working alongside acute colleagues to ensure integration of the CCC with the hospital discharge team. The aim of the TOCH function is to improve experience for individuals leaving hospital settings and maximise system capacity by managing effective transfer of care. The PRISM final report was presented to LDB with all recommendations approved. A TOCH Planning Group has been set up with an overarching priority plan, detailed project plan, action logs and risks /issues. This Group meets weekly to progress plans and has set priorities for Phase 1 delivery by mid-April for essential component of TOCH model and Phase 2 delivery by September for priorities that are reliant on external dependents.

Integrated Urgent Assessment and Treatment Centre (IUATC) at PAHT: In the first few months the IUATC has only reported two 4-hour breaches and the average wait times to be seen in the IUATC is still well under 30-minutes which is a significant improvement. PAHT has also been able to demonstrate a significant reduction in investigations being completed as a consequence of the new primary care led model. In partnership the PAHT and ICB BI teams are working together to gather and analyse rich data to understand patients attending the service which will help transform the service further in its support to improve UEC across the ICB. This also includes a review of all pathways into and from the IUATC.

Working across the partnership to improve employment: Over 400 people attended a highly successful 'NHS Careers Showcase' in Harlow on 19 January run jointly by PAHT, EPUT, the HWE ICB and Harlow College. This was set up by the WEHCP Workforce Delivery Group whose members also include Essex County Council, the DWP and Essex Chamber of Commerce.

Connecting and enabling: The WEHCP is continuing to play a key role in 'joining up the dots' between partners and stakeholders in west Essex, not just in terms of improving health and care service delivery but in addressing prevention and the wider determinants of health. Several joint initiatives are now underway between partners in health, education, councils, the voluntary sector, and the police. Priorities being joined up include those in relation to early years and primary education - healthy weight and oral health, employment, mental health and suicide prevention. Those involved are also exploring how to co-locate frontline services, such as parenting support, health checks in 'community supermarkets' and citizens advice support in GP surgeries.

Delivering the ICB priorities from April 24: WEHCP held a series of workshops in January to agree its priorities for delivery from April 24 as a contribution to the ICBs operational and medium-term plans. Clinical and professional leads selected priorities based on those that would benefit most from a partnership approach that will deliver greatest improvement in outcomes and experience for the population, ensure best use of collective resources and builds on the progress the Partnership has made to date. Priorities include:

- A focus on prevention to address obesity and support wellbeing in young children and for adult mental health to consider opportunities to address more wider determinants including employment.
- Addressing health inequalities with a particular focus on CVD through prevention, case finding hypertension across all partners and a local integrated heart failure pathway.
- Continued development of our out of hospital model of care enhancing our home first approach for the frail and complex population cohort including end of life. This includes our model for proactive and anticipatory care with the expansion of our INTs. We will also continue to improve access to same day emergency care with the further development of our IUATC.

Up-coming opportunities, challenges, and key events:

Supporting patients whilst waiting to access their next stage of treatment: Two projects are now underway in west Essex. While You Are Waiting is a project focussed on health inequalities in Harlow providing holistic support to address wider determinants of health for people and their carers experiencing waits between 7-41 weeks on multiple lists at PAHT. Waiting Well Project is an ICB wide project supporting people and their carers experiencing waits between 42-77 weeks. Service commenced 1 October.

New initiative to reduce health inequalities through research: WEHCP is joining partners across Greater Essex in forming a new Health Determinants Research Collaboration (HDRC). Funded by the National Institute for Health and Care Research (NIHR), and led by Essex County Council,

HDRCs are centres of research excellence focused on the wider social, economic and environment factors that can affect health outcomes.
The core idea behind the Essex proposal is to examine 'what works' in improving the wider determinants of health and, in so doing, inform policy and service provision interventions. The HDRC will focus on those parts of Essex where health outcomes are poorest (Tendring coastal towns, parts of Colchester, Basildon, Harlow, Canvey Island, Southend and Thurrock). More details will emerge over the coming weeks.

Housing, planning and growth: Harlow is hosting the next meeting of the Local Government in the HWEICS Task and Finish Group focusing on this topic on 5 March. Harlow faces many challenges around housing, planning and growth. As well as the new Harlow and Gilston Garden Town development, there is a growing demand for temporary accommodation in the town. WEHCP is forming a spin-off from the ICS group to look at west Essex as a whole, and to also tie in with similar activity across the rest of the county.

HCP Development: As part of the ICB's Health & Care Partnership Development Programme the WEHCP's March Board will be receiving the West Essex 24-25 Delivery Plans for the priorities recommended by the clinical and professional leadership and a revised WEHCP governance framework.

5. Herts Mental Health, Learning Disabilities and Autism Health and Care Partnership:

The MHLDA HCP has supported the mobilisation of the new Mental Health Urgent Care Centre on the Lister site which went live on 31 January 2024. HPFT colleagues have developed the service and the MHLDA HCP has convened the wider partners to consider how the new service will complement and integrate with the wider provision available to support people in crisis. Outcomes so far include activity to align job descriptions between our VCFSE partners and HPFT to support the development of a multi-disciplinary, multi-agency team.

January also saw the closure of the Specialist Residential Service (SRS). SRS has been home for over 20 years to service users with severe profound and multiple learning disabilities and the safe transition of its residents into supported living services is testament to the hard work and dedication of staff across a number of partner organisations.

For the second year in a row, the MHLDA HCP has led on system-wide communications to support people in MH crisis over the winter period. The campaign went live in December with digital and physical material distributed to partner organisations including Hertfordshire Library Service, Hertfordshire Constabulary and Network Rail. The campaign included messaging tailored for specific audiences to promote uptake, including activity to encourage participation from local GPs. Pocket-sized copies of the material have been produced to allow frontline staff from different organisations to have the material on-hand.

The MHLDA HCP has led significant progress in the development of a Hertfordshire-wide approach to transforming services and support for neurodivergent children and young people and their families and carers. In November 2023, the MHLDA HCP's Clinical and Practice Advisory Committee approved a combined clinical pathway for the triage and assessment of ASD/ADHD for children and young people. Following this approval, the MHLDA HCP has led on 'walkthrough' workshops with

HPFT, HCT and ENHHT to consider how the clinical pathway would operate in practice, including the types of roles required and the time that each step of the process should take. We have held similar sessions with representatives from Hertfordshire Parent Carers' Involvement Network to fully understand how the pathway would be experienced from the perspective of the service users.

The most recent meeting of the MHLDA HCP Board took place on 09 February 2024 and was focused on the activity required to address inequalities in access, experience and outcomes for individuals with serious mental illness or learning disabilities from BAME communities in Hertfordshire. Having received specific updates on work underway and future plans, the MHLDA HCP Board noted the opportunities to bring together some of the activity so that we are maximising the support and outreach to currently underserved communities.

6. Community Provider update:

Key successes:

- Significant work from partners across the system has been undertaken to produce an assurance paper to further develop and provide virtual wards / Hospital at Home. The assurance paper focuses on adult provision, with a business case being produced specifically for Children's and Young People's models and to support planned care across the ICS.
- Following collaborative work with EEAST, Community Providers have achieved further improvements in acceptance rates from the EEAST stack with more patients being supported in the community and reducing pressure on both ambulance conveyances and A&E attendances.
- To further support a greater focus on secondary prevention for people with chronic health conditions and enable more people to be cared for in the community, a new Integrated Heart Failure service has commenced in East and North Hertfordshire. Similar services are already in operation in South and West Hertfordshire and West Essex, creating parity for patients across the ICS geography.
- EPUT and HCT continue to support and develop the service model for Princess Alexandra Hospital Integrated Urgent Assessment and Treatment Centre, alongside primary care and acute colleagues. The focus now is on raising awareness of existing community pathways and services across West Essex and Hertfordshire, alongside development of quality metrics. Average waits are significantly below 60 minutes, and the range of attendances is from 72 to 145 patients per day.
- CLCH have successfully participated with partners in South and West Hertfordshire in a virtual MADE event to support flow when struggling within the system.

Upcoming events, key opportunities and challenges:

- Linked to the Community Services Review, community providers are working with the ICB to develop a strategic vision and proposal to help drive a significant shift in delivery of care in the community at scale, whilst improving patient experience and outcomes and reducing total cost to the system.
- This will include adopting a population health approach deployed to the Integrated Neighbourhood Teams to provide proactive care and support to at risk and frail/elderly individuals to reduce unnecessary unplanned admissions, reducing demand on secondary care. This will be achieved by maximising existing community capacity and the commitment of all system partners to support delivery of care closer to home.

- HCT are also hosting a summit that will bring together ICS, academic, technology, clinical and operational colleagues to discuss the potential use of Big Data and AI in supporting the design / launch of a remote monitoring proactive preventative care approach for patients with COPD, Heart Failure and Frailty at risk of deterioration.
- Community providers continue to work with the ICB on establishing a strategic vision and future common model for the Long Covid service from 2025.
- EPUT hosted an inclusive recruitment event in partnership with ECL Ltd to provide employment opportunities for West Essex residents with learning disability and neurodiverse conditions – one offer has been made and 4 more people have been invited for a second interview.
- Mobilisation of the HWE ICS Diabetic Eye Screening Programme continues, with contract start on 1st April 2024.

7. Medical Directorate:

Tobacco:
The National Smoking in Pregnancy incentive scheme is due to start soon (around April 2024). This will support pregnant people who smoke to quit with financial incentives alongside behavioural support.
The national Swap to Stop scheme (S2S) aims to support almost 1 in 5 of all smokers to quit by providing a vape starter kit alongside behavioural support. HCC, HPFT, EPUT & all local Maternity units, are all putting in bids to get these starter kits for our patients. We are also exploring if and how this scheme could help our ICB staff who smoke and want to quit.
- Keen to start discussions about whether the ICB (and our providers) are willing to sign the NHS Smokefree Pledge (ahead of National No Smoking Day on 13th March).

Prioritisation:
The clinical prioritisation team have been working closely with adult and paediatric diabetes teams to understand the current picture for people with type 1 diabetes and the use of diabetes tech as we prepare to implement the new mandatory NICE TA on hybrid closed loop over the next 5 years, which represents a significant demand.

Frailty:
Population outcomes have been agreed and working with our PHM team to baseline the HWE position (where possible) and set realistic improvement targets. Frailty has been flagged as a priority area within Health Care Partnerships and we are working with HCPs to coordinate plans and deliverables.

Falls pathways; Training has been developed for care homes to implement the anticoagulation pathway and we are aiming to deliver this throughout March. Communications have been circulated throughout the ICS regarding the long lie pathway with the aim of increasing utilisation of the pathway.

Osteoporosis pathways have been drafted and agreed initially within 2 forums. This Is now being circulated for wider agreement aiming for sign off April 2024.

Enhanced Commissioning Framework (ECF):

The new clinical aspects of the enhanced commissioning framework have been lead by the medical directorate, working closely with the primary care team. An almost final draft version of this was presented in February to the primary care commissioning committee. This year's ECF has already shown measurable improvements eg many less patients with diabetes in the high risk category.

Children and Young People (CYP):
Children's Asthma Refresher Workshop for Primary Care was held on 15th Feb, where more than 100 Primary Care staff attended. As it was over-subscribed so a second workshop will be scheduled. The number of users accessing the healthier together website has doubled between 2022 and 2023, with over 34,000 users in 2023. This is likely due to increased promotion and increased confidence in the website by both families and health colleagues.
The HWE Youth Council has co-produced a video project with the Patients Association to be shared across PCN'S and wider platforms to improve CYP's experience when visiting GP surgeries.
The next Asthma Friendly Workshop for schools is taking place on 20th March with over 40 participants signed up.

New website:
The New ICB Prescribing, Policy and Pathways website https://www.hweclinicalguidance.nhs.uk went live on the 1st Jan 2024. This website replaces the three predecessor Clinical Commissioning Groups websites in Hertfordshire and West Essex. This website provides clinical and prescribing information including decisions, guidance, pathways and policies, all held in one site, to healthcare workers within Hertfordshire and West Essex Integrated Care System to support optimal patient care.

Population Health Management (PHM):
The contract for the HWE PHM Data Platform an integral part of a mature PHM infrastructure has been signed. This will enable the development of tools including our outcomes framework which will be used in part to measure the impact of our interventions for our key priorities in improving our population health outcomes. The team has also developed key insight packs to supplement the overview of the Health Needs of our population which are available on the PHM website, these are available at Place, Locality and PCN level. Population health management – Hertfordshire and West Essex Integrated Care System (hertsandwestessexics.org.uk)

Pharmacy and Medicines Optimisation (PMOT):
Challenges relating to medicines spend in primary care remain. The system wide prescribing financial plan is progressing well and on track, however we continue to see areas of growth as a result of NICE recommended treatment in diabetes and in lipid lowering therapies which will improve outcomes for patients in the longer term.

The cost of Oral Nutritional Supplement (ONS) prescribing across HWE is now falling despite a 14% average increase in costs for England. Prescribing of opioid analgesics continues to fall across the area; work continues to encourage whole system working to ensure safe prescribing and consideration of non-pharmacological options for pain management.

As a result of the Medicines Optimisation ECF for 23/24 and wide-reaching educational support provided by the pharmacy medicines optimisation team, high dose inhaled corticosteroid prescribing rates are reducing across the three places. This is a safety indication as national guidance on the treatment of asthma recommends that patients should be maintained at the lowest possible dose of inhaled corticosteroid and the latest guidance for treatment of COPD now recommends use of another treatment in preference to inhaled corticosteroids. There is some evidence that inhaled corticosteroids increases the risk of pneumonia. This risk appears to increase with dose.
The new Prescribing, Policies and Pathways ICB website was launched in December 2023 providing quick and easy access to relevant resources. (see above).

The team are leading the system wide response to the Valproate National Patient Safety Alert supporting organisations to prepare for the new regulatory measures for oversight of prescribing to new patients and existing female patients.

The team continue to work with care homes Between April 2023 and January 2024 the care home team have reviewed 3288 medicines – 605 (18%) of medicines reviewed were stopped. Of the medicines that were stopped 77 (12%) were medicines that may lead to a fall. The average saving on prescribing costs / patient reviewed is £265/annum. The care home team have delivered a series of training webinars around safe handling of medication for care home staff, this was facilitated by Hertfordshire Care Home Providers Association (HCPA), topics covered include covert administration, when required medication, self-care and homely remedies. To date over 1000 care home staff have accessed the webinars.

The national Pharmacy First service launched on 31 January 2024. There have been 267 community pharmacies (98.5%) across HWE ICB have opted in to provide the national Pharmacy First service as of 21 February 2024

Clinical and Professional Development:
A Hertfordshire and West Essex Health and Care Professional Senate has now been fully established. The senate was set up in light of NHS England ICS implementation guidance on Effective Clinical and Care Professional Leadership and following an ICB hosted engagement workshop. It provides oversight and advice to the health and care system to ensure decision making is safe and effective, and responds to the population's needs, and as such was launched with a population health overview.

The Senate has helped to ensure health and care professionals are engaged, involved and invested in significant decision making at Integrated Care System level. The first two meetings have focused significantly on major programme areas which reach across professional and organisational boundaries, notably the development of the Elective Care Hub, frailty, actions of winter planning, clinical actions to be taken at the two higher levels (of four) of system pressures (Operational Pressures Escalation Level Framework) and prescribing.

Additionally, the Senate receives reports from the other professional lead groups, notably well-established leadership groups for pharmacists and for allied health professionals, and a more recently established medical director-level committee leading on medical workforce transformation. The Medical Workforce Transformation Committee, is led and organised by Medical Directorate but receives significant support from Primary Care Training Hub and Workforce Colleagues on significant workstreams which include, but are not limited to:

- Expansion of preorganised GP fellowships and the development of follow-on GP with Specialist Interest (GPSI) roles hosted by Acute and Community Providers within HWE ICS.
- Pathway changes with new medical roles to support the sustainable delivery of areas under significant pressure (such as diagnosis and management of Attention Deficit Hyperactivity Disorder)
- International Recruitment

Amongst other sources, the Medical Workforce Transformation Committee receives population health information, workforce intelligence reports, bank and agency spending data, General Medical Council Trainee Survey results and updates from the East of England Deanery in setting and executing its priorities.

8. VCFSE Alliance:

Asset Based Community Development (ABCD):

- 30 out of 34 PCNs have started planning possible projects for use of c£8k to spend on local grass roots groups to work on a particular health inequality.
- On 23 February, the Health Inequalities lead led (and recorded for those who couldn't make it) a 30 min Webinar for PCNs and VCFSE Infrastructure Organisations (CVSs) to answer any questions on the process and to launch the online form to get the monies released – deadline for applications 15 March.
- This work will be particularly helpful in developing links between primary care and the local VCFSE and will support development of networks around the Integrated Neighbourhood Teams.

Prevention:

- NAVCA Associate Consultant presented to Prevention Sub-Group in February on proposals to take annual reports from 10 large charities and 10 small charities from across the footprint, to create a snapshot of impact based on funding, outputs, outcomes, economic impact for users and for the system. Grass roots charities can be interviewed if that is easier for them.
- Working in partnership with Uni Herts, the Alliance has gained funding to develop a web based Social Value Tool to support the VCFSE and Health sector in Herts and West Essex to demonstrate the sector's value and the first researcher has been appointed.

Volunteering:

- A bid for £550k over three years has been submitted to develop a three year project.
- If successful this will deliver an ICS-wide set of resources and standards for safe volunteering, allowing a volunteer passport to be issued, which will:
  - Support the sharing of volunteers (eg between hospitals and the community)
  - Support the setting up of a pool of 'reservists' for crises.
  - Bring additional place-based workers to encourage more volunteering locally, help manage peaks and troughs of supply and demand and focus on making it easier for those facing challenges to volunteer.
  - Develop the 'user to volunteer to career' pathway across the ICS.

New Prevention Sub Group:

As agreed by Health Creation Strategy Group in December a new Prevention group met for the first time in February through the merging of the task and finish groups looking at:

- Data
- Impact
- Health Inequalities
- Asset Based Community Development

The new group will focus on the role of the VCFSE in primary prevention around the wider determinants of health and seek to complement the work of other groups and boards (eg Long Term Conditions (ICB) and Prevention Strategy Group (ICS) to focus on three levels of activity:

- General community wellbeing and connectedness.
- Help to access preventive services and support and prevent exacerbation.
- Provide services which the state won't or can't provide for reasons of lack of resources, lack of trust etc.
- The group also agreed to add Creative Health to its Terms of Reference.

9. Local Authority – Herts County Council:

Financial pressures:
Hertfordshire County Council's budget for 2024/25 was approved by Full Council on Tuesday 13 February. Councillors approved a budget of £1.1 billion to protect, maintain and improve council services for the 2024/25 financial year, including increasing spending by £98m overall. Decisions by Councillors to reach this budget included using £11m of the council's reserves and to increase council tax by 4.99% (including 2% ringfenced for social care). However, the budget also requires very significant financial savings of around £46m.

As part of these savings, the County Council is commencing a detailed organisational review to redesign our staffing structures and reduce approximately 400 posts from the council's base by August 2024. In doing so we remain committed to delivering excellent services that have the greatest impact. We are already seeking opportunities with partner colleagues including the ICB to work in a more joined up way that best meets the care and health needs of our residents as well as delivers the greatest cost effectiveness.

ASC CQC Inspection:
From Monday 4th March our Adult Social Care teams welcome inspectors from the Care Quality Commission (CQC). The CQC will be speaking to a wide range of staff and partners to consider and assess the extent to which the range of work we deliver and importantly how we deliver our services meets the quality standards expected. We are very proud of the collaborative working with have with our partners and grateful colleagues in the NHS and voluntary community sector who have kindly given their time to meet with the inspectors. We should have an indication of the CQC's rating by early April.

Childcare Expansion:
Childcare for working parents is due to be extended over the next 18 months:

- From April 2024: Up to 15 hours childcare support per week for children aged between two and three years (Phase 1)
- From September 2024: Up to 15 hours childcare support for children aged between nine months and two years (Phase 2)
- From September 2025: Up to 30 hours childcare support for children aged between nine months and three years (Phase 3)

Current engagement with Hertfordshire early years providers and parents has been positive. The vast majority of our current early years providers have confirmed they will be offering the new entitlement to families in April 2024 (Phase 1). Also, there was an overwhelming positive response to the payment rates for the new entitlements from providers. As of 1st Feb. 24 there have been 2,436 eligibility codes issued to 2-year-olds of working parents, this places Hertfordshire 5th in the country.

The new entitlements are likely to increase demand for childcare for children with SEND of working parents. Hertfordshire supports all providers to be inclusive and welcoming to all children regardless of need. The expansion provides the opportunity for early years practitioners to identify any additional support children may need.

Additional funding is available to support children with the new entitlements:

- Inclusion funding, for children with low or emerging needs
- Targeted SEN funding for children in receipt of SEN support who require additional support but do not have an EHCP
- Disability Access Fund (DAF), which allows additional equipment or adaptations to the childcare setting

Family Hubs:

Family Hubs are for families with children 0-19 (or up to 25 for young people with special educational needs and disabilities). They bring together multiple partners and services into a 'one stop shop', making it easier for families to get the help they need. Family Hubs can offer guidance and advice on a range of areas including, midwifery, infant feeding, mental health support, health visits, parenting classes, housing and debt advice, youth services, as well as services run by charities. The hub itself may or may not be a single building – instead, it could be a network of different physical locations in the community, as well as online services.

At the heart of Family Hubs are services that give babies a great start for life, helping parents build strong relationships with their babies. While Hertfordshire didn't receive any funding to deliver this ambition, it was an opportunity to develop the Family Centre service into the early year's element of Family Hubs, through recommissioning. The tender for this is currently live, with the specification containing a strong voice from Hertfordshire parents and professionals, through the robust consultation process carried out between July and October 2023.

We have set up a Family Hub Strategic Group with representation across a wide range of partners with a partnership event planned for the 27th March. This event will be held in person and will offer the chance for partners and organisations, in and out of HCC, to come together and build a picture of the current offer, and the direction of travel. The event will inform initial actions to take forward, including how we co-produce this programme with children, young people, and families.

10. Local Authority – Essex County Council:

Tobacco:
We have moved the tobacco agenda forwards through the NHS long Term plan agenda and a focus on Maternity, Acute hospital and in patient smoking. This joint focus has achieved substantial gains in maternal smoking rates across Essex with an expected improvement around in patients. Much work still to do around MH and smoking but plans are in place Grant funding letter now received. Circa £1.8m for Essex with an expected increased level of activity below. We will require full support from all partners but, particularly Primary Care to achieve the Governments ambitious targets. Chris F will be working up delivery plans including a harm reduction payment mechanism with GP's and pharmacies rather than just payment per quit, plus a host of other interventions.

National Goal Increase	Smoking Population Proportion	1 Year figure (Goal*Smoking Proportion)	5 Year Figure	Y1 (25%) Increase	Y2 (50%) Increase	Y3 (125%) Increase	Y4 (150%) Increase	Y5 (150%) Increase
193,908	2.672%	5,182	25,910	1,296	2,591	6,478	7,773	7,773

Health Improvement performance:

Performance in West has improved slightly yet it is still the lowest in Essex across smoking, Health Checks and T2WM.

Smoking quit figures and targets:

Rank CCG (1 = highest HC % YTD)	CCG	Target	Actual	HC % YTD
1	NORTH EAST ESSEX	8971	8347	93.0%
2	BASILDON & BRENTWOOD	8098	7512	92.8%
3	MID ESSEX	11470	9867	86.0%
4	CASTLE POINT & ROCHFORD	4807	3495	72.7%
5	WEST ESSEX	8373	5755	68.7%
	Total	**41719**	**34976**	**83.8%**

Smoking Cessation Referrals:

Rank CCG (1 = highest % of Total)	CCG	CCGs, % Active Smokers (2022, 16+, GPPS)	Number of Referrals	% of Total Referrals
1	MID ESSEX	11.1	680	61%
2	NORTH EAST ESSEX	15.4	182	16%
3	BASILDON & BRENTWOOD	11.8	103	9%
4	CASTLE POINT & ROCHFORD	11.8	76	7%
5	WEST ESSEX	12.6	70	6%
	Total		**1111**	

Tier 2 Weight Management Referrals:

Rank CCG (1 = highest % of Total)	CCG	Number of Referrals	% of Total Referrals
1	MID ESSEX	462	28%
2	BASILDON & BRENTWOOD	451	27%
3	CASTLE POINT & ROCHFORD	343	21%
4	NORTH EAST ESSEX	258	16%
5	WEST ESSEX	146	9%
	Total	**1660**	

Work and Health Vanguard Bid:
We are awaiting outcome of Harlow work and Health Outcome bid.

Case Finding:
We have good progress on joining Essex Well Being service data systems with Primary care data systems allowing us to case find those patients in most need independently from GP systems.

Essex Healthy Weight Strategy:
ECC PH have been working on a high-level Essex Healthy Weight Strategy, which aims to effectively prevent and treat excess weight across all-ages in Essex. A draft is complete, which awaits final stakeholder engagement, resident views, and academic evidence, with a further draft due by the end of March. Thank you to HWE colleagues, from HWE ICB and West Essex Place, for contributing to the stakeholder co-design workshops. Please share our resident survey

https://www.smartsurvey.co.uk/s/HealthyWeightEssex/, to capture the views of West Essex residents. Promotional assets and toolkits are available, please contact healthy.weight@essex.gov.uk for more information.
The strategy is the first of a series of products designed with partners to move from a high level shared approach to healthy weight, to a more detailed county wide action plan, and subsequent more detailed local action plans, where appropriate.

Public Health Accelerator Bids (PHAB):
Launched in September 2023, ECC's Public Health Accelerator Bid (PHAB) programme aims to stimulate new and enhance existing prevention and health inequality work which contributes to the priorities in ECC's public health business plan. Applications for a small grant of up to £7,500 will be accepted at any time up until the grant closes on the 31 March 2026 or the funding commitment is met. So far ECC has awarded 40 projects funding, of which eight will be delivered in West Essex and include:

1. The county trust, Harlow: which will host a year of immersive food discovery sessions for three schools including one for children with complex needs.

2. Making it mindful, Harlow: which will host dance and cooking workshops for women and families

3. Enterprise East Group CiC, Uttlesford: which will run a series of weekly workshops covering healthy eating, diet, exercise and nutrition and include practical healthy cooking sessions.

4. Integration support services, Harlow: will offer an opportunity for ethnically diverse women to connect, improve their physical activity and health care professional led discussions on health and wellbeing.

5. Mind in West Essex, Uttlesford: Which will deliver a regenerating of a large derelict allotment in the heart of the historic town. The Garden will be accessible to all in and around the Saffron Walden area. The initial clearance and building of the garden will be undertaken by community volunteers including personnel from the local MOD Barracks, who are engaged in a Wellbeing Project with Mind in West Essex.

6. Rhiannon Faith Company, Harlow: which will offer a sustained year-round of Care Workshops in Harlow in partnership with RSS. Weekly 1.5 hour creative workshops will be followed by a 1 hour 'Care Cafe' - an opportunity to socialise and discuss mental health, supported by a counsellor.

7. Essential SEND Consultancy CIC (ESC), Harlow, Uttlesford: will offer The Champs programme which is designed for children and young people (aged 10 – 25) with special educational needs (SEN) to give them the knowledge and skills to become peer educators promoting a positive lifestyle within their settings and wider communities.

8. Let's Get Out C.I.C, Uttlesford: which will deliver the "Every Acorn" Project which is an innovative approach, using nature-based interventions and community-building strategies. It leverages the therapeutic benefits of nature to improve mental well-being, which is a novel approach in public health initiatives.

For grants over £15,000 organisations submit expressions of interest (EoI) which are assessed and then they are invited to make a full application. We have already had two rounds of EoIs, the third and final round opens on the 8th April 2023 with the deadline of submitting by Friday 3 May 2024. In round 1 of the large grant process five projects were awarded a total of £464,963.29 with one of the successful projects operating in West Essex. Headway Essex a charity that supports people with an

acquired brain injury (ABI) in Essex, will use the funding to introduce a new hospital link-worker role and a 'What Happens Next after ABI' booklet. The grant will also help the charity introduce general health reviews and health goal planning at its day centres and support groups.

11. Workforce:

The seventh edition of our careers event for community and young people was held at the beginning of February in partnership with the University of Hertfordshire. Nine schools from across Hertfordshire and Essex sent students to the event to meet with our health and care staff from across the sector and find out about the wide variety of roles. The event also had a Speech and Language Therapist talking about careers who had been inspired by the very first 'Future Heroes' event and had gone on to take a role in Hertfordshire. Building on that success the system is working with regional and national colleagues to host a widening participation recruitment event on the 14th March in Stevenage which seeks to encourage members from a wide range of different communities into the sector.

Significant focus has moved onto supporting and developing our domestic pipeline, and we have actively participated in setting the region's clinical learning environment priorities for the following year. Additionally, system Chief People Officers came together with University leads across the region to review the wider strategy and understand best ways of working together. Our main focus is to improve student experience and therefore retain graduating students into Hertfordshire and West Essex health and care settings. As part of that, our innovative 'learners' app which was developed and piloted in Hertfordshire and West Essex, providing pastoral support, information and signposting to students, has been expanded to be offered across the region.

The system received confirmation that there would not be further funding for the continuation of the system's Allied Health Profession Faculty. The Faculty has supported the system with a wide range of recruitment, retention and development projects for allied health professionals across the system. A full evaluation of the Faculty is currently being undertaken and is due to report shortly. In the interim transition arrangements are being developed to see which areas of work need to be prioritised and continued. More positively the ICB has confirmed pilot investment in a part-time Allied Health Professional Lead role for the system, which will seek to provide some equity for AHP roles compared to medicine and nursing going forwards. The position is currently out to advert and will be trialled for 12 months.

The second cohort of our Transforming Culture Programme has now been completed with Eden

Charles, with one further cohort to complete before a full evaluation being undertaken of the programme and identification of appropriate next steps.

Herts Partnership Foundation Trust have successfully recruited to their post of People Promise Manager and so a programme of work around retention within the organization will shortly be under way.

Healthwatch Hertfordshire have begun to engage across the system to undertake a detailed review of the experience of international recruits within acute providers across the system. The programme is linking into an existing piece of work underway in Princess Alexandra Hospital to avoid duplication and confusion – and is expected to report findings in April.

Work continues to progress in relation to the banding issues for Band 2/3 members of staff. A set of system principles are being developed to be shared with key representatives across the system prior to engagement with colleagues in social care and primary care to understand the impact this will have on our broader system.

Our workforce planning team have met with the wider primary care training hub team to improve our understanding of the primary care workforce on an ongoing basis, and improve the quality of data received from the national workforce reporting submission.

A new project is being developed to support our supply pipeline across the system, with the development of a 'talent pool' for Hertfordshire and West Essex, where qualified and strong candidates that are employable, but unsuccessful in their initial application are shared across organisations where there may be similar vacancies and opportunities. This is better of our wider programme of work seeking to overhaul recruitment practices for which we have now completed the initial toolkit assessment.

The operational planning process is well underway, with organisations being supported in developing and managing their workforce planning process. Supporting this, the system is well under way in completing workforce based modelling of Allied Health Professional roles as part of reablement services and is seeking to complete a robust data review and analysis by the end of March.

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:**	**22/03/2024**
Report Title:	**Governance report**		**Agenda Item:**	**07**
Report Author(s):	Michael Watson, (Chief of Staff), Simone Surgenor (Deputy Chief of Staff-Governance), Redouane Serroukh (Head of IG and Risk) Leon Adeleye, (Governance Manager- Risk)			
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:	
Report History:	
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
Recommendations:	Members are kindly requested to: ▪ note the Board Assurance Framework ▪ Provide indicative approval for the recommendations of the governance review. The full governance proposals will come to the board for final approval in March. ▪ Approve update changes to the ICB Handbook. ▪ Approve proposal to approach NHS England for the detailed updates to the ICBs Constitution.

	▪ Approve proposal to amend the ICBs Scheme of Reservation and Delegation.			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
Implications / Impact:				
Patient Safety:	*[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]*			
Risk: *Link to Risk Register*	*[Refer to latest Risk Register when completing]*			
Financial Implications:	*[State funding costs and potential savings]*			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	NHS Constitution proposed changes are supported by an approved EQIA.		
	Quality Impact Assessment:	< N/A >		
	Data Protection Impact Assessment:	< N/A >		

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.

Implementation plan

1.4 As discussed at the Board Day in February, it remains the plan to implement the recommendations of the Governance review in the following way:

Phase one: From March:

- Proposed changes to the composition of the board- with two additional members added to ensure HCP and acute sector representation. This will take place from the March Board.
- Recruitment of Primary Care partner members to begin.

Phase two: From April:

- Creation of the Strategy Committee and associated changes
- Change of name from People Board to People Committee
- Primary Care Committee to become a sub-committee of Quality and Performance Committee
- Defined Terms of Reference (ToR) for the Executive team
- HCPs to begin to operate in a shadow form under draft ToRs for a two month period.

Phase three: From June 1st

- HCP Board sub-committees come into formal existence.
- Quality and Performance committees merge to become Quality and Performance Committee
- Finance and Investment Committees merge to become Finance & Investment Committee

1.5 Draft ToRs of reference have been developed and are currently being further iterated.

1.6 It is not possible to complete some of the new ToRs and Scheme of Delegation until some of the design work to create the Health and Care Partnerships have been completed.

1.7 In order to achieve the timeframe above, it is proposed that the April Board Day becomes a formal meeting of the board, to enable it to approve terms of reference and the wider approach to HCPs.

2. Constitutional Amendment - for Approval

Executive summary

2.1 In compliance of the Health and Care Act 2022 and as a continuance from Clinical Commissioning Group times – all Integrated Care Boards are required to have a Constitution.

2.2 In support of the Governance update received by the ICB Board on the 26th January 2024 and 16th February 2024 - the following paper sets out a number of proposed amendments to NHS Hertfordshire and West Essex ICBs Constitution, with the last revision having been approved by NHS England on 20th February 2024. The Board will see that these proposals have been triggered in support of the ICB Governance Review and continued development of Health Care Partnerships within its geography.

2.3 Once support has been received for these amendments through the ICBs governance process, a formal application will be made to NHS England. The amendments will only come in to force once NHS England approval has been received. At that point, a revised Constitution (v.6.0) [appendix A] would be published. For clarity - version 5.0 of the ICBs Constitution remains in force until formal approval of the changes has been received by NHS England.

Background

2.4 In July 2022 when Integrated Care Boards were enacted nationally, NHS Hertfordshire and West Essex ICB acknowledged at its inaugural board meeting, that its supporting governance would be given chance to evolve. This stance was poignant in that the three Clinical Commissioning Groups falling within the geographical area of this ICS had not merged prior to their duties and functions transferring, and the ICB of which they now formed was brand new as an entity structure and board construct.

2.5 The proposals within this paper form the next stage in this ICBs development, with the supporting governance remaining under continual review.

2.6 The proposed amendments will be referenced in turn at paragraph 3 below with the amendments highlighted in yellow in the draft revised Constitution found at appendix A. This paper will identity areas proposed by Board on 16th February 2024.

Proposal amendments to ICB Constitution - triggered by the ICB Governance Review:

- Section 2.2.1 – revision of eight Partner Members to six.
- Section 2.2.1(a) – revised of three Partner Members nominated jointly by the NHS trusts and NHS foundation trusts to one. Update also included in 2.2.3(c), 2.2.3 (h), 3.5.1, 3.5.2.
- Section 2.2.2 (c) – new paragraph in support of new section 3.12.2 – and the proposed appointment of four Ordinary Members bringing specific knowledge, skills and experience of the provision provided by HWE ICBs Health Care Partnerships (HCPs).

- Section 3.5.2 (d),(e), (f) – amended to reflect newly revised wording in section 3.12.2 (from page 29) – appointing four Ordinary Members.
- Section 3.5.6, 3.6.7, 3.7.6 – inclusion of "with a maximum of three terms being held by the same individual.
- Section 3.12.2 – proposed new paragraph. Key points to note:
  - The seats are appointed from the Health Care Partnership (HCP) Accountable Officer Roles.
  - In respect of the Mental Health HCP – this specifies the role holder having "specific knowledge and experience in services relating to the prevention, diagnosis and treatment of mental illness." This wording reflects that held by the amended Partner Member structure – referenced in 2.2.2 and 3.5.2 (f).
  - 3.12.2.2 (a) – the member fulfilling each of the four roles will - Be the Chief Executive or hold a relevant Executive level role in one of the Trusts or Foundation Trusts – as identified in section 3.5.1 on the Constitution.
- Section 4.7 (page 54) –
  - Section 4.7.1 (d) – proposed removal of "(comprising of at least one Partner Member from each of the categories listed at 2.2.1 (a), (b) and (c))".
  - Section 4.7.1 (e) – inclusion of a new paragraph "at least three ordinary members (above at page 13)", page number to be added on formal approval of the proposed changes. Revision added to reflect the increase of Ordinary Members to this board.

Next steps

Following support for the above amendments from both the ICB Executive Committee and Board – a formal proposal will be submitted to NHS England for:

- Approval of the revisions to HWE ICBs Constitution; and
- The increase in HWE board by two – this increase comes from the additional membership via Ordinary Members (by way of explanation on this point – two Partner Members have been reduced from those representing NHS trusts and NHS foundation trusts at 2.2.1(a). The ICB is obliged to have one role in post for this position. These two roles have under the proposed changes been moved to paragraph 3.12.2 – as part of the four new Ordinary Members).
- The submission would include an Equality Impact Assessment – using NHS England's template [appendix B].

Recommendations

NHS HWE ICB Board:

a) To note the proposed changes for discussion and comment.
b) To confirm support for the revised Constitution version 6.0
c) To confirm support for an increase in board membership by two.
d) To confirm support for a formal application to be lodged with NHS England seeking formal approval for points (b) and (c) above.

3. Urgent decision on redistribution of funds

3.1 On the 4th of March the Chair emailed the board and requested approval for the redistribution of funds under the provisions for urgent decisions set out under SO 4.9.5.

3.2 That section of the standing order states that:

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

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

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

3.3 The email responses confirming approval constituted a quoracy of greater than 50% and were:

Approval of full recommendations:

- Catherine Dugmore – 05.03.24 – 08:50
- Gurch Randhawa - 05.03.24 – 07:46
- Ruth Bailey – 05.03.24 – 05:39
- Nick Moberly – 04.03.24 – 16:46
- Prag Moodley – 04.03.24 – 20:07
- Nicolas Smith – 05.03.24 – 11:41
- Karen Taylor – 04.03.24 – 11:01
- Lucy Wightman – 04.03.24 – 16:53
- Alan Pond – 05.03.24 – 08:45
- Natalie Hammond – 05.03.24 – 17:41 – MS Teams message.
- Beverley Flowers (non-voting, but deputising as Board member for Jane Halpin as Deputy CEO) – 05.03.24 – 10:32

Qualified approval:

- Elliot Howard -Jones – 05.03.24 – 13:16 - *I agree with option 2B as a non-recurrent approach in 2023/24 only*.

3.4 The Board is asked to note the decision taken under SO 4.9.5

4. Scheme of Reservation and Delegation (SoRD) Amendments – For Approval

In support of Specialised Services due to be delegated to HWE ICB on 1st April 2024, Board approval is sought to approve the following additions:

a) Board Member/employee – Chief Executive (Deputy Chief Executive)

NHS England Delegated Specialised Commissioning

- *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.*

b) Decisions and functions delegated to the Board by other organisations

For all Specialised Services delegated on 1st April 2024, to be cited within the SoRD.

5. Updates to the Governance Handbook – For Approval

Approval for the inclusion of the following updates from pages 36 – section 16:

- Sollershott Surgery is to become a branch of Birchwood Surgery with effect from 01.04.2024.
- Stansted Surgery is to become a branch of Elsenham Surgery with effect from 01.04.2024
- Highfield Surgery to become a branch of Lincoln House Surgery with effect from 01.04.2024.
- Baldwins Lane Surgery to become a branch of New Road Surgery with effect from 01.04.2024.

6. **Board Assurance Framework (currently separate PDF).**

Hertfordshire and West Essex ICB's Board Assurance Framework

Date: 09/01/2024

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	Rachel Joyce
SO2	Give every child the best start in life	1	Prof. Natalie Hammond
SO3	Improve access to health and care services	9	Frances Shattock
SO4	Increase the number of citizens taking steps to improve their well-being	0	Beverley Flowers
SO5	Achieve a balanced financial position annually	2	Alan Pond

Assurance Statement

The ICB (Board) is provided with assurance that the Corporate Risk Register containing 49 risks (12+) was presented to the Executive Team on 11 March 2024 for discussion. Of the 49 corporate risks, 12 are scored 16+ significant impact on the achievement of the ICB's strategic objectives, including risks IDs 351, 498, 526, 582, 608, 609, 610, 611, 612, 644, 649 and 653. Two of these risks have a score of 20, (risk IDs 608 & 609), as shown on the Risk Matrix.

The Audit and Risk Committee on behalf of the ICB (Board) will gain further assurance on systematic ireview of strategic and system risks acros the ICB and ICS, including the rationale for current risk scores and the effectiveness of the controls in place to mitigate the identified risks.

Additionally, the Board is expected to discuss and consider the adequacy of the mitigations and the level of assurance indicated in the three lines of defence, ensuring that risks are identified, assessed, and managed appropriately throughout the organisation.

RAG rating of overall perfomance: Green

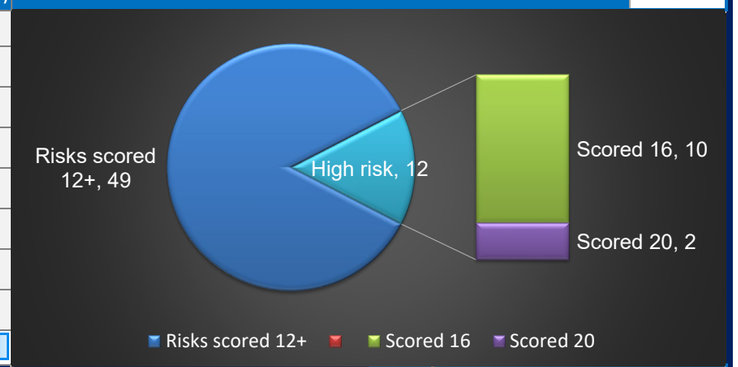
Progress: →

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				2	
	4. Highly Likely				10	
	3. Possibly					
	2. Unlikely					
	1. Rare					

No#	HWE ICB Directorates	No of risks (12+)
1	Chief of Staff (Communication, Corporate Governance, Information Governance)	0
2	Finance, Contract, Premises	1
3	Medical	0
4	Operations (3 Places & HBLICT)	2
5	Performance (Business Intelligence, Digital Transformation & Performance)	6
6	Primary Care	0
7	Quality and Nursing	2
8	Strategy (People, Workforce, Strategy)	1
		12

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
12										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
498	05/10/2022	SO3	Tania Marcus	Strategy, People, Workforce	**Staffing and Recruitment Difficulties:** If staff vacancies and recruitment difficulties in specialist areas persist within Hertfordshire and West Essex, then capacity will continue to be reduced and productivity will be affected. This will result in deteriorating service performance, reduced staff morale and increased turnover.	This statement has been re-artculated to describe the risk. The rational for current risk score is that "there are increasing concerns and issues relating to pay and staff conditions, including staff burnout. The pipeline of students applying to University of Hertfordshire is reported as reducing.". It can hamper the ability of the ICB to achieve each one of its strategic objectives	Open	4	4	16	1. Supply Committee established to prioritize recruitment issues 2. Temporary staffing group monitoring bank/agency use and incentives 3. Reservist model being developed to fill staffing gaps 4. Various initiatives to support recruitment and retention, including international recruitment, a retention pathfinder programme, and collaboration with the Health and Care Academy and the University of Hertfordshire.	↔	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

Hertfordshire and West Essex ICB's Board Assurance Framework

Date: 09/01/2024

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		
12								L	C	L x C = RS			1st line	2nd line	3rd line
										1					
582	30/09/2022	SO3	Davis Eward	Operations	**Emergency Department Operations - enhancing patient flow and reducing hospital delays** If patients are not assessed with a management plan and treated, admitted and/or discharged out of the Emergency Department within 4hrs then patients will be waiting for long periods resulting in an increased risk of harm to those in the department with a serious illness/condition that requires a quick response. Delays could also negatively impact performance targets, causing reputational risk.	December performance against the 4-hour standard for all types was 66.8%. Q3 performance (all types) was 70%. This is below the national target of 76% and the local planned trajectory of 75% January 2024 performance against the 4-hour standard for all types was 69.5%. This is below the national target of 76% and the local planned trajectory of 75%	**Averse**	4	4	16	Walk-in stream separated from ambulance stream to provide clearer visibility across the department and decompress bottleneck areas. Fit to sit implemented.	⇆			
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**	5	4	20	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	Reasonable	*None*
609	10/03/2023	SO3	Frances Shattock	Performance, Business Intelligence, Digital Transformation	**Mental Health Targets and Patient Health:** If Mental Health targets are not met thent there isa risk to patients Resulting in: potential deterioration of patients health and wellbeing	The risk description provided is clear and specific about the potential harm to patients if mental health targets are not met. However, it lacks details about the specific targets that need to be met, the factors that could cause them to not be met, and the potential impact on patients. To understand the ratonal for current risk score, a pequest has been made for the risk description to could include more specific information about the targets, more details about the potential causes of not meeting the targets, and specify the potential impact on patients in more detail.	**Open**	5	4	20	Mitigations: work is continuing across the system to ensure system working and improving the performance of particular areas of focus including OOAP which remain high	⇔	Limted	Reasonable	Reasonable
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*
612	10/03/2023	SO3	Frances Shattock	Performance, Business Intelligence, Digital Transformation	**Cancer Waiting times** If: waiting times are longer than the constitutional standards Then: this could result in a delayed diagnosis and heightened risk for patients Resulting in: worsening patient outcomes	1 Sept: increased likelihood as 62 day standard performance has decreased 26 Oct: performance has improved slightly in July & August for both the 62 day backlog and the 62 day standard but the risk currently remains the same	**Open**	4	4	16	There is an ICB wide transformation programme which works with all providers and across the system to improve cancer performance and outcomes Cross reference to the cancer programme mitigations		Reasonable	Substantial	*None*

Hertfordshire and West Essex ICB's Board Assurance Framework

Date: 09/01/2024

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		
12								L	C	L x C = RS			1st line	2nd line	3rd line
										1					
644	19/06/2023	SO5	Tania Marcus	Strategy, People, Workforce	**Overspend and Productivity Loss from increased establishment and Bank & Agency Staff Reliance:** If we do not address the increase of staff establishment and the accompanying use of bank and agency staff across the system, then we will see continuing trends of losses in productivity and increased financial pressures and overspend.	Monitoring of increased use of bank and agency month by month and utilisation of the national diagnostic tool suggests that the system is losing productivity since pre-covid in certain areas of acute activity	Cautious	4	4	16	System's operational plan setting out key targets across all organisations to reduce staff bank and agency usage Regional requirements set out ensuring new protocols to be put in place for use of agency staffing Temporary staffing group in place for the system to review activity and lead on new initiatives to reduce bank and agency spend. Series of workforce transformational projects encouraging transfer from bank to substantive posts, e.g. flexible working and job planning. Workforce workstream established as part of the ICS financial recovery programme Pilot activity within the national ICS diagnostic tool	⇔	Substantial	Reasonable	Reasonable
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
653	14/09/2023	SO5	Alan Pond	Finance, Contract, Premises	**Financial Efficiency Risk:** If the Integrated Care System and its component organisations fail to deliver the agreed efficiencies contained within the 23/24 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.	New risk being reviewed	Seek	4	4	16	System CEO group meeting fortnightly with Directors of Finance to track delivery of the financial plan. Leads for key areas of work identified. Further actions to be taken identified in the report on finance to today's board	⇔	*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
	↑	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	
	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

Report Author:

Leon Adeleye, Governance Manager - Risk

Hertfordshire and West Essex ICB's Board Assurance Framework

Date: 09/01/2024

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		
12								L	C	L x C = RS			1st line	2nd line	3rd line
										1					

	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

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐				
	NHS HWE ICB Board meeting held in Public				**Meeting Date:**	**22/03/2024**		
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	The system is ahead of trajectory on its financial plan for 23/34.
Planning for 24/25	The first planning submission was made on the 29th of Feb and showed a deficit position. Further work is taking place to understand that and to develop a financial plan for 24/25, with the next submission due in on the 21st of March.
Urgent and Emergency Care Performance	The operational position remains challenged. However, performance against the 4 hour ED standard improved to 67.8% in Jan- this is the best performance since June 2023. This was in the context of 16% more ED attendances in Jan 24 compared to Jan 23. Ambulance hours lost to handover reduced to 1963 hours in Jan, which is the best performance since September, but remains behind improvement trajectory.
Elective waiting times	We have now seen 4 months of reductions in the total elective patient tracking list- despite ongoing Industrial Action.
Waiting time inequality for Children and Young People	Childrens performance remains challenged and is covered in more detail below.
Workforce productivity	The system continues to work with regional colleagues and system partners to progress the six high-impact action areas identified by NHS England for progress, including skill mix reviews, completion of the national diagnostic tool and a range of measures associated to temporary staffing. So far two of our three acute trusts have completed the diagnostic tool and we are reviewing submissions to understand the differences in establishment to pre-Covid. Governance and working practices are now being considered along with completion of reporting templates for the regional team showcasing progress being made. Extensive narrative on workforce productivity and efficiencies is expected for the forthcoming operational plan submission.

3. Overview by area

Performance

Executive Summary – KPI Risk Summary

	P	?	F
H / L	0	4	7
	5	6	9
H / L	1	0	4

Highest Risk	Programme
ED 4 Hour Standard	UEC
% in ED > 12 Hours	UEC
RTT 78 Week Waits	Elective
RTT 65 Week Waits	Elective
RTT 52 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
NHS 111 Calls Abandoned	UEC
Ambulance Response Times	UEC
Ambulance Handovers	UEC
4 Hour Stroke Unit	Stroke
Thrombolysed < 1 Hour	Stroke
Adult 28 Day Standard	Mental Health
CAMHS 28 Day Standard	Mental Health
Community MH - Adult Waits for 2nd Appt	Mental Health
62 Day Standard	Cancer
6 Week Waits	Diagnostics
Autism Spectrum Disorder (ASD)	Community
CHC Assessments < 28 Days	Community

Lowest Risk	Programme
CHC Assessments in Acute	Community

Low Risk	Programme
2 Hour UCR	UEC
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
Learning Disability (LD) Health Checks	Primary Care
No Criteria to Reside (NCTR)	UEC
Out of Area Bed Days	Mental Health
Community MH - CYP Waits for 1st Appt	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 worse than average	National: HWE worse than average

- Hours lost to handover improved further to 1,963 hours in January. Whilst still not meeting trajectory, the gap to planned recovery is narrowing;
- Performance against the 4-hour ED standard improved to 67.8% in January, but remains adrift of the 73.7% recovery trajectory;
- NHS 111 abandoned calls increased further in December and January to 22.8%;
- Category 2 ambulance response times remain significantly above the 30-minute ambition, averaging 57 mins in January. HWE response times are the highest in East of England.

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) continues to improve, and the system met the 75% standard for the first time in 6 months;
- Patients waiting >62 days increased in December & January because of industrial action (IA) and seasonal leave / patient availability;
- 62-day performance betters the national and regional averages at 72.1%, but has been below the historic mean for the last 12 months; 31-day cancer performance achieved the national standard at 96.4%;

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

- The overall elective PTL had been increasing since April 21, but has shown some improvement in each of the last 4 months – down by c.10,000 patients since August
- Patients waiting >78 weeks continue to increase; all HWE acute trusts had breaches in December and were impacted by the ongoing IA. The majority remain in Community Paediatrics at ENHT;
- The 65 weeks backlog is largely unchanged since September and not achieving trajectory. Community Paediatrics again is the key risk;

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

- 6 week wait performance fell to 63.9% in December, driven by declines at ENHT & PAH. Performance continues to better the regional average.

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.

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 are largely unchanged at 107 weeks, compared to 53 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 been consistently reducing over the last 12 months, but the 28-day access standard has not been achieved since 2021;
- Children's waits for a Community MH 1st appointment are more stable and better than the national average. However median waits are 110 days, compared to 78 days for a 2nd contact is adult services.

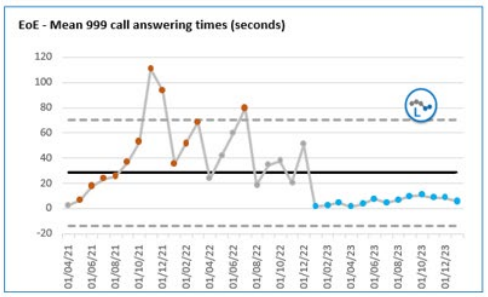
MENTAL HEALTH, Slides 21-31	Community MH (1st / 2nd Appts)	National: HWE better than average (Adult)	National: HWE better than average (CYP)

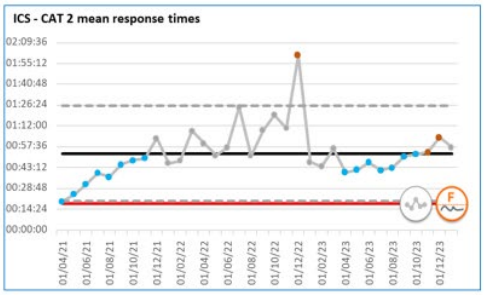
- Mental Health (MH) out of area bed days have improved for the 7th consecutive month. Access to community MH services however remains challenged and high risk;
- Community adult MH waits for a 2nd contact are high risk and declining, but better the national average.

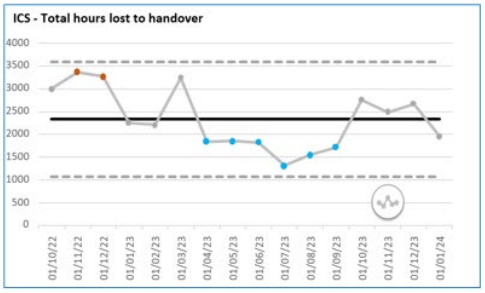
PRIMARY CARE & CHC, Slides 43-46	Appointments <14 Days	National: HWE in line with national average

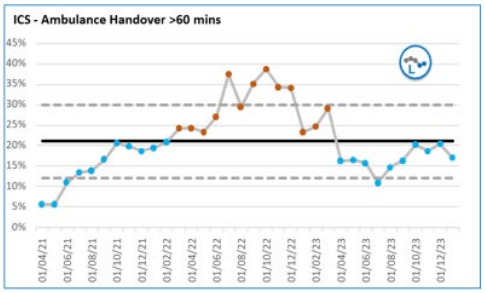
- Total number of GP appointments are variable but remain higher than pre-pandemic levels. Appointments in 2023 are highest since 2019;
- The percentage of appointments seen on the same day and <14 days are both deteriorating;
- CHC assessments within 28 days remains high risk, with performance particularly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

UEC - Ambulance Response and Handover

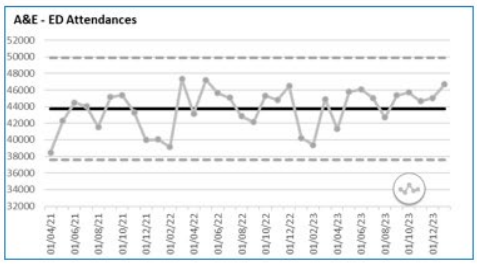


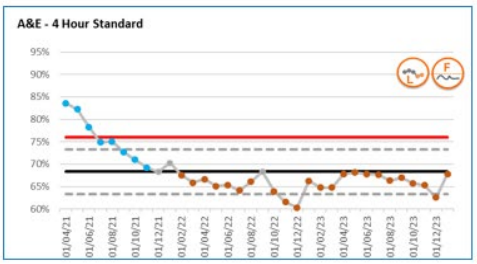






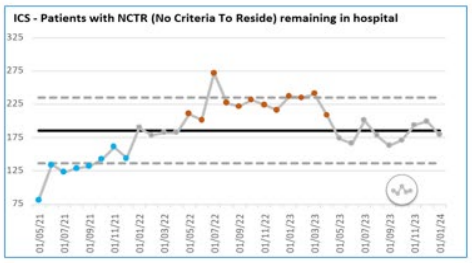
Urgent & Emergency Care (UEC)

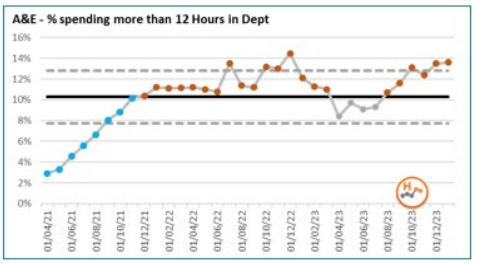




	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
East And North Hertfordshire Place (ENHT and HUC)	15,239	16,655	17,784	17,902	16,812	18,586	18,419	17,767	16,127	15,988	15,954	18,158	17,012	19,008	18,869	18,235	17,116	18,692	17,891	17,424	17,781	15,779	15,355	17,581	15,954	18,228	18,131	17,539	16,857	17,700	17,902	17,855	17,761	17,358
West Hertfordshire Hospitals NHS Trust	13,202	14,413	15,172	15,225	13,940	14,977	15,203	14,527	13,429	13,503	13,027	15,533	14,791	15,830	15,832	15,147	14,854	14,134	15,541	15,554	16,669	14,112	13,781	15,736	14,755	16,028	16,072	15,899	14,845	15,941	15,771	15,301	16,154	16,592
West Essex Place (PAH and HCT)	10,833	11,227	11,550	11,210	10,792	11,780	11,790	11,380	10,397	10,309	10,184	12,617	11,395	12,377	12,899	11,681	10,892	11,379	11,946	11,888	12,017	10,392	10,318	11,585	10,586	11,525	11,487	11,543	11,206	11,680	11,586	11,089	11,137	12,160
ICS	38,473	42,295	44,489	44,337	41,544	45,343	47,412	43,674	40,953	39,800	39,165	46,308	43,198	47,215	47,600	45,063	42,862	44,205	45,378	44,866	46,467	40,282	39,374	44,902	41,295	47,791	46,690	45,081	43,908	45,321	45,258	44,245	45,052	46,110

	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
East And North Hertfordshire Place (ENHT and HUC)	84.8%	85.9%	80.8%	77.9%	74.9%	71.8%	73.1%	72.2%	72.4%	73.2%	71.1%	70.9%	70.5%	70.9%	70.1%	67.9%	71.9%	70.7%	68.4%	64.8%	64.9%	69.3%	67.2%	67.6%	70.5%	69.5%	69.2%	70.5%	69.2%	70.8%	68.8%	68.7%	64.6%	70.2%
West Hertfordshire Hospitals NHS Trust	86.0%	81.0%	79.2%	73.9%	76.2%	77.4%	73.6%	75.5%	70.5%	63.3%	65.7%	62.7%	58.8%	62.1%	58.2%	60.5%	63.2%	65.3%	70.2%	64.6%	60.2%	60.0%	68.4%	69.0%	68.1%	71.4%	74.2%	73.1%	75.1%	69.1%	69.9%	71.8%	71.4%	67.1%
West Essex Place (PAH and HCT)	78.7%	75.8%	73.3%	72.0%	71.9%	66.4%	64.2%	65.0%	68.2%	71.6%	68.2%	66.9%	66.8%	64.9%	64.6%	60.2%	58.9%	62.7%	56.6%	58.6%	54.9%	58.6%	55.6%	55.8%	58.1%	57.8%	58.6%	59.1%	58.5%	57.1%	53.3%	54.2%	52.7%	61.8%
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%	64.6%	65.1%	65.4%	64.1%	66.2%	68.4%	64.0%	61.5%	60.3%	66.2%	64.8%	64.8%	67.8%	68.2%	67.8%	67.7%	68.4%	67.0%	65.8%	65.3%	62.6%	67.8%





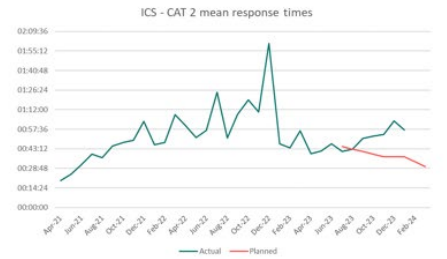
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
East And North Hertfordshire NHS Trust	2.8%	2.4%	4.7%	6.3%	8.6%	10.2%	11.8%	13.0%	12.8%	13.9%	14.1%	15.0%	14.8%	13.4%	13.8%	16.9%	12.5%	11.7%	15.7%	15.9%	15.7%	15.3%	16.3%	15.6%	11.7%	11.8%	13.2%	9.3%	11.7%	12.6%	13.0%	13.2%	15.1%	13.9%
West Hertfordshire Hospitals NHS Trust	1.5%	2.4%	2.6%	3.2%	5.4%	3.1%	2.9%	5.4%	8.1%	7.9%	7.5%	8.1%	7.5%	7.9%	8.8%	8.7%	9.4%	7.5%	6.7%	9.6%	8.9%	12.4%	10.9%	7.1%	5.6%	5.7%	4.9%	5.6%	8.3%	10.7%	4.7%	11.2%	12.3%	14.4%	14.7%
The Princess Alexandra Hospital NHS Trust	4.2%	5.3%	3.3%	4.3%	7.2%	8.7%	10.3%	11.2%	9.8%	11.2%	10.3%	11.3%	10.7%	10.7%	9.7%	10.3%	10.8%	10.4%	10.8%	11.1%	11.3%	10.1%	10.2%	9.8%	8.5%	9.6%	7.8%	8.3%	10.4%	10.9%	11.7%	11.1%	10.4%	10.4%

Urgent & Emergency Care (UEC) Improvement Trajectories

4 Hour Standard

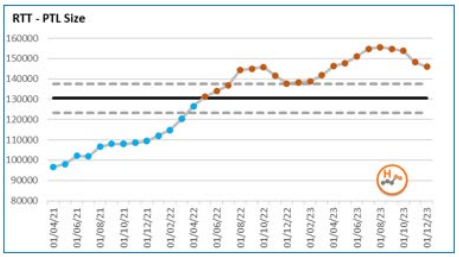
% of Patients Spending > 12 Hours in ED

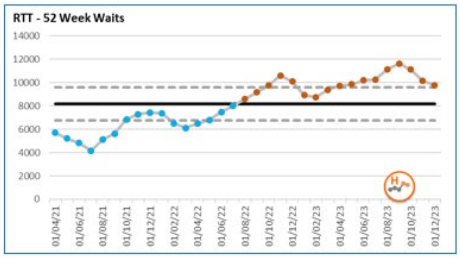
Ambulance Category 2 Mean Response Times

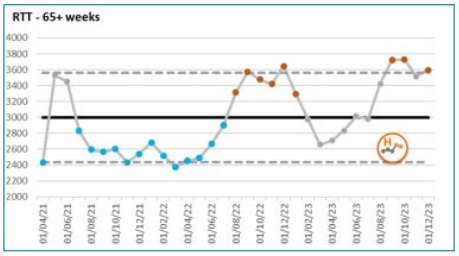


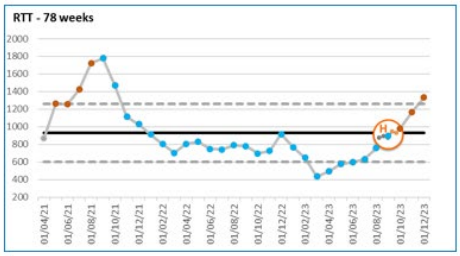
Hours Lost to Handover

Planned Care – PTL Size and Long Waits

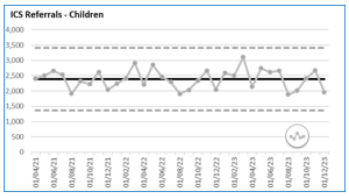


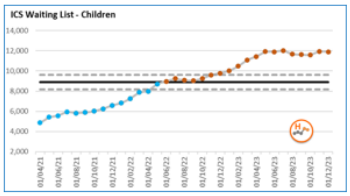


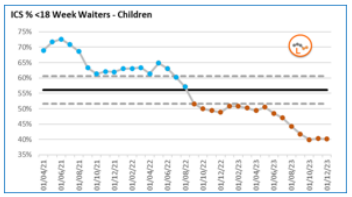


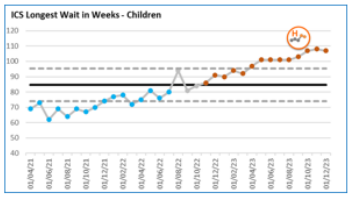


Community Waiting Times (Children)









		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	2673	1966	↓	11933	11900	↓	40.30%	40.14%	↓	108	107	↓	December

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	380	272	↓	1092	1057	↓	70.42%	71.52%	↑	43	46	↑	December
ENH	AJM/Millbrook	22	29	↑	121	129	↑	75.21%	73.64%	↓	32	36	↑	December
ENH	ENHT Community Paeds.	307	228	↓	4987	5054	↑	17.73%	17.12%	↓	108	107	↓	December
ENH	**All**	**709**	**529**	↓	**6200**	**6240**	↑	**28.13%**	**27.50%**	↓	**108**	**107**	↓	**December**

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	1370	1051	↓	4754	4672	↓	45.23%	46.58%	↑	76	78	↑	December
SWH	AJM/Millbrook	24	13	↓	110	107	↓	71.82%	71.03%	↓	32	36	↑	December
SWH	**All**	**1394**	**1064**	↓	**4864**	**4779**	↓	**45.83%**	**47.12%**	↑	**76**	**78**	↑	**December**

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	22	12	↓	33	31	↓	96.97%	96.77%	↓	20	19	↓	December
WE	HCRG / Virgin	548	361	↓	836	850	↑	96.17%	91.65%	↓	26	52	↑	December
WE	**All**	**570**	**373**	↓	**869**	**881**	↑	**96.20%**	**91.83%**	↓	**26**	**52**	↑	**December**

NOTE: ENHT Community Paediatrics data is included above to give a full picture for Children's Services, but is also included in the Planned Care position described in Slides 16 & 17

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 were low in December but within expected common cause variation • 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.40%, compared to the national average of 56.7% • The longest waits are within the ENHT Community Paediatrics Service at 107 weeks. There are also long waits of up to 78 weeks within HCT services in South & West Hertfordshire • Consultant led 18-week RTT performance: SWH Community Paediatrics – 44.8% SWH Children's Audiology – 25.7% ENH Community Paediatrics – 17.1% WE Community Paediatrics – 93.6% • The ENHT Community Paediatrics position is described within the Planned Care and ASD slides of this report	**Hertfordshire** • Referrals to HCT children's specialist services in have increased by 33% YTD compared to 2019/20, with the majority of 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 2019/20, but referrals have increased by c.30% • There are continued waiting time pressures in Paediatric Audiology in SWH. 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 % has fallen further to c.92% • Waits for first appointments have increased as HCRG have targeted longest waiting follow ups in recent months • The volumes on the Community Paediatrics waiting list is increasing as a result • Admin exercise to review / discharge long waiters – completion delayed to February	**Hertfordshire** • For HCT services the number of over 52-week waits has reduced from 605 in July, to 362 in January, and continues to improve in the most recent data • 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. Analysis for workforce business case has resulted in increased capacity, with recruitment successful to two posts • Children's Therapies – increasing capacity through successful recruitment, waiting list initiatives and outsourcing • EHCP dashboard developed to improve waiting list management **Community paediatrics ENHT** • New clinical model agreed by all providers: HPFT, HCT and ENHT • Herts Mental Health Learning Disability and Autism Care Partnership developed capacity model to be populated with input parameters from the providers in order to develop the business case • Target date for the business case is April 2024; dependent on populating capacity model • Single point of access / single referral form expected to be in place by Apr-24 • Target implementation date for the new model is January 2025 • Providers have forecast investment levels to continue with outsourcing / backlog work in 2024/25. Neurodiversity Directors Group to review / agree; then governance process to be agreed • ICB / HCC has agreed to expand the Neurodiversity Support Centre across Herts. (staffed by experts by experience). Diagnosis not required to access the support. External evaluation completed and the feedback is extremely positive. Full evaluation will be available in the next two months **West Essex (WE)** • WE Community Paediatrics Business Case: Additional in year funding and annual growth for future years now agreed, although not at the requested levels. Funding this year is being utilised to offset prescribing overspend • New Community Paediatrician in post from January. Staffing now at full establishment • 24/25 plans in discussion, but levels of available funding will still leave a capacity gap

Performance v. 23/24 Operational Plans

		M7 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	37,898	42,244	11.47%	4,346	↑	291,168	286,836	-1.49%	-4,332	↓
EM11a	Number of specific acute non-elective spells in the period with a length of stay of zero days	3,544	3,095	-12.67%	-449	↓	24,538	20,700	-15.64%	-3,838	↓
EM11b	Number of specific acute non-elective spells in the period with a length of stay of one or more days	6,327	6,688	5.71%	361	↑	43,144	46,570	7.94%	3,426	↑
EM10a	Elective day case spells	9,754	10,221	4.79%	467	↑	61,475	67,460	9.74%	5,985	↑
EM10b	Elective ordinary spells	1,284	951	-25.93%	-333	↓	7,949	6,145	-22.69%	-1,804	↓
EM32g	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance	46,177	43,555	-5.68%	-2,622	↓	300,938	290,650	-3.42%	-10,288	↓
EM32h	Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance	54,195	68,003	25.48%	13,808	↑	365,552	445,582	21.89%	80,030	↑
EB20	The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 65 weeks or more	2,364	3,727	57.66%	1,363	↑	17,831	22,411	25.69%	4,580	↑

ICB Issues and escalations

- Performance v. plan data above has not been updated due to reporting issues in the Month 8 Freeze and Month 9 Flex positions
- Resolution is being progressed and we expect a return to normal reporting in the next report

Performance v. 23/24 Operational Plans

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ICB Issues and escalations

- Zero-day length of stay and elective day case spells are within plan, and the number of attendances are less than plan YTD
- Elective recovery and activity in all areas continues to be impacted by the ongoing Industrial Action
- Elective inpatient activity is below plan; day cases are significantly above plan

Quality

Key areas

Area	Position	Further info
Infection Prevention and Control- C.difficile.	Ongoing assurances continue to be required	National increase in C. difficile cases. All HWE Integrated Care Board (ICB) places and 3 acute Trusts are now above NHS England thresholds.
Ophthalmology at Princess Alexandra Hospital Trust (PAHT) and East and North Hertfordshire Trust (ENHT).	N/A	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.
UPDATE: East & North Herts NHS Trust Paediatric Child Hearing Impairment (PCHI) Service.		Improvement work is ongoing following concerns identified relating to the paediatric audiology pathways. Areas requiring improvement have included leadership and governance, workforce levels and competencies, and estates and equipment. Improvements continue to be overseen by the ICB and NHSE via fortnightly oversight meetings, steady improvements are evident, and it is anticipated initial pathways will re-open in March.
East and North Hertfordshire Trust (ENHT) X-ray backlog		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, and an improvement plan is in place.

Sharing Best Practice: Reasons to be Proud

East and North Herts NHS Trust (ENHT).

- ENHT have been successful in their application for the National Preceptorship Interim Quality Mark. Following the National Preceptorship Panel meeting held on 11 January 2024 the submission from ENHT was successful. The panel also commended the Trust on the following aspects of submission 'The Multi-Professional Preceptorship Policy was excellent.
- DrEaMing Collaborative - ENHT is an early adopter. Detailed work regarding mobilization, nutrition and hydration is being undertaken across 3 specialties. These are Ear Nose and Throat, Orthopaedics, and General Surgery. ENHT has shared their work at a recent System Quality Group meeting.
- Opening of Urgent Treatment Centre is improving patient flow, increasing staff morale and the capacity to deliver care promptly.
- Surgical Assessment Unit opened December 2023. Relocated to Emergency Duty which has facilitated patient transfers directly to surgical teams for assessment. This is providing positive outcomes especially during peak periods within the Emergency Department.

Princess Alexandra Hospital NHS Trust (PAHT).

- Getting It Right First Time (GIRFT) re-visit took place in December 2023. The previous visit identified that improvements were needed In Orthopaedic length of stay and theatre utilisation. The re-visit identified that significant progress and improvements have been made. The hard work, commitment and system working was acknowledged. A GIRFT visit will take place again in 6 months.
- PAHT Maternity Peri Prem Passport - In order to improve outcomes for preterm infants PAH maternity services have launched their perinatal optimization pathway passport for women at risk of birth before 34 weeks. The bundle is part of an improvement project which supports the national Maternal and Neonatal Safety Improvement Programme mission to improve safety and outcomes for mothers/people and babies across England.

Central London Community Healthcare NHS Trust (CLCH).

- ITV London news report aired on 12 February 2024 to highlight National Apprenticeship week. The report features Patsy Fung, Chief Allied Health Professional and Rebecca, Occupational Health Therapy Apprentice at CLCH's Holywell Unit at Langley House. This report showcases the initiatives to improve staffing challenges but also the positive impact of the care provided to patients.
- The news report can be found here - ITV London News report - YouTube.

Patient Experience and Safety - ICB

ICB Area	Compliments	Complaints	PALS	Member of Parliament (MP)	General Practitioner (GP)	Whistleblowing	Serious Incidents	Never Events
East and North Herts.	0	19	142	10	41	3	19	1
South and West Herts.	2	21	99	8	18	1	17	0
West Essex.	0	13	76	3	27	0	3	0
Other.	0	20	91	2	0	0	2	0
Total.	2	73	408	23	86	4	41	1

ICB area	Key themes/ Risks	Improvement Actions and Mitigations
Across the ICB	Feedback from primary care in relation to quality concerns about secondary care services: • Requests to primary care to follow up tests carried out in secondary care. • Requests from hospital for onward referrals • Timeliness and quality of discharge summaries.	Discussions have taken place at the Primary care/acute Trust interface groups in each locality to identify actions that can be taken to improve safety in relation to the linked aspects of care.
Access to services	The concerns being raised relate to: • Primary care services. • Secondary care services. • Dental services.	• Some of the concerns relate to booking systems in primary care, in practices where total triage has been implemented it is generally working well. • Secondary care access is problematic across all specialities with waiting time for initial assessment, investigations and treatment • Dental provision is a national area of concern. The dental recovery plan has just been launched by the Department of Health and Social Care.

Infection Prevention and Control (IPC)

Area	Issue	Mitigating Action	Timescale
Measles	Since October 2023, significant increase in number of laboratory confirmed cases of measles in England - currently over 400 cases (usually approx. 10 cases confirmed during the same period in previous years). Majority are in London and West Midlands. Since October 2023, there has been one confirmed case in the HWE population.	• HWE Task and Finish Group chaired by Herts County Council. • Measles mumps rubella (MMR) vaccination pathways reviewed and 'pop up' clinics organised. Communications regarding immunisation, triage, IPC measures sent to all healthcare and social care providers including primary care. Pathways being established for immunoglobulin administration.	On-going
Streptococcal infection	There has been an increase in community streptococcal outbreaks locally and regionally, with links to domiciliary healthcare services. I.e. Group "A" and Group "G" Streptococcus.	• Organism typing and tracking of "M Protein Gene" (EMM) type, *emm typing helps differentiate between strains of the bacterium.* • Incident Management Teams with ICB and United Kingdom Health Security Agency (UKHSA) input • Staff/patient screening and review of IPC measures for home visits. Regional discussion of learning across outbreaks/ incidents	16th March 24
C. difficile	National increase in Clostridium difficile cases. December data shows HWE ICB places / 3 acute Trusts remain above NHS England objectives. Cumulative figures year to date demonstrate West Essex and East & North Herts Trust above East of England regional rates. WHTHT Trust continue downward trend and now have rate of infection below region.	• ICS Antimicrobial Stewardship Technical Working Group focusing on reducing the incidence of C. difficile across the system. • ICB Healthcare associated infection oversight groups established. • ICB /Trusts further analysing C. difficile data, reviewing themes/ trends and learning via case reviews. HWE ICS C. difficile system summit and system approach/ action plan. Enhanced surveillance of C. difficile cases in care homes. Engagement being improved with primary care IPC Champions regarding C. difficile surveillance via monthly webinars.	On-going

Finance

HWE ICS – Financial Report for Month 11 2023/24

Executive Summary

ICS Year to Date Position (YTD) – Month 11

In month 11, the HWE System reported a YTD position of £7.6m deficit, ahead of plan by £11.7m. The ICB has distributed funding made available by NHSE to support the system and for industrial action, as well as from the financial recovery plan. The favourable variance represents distribution of funding and delivery of financial recovery plans one month early.

ICS Forecast Outturn Position (FOT)

The full outturn position forecasts the system will break-even, in line with plan. The position for each organisation has moved, reflecting the distribution of funding by the ICB.

Planning 2024-25

The System submitted its first formal high-level plan on 29th February, which showed a £97m deficit across the system, efficiency programme of £130.4m (4%) and an underlying exit rate from 2023-24 of £146.1m deficit.

Capital

Capital reporting for month 11 is not available at the time this report was written. In month 10 the HWE system reported YTD capital spend of £38.7m against a YTD plan of £54.0m, with the full allocation of £79.2m forecast to be spent by the end of the year.

NHSE provided additional information, stating it would provide capital cover to meet all IFRS16 obligations as reported in month 10. They will look to true up this position in month 11 if sufficient capital cover is available and required.

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.

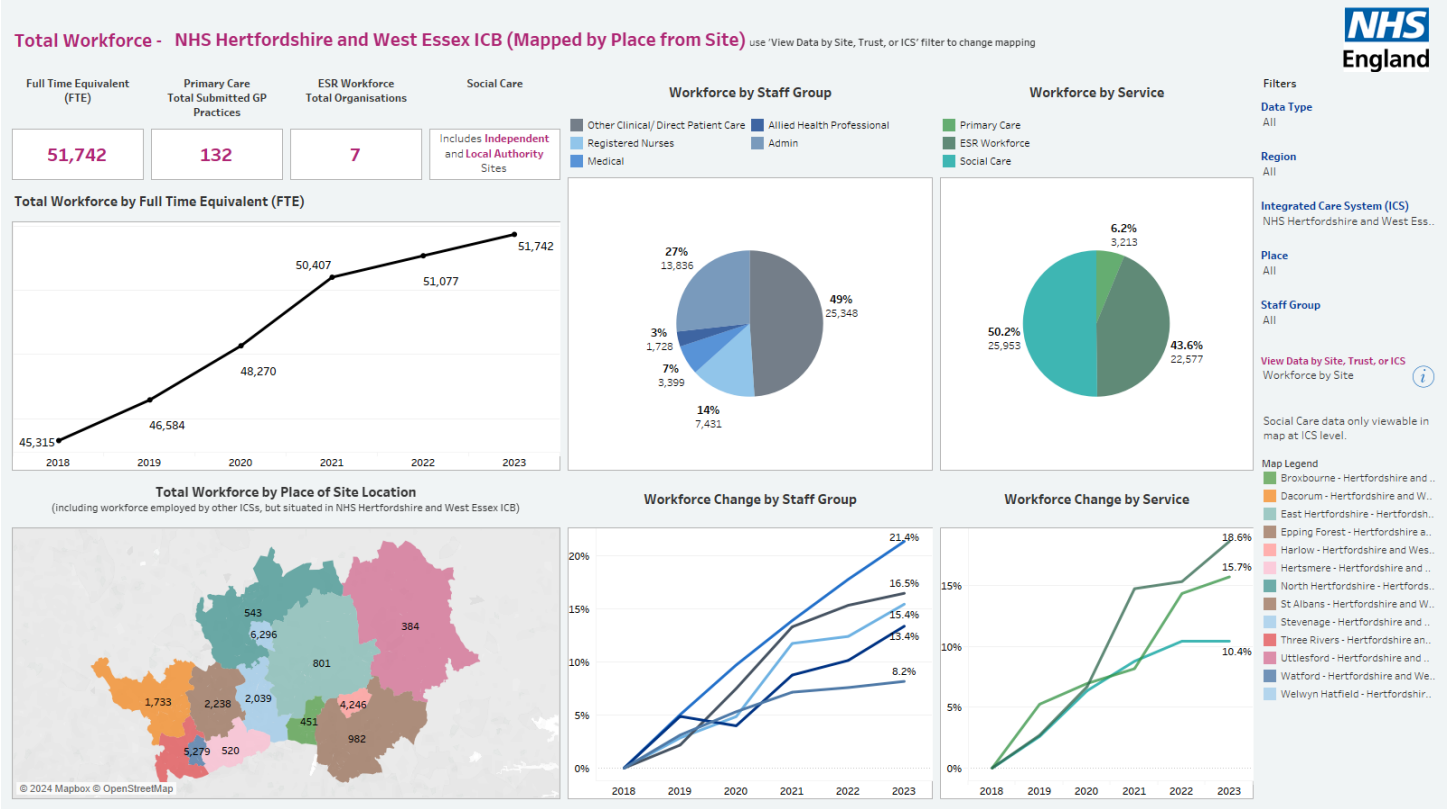
Operational and Finance leads within the system have now met, to start to identify potential initiatives that could be taken forward to address the financial position. This will be an on-going piece of work.

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.

Workforce

HWE System workforce dashboard (source: NHSE portal)



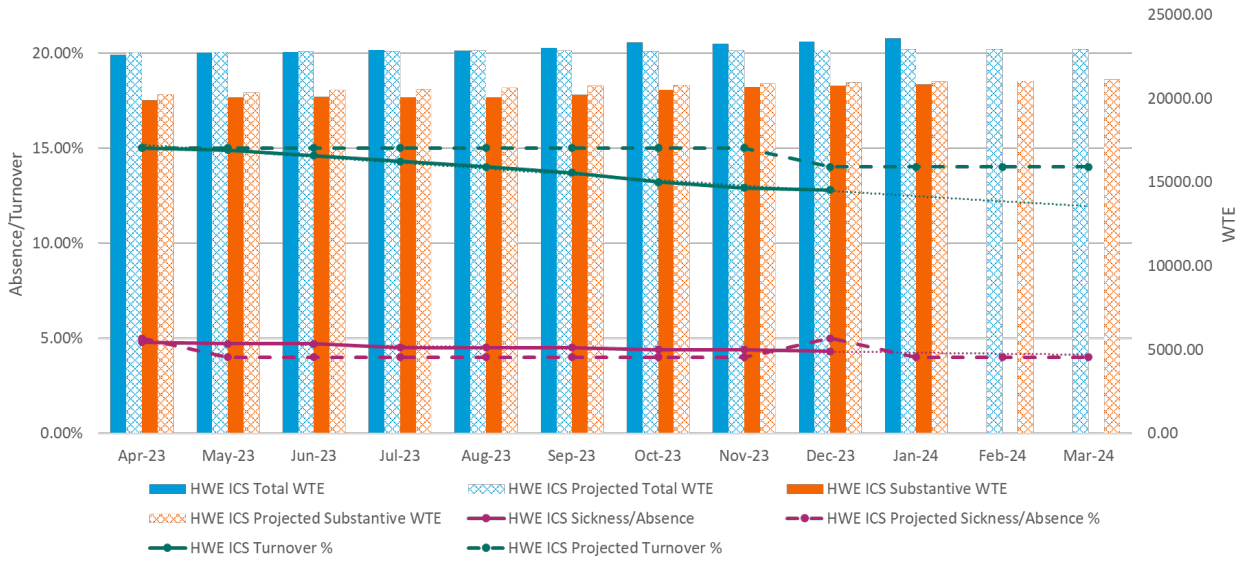
NHS Staff in post update

NHS secondary care providers are currently exceeding their 23/24 operational forecast total workforce by 2.8%. This obviously creates financial pressure on the system and is further enhanced by not meeting the forecasted position on substantive staff (-0.8%) meaning increased use and spend on temporary staffing within the system, with both bank and agency WTE figures over target for the system. ENHT, HPFT and PAH as providers are all above their forecasted total workforce from 23/24 operational plans – and these figures should be triangulated against performance and activity to understand whether the additional workforce is making an impact, or whether this is caused by other areas.

More positively trends in staff turnover and sickness absence continue to reduce, and both are now below the system forecast from the operational plan. The system reported a turnover rate of 12.7% in December 2023, still above the regional average of 11.1% - although showing signs that the gap to this average was beginning to close.

Leaver rates are close to recent unprecedented lows of 8.3% during the covid pandemic, although did unfortunately rise between November and December 2023 and currently stand at 8.5%.

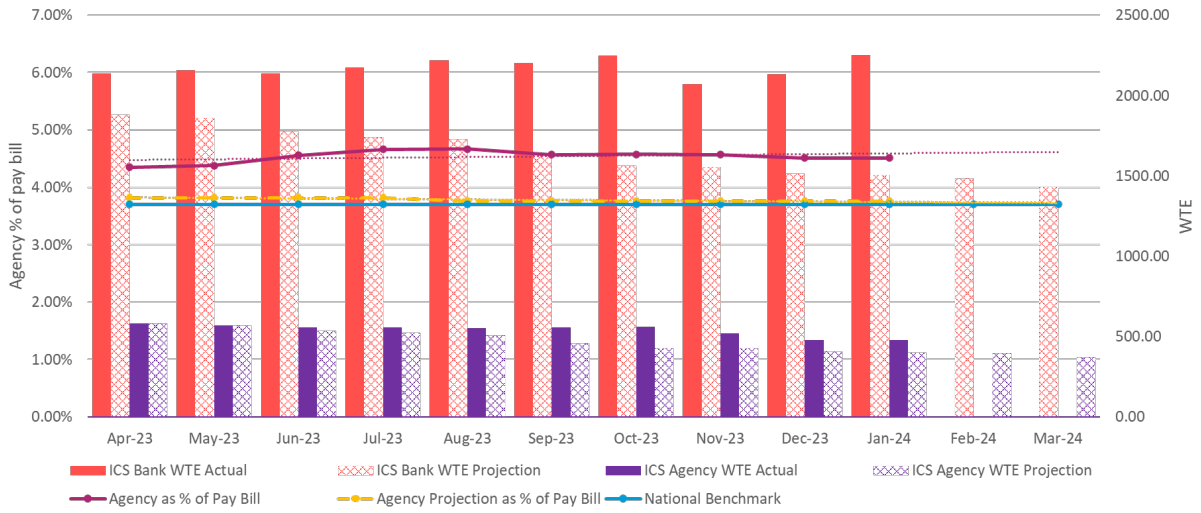
Secondary Care providers sickness absence rate (4.3%) continues to be well below the national (5.0%) and regional average (4.7%). For December 2023 minor illnesses became the highest reason for absence (22%), followed by mental health (20%) and then musculoskeletal problems (15%).



System figures for Total WTE (Whole Time Equivalent) workforce and substantive WTE, along with turnover and sickness/absence percentages compared to 23/24 operational plan forecasts (source: Provider Workforce Returns)

NHS Temporary staffing update

Bank and agency use across the system remains stubbornly high across the system, although the figures are starting to show green shoots of the work being undertaken within individual providers financial recovery workstreams.

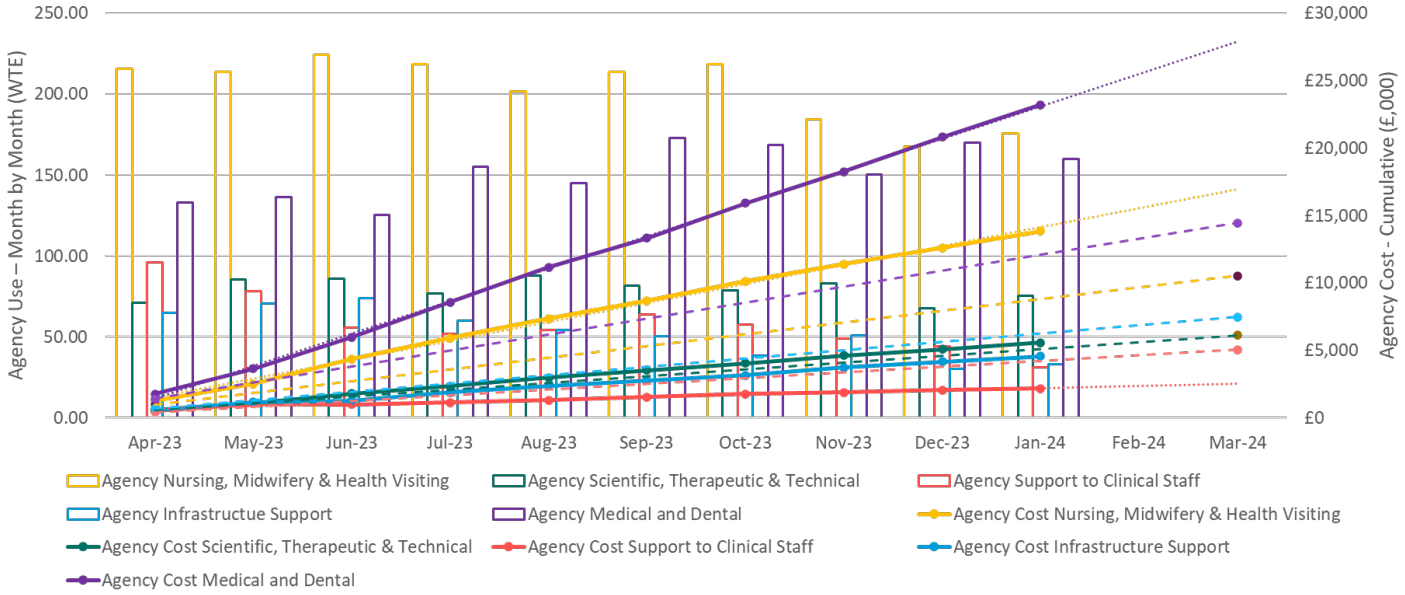


System figures for Actual Bank and Agency WTE (Whole Time Equivalent), along with the agency cost as a percentage of wage bill compared to 23/24 operational plan forecasts (source: Provider Workforce and Finance Returns)

While use of bank staff remains high and is significantly above the forecasted decrease within the 23/24 operational plan agency staff is beginning to decrease, and correspondingly the trend in agency staff as a percentage of wage bill is slowly beginning to turn.

There are however clearer signs of success at provider level. For example, at WHTH the provider's work on nursing agency staff and the review of establishment figures is clearly starting to take effect with the cumulative spend on nursing agency staff beginning to flat line for December 2023 and January 2024.

Medical agency rates are clearly still a significant concern for PAH and WHTH, and while there has been extensive work undertaken at trust level to support recruitment to hard to fill consultancy posts this is not yet resulted in halting the cumulative spend on medical and dental agency.



System figures for Actual Agency WTE (Whole Time Equivalent) broken down by staff grouping, along with the associated cumulative cost for each staff group compared to 23/24 operational plan forecasts which are shown as the dotted line (source: Provider Workforce and Finance Returns)

Productivity Diagnostic Tool

In December 2023 NHS England shared an early iteration of the national workforce productivity benchmark tool as part of their work to understand the differences in workforce establishment and productivity across secondary acute settings. The tool has been piloted in several areas, and as this aligned with aspirations for the financial recovery board HWE offered to also pilot.

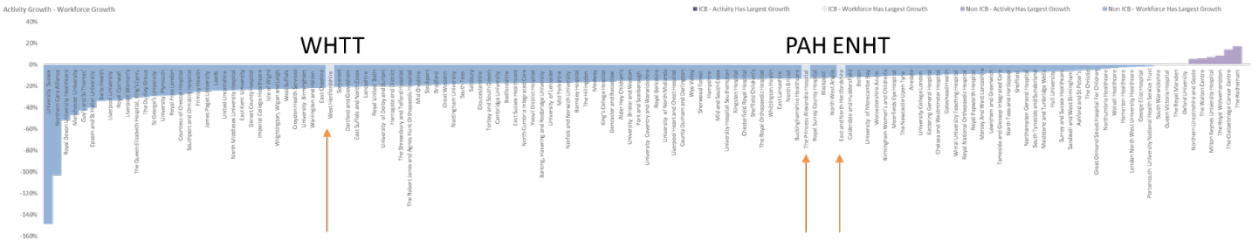
The tool aims to enable ICBs and providers to benchmark variation in workforce vs cost weighted activity growth between 19/20 and 22/23, and then self-assess where the workforce has been deployed (including for national schemes and locally driven change).

Issues identified:

- Only substantive workforce data is accounted for, and there have been several discrepancies in both activity and workforce data,
- The staff role breakdown is crude, and the tool is only applicable to acute trust activity,
- More detailed analysis and breakdown is required, although this had been paused while workforce planners focus on supporting operational plan submissions.

ICB Name	2019/20	2022/23	Growth (#)	Growth (%)	Growth (%)	Activity - Workforce
NHS Hertfordshire And West Essex Integrated Care Board	13,087	14,180	1,092	8.3%	-8.1%	-16.5%

	Substantive Workforce				Activity*		Temporary Staffing Quintiles**	
Provider Name	2019/20	2022/23	Growth (#)	Growth (%)	Growth (%)	Activity - Workforce	Bank WTE utilisation	Agency WTE utilisation
East and North Hertfordshire NHS Trust	5,327.9	5,861.7	533.8	10.0%	-1.9%	-11.9%	5	4
The Princess Alexandra Hospital NHS Trust	3,255	3,473	217	6.7%	-5.9%	-12.5%	4	4
West Hertfordshire Hospitals NHS Trust	4,504	4,845	341	7.6%	-13.6%	-21.2%	4	4



The tool utilises national data to review key areas of activity against substantive workforce growth within acute hospitals. The diagram above shows the key metrics taken and our organisations respective positions when compared nationally. It should be noted that the data reviewed for West Herts has been challenged and the organisation has recently participated in a McKinsey productivity review, for which the system is yet to see the outputs of.

Analysis:

- The national data suggests that activity within ENHT and PAH has had small increases in outpatients and emergency areas – but there has been significant decline in outpatients. It suggests that correspondingly WHTH has seen reductions in all activity with exception of A&E attendances. We are reviewing WHTH activity growth calculations from the tool as this doesn't align with our current understanding.
- There is significant difference in the workforce deployment measures identified by Trusts for workforce. National measures or quality measures account for between 41%

Reason for growth / % of total staffing change		All staff
ENHT	National Programmes	34%
	National Response	1.8%
	Local Demand changes	27.2%
	Local Service Improvement	9.3%
	Quality & Safety	24.8%
	TOTAL	94%
PAH	National Programmes	16.2%
	National Response	-
	Local Demand	-
	Local Service Improvement	2%
	Quality & Safety	22.5%
	TOTAL	41%
WHTH	National Programmes	23.7%
	National Response	1%
	Local Demand	35.1%
	Local Service Improvement	-
	Quality & Safety	-
	TOTAL	60%

and 94% of the differences identified by Trusts.

- ENHT and WHTH have both identified significant local service changes that have impacted upon workforce numbers.
- There are a number of additional drivers identified for productivity reduction including staff turnover and staff sickness within the Trusts that has impacted productivity across the system, but the tool does not enable an estimated impact assessment of those drivers on activity.

Next steps

The detail above and each organisation's submission was presented to the system's recent financial recovery workshop held at the beginning of March. We have suggested a series of follow-up actions to further progress this area of work following submission of the operational plan, and as part of this we are seeking to improve our project development, governance and monitoring arrangements on reform, innovation and productivity moving forwards.

Draft - 2024/25 Operational Plan Submission – data correct as of 13th March 2024 and subject to change

FLASH SUBMISSION	TOTAL WORKFORCE (MAR-25)	Change against 23/24 Op. Plan	Change against current Mar-24 fore.	TOTAL SUBSTANTIVE (MAR-25)	Change against 23/24 Op. Plan	Change against current Mar-24 fore.	TOTAL BANK & AGENCY (MAR-25)	Change against 23/24 Op. Plan	Change against current Mar-24 fore.
HWE ICS	23,419	2.1%	-0.7%	21,279	0.7%	0.1%	2,140.5	18.8%	-7.5%

REVISED RAPID SUBMISSION	TOTAL WORKFORCE (MAR-25)	Change against 23/24 Op. Plan	Change against current Mar-24	TOTAL SUBSTANTIVE (MAR-25)	Change against 23/24 Op. Plan	Change against current Mar-24	TOTAL BANK & AGENCY (MAR-25)	Change against 23/24 Op. Plan	Change against current Mar-24
HWE ICS	22,915.5	0%	-3%	20,742.7	-2%	-2%	2,172.8	21%	-6%
ENHT	6,453.6	-1%	-5%	5,969.2	-5%	-4%	484.4	104%	-14%
HCT	2,240.5	0%	0%	2,105.8	-3%	-1%	134.7	53%	7%
HPFT	4,806.2	8%	2%	4,076.6	6%	4%	729.6	18%	-7%
PAH	3,971.2	-2%	-2%	3,633.0	-2%	-2%	338.2	0%	0%
WHTH	5,443.9	-4%	-7%	4,958.0	-4%	-7%	485.8	-7%	-3%

Overall submission:

The original flash submission received two revisions – one from HCT who had originally supplied establishment figures over staff in post, the other from ENHT who's original figures had not been triangulated against finance. The blue table above shows the current workforce position for the system, although as these areas are further triangulated against finance and activity for the first submission which is due on the 21st March, these numbers may change further.

- The table above compares our revised operational plan forecast for 24/25 against our original forecast in 23/24, but also against our current forecasts for our out-turn position at the end of this month, which shows we will forecast an overall reduction in total WTE by -3% and reducing our current system bank and agency by -6%.
- The most significant difference between these positions is the change in forecast of our bank and agency projections, which moves from 21% growth in bank and agency use to a reduction of -6%. This is a particular issue at ENHT or HPFT who are unlikely

to meet their potential forecasts in transferring staff from bank and agency to substantive in 23/24.

Providers forecasting growth:

- HCT – It is anticipated that there will be growth of 116 FTE WTE. This relates to a mid-year TUPE of services into HCT and some contracted new business, explicitly: 52.58 FTE of transferring businesses and 54.13 FTE are previously agreed Service Development proposals. These include Hospital from Home, Community Dental as well as new block contracts for diabetic eye screening and childrens' services. There is more work required on HCT's submission to review the use of bank and agency, and whether short-term fixed-term contracts could be utilised.
- HPFT - HPFT's current position is that staff in post will increase through improved retention and attraction, but budgeted establishment will remain the same. HPFT are investing in the future pipeline and growing our own people, mostly through apprenticeships as well as some trainee roles, some of which is reflected in staff in post projections for 24/25. There is investment in several areas of service development.

Roles forecasting growth:

- The only areas of significant forecast growth are substantive 'nursing' (6%) and 'Other Clinical roles' (3.6%) within HPFT. This relates to the priorities stated above by HPFT and the introduction of a series of new apprenticeship opportunities within this area. This will need further analysis and review prior to the first submission on the 21st.

Temporary staffing:

- Our current proportion of bank and agency staff use across the system stands at 11.6% (January 2024). As previously noted, providers have been unable to achieve their previously forecasted reductions in use of bank and agency, and we believe previous forecasts had been overly ambitious within some providers in the system. Our revised forecasts show a reduction in bank and agency use across the system to 9.7% across the system, which we believe to be a more realistic ambition within one year.
- All organisations have introduced both vacancy control processes and are proactively seeking to transfer agency staff from hard to recruit roles into substantive positions. The system is seeking to share best practice from WHTH which has seen an almost total removal of agency nursing costs in the last two months.
- There are a significant number of temporary staffing roles within Princess Alexandra Hospital working within electronic health record and new hospital programmes of work which are due to come to a close within this financial year.

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:**	**22/03/2024**		
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 7th March 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.							
Executive Summary:	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 have been successful in their application for the National Preceptorship Interim Quality Mark • PAHT have developed a Maternity Peri Prem Passport to support improved outcomes for preterm infants • CLCH staff highlighted in recent national news relating to National Apprenticeship week, noting the positive impact on care to patients. 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 and oversight of the service. • Improvement work following the SEND inspection report published in November 2023. • Ongoing demand on all services across the system, alongside periods of industrial action, are impacting on delivery of safe and timely care. • All HWE Integrated Care Board (ICB) places and 3 acute Trusts are still above NHS England trajectories for C.difficile. • Ophthalmology challenges across the system linked to waiting lists and timely care. • Ongoing support to EPUT following their CQC inspection earlier in 2023.
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:	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 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 ale 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

March 2024

Hertfordshire and West Essex Integrated Care System

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NHS Hertfordshire and West Essex Integrated Care Board

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Executive Summary (1/2)

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.	22	Ongoing assurances required.
UPDATE: East and North Hertfordshire Trust (ENHT) backlog of x-rays.	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, and an improvement plan is in place.	23	Ongoing assurances required.
UPDATE: Publication of Hertfordshire Special Education Needs and Disabilities (SEND) report**.**	Report published 10th November 2023 outlining significant concerns around experiences and outcomes of Children and Young People with SEND. The priority action plan has been submitted to the Office for Standards in Education, Childrens Services and Skills (Ofsted) and Care Quality Commission (CQC) and approved on 11 January 2024. Work is underway to develop and finalise the aligned SEND Quality Assurance Framework and implement in partnership with health and social care providers the aligned quality assurance and improvement activity.	18	Significant assurances required.

Executive Summary (2/2)

UPDATE TO PREVIOUS POSITION OR NEW. Area of Focus	Headlines	Slide Number	Position since Previous Report
UPDATE: ENHT Paediatric Child Hearing Impairment Service.	Improvement work is ongoing following concerns identified relating to the paediatric audiology pathways. Areas requiring improvement have included leadership and governance, workforce levels and competencies, and estates and equipment. Improvements continue to be overseen by the ICB and NHSE via fortnightly oversight meetings, steady improvements are evident, and it is anticipated initial pathways will re-open in March.	20	Progress, with further assurances required.
UPDATE: Mount Vernon Cancer Centre (MVCC) Gynaecology Outcomes.	Improvement plan and actions continue for the gynaecology pathway with regular NHS England oversight, this includes pathway review and strengthened governance.	21	Progress on improvement plan, regular oversight via NHS England/ HWE ICB.
UPDATE : Herts and West Essex (HWE) Infection Prevention & Control (IPC).	National increase in Clostridium difficile cases. December 2024 data shows that all HWE Integrated Care Board (ICB) places and 3 acute Trusts remain above NHS England objectives. Cumulative figures for the year to date demonstrate that West Essex place and East and North Hertfordshire Hospital Trust are also above the East of England regional rates. West Hertfordshire Teaching Hospital Trust (WHTHT) have continued their downward trajectory and now have a rate of infection below that of the region.	15	Progress made against actions with further assurances required.

Sharing Best Practice: Reasons to be Proud

East and North Herts NHS Trust (ENHT).

- ENHT have been successful in their application for the National Preceptorship Interim Quality Mark. Following the National Preceptorship Panel meeting held on 11 January 2024 the submission from ENHT was successful. The panel also commended the Trust on the following aspects of submission 'The Multi-Professional Preceptorship Policy was excellent.
- DrEaMing Collaborative - ENHT is an early adopter. Detailed work regarding mobilization, nutrition and hydration is being undertaken across 3 specialties. These are Ear Nose and Throat, Orthopaedics, and General Surgery. ENHT has shared their work at a recent System Quality Group meeting.
- Opening of Urgent Treatment Centre is improving patient flow, increasing staff morale and the capacity to deliver care promptly.
- Surgical Assessment Unit opened December 2023. Relocated to Emergency Duty which has facilitated patient transfers directly to surgical teams for assessment. This is providing positive outcomes especially during peak periods within the Emergency Department.

Princess Alexandra Hospital NHS Trust (PAHT).

- Getting It Right First Time (GIRFT) re-visit took place in December 2023. The previous visit identified that improvements were needed In Orthopaedic length of stay and theatre utilisation. The re-visit identified that significant progress and improvements have been made. The hard work, commitment and system working was acknowledged. A GIRFT visit will take place again in 6 months.
- PAHT Maternity Peri Prem Passport - In order to improve outcomes for preterm infants PAH maternity services have launched their perinatal optimization pathway passport for women at risk of birth before 34 weeks. The bundle is part of an improvement project which supports the national Maternal and Neonatal Safety Improvement Programme mission to improve safety and outcomes for mothers/people and babies across England.

Central London Community Healthcare NHS Trust (CLCH).

- ITV London news report aired on 12 February 2024 to highlight National Apprenticeship week. The report features Patsy Fung, Chief Allied Health Professional and Rebecca, Occupational Health Therapy Apprentice at CLCH's Holywell Unit at Langley House. This report showcases the initiatives to improve staffing challenges but also the positive impact of the care provided to patients.
- The news report can be found here - ITV London News report - YouTube.

Key Priority Areas

Patient Experience and Safety - ICB

ICB Area	Compliments	Complaints	PALS	Member of Parliament (MP)	General Practitioner (GP)	Whistleblowing	Serious Incidents	Never Events
East and North Herts.	0	19	142	10	41	3	19	1
South and West Herts.	2	21	99	8	18	1	17	0
West Essex.	0	13	76	3	27	0	3	0
Other.	0	20	91	2	0	0	2	0
Total.	2	73	408	23	86	4	41	1

ICB area	Key themes/ Risks	Improvement Actions and Mitigations
Across the ICB	Feedback from primary care in relation to quality concerns about secondary care services: • Requests to primary care to follow up tests carried out in secondary care. • Requests from hospital for onward referrals • Timeliness and quality of discharge summaries.	Discussions have taken place at the Primary care/acute Trust interface groups in each locality to identify actions that can be taken to improve safety in relation to the linked aspects of care.
Access to services	The concerns being raised relate to: • Primary care services. • Secondary care services. • Dental services.	• Some of the concerns relate to booking systems in primary care, in practices where total triage has been implemented it is generally working well. • Secondary care access is problematic across all specialities with waiting time for initial assessment, investigations and treatment • Dental provision is a national area of concern. The dental recovery plan has just been launched by the Department of Health and Social Care.

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.	• All 3 local Medical Examiner Offices continue to roll out scrutiny to community providers including primary care. Some practices continue to wait until implementation is statutory requirement. However, progress remains positive.	On track as an ICS. Delay in national IT system has resulted in need for local IT solutions.
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 training has been facilitated by the ICB. System workshop 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 PSP Policy.	On track. Evaluation required by February 2024 to secure ongoing funding.
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 (Understood that all primary care to have fully implemented by April 2025)
Patient safety education and training.	• Level 1 training made mandatory within ICB with good uptake (approximately 85%). Level 2 training made mandatory within ICB and launched on 3rd February 2023; 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 QI 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 QI event in the spring.	On track
Herts and West Essex Quality Improvement Network.	• Ongoing development of the system QI Network, currently just under 100 members. • NHS Futures Platform dedicated page • Recent webinars include hosted sessions on Quality Management Systems and Co-production. • Part time fixed term administrator commenced in post October 2023 for 6 months. • 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 QI Network. • Current work includes completion of the NHS Impact self-assessment by organisations 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, outlined in national letter published September 2023 (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 Adults and Children

Adults		
Theme	**Issues and Impact**	**Mitigating Action**
Gaps in Safeguarding Adult provision and resource across primary care. Named GPs are currently contracted to support safeguarding children.	• Creates systems pressures. • Staff awareness and training. • Staff capacity.	• Safeguarding team transitioning towards an all age model to support services across the lifespan. • A review of current model is underway. • Introduction of domestic abuse toolkit.
There is a 50% increase in high- risk domestic abuse cases identified in acute settings impacting on resources and capacity within services.	• Creates systems pressures. • Staff awareness and training. • Staff capacity. • Chrysallis is provided to support perpetrators by Hertfordshire Office of Police and Crime Commissioner.	• Increased Independent Domestic Violence and Sexual Advocacy. • Introduction of domestic abuse toolkit. • Safeguarding Team to explore solutions with partners on HWE inequity in provision of Independent Domestic Violence Advisors services in Hertfordshire.
50% increase in Deprivation of Liberty Safeguards application for adults/ children in Hertfordshire.	• Creates systems pressure • Staff awareness and training • Staff capacity • Understanding of legal literacy	• Requirements are included within the workplan for the Hertfordshire Training and Development subgroup • Discussed within the safeguarding supervision
Children		
Theme	**Issues and Impact**	**Mitigating Action**
Following transfer of Child Health Information System (CHIS) 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. • Incomplete information available to the Essex 0-19 service to inform assessments.	• Mapping of other provider CHIS processes to determine whether this is a local or regional issue. • To be discussed at the SET Health Executive Forum as system risk. Mitigations in place within 0-19 service to address gap in information sharing.
Gaps in ICB commissioning for Female Genital Mutilation.	• Lack of a commissioned pathway resulting in timely access for assessment.	• Spot purchasing of specialist care and treatment available for women and girls. • Work in progress to develop commissioning service level agreements with University College Hospital London.

Infection Prevention and Control (IPC)

Area	Issue	Mitigating Action	Timescale
Measles	Since October 2023, significant increase in number of laboratory confirmed cases of measles in England - currently over 400 cases (usually approx. 10 cases confirmed during the same period in previous years). Majority are in London and West Midlands. Since October 2023, there has been one confirmed case in the HWE population.	• HWE Task and Finish Group chaired by Herts County Council. • Measles mumps rubella (MMR) vaccination pathways reviewed and 'pop up' clinics organised. Communications regarding immunisation, triage, IPC measures sent to all healthcare and social care providers including primary care. Pathways being established for immunoglobulin administration.	On-going
Streptococcal infection	There has been an increase in community streptococcal outbreaks locally and regionally, with links to domiciliary healthcare services. I.e. Group "A" and Group "G" Streptococcus.	• Organism typing and tracking of "M Protein Gene" (EMM) type, *emm typing helps differentiate between strains of the bacterium.* • Incident Management Teams with ICB and United Kingdom Health Security Agency (UKHSA) input • Staff/patient screening and review of IPC measures for home visits. Regional discussion of learning across outbreaks/ incidents	16th March 24
C. difficile	National increase in Clostridium difficile cases. December data shows HWE ICB places / 3 acute Trusts remain above NHS England objectives. Cumulative figures year to date demonstrate West Essex and East & North Herts Trust above East of England regional rates. WHTHT Trust continue downward trend and now have rate of infection below region.	• ICS Antimicrobial Stewardship Technical Working Group focusing on reducing the incidence of C. difficile across the system. • ICB Healthcare associated infection oversight groups established. • ICB /Trusts further analysing C. difficile data, reviewing themes/ trends and learning via case reviews. HWE ICS C. difficile system summit and system approach/ action plan. Enhanced surveillance of C. difficile cases in care homes. Engagement being improved with primary care IPC Champions regarding C. difficile surveillance via monthly webinars.	On-going

Mental Health - Childrens

Area	Issues and Mitigating Actions
Southend, Essex and Thurrock CAMHS. Did Not Attend (DNA) Deep Dive.	DNA figures above 14% since October 2023. Deep dive undertaken which has determined these mainly sit with Health Care Resourcing Group. Action plan developed which includes joint regular monthly audits going forward and contacting families after a DNA. Key themes, good practice, areas for improvement and learning identified. Further qualitative data is required focusing on engagement of young people. There is also a high rate of DNA in Children and Young People (CYP) with Autism Spectrum Disorder/Attention Deficit Hyperactivity Disorder, and work is underway with the Neurodevelopmental Lead to consider how to improve this.
Hertfordshire. • Transforming Care (TC). • Social Care.	• Continued high numbers in Transforming Care cohort who are currently inpatients. Planned trajectory is set at 4 inpatients, and there currently are 11 CYP inpatients. Active planning in place for discharge plans, work across health and social care to agree care and support packages. • There are several CYP awaiting discharge as inpatients. Actively working with health and social care colleagues to agree care and support packages. There are placement challenges within social care that are having an impact, but the system remains in communication to support sustainable discharge.

ICB Risk		Issue	Mitigating Action	Timescale
Transforming Care Inpatient number increases.	Herts	Target is 4. Currently 11 inpatient TC cohort. Steady increase in numbers of TC and this needs to reduce.	As above. There is a requirement to ensure that we are considering needs of CYP holistically, including the social and environmental that could influence positive and sustainable discharge.	Ongoing

Maternity and Children

Issues and Overview	Mitigating Action
Maternity Incentive Scheme Full compliance at East and North Herts Trust (ENHT) and West Herts Teaching Hospitals Trust (WHTHT). Princess Alexandra Hospital Trust (PAHT) achieved compliance with 9 of the 10 safety actions.	Actions in place to support full compliance at PAHT for current staff, linked to medical training.
Maternity Safety Support Programme Exit and sustainability plan -PAHT entered NHS England Maternity Safety Support Programme in 2020 following Care Quality Commission (CQC) maternity inspection in 2019 and 2021.	PAHT have been working in conjunction with a Maternity Improvement Advisor to develop a plan bringing together national and local initiatives, drivers, and improvement plans including the maternity and neonatal 3-year delivery plan. Detailed monitoring will be via the Divisional Board, assurance via the monthly PAHT Quality and Safety Committee, with a summary sent to the Trust Board. External scrutiny will be provided Local Maternity Neonatal System (LMNS), ICB, and the regional maternity team.
Quality Assurance Framework development is underway to support response to Herts Special Educational Needs and Disabilities (SEND) Inspection report findings in 2023.	An improvement action plan is in progress to transform SEND services in Health and Local Authority services in response to the inspection report published in November 2023. Work is underway to develop and finalise the aligned SEND Quality Assurance Framework and implement in partnership with health and social care providers the aligned quality assurance and improvement activity.
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.

Local Maternity Neonatal System – LMNS

Area of Focus	Mitigating Action
Midwifery Staffing	• Midwifery vacancy rates are improving however there are new risks associated with skill mix particularly surrounding newly qualified midwives and international recruits which may have a potential impact on safety. Preceptorship in place across all 3 sites and acuity reviews part of daily business as usual. • Support sought from regional workforce colleagues to consider specialist roles, benchmarking across other systems and opportunities for shared learning to offer additional support to new and international recruits.
Digital Maturity	• LMNS digital lead leaving post Feb 24. Business case submitted to reappoint into a substantive role within the ICB. • A digital implementation project is underway and on track to implement a new digital maternity record system between May – October 2024. • Digital maturity assessment to be completed March – April 2024 • One of our trusts has an established maternity digital system and families have access to their records in real time. • Cross border working group in place however further work needed to understand how disparity in digital systems can impact clinical care.
Culture	• Highlighting changes to senior leadership across the system which is known to impact culture. • Ongoing cultural concerns currently being mitigated with support from SCORE survey and perinatal listening events as example supportive offers. • Continue to practice openness and transparency with cultural concerns utilizing Professional Midwifery advocates, Freedom to Speak up Guardian. • Ensure clinical safety by optimizing a supportive working environment. • Trusts monitoring impact of Industrial Action in medical workforce and potential for cultural concerns arising as a result.

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

Area	Risk	Mitigating Action	Timescale
East and North Hertfordshire (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. • Quality and Safety, Environment and Equipment, Digital, Operational, Workforce, Communications workstreams progressing. • Mutual aid in place from Hertfordshire Community Trust and Cambridge University Hospital. • Progress being made with under 5 years/over 5 years pathways, anticipated date for opening of initial pathways is March 2024.	Ongoing.
ENHT - X-Ray backlog.	A backlog of X-rays including chest and long bone was 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.	Ongoing
East and North Hertfordshire Trust (ENHT)-Mount Vernon Cancer Centre.	Risk of harm within the Systemic Anti-Cancer Therapy pathway.	• 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 - 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
Out of Hours Ophthalmology provision for West Essex	There are currently no formal arrangements for out of hours non-emergency patients, however emergency provision continues to be available at PAHT 24/7.	• Discussions with Moorfield's continue to progress positively. All other measures as reported to the January meeting.	Ongoing

Assurance and Oversight – Adult Mental Health (1/2)

Area	Issue and Impact	Mitigating Action	Timescale
Essex Partnership University Trust (EPUT)	Care Quality Commission (CQC) Improvement plan: The Trust continues with work to implement and embed the detailed action plans required by CQC following recent inspections.	• Monthly sharing of detailed progress reports to the 3 ICB's setting out actions completed, in-progress or overdue. The action plan brings together core CQC and other related plans into one document to ensure consistency of delivery, avoidance of duplication and consistent assurance routes. • Monthly Quality together forum ongoing to discuss key achievements, challenges etc with NHSE and ICBs.	Ongoing
EPUT	The Lampard Inquiry: (formerly the Essex Independent Mental Health Inquiry). Revised Terms of Reference are awaited following a public consultation that took place in Q3 2023.	• 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
Herts Partnership Foundation Trust (HPFT)	Non-complex ADHD assessment: The Trust has reported that it has reduced capacity for assessment of non-complex ADHD due to the number of adults currently on its waiting list.	• There are processes in place to monitor and contact people on the waiting list. • Assurance mechanisms in place. Ongoing discussions between GP Leads / ICB Medical Directorate.	Ongoing Ongoing
Hertfordshire	Multi-agency suicide review: Hertfordshire Public Health Team recently convened a multi-agency review following a cluster of suicides which occurred across a 6-month period and within a single post-code area. The purpose of the review is to determine whether there may be any linking or connecting factors between the cases, and any actions required to respond.	• All partner agencies attending with good representation. • Action for Adult safeguarding for consideration of a Safeguarding Adult Review process is being taken forward. • Further review meeting in March. • ICB Leads reviewing options for wider support, training or information for local professions/groups as part of the learning and next steps.	March 24

Assurance and Oversight – Adult Mental Health (2/2)

Area	Update	Mitigating Action	Timescale
Routine referrals to community Mental Health team meeting 28 day wait.	63.89% - Q3	68.42% - Q3	100 % -August
Delayed transfers of care to the maintained at a minimal level (target 3.5% from Sept-17 previously 5.4%).	13.64% - Q3		0% - August
Reduction in Inappropriate Out Of Area for Herts and West Essex (bed days).	207/1,472 above target Q3		293 – August

Area	Issue	Mitigating Action	Timescale
Delayed transfers of care (DTOC). Herts Partnership Foundation Trust (HPFT).	Increase in DTOC due to ongoing difficulties finding suitable placements and care packages for service users with complex needs. Quality Review Meeting in December and Technical meeting with HPFT for further update.	• Strengthened contractual management arrangements to support contractual lengths of stay targets, with exception reporting. Enhanced Discharge team almost fully recruited - ways of working developed. Home Group actively working with team as part of the multi-Disciplinary Team. • Wider system work, led via Executives to support placement of longer-term Delayed Transfer of Care and bespoke planning.	By Quarter 4 (2023/24).
Autism Spectrum Disorder (ASD) & Attention Deficit Hyperactivity Disorder (ADHD) diagnostic services.	Wait times for assessment locally exceed 2 years risks detrimental impacts on patient safety and experience. Shortage of ADHD medication nationally.	• Ongoing work to support required improvement, business case in progress, and locality-based teams being introduced within IT system to improve reporting.	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.	Ongoing.

Assurance and Oversight - Care Homes and Home Care

Care Homes

ICB Place	Outstanding	Good	Requires Improvement	Inadequate	Inspected and waiting publication	Total
EN	2	83	21	1	9	116
SW	8	90	26	3	7	134
WE	0	41	7	0	1	49
Total	**10**	**214**	**54**	**4**	**17**	**299**

Home Care

ICB Place	Outstanding	Good	Requires Improvement	Inadequate	No published Rating	Total
East North Herts	13	80	11	0	26	130
South & West Herts	1	23	1	0	23	48
West Essex	3	53	5	2	13	76
Total	17	156	17	2	62	254

Area	Issue	Mitigating Action	Timescale
ICB.	1 Home closure (ENH area),total 29 beds.	ICB attendance at closure meetings for oversight and support.	Ongoing.
ICB.	Service Improvement Process (SIP) and Quality Assurance Meetings for several homes across Herts. Process is led by Herts County Council. Key concerns relate to leadership, governance, workforce and safeguarding	• Ongoing oversight meetings and support visits as appropriate • To note: SIP policy currently being reviewed.	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	3	44	0	1	48
	South and West Herts (SWH)	0	1	48	1	1	51
	West Essex (WE)	0	1	27	1	1	30

Issue	Mitigating Action	Timescale
Currently 5 practices across HWE are rated as Requires Improvement, some practices awaiting inspection outcomes.	• 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.	Ongoing, timescales for re-inspections not currently known.
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 & reduce potential risks. • Development of risk-based Contract and Quality review /visit programme with prioritisation process based on principles of revised Framework. Pilot underway. • Review of ICB CQC support offer to reflect new CQC assessment framework	Ongoing. March/ April 24 – Pilot May 24- Finalise. To Be Confirmed – when more information is available.

Acronyms

ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
CAMHS	Child Adolescent & Mental Health Services
CHIS	Child Health Information System
CLCH	Central London Community Healthcare NHS Trust
CYP	Children and Young People
CQC	Care Quality Commission
DNA	Did Not Attend
DTOC	Delayed Transfers of Care
ED	Emergency Department
ENHT	East and North Hertfordshire NHS Trust
EPUT	Essex Partnership University NHS Foundation Trust
GIRFT	Getting It Right First Time
GP	General Practitioner
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
LFPSE	Learning from Patient Safety Events
LMNS	Local Maternity and Neonatal System
MVCC	Mount Vernon Cancer Centre
NHS	National Health Service
NHSE	NHS England
PAHT	Princess Alexandra Hospital NHS Trust
PSIRF	Patient Safety Incident Response Framework
QI	Quality Improvement
SEND	Special educational needs and disabilities
SIP	Safety Improvement Process
TC	Transforming Care
UKHSA	UK Health Security Agency
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)*	☐
	NHS HWE ICB Board meeting held in Public		**Meeting Date:**	**22/03/2024**
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, 13th March 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. Performance is challenged in many areas as highlighted in the Executive Summary on pages 2 and 3 of the report. Urgent and Emergency Care (UEC), elective recovery of 78, 65 & 52 week waits, and children's services remain the areas of highest risk. The total elective waiting list has reduced for four consecutive months, with 10,000 fewer patients waiting for treatment in January than in August. However, recovery of 78 & 65 backlogs remains a challenge and plans are not being achieved. Community Paediatrics is the main risk.			

	Performance against the 4 hour A&E standard showed notable improvement in January, recording the highest percentage since June 23. Ambulance handover times were the best since September 23, however Category 2 ambulance response times remain the highest in the region. The 28-day cancer faster diagnosis standard was achieved for the first time in 6 months. The 31-day standard was also achieved, however 62-day cancer backlogs were again impacted by the ongoing industrial action and increased in both December and January. Despite the challenges, performance against the 62-day standard continues to better regional and national averages. Mental Health (MH) out of area bed days continue to improve. Access to community adult MH services remains challenged and high risk. Children's community waiting lists (including for ASD) remain high, with waiting times notably longer than in adult services. Waiting times for children awaiting a 1st community MH appointment are better than the national average, however again they are considerably longer than in adult services. GP appointments in 2023 were the highest recorded since 2019, and the percentage of appointments seen on the day, and with 14 days, are both below the historic average. Performance for CHC assessments remains high risk, but has improved for the last two months.
Recommendations	▪ To note Executive Summary highlights as reported to Performance Committee

Potential Conflicts of Interest:				
	Indirect	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒

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

March 2024

Working together
for a healthier future

Executive Summary – KPI Risk Summary

	P	?	F
H L	0	4	7
	5	6	9
H L	1	0	4

Highest Risk	Programme
ED 4 Hour Standard	UEC
% in ED > 12 Hours	UEC
RTT 78 Week Waits	Elective
RTT 65 Week Waits	Elective
RTT 52 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
NHS 111 Calls Abandoned	UEC
Ambulance Response Times	UEC
Ambulance Handovers	UEC
4 Hour Stroke Unit	Stroke
Thrombolysed < 1 Hour	Stroke
Adult 28 Day Standard	Mental Health
CAMHS 28 Day Standard	Mental Health
Community MH - Adult Waits for 2nd Appt	Mental Health
62 Day Standard	Cancer
6 Week Waits	Diagnostics
Autism Spectrum Disorder (ASD)	Community
CHC Assessments < 28 Days	Community

Lowest Risk	Programme
CHC Assessments in Acute	Community

Low Risk	Programme
2 Hour UCR	UEC
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
Learning Disability (LD) Health Checks	Primary Care
No Criteria to Reside (NCTR)	UEC
Out of Area Bed Days	Mental Health
Community MH - CYP Waits for 1st Appt	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 worse than average	National: HWE worse than average

- Hours lost to handover improved further to 1,963 hours in January. Whilst still not meeting trajectory, the gap to planned recovery is narrowing;
- Performance against the 4-hour ED standard improved to 67.8% in January, but remains adrift of the 73.7% recovery trajectory;
- NHS 111 abandoned calls increased further in December and January to 22.8%;
- Category 2 ambulance response times remain significantly above the 30-minute ambition, averaging 57 mins in January. HWE response times are the highest in East of England.

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) continues to improve, and the system met the 75% standard for the first time in 6 months;
- Patients waiting >62 days increased in December & January because of industrial action (IA) and seasonal leave / patient availability;
- 62-day performance betters the national and regional averages at 72.1%, but has been below the historic mean for the last 12 months; 31-day cancer performance achieved the national standard at 96.4%;

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

- The overall elective PTL had been increasing since April 21, but has shown some improvement in each of the last 4 months – down by c.10,000 patients since August
- Patients waiting >78 weeks continue to increase; all HWE acute trusts had breaches in December and were impacted by the ongoing IA. The majority remain in Community Paediatrics at ENHT;
- The 65 weeks backlog is largely unchanged since September and not achieving trajectory. Community Paediatrics again is the key risk;

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

- 6 week wait performance fell to 63.9% in December, driven by declines at ENHT & PAH. Performance continues to better the regional average.

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.

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 are largely unchanged at 107 weeks, compared to 53 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 been consistently reducing over the last 12 months, but the 28-day access standard has not been achieved since 2021;
- Children's waits for a Community MH 1st appointment are more stable and better than the national average. However median waits are 110 days, compared to 78 days for a 2nd contact is adult services.

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 have improved for the 7th consecutive month. Access to community MH services however remains challenged and high risk;
- Community adult MH waits for a 2nd contact are high risk and declining, but better 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 are both deteriorating;
- CHC assessments within 28 days remains high risk, with performance particularly challenged in South & West Hertfordshire.

Executive Summary – Performance Overview (1)

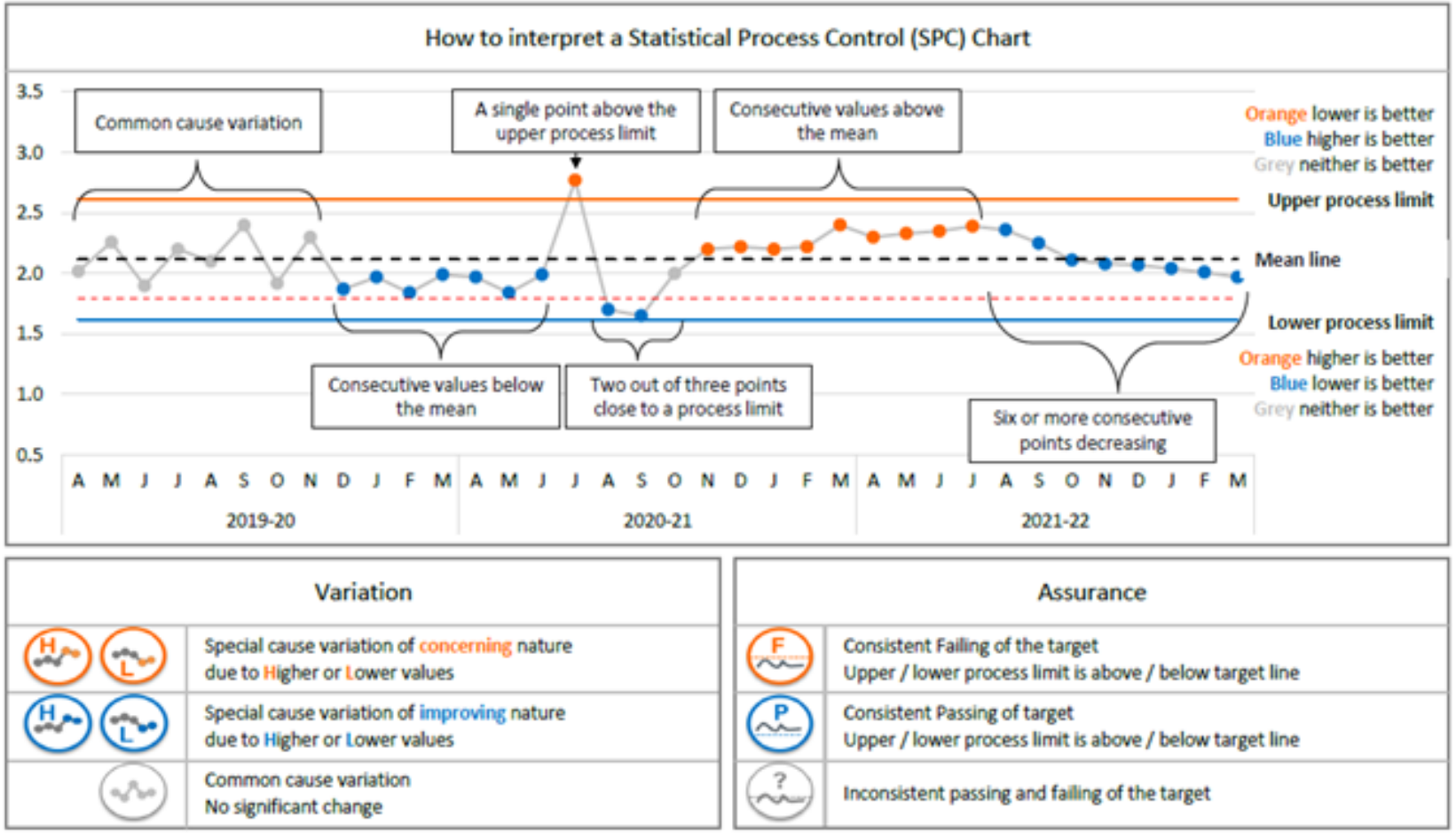
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
A&E - 4 Hour Standard	Jan 24	67.8%	76.0%			68.3%	63.4%	73.2%
A&E - % spending more than 12 Hours in Dept	Jan 24	13.6%	-			10.3%	7.8%	12.8%
A&E - ED Attendances	Jan 24	46690	-			43722	37557	49888
Trolley Waits	Jan 24	348	-			174	-43	391
2 Hour Community Response	Jan 24	77.9%	-			82.6%	71.1%	94.1%
14 day LOS	Jan 24	25.6%	-			25.2%	21.8%	28.5%
Ambulance - Handover >60 Mins	Jan 24	1097	-			1001	611	1390
EEAST: Cat 1 - Mean (<7min)	Jan 24	00:09:02	00:07:00			00:09:30	00:08:00	00:11:01
EEAST: Cat 2 - Mean (<18 Mins)	Jan 24	00:57:01	00:15:00			00:52:58	00:20:07	01:25:48
CHC - Decision within 28 days	Dec 23	67.9%	80.0%			68.6%	52.8%	84.5%
CHC - Assessments in Acute	Dec 23	0.0%	0.0%			0.2%	-0.7%	1.0%
111 - Calls received by telephony system	Jan 24	49298	-			53148	31533	74762
111 - Calls answered within 60 seconds	Jan 24	35.6%	100.0%			48.4%	16.4%	80.3%

Executive Summary – Performance Overview (2)

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT - 18 Weeks	Dec 23	49.5%	92.0%			55.7%	52.8%	58.5%
RTT - 52 Week Waits	Dec 23	9777	-			8182	6748	9617
RTT - PTL Size	Dec 23	145930	-			130499	123363	137636
RTT - 78 weeks	Dec 23	1334	-			929	600	1259
RTT - 65+ weeks	Dec 23	3596	-			2999	2433	3565
Cancer - 2 Week Wait Referrals	Jan 24	7955	-			7014	3224	10804
Cancer - 62 Day Standard	Dec 23	72.1%	85.0%			72.5%	63.6%	81.4%
Cancer - 62 Day Total Waiting	Jan 24	508	-			570	382	759
Cancer - 104 Day Total Waiting	Jan 24	145	-			156	106	207
Cancer - 28 Day Faster Diagnosis Standard	Dec 23	77.2%	75.0%			70.9%	61.5%	80.4%
Cancer - 31 Day Standard	Dec 23	96.4%	96.0%			95.1%	90.8%	99.3%
Diagnostics - 6 Week Wait	Dec 23	63.9%	99.0%			64.9%	57.2%	72.6%
Diagnostics - PTL Size	Dec 23	24000	-			25216	20373	30059
Primary Care - Attended Appointments	Nov 23	726599	-			657331	491783	822879
Primary Care - Routine Referrals	Jan 24	28141	-			24916	11388	38444
Primary Care - Urgent Referrals	Jan 24	6700	-			5451	2565	8338
Mental Health - Out of Area Bed Days	Dec 23	106	-			878	503	1253
Mental Health - Recorded >65s Dementia Diagnosis	Dec 23	64.8%	66.6%			62.3%	61.6%	63.0%
Mental Health - IAPT Entering Treatment	Dec 23	2009	-			2389	1416	3362
Early Intervention in Psychosis	Dec 23	83.3%	60.0%			81.3%	58.6%	104.1%

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

Statistical Process Control (SPC)



Hertfordshire and West Essex Integrated Care System

Performance by work programme

Slide 8: Urgent & Emergency Care (UEC)
Slide 12: NHS 111
Slide 13: Urgent 2 Hour Community Response
Slide 14: Planned Care PTL Size and Long Waits
Slide 16: Planned Care Diagnostics
Slide 17: Planned Care Theatre Utilisation
Slide 18: Cancer
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Slide 32: Autism Spectrum Disorder (ASD)
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Slide 39: Community Beds
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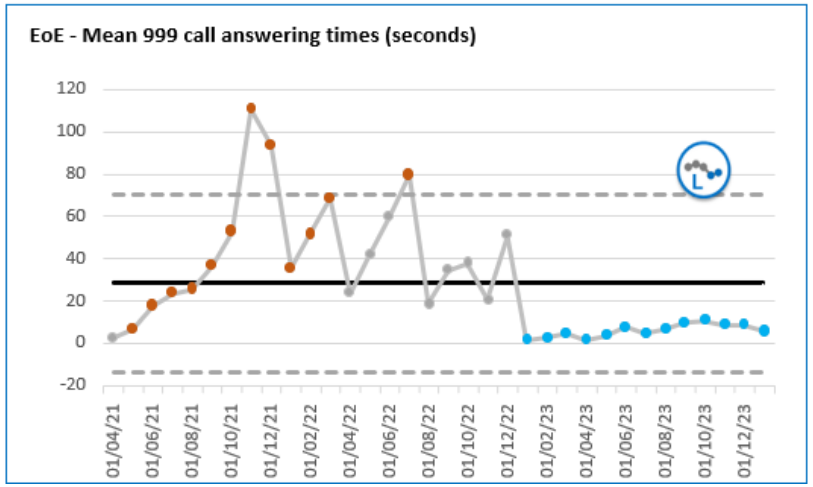
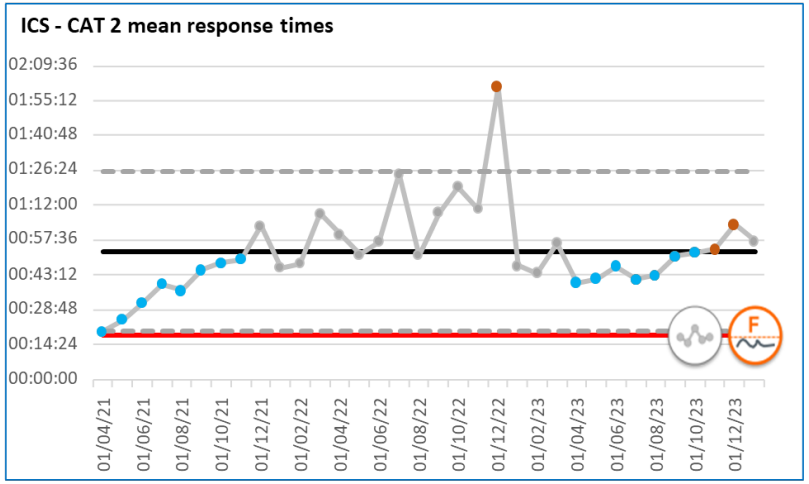
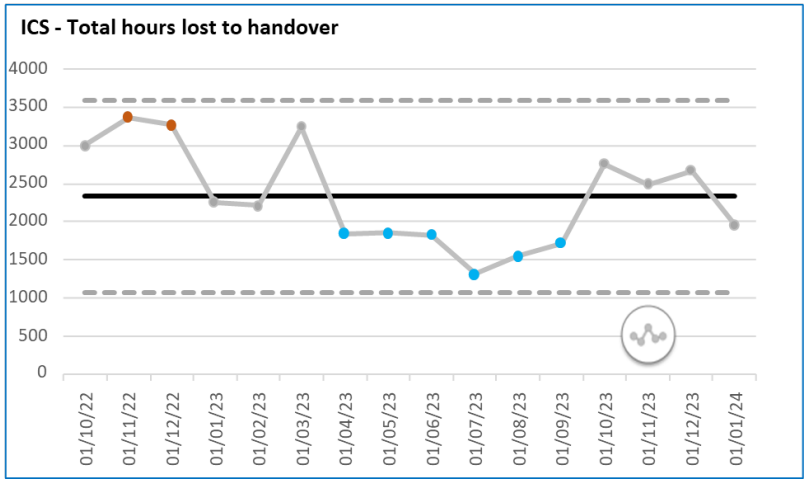
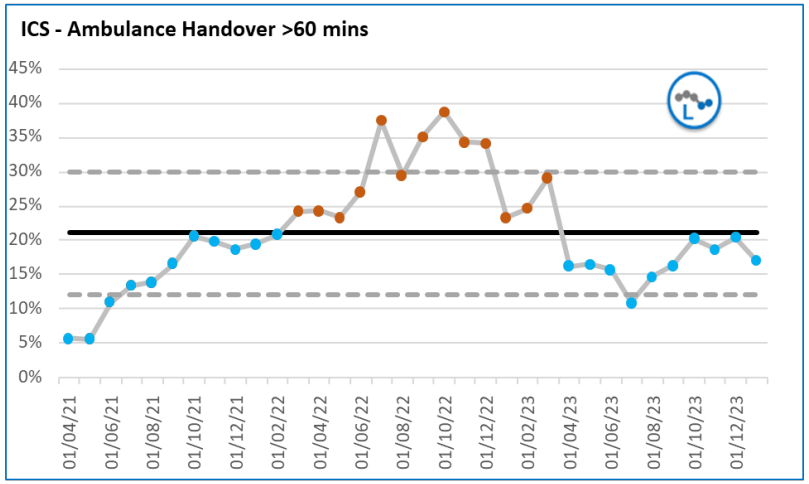
Slide 47: Performance against Operational Plan
Slide 48: Appendix A, Performance Dashboard
Slide 49: Appendix B, Commissioned Community Services
Slide 51: Glossary of Acronyms

UEC - Ambulance Response and Handover

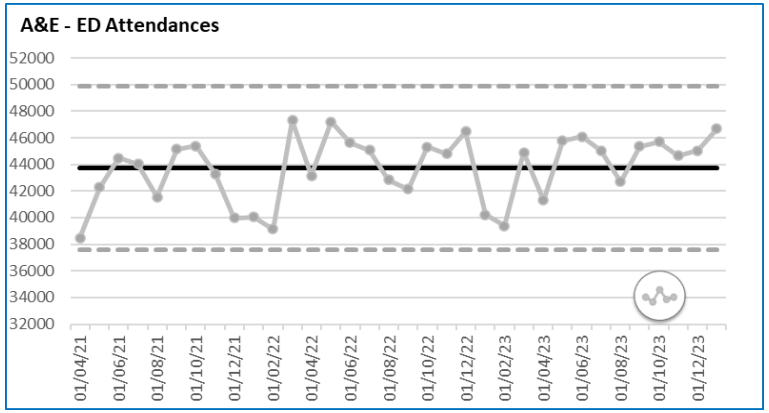




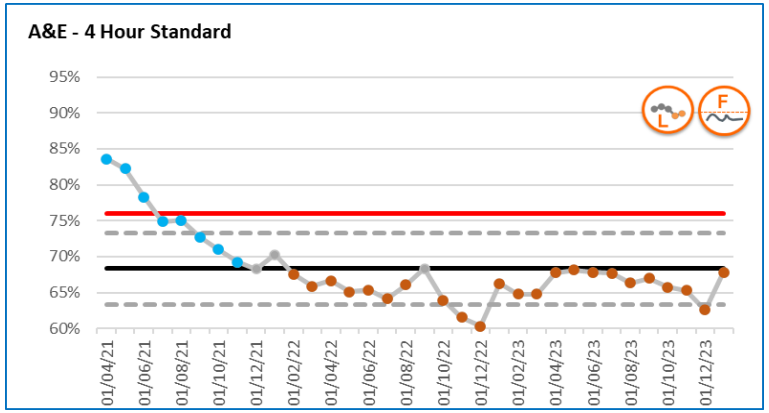




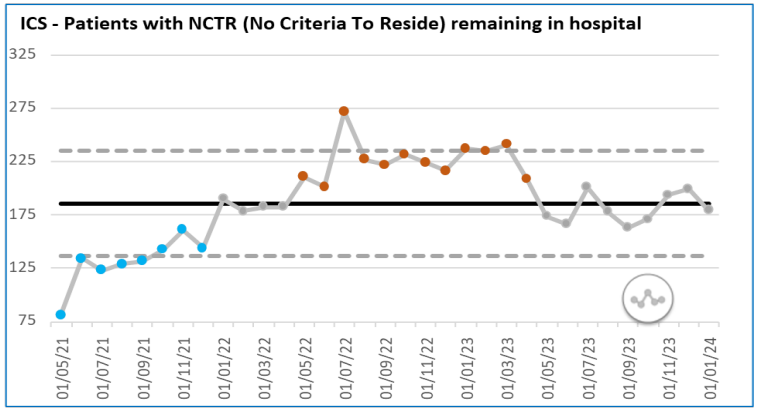
Urgent & Emergency Care (UEC)

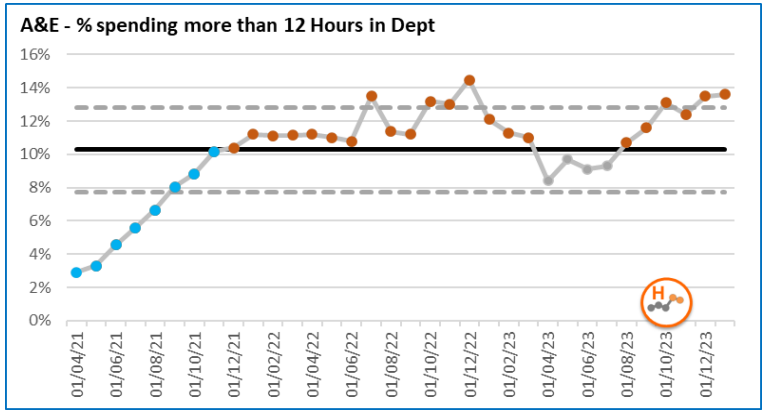


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
East And North Hertfordshire Place (ENHT and HUC)	15,239	16,653	17,784	17,602	16,812	18,386	18,419	17,502	16,217	15,988	15,934	19,138	17,012	19,008	18,003	18,235	17,116	16,632	17,831	17,424	17,781	15,778	15,355	17,581	15,954	18,226	18,131	17,593	16,637	17,700	17,932	17,653	17,761	17,938
West Hertfordshire Hospitals NHS Trust	13,202	14,413	15,172	15,225	13,940	14,977	15,203	14,527	13,429	13,533	13,027	15,533	14,731	15,630	15,632	15,147	14,834	14,136	15,541	15,554	16,669	14,112	13,701	15,736	14,755	16,028	16,072	15,899	14,865	15,961	15,771	15,931	16,156	16,592
West Essex Place (PAH and HCT)	10,031	11,227	11,533	11,210	10,792	11,780	11,750	11,280	10,333	10,509	10,164	12,617	11,395	12,577	12,009	11,681	10,892	11,373	11,960	11,808	12,017	10,332	10,318	11,583	10,586	11,525	11,887	11,542	11,206	11,680	12,006	11,085	11,127	12,160
ICS	38,472	42,293	44,489	44,037	41,544	45,143	45,372	43,309	39,979	40,030	39,125	47,288	43,138	47,215	45,644	45,063	42,842	42,141	45,332	44,786	46,740	40,223	39,374	44,900	41,295	45,779	46,090	45,034	42,708	45,341	45,709	44,669	45,044	46,690



	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
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%
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%
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%
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%



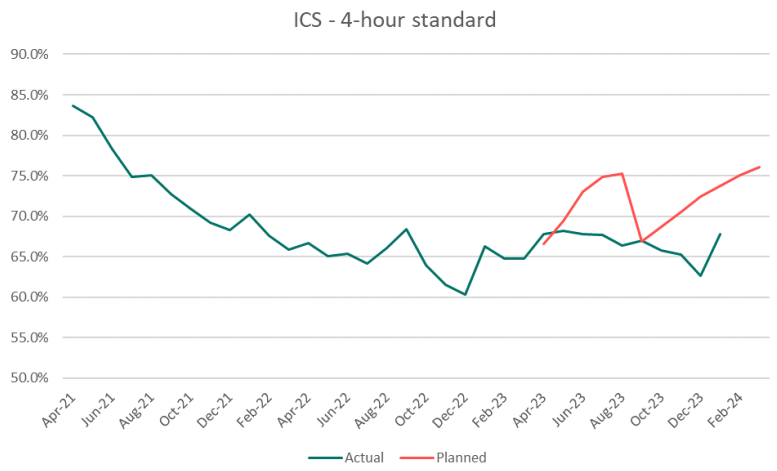


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
East And North Hertfordshire NHS Trust	2.8%	2.4%	4.7%	6.3%	8.6%	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%	9.3%	12.7%	12.6%	13.0%	13.2%	15.1%	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%
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%	9.3%	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%
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%	9.3%	10.7%	11.6%	13.1%	12.4%	13.5%	13.6%

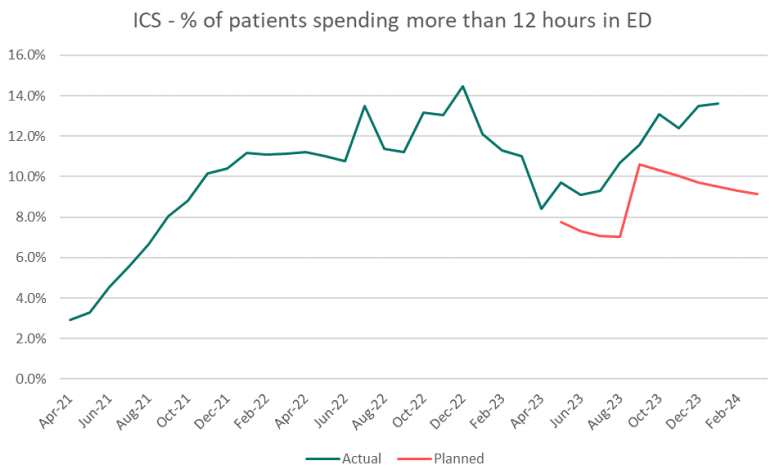
Hertfordshire and West Essex Integrated Care System

Urgent & Emergency Care (UEC) Improvement Trajectories

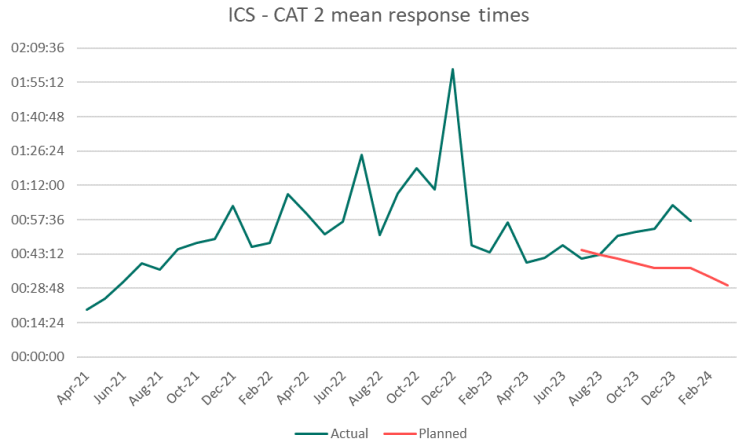
4 Hour Standard



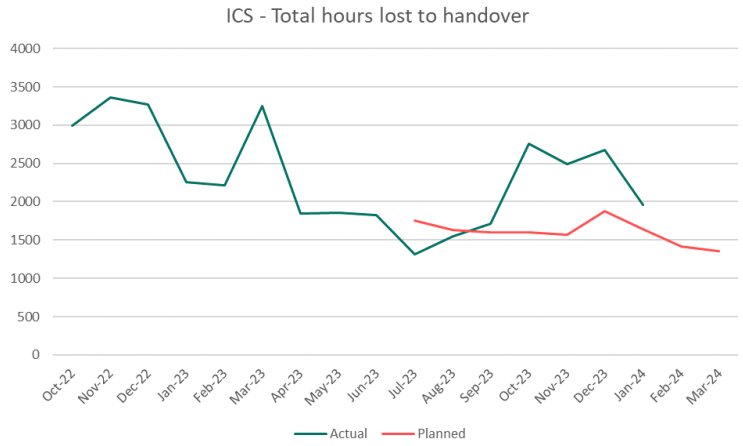
% of Patients Spending > 12 Hours in ED



Ambulance Category 2 Mean Response Times



Hours Lost to Handover

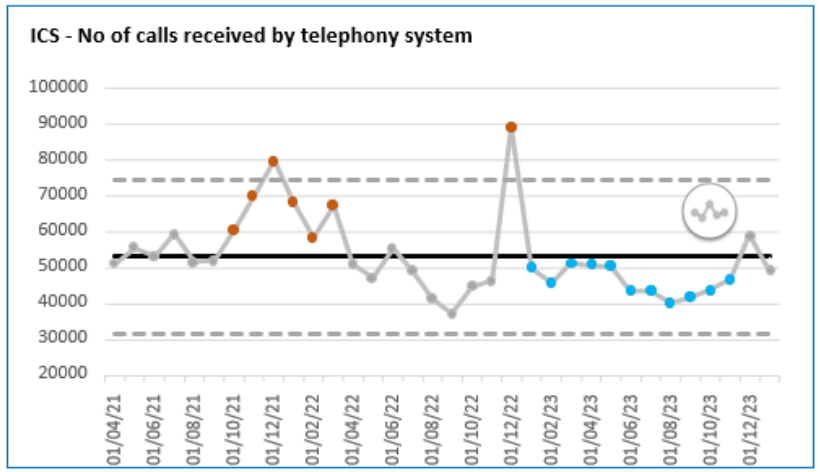


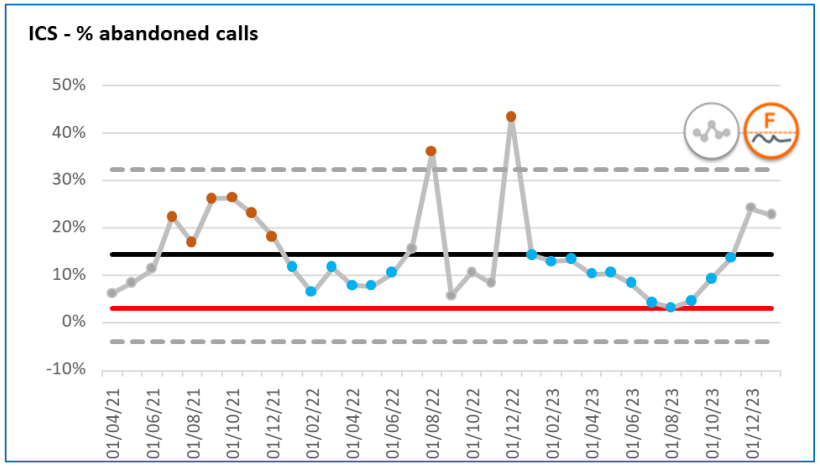
Hertfordshire and West Essex Integrated Care System

Urgent & Emergency Care (UEC)

ICB Area	What the charts tell us	Issues	Actions
ICB	• Performance against the 4-hour ED standard improved to 67.8% in January which is the best performance since Jun-23. It is also worth noting that there were 16% more ED attendances in Jan-24 compared to Jan-23. • There remains variation at a place level for performance against the 4-hour standard. However, the gaps have reduced: – SWH = 69.5% – ENH = 70.2% – WE = 61.8% • 999 call answering times have remained low with an average of 6 seconds in January. This is the 13th consecutive month with performance between 2 and 10 seconds • The mean category 2 ambulance response time was 57 mins in January. Category 2 response times have been consistently worse than the recovery trajectory and are consistently longer than other systems in the region • Hours lost to handover reduced to 1963 hours in January which is best performance since September. However, it is still worse than the recovery trajectory of 1645 hours for January • Across the ICS, the average patients per day with NCTR remaining in hospital improved to 172 in January to 179 in January. This is ahead of the recovery trajectory for Jan-24	• Continued high demand and high acuity of patients requiring UEC services. ED attendances and ambulance conveyances across the health system in Jan-24 were 16%higher than in the previous year • Increase in 111 call volumes during the winter months; call volumes in Jan-24 were 8.6% higher compared to Jan-23. Call volumes have been particularly high between 7am and 10am. Accuracy of 111 call abandonment data is currently under review • Recruitment challenges continue for HUC • 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 January was 98.3%	**System** • At the end of December, a series of actions were introduced to help reduce handover times, including: – Zero tolerance over 45 mins – patient brought into hospital and ambulance released – Never over 5 ambulances outside – on arrival of 6th ambulance, most appropriate patient brought into hospital and ambulance released – Place based escalations and incremental actions to support delays beyond 1 hr – Aspiration of 3 hr ambulance handover delays to never happen in HWE • These protocols have reduced handover times during January • Access-to-stack patients passed continues to increase. In January there was an average of 30.8 patients passed per day compared to 12.7 patients per day in May-23 • EEAST developing a plan for category 2 segmentation rollout • Mobilisation plan in development for category 2 revalidation **East and North Herts** • New Lister site UTC went live on 15/01/24 • In addition, there has been an expansion of the medical SDEC and the introduction of the surgical SDEC during January • New ED nursing rotas have been introduced and new ED medical rotas are being progressed • Access-to-stack workshop took place with Herts Community Trust • Next steps for UTC at Lister: NHS DOS go live; walk-ins to Lister UTC to commence 12/02; Paediatric UTC to commence from end of Feb **West Essex** • Two corridors being used as secondary cohort areas to support ambulance handovers • Additional transfer team to support moves from ED in place from Jan-24 • 111 pathways now have direct access to SDEC • GPs can contact SDEC through the GP navigator, direct access to medical SDEC • Phase 2 work programme for the IUATC commencing in Jan-24 **South and West Herts** • Access-to-stack acceptance rates have been maintained since November workshop • Discharge process review project in progress and four workstreams / task and finish groups agreed • Virtual ward diabetes pathway provisional launch date set for Jan 24 • CLCH to move to a trusted assessor model for transfers of patients into rehab beds

NHS 111



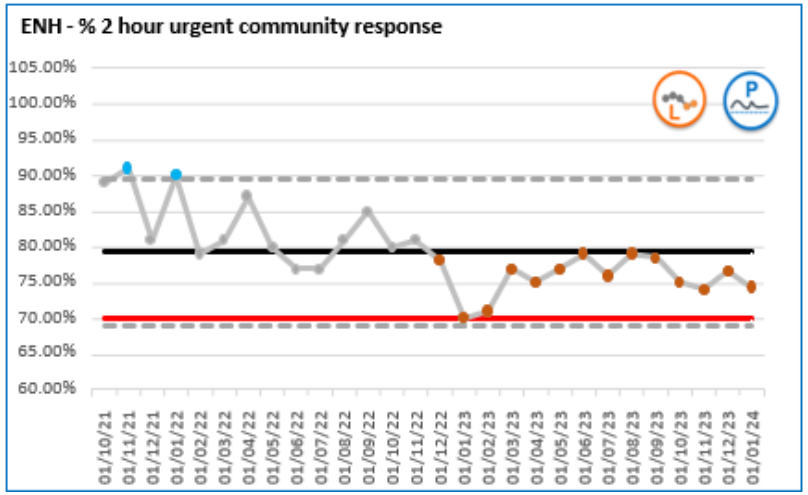


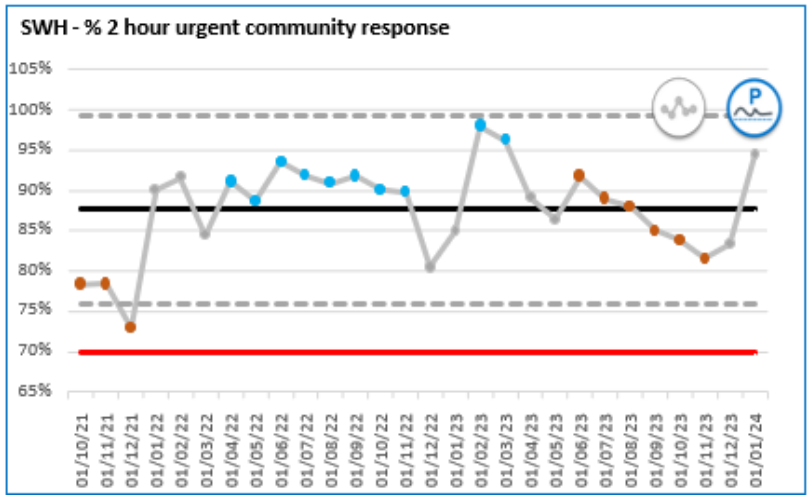
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Hertfordshire	40,961	44,295	42,714	47,283	41,153	41,252	48,102	59,032	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
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
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

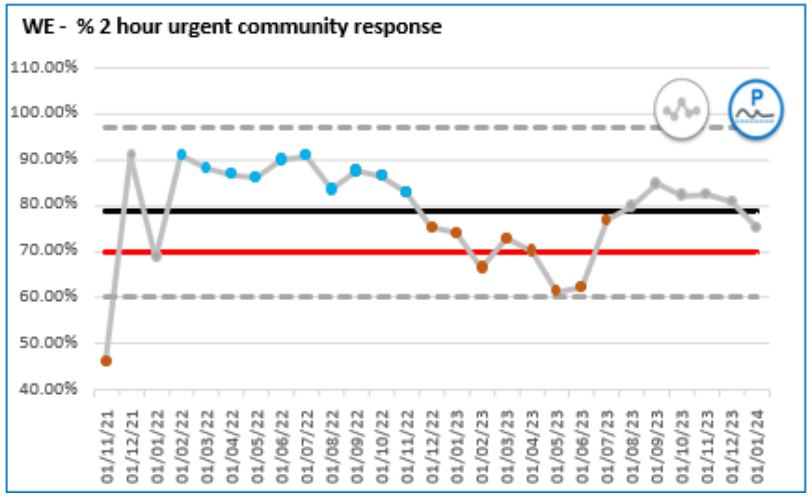
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Hertfordshire	6.1%	8.3%	11.2%	21.7%	16.4%	25.6%	25.7%	22.5%	18.0%	11.7%	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%
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%
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%

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 in December were the highest seen this year at 24.1% • The historic variation between Hertfordshire and West Essex is no longer a significant issue	• Recruitment issues (non-GP); 13.5 vacancies across HWE • Attrition and sickness levels amongst staff • High abandonment rates • Junior Doctor Industrial Action • Activity levels higher than planned for December	• Financial enhancements for staff in place across the Christmas period to support rota fill • Non-clinical floorwalker (NCFW) in person (and remote trailed for the first time) in place to support Health Advisors (call handlers) • Clinical Navigator in place to support clinical staff • Automated call handling went live in December to reduce call answering by 10 seconds • Provider met with new recruitment agency in January 2024 regarding recruitment of operational staff • Pooling resources across HUC-Footprint • Some of the current vacancies are supported across the HUC Footprint (by C&P ICB and BLMK ICB) • Additional shifts in place to support activity due to Industrial Action

UEC - Urgent 2 Hour Community Response (UCR)





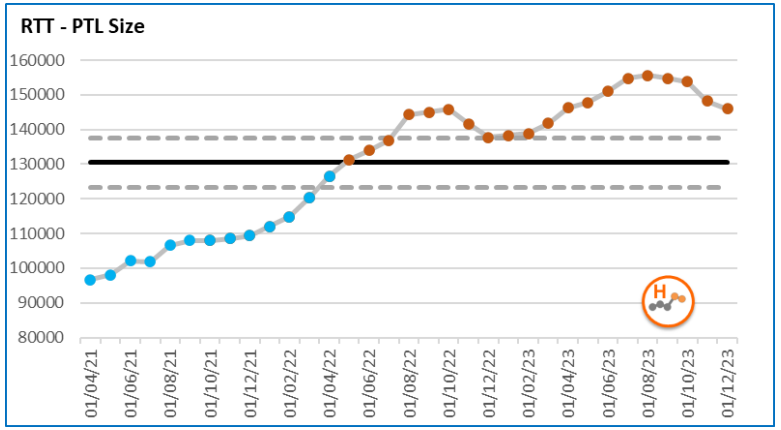


Activity	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
West Essex	442	466	376	348	472	430	489	375	413	464	357	374
East & North Herts	459	471	454	545	545	641	649	693	643	631	650	709
South & West Herts	103	136	203	222	196	232	159	175	180	158	157	213

ICB Issues, escalation and next steps

- All three Places continue to consistently achieve the 70% standard
- Increased activity in SWH, with 2-hour performance also improving to 92%
- Although activity capture has improved, work continues at CLCH to review and improve recording practices, and how data is pulled
- The system is working with the regional team to ensure consistency of reporting and capture of all UCR activity. There may be eligible activity in areas such as GP Out of Hours and Hospice at Home which is not currently being reported as UCR

Planned Care – PTL Size and Long Waits



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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
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
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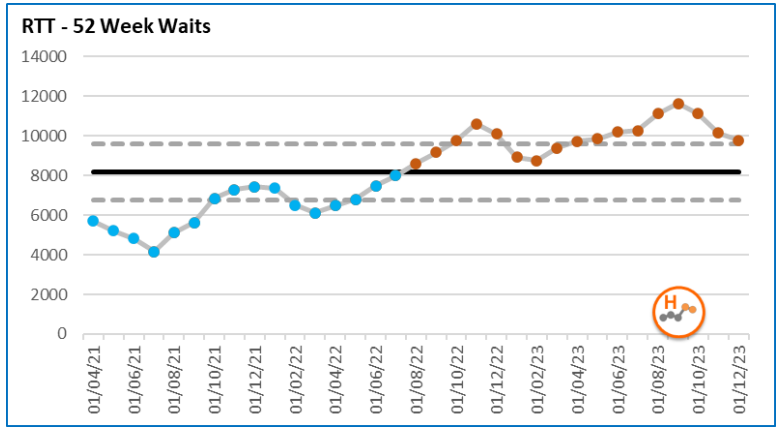

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	202122												202223												202324								
Other	3740	3162	2782	2578	2447	2441	2394	2296	2321	3348	2853	2868	3033	2496	2412	2648	2532	2437	2533	2570	2728	2691	2641	2782	3133	3318	3109	3073	3122	2976	2829	2766	2607
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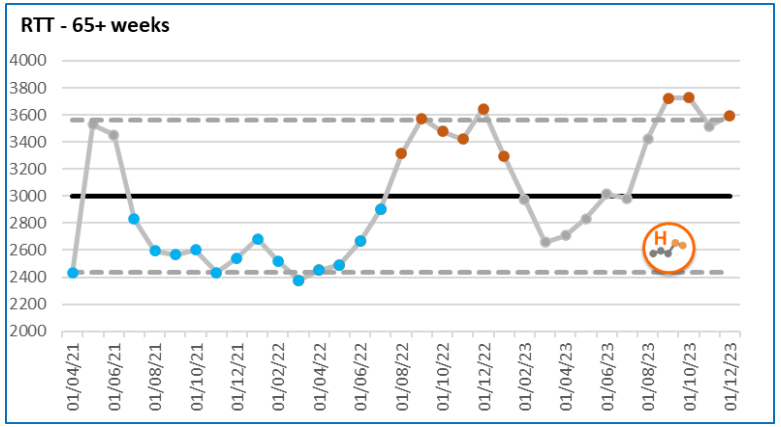

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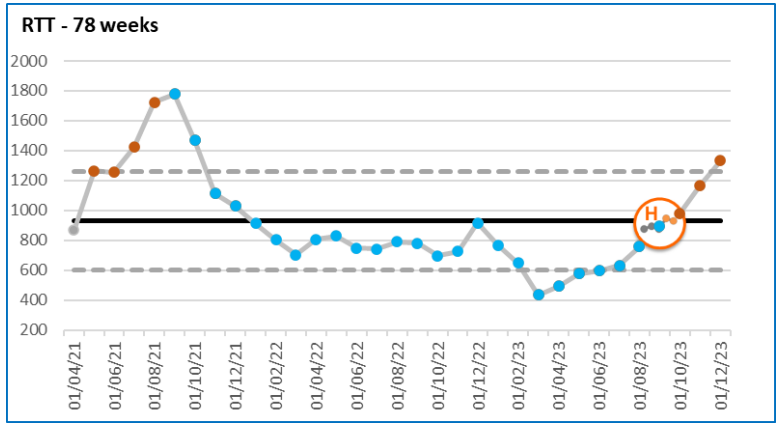

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THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	0	231	218	288	378	434	399	325	283	260	243	190	223	266	281	296	248	208	141	108	157	147	95	14	23	37	37	51	90	117	118	104	136
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EAST AND NORTH HERTFORDSHIRE NHS 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

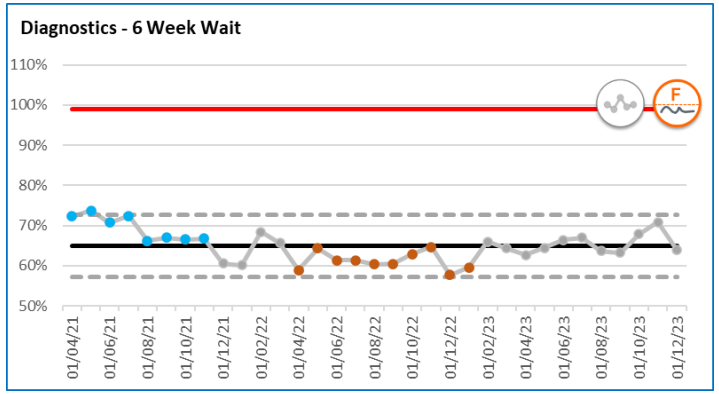
Hertfordshire and West Essex Integrated Care System

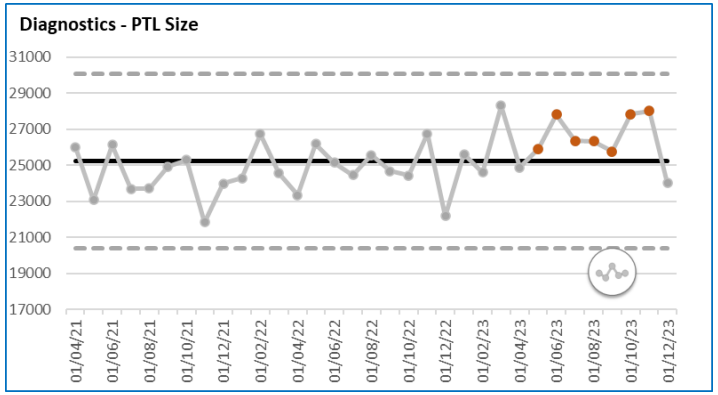
Planned Care – PTL Size and Long Waits

ICB Area	What the charts tell us	Issues	Actions

HWE	• The overall PTL size remain high, although showing a decreasing trend over the last four months. It is driven predominantly by Outpatients at ENHT. WHTH and PAH are showing signs of stability
	• December saw a significant increase in numbers of patients waiting >78 weeks. The increases were driven mainly by ENHT, PAH also increased, whilst WHTH has remained both steady and low
	• 97% of the patients >78w are Community Paediatrics at ENHT. Going forward, following national guidance, community paediatrics patients will no longer be reported in RTT submissions, they will be reported in the community health services sitrep
	• The number of patients waiting >65 weeks decreased in November and remained steady in December, although it is not on trajectory
	• 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) and Community Paediatrics remain the main specialties under pressure
		• Industrial action (IA) in December and January saw increases in waiting lists. Future action remains high risk, although Trusts have had robust plans in place
		• Staffing remains a challenge, particularly Anaesthetics & Community Paediatrics at ENHT
		• ENHT 78-week waits are primarily in Community Paediatrics
		• PAH 78-week waits have been increasing steadily due to IA and reduced capacity over the festive period
		• The latest 78ww forecast for the end of February (as of 21/2) is 90 for the system excluding community paediatrics (ENHT 17 / WHTH 16 / PAH 54 / ISP 3)
			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
			
			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
			
			Community paediatrics ENHT
			• Going forward Community Paediatrics patients will no longer be reported in RTT submissions, the service will be reported in the community health services sitrep
			• Hertfordshire wide single service model for Community Paediatrics has been developed. Not all elements have been agreed with all providers yet. Once in place, the new service model will improve RTT performance through:
			  • ADHD pre-screening service will increase the number of patients referred into a more appropriate service and reduce demand on Community Paediatrics
			  • Increased use of the MDT will free-up Consultant time for the most complex patients and reduce the number of pathways which are Consultant-led
			  • Ongoing monitoring of ADHD patients outside of an acute setting will increase Consultant capacity for new patients at ENHT

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%	52.2%	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%
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%
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%
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%

ICB Area	What the charts tell us	Issues	Actions
HWEICB	• 6-week wait performance across the ICS fell by 6.9% in December • ENHT & PAH saw decreases of 8-9%, whilst there was a small improvement at WHTH • The overall PTL fell below the historic mean for the first time since April 23	• Workforce remains the key area of concern across the ICS **ENHT** • Imaging is the highest risk modality, with the number of people waiting over 6 weeks increasing to 7550, compared to 1848 at PAH, and 321 at WHTH • Non-Obstetric Ultrasound (NOUS) is also a significant factor in the worsening 6-week wait performance **PAH** • Audiology, NOUS, Echocardiography and Cystoscopy are the key challenges at PAH. Audiology is seeing some improvement due to extra capacity at St Margaret's Hospital **WHTH** • Audiology presents the greatest risk to 6 week wait performance • Cystoscopy is an area of challenge at WHTH, but a suspected data quality issue is expected to improve the WHTH position • Nuclear medicine has also been flagged as an area of concern at PAH due to staffing • There has seen substantial improvement in Echos and DEXA	• Workforce lead for diagnostics in post and working with providers on the various projects • Recovery trajectories in place and monitored through the performance meetings and diagnostic programme **ENHT** • Seeking to outsource imaging to the independent sector • Increased DEXA capacity through return from sickness, and more radiographers qualifying to scan autonomously • New Cardiac CT Consultant capacity coming online **PAH** • Audiology funding approved from NHSE for additional CDC activity being used for insourcing. This activity has commenced • PAH CDC is live for MRI and ultrasound extended access using insourcing and existing facilities • Working with PAH on CDC and Endoscopy Unit mobilisation • Additional Saturday Cystoscopy capacity planned at PAH subject to additional required equipment **WHTH** • Continued focus on DEXA is improving the position • Working with WHTH on CDC and Endoscopy Unit mobilisation • WHTH are putting on ad hoc additional clinics and have looked at insourcing / outsourcing options, however this is costly. Included in CDC funding bids for 24/25

Planned Care – Theatre Utilisation

Theatre Utilisation (w/e 28/01/24 unless otherwise stated)	ENHT	WHTH	PAH	ICB Total	Peer Average	Watford	St Albans City
Number of theatres	19	11	10	40	40	6	5
Number of cases*	417	233	199	849	694	93	140
Average cases per 4 hour session*	2.7	2	1.9	2.3	2.1	1.6	2.6
Utilisation - Capped	79.7%	73.9%	74.5%	78%	76.9%	71.5%	76.6%
Average late starts (Minutes)**	29	28	44	33	30	33	24
Average inter case downtime (Minutes)	15	13	15	15	16	24	7
Average early finish (Minutes)**	68	106	73	80	75	128	87
Average unplanned extensions (Minutes)**	40	41	93	56	43	54	27
% of emergency surgery conducted within elective lists*	0.7%	1.7%	0%	0.8%	1.5%	3.2%	0.7%
BADS day case (August - October 2023)	83.8%	77.0%	77.1%	77.5%	77.9%		
Conversion from day case to inpatient (August - October 2023)	7%	11%	18%	13%	12%		

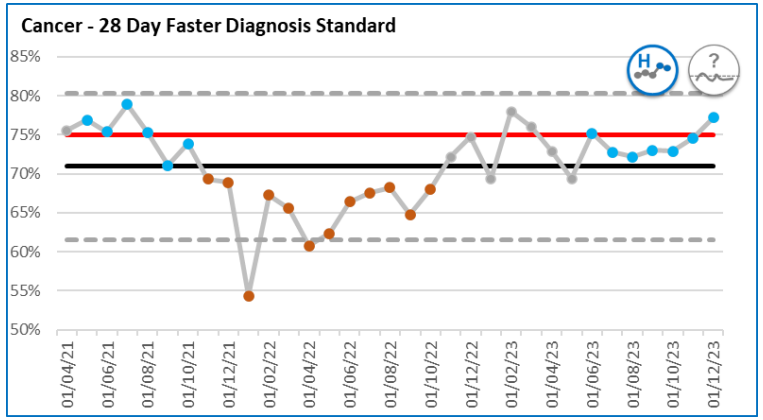
* no national target

** lists started late/finished early/extended time

Performance is RAG rated against internal operational aims

ICB Area	What the charts tell us	Issues	Actions
HWEICB	• Comparative performance v. peers for Capped Utilisations, BADS and average late starts • Average cases per session for the ICB is higher than peer average, although ENHT are performing better, and PAH & WHTH worse than average • Average early finishes are worse than peer average and much higher than the accepted 15-30 minutes • BADS rate is lower than the 85% target	• Overall productivity has dropped in January / February across all three providers. The main drivers are early finishes and cancellations on the day • ENHT – although overall good performance, capped utilisation has yet to achieve the national target of 85%. The average inter case downtime has decreased • PAH – consistently high conversion from day case to inpatient rate, alongside a low day case rate • WHTH – lower efficiency and increased emergency surgery rate on Watford site. Although capped utilisation rates and average cases per session have maintained improvement over the last 4 months • UEC pressures and Industrial Action have meant the utilisation is not consistent	• Drop in productivity, early finished and cancellations on the day are being discussed at the monthly Theatre Utilisation Network Group • A series of reviews of DQ issues and solutions have taken place with Trusts through the GIRFT theatre programme team • A theatre utilisation away day was held on 25 January with participants from ICB and each acute trust. Five areas of improvement have been identified and will be reviewed over the next 5 monthly meetings. • Active theatre improvement programmes at each of the acute providers • There will be a further GIRFT review visit in 6 months

Cancer



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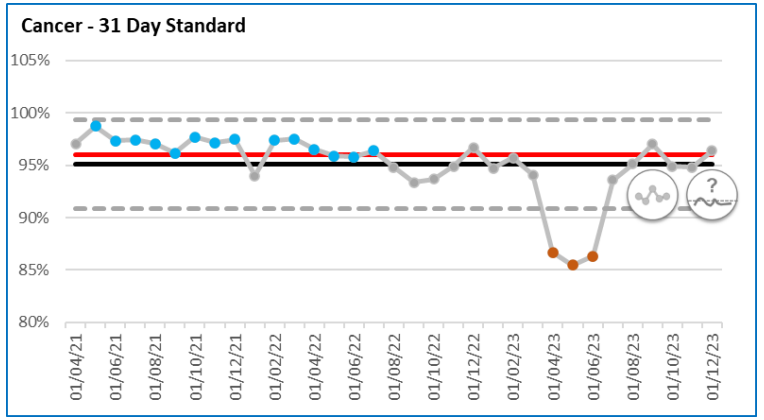
EAST AND NORTH HERTFORDSHIRE NHS TRUST	72.1%	75.6%	76.2%	76.7%	72.0%	71.8%	76.5%	74.8%	74.1%	64.2%	72.9%	74.6%	68.1%	64.2%	70.8%	71.8%	72.7%	69.7%	71.4%	71.7%	77.4%	65.8%	76.1%	72.9%	69.8%	69.3%	76.4%	75.9%	73.0%	74.1%	77.8%	78.2%	80.5%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	81.3%	79.8%	81.4%	82.1%	77.8%	77.2%	77.7%	71.9%	64.7%	47.0%	59.2%	54.6%	52.2%	58.5%	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%
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%
ICS	75.6%	76.9%	75.4%	78.9%	75.3%	71.1%	73.8%	69.3%	68.9%	54.4%	67.5%	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%



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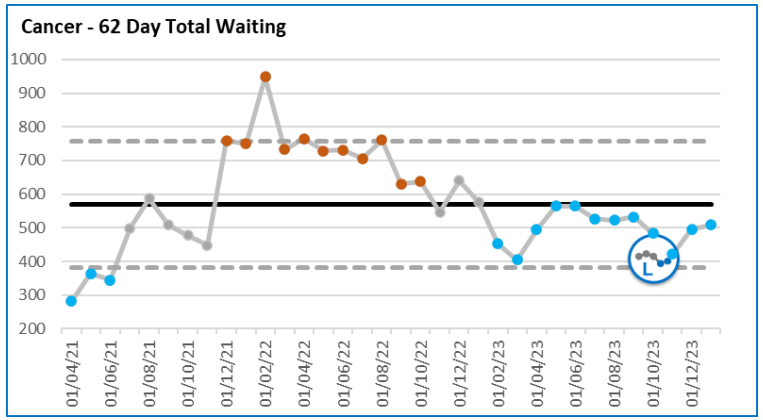
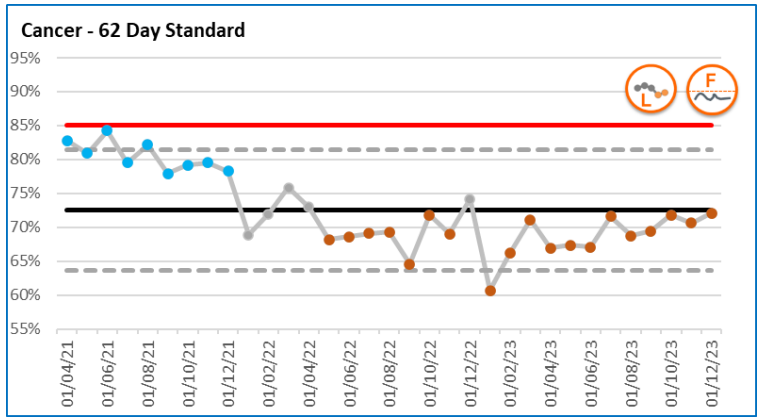
EAST AND NORTH HERTFORDSHIRE NHS TRUST	98.6%	98.8%	97.7%	98.4%	97.9%	97.4%	98.1%	98.2%	98.6%	96.9%	99.0%	98.6%	98.4%	97.6%	97.5%	97.1%	95.8%	93.2%	92.9%	95.5%	97.8%	95.8%	96.1%	93.0%	83.7%	80.5%	83.2%	93.8%	96.6%	97.0%	96.3%	95.9%	96.7%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	94.6%	97.8%	95.9%	95.9%	97.2%	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%
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%
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%



WEST HERTFORDSHIRE HOSPITALS NHS TRUST	184	129	125	148	127	158	149	135	139	100	118	121	148
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	182	153	120	148	213	203	166	148	167	149	110	141	165
EAST AND NORTH HERTFORDSHIRE NHS TRUST	211	170	160	199	224	203	212	239	226	234	194	234	195



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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%
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%
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%
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%

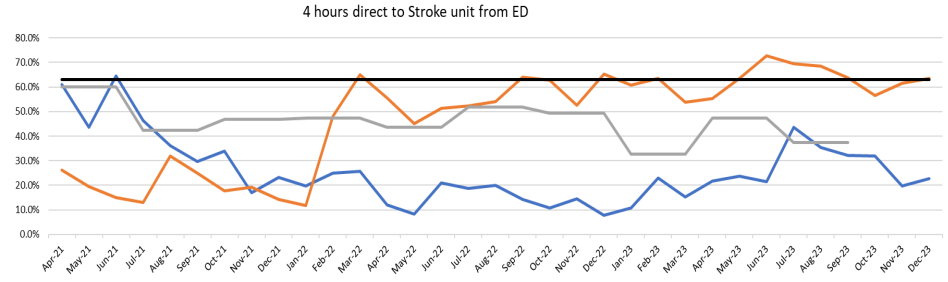
Hertfordshire and West Essex Integrated Care System

Cancer

ICB Area	What the charts tell us	Issues	Actions

ICB	• 28 Day Faster Diagnosis Standard (FDS) performance has improved over the last two months and is now at 77%
	• PAH and ENHT both achieved the 75% FDS standard, with performance also improving sharply at WHTH
	• The 31-day combined KPI met the 95% target
	• The 62-day backlog increased over the last two months, predominantly at WHTH and PAH
	• 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
		ENHT
		• 62-day backlogs increased in January due to Industrial Action (IA) and annual leave, but improved in early February
		• Issues include:
		  ○ Late referrals from other providers (up to 55 patients currently on the backlog were late referrals vs. a plan of 25 patients)
		  ○ Patient choice delaying TP biopsies
		  ○ Skin capacity impacted IA
		WHTH
		• Dermatology Pathway remains challenged but improving. Head and Neck, Gynae and Lower GI pathways are also challenged
		• Although cancer patients are prioritised during IA, overall capacity has been compromised
		• Relative backlog position has deteriorated to 148 patients (7.8%)
		• Delays in referrals received from breast screening services
		PAH
		• 62-day backlogs increased significantly as a direct result of the IA in December and January
		• PAH have now returned to a position of improvement, but the further IA planned in February will again impact
		• 62 day % performance remains low as the Trust continues to focus on treating the longest waiting patients
		• Urology is the key tumour site driving underperformance, with 30% being achieved across Q3
		• Urology recruitment delayed, and notable increase in prostate referrals
			ENHT
			• New PET Unit is up and running at Lister which will increase capacity for PET CT
			• Operational Teams working with consultants to remove negative results patients
			• Consultant admin turnaround times delays for Gynae and Head & Neck have been resolved
			• Ongoing use of the pathway analyser tools to help identify bottlenecks in pathways
			• Increased regularity of meetings with leads at Watford, Hillingdon, Luton and Northwick Park
			• Continued Colonoscopy outsourcing to Pinehill
			
			WHTH
			• Cancer Improvement Programme Board now overseeing service level improvement plans and service developments
			• Key actions on FDS and challenged areas include:
			  • Benign diagnosis project (discharge from MDT via template letter) pilot sites Gynae and LGI now live. Next phase – Urology and Skin
			  • Review of Urgent Suspected Cancer referral forms; Gynae and Urology forms close to completion. Agreement given by Primary Care Transformation Committee to proceed with 'strict mandatory fields'
			  • Increased scrutiny over the Skin pathway, with Cancer Alliance RCAT process along with outsourcing Dermatology clinic provision and additional photography clinics. New consultant appointed
			  • Impact of delays in breast cancer screening referrals escalated to Regional Screening Lead.
			• 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 and escalated as necessary using new escalation process. Any patient found to have cancer will be subject to a clinical harm review after treatment
			
			PAH
			• Aiming to maintain cancer operating and MDTs wherever possible during February IA
			• Cancer Improvement Plans refreshed and agreed at tumour site level
			• New prostate RAPID pathway in implementation
			• Urology recruitment now back on track. CNS Triage post starts 1st March. New registrar, return of long-term sick registrar, and return of consultant on restricted practice all expected by end of April
			• Additional Saturday Cystoscopy capacity planned to support Urology pathway
			• 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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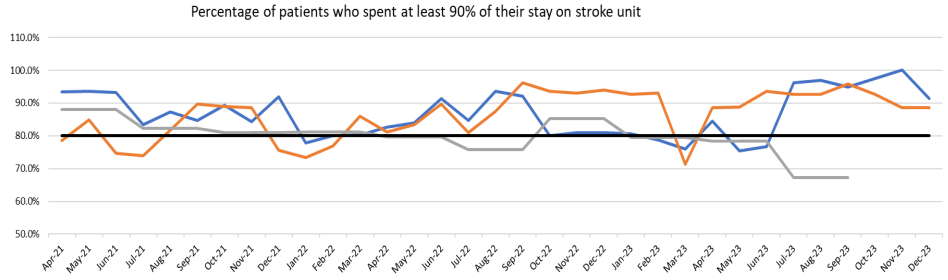
East & North Hertfordshire Trust	61.0%	43.5%	64.4%	46.4%	36.1%	29.7%	33.9%	17.1%	23.3%	19.7%	25.0%	25.7%	12.0%	8.2%	20.9%	18.8%	20.0%	14.3%	10.8%	14.5%	7.7%	10.9%	22.9%	15.3%	21.8%	23.6%	21.4%	43.7%	35.4%	32.1%	32.0%	19.7%	22.7%
West Hertfordshire Trust	26.2%	19.6%	15.0%	13.0%	31.8%	25.0%	17.8%	19.2%	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%	63.6%
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%	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%			
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%



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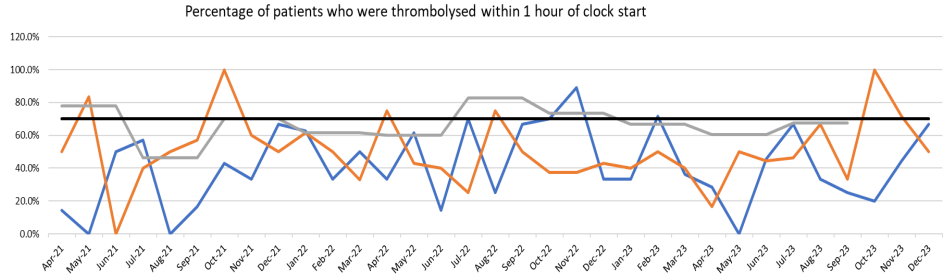
East & North Hertfordshire Trust	93.4%	93.5%	93.2%	83.3%	87.3%	84.6%	89.3%	84.4%	91.9%	77.9%	80.0%	80.3%	82.7%	84.0%	91.4%	84.7%	93.6%	92.1%	80.0%	81.0%	80.9%	80.6%	78.8%	75.9%	84.5%	75.4%	76.7%	96.1%	97.0%	94.8%	97.5%	100.0%	91.4%
West Hertfordshire Trust	78.5%	84.8%	74.6%	73.9%	81.8%	89.7%	88.9%	88.5%	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%	88.5%	88.5%
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%			
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%



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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%
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%
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%			
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%

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. BHRT overall 23/24 Q2 SSNAP rating is D. At the time of writing Q3 is yet to be published
- Integrated Stroke Delivery Network (ISDN) have escalated TIA pathway delay issues at Queens Hospital. There has been some improvement from c.21 day waiting times to 10-12 days, but this remains a significant concern. Escalation ongoing through contractual routes with the lead commissioner
- Local meetings taking place between PAH / Queens to review pathways, capacity and potential approach to alternative HASUs for PAH stroke patients
- Catalyst Project awarded £183k for one year to implement a vocational rehab service for people affected by stroke of working age with EPUT. Service opened to referrals on 1/11 – evaluation scheduled from July
- SQUIRE ICSS (Integrated Community Stroke Service) programme with 4 objective areas: workforce, 7 day working, training and 6-month reviews. Gap analysis to be completed by April. Working through a case for change paper to be presented LTC board in May

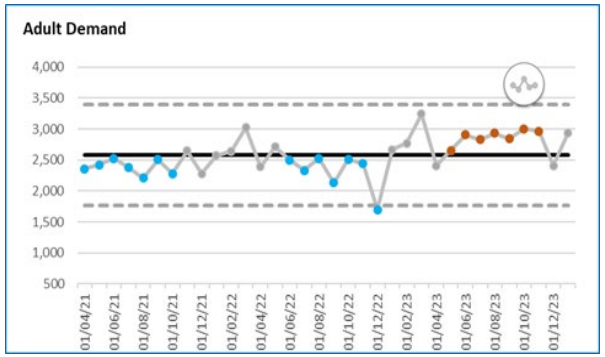
ENH

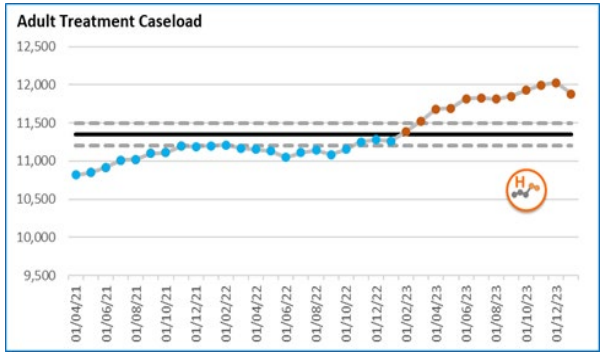
- The ENHT SSNAP performance for Q2 FY2324 improved from a C to a B rating. Q3 FY2324 is pending
- The % of patients spending >90% of their stay on a stroke unit remained above target for the 6th month in a row. Four ring-fenced stroke beds remain in place. Dec. % dipped due to winter pressures and outlier patients on the stroke wards
- Stroke Video Triage Pilot went live in Dec-23 and will support improvements in 4 hour direct to stroke unit target. In December performance was 23% vs a target of 63%. Recovery being progressed through ENHT regular performance calls
- The % of patients thrombolysed within 1 hour of arrival was 66.7% in December which is just below target of 70%
- Thrombolysis in Acute Stroke Collaborative (TASC) project launched in Jan-24. This will take a quality improvement and data driven approach to improving the thrombolysis rate. Improved thrombolysis rates will support overall flow within the stroke wards, due to positive impact on simple discharges

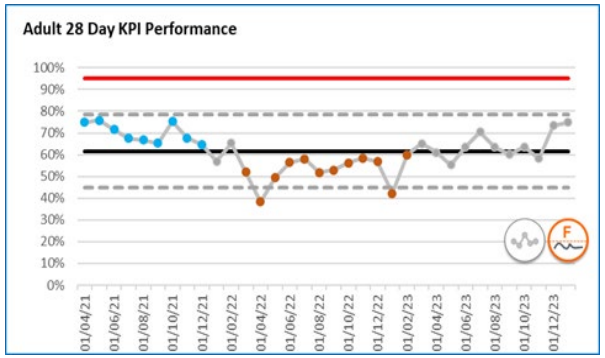
S&W Herts

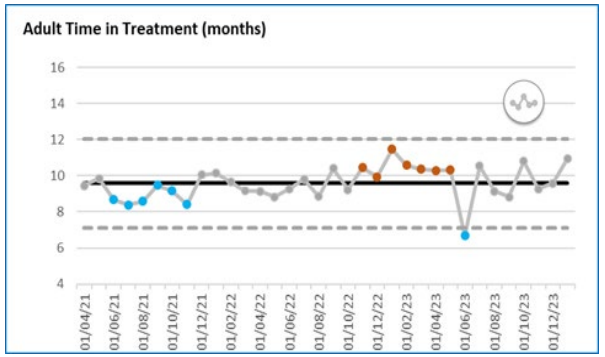
- Wider system pressures and industrial action has impacted on stroke performance across the whole pathway
- Performance remains consistently below the national standard (90%) for 4 hours direct to stroke unit from ED at 63.6%. However, this has increased from November 2023 (61.5%) and is higher than neighbouring providers. 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
- The % thrombolysed within 1 hour of clock start has decreased again to 50% (local standard 50%). WHTHT are taking part in the EOE Ambulance Video Triage pilot (started December 2023), it is hoped that this will have a positive impact on patients' movement through ED and time to Thrombolysis. (Awaiting Impact data)
- Rehab gym continues to be used as a bed capacity surge area which impacts the whole rehabilitation pathway
- TIA performance has been consistent with 79.5% of patients referred seen within 24hrs of referral (Nov 23-Jan 24). TIA services are under increased scrutiny from the ISDN, focus likely to continue 2024/2025. Noted by the ISDN that TIA clinics to have been particularly affected by ongoing industrial action
- ESD, NETT and Community Stroke Service: ESD now fully staffed but experiencing high levels of staff sickness. Performance has improved with ESD patients seen within 1 week of referral and NETT waiting list reduced to 9 weeks

Mental Health – Adult Services



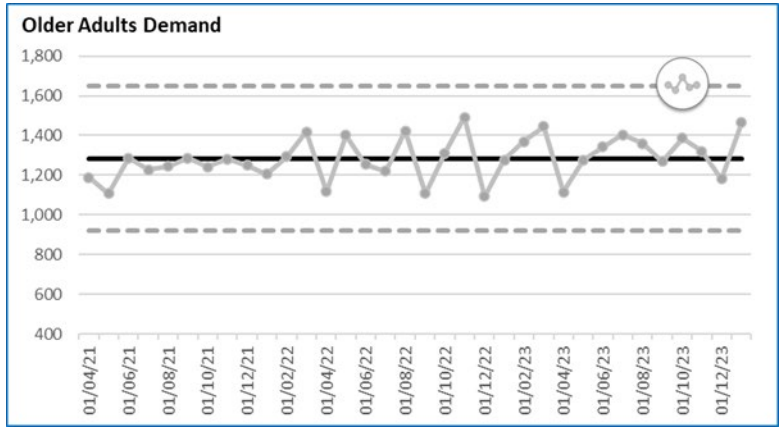


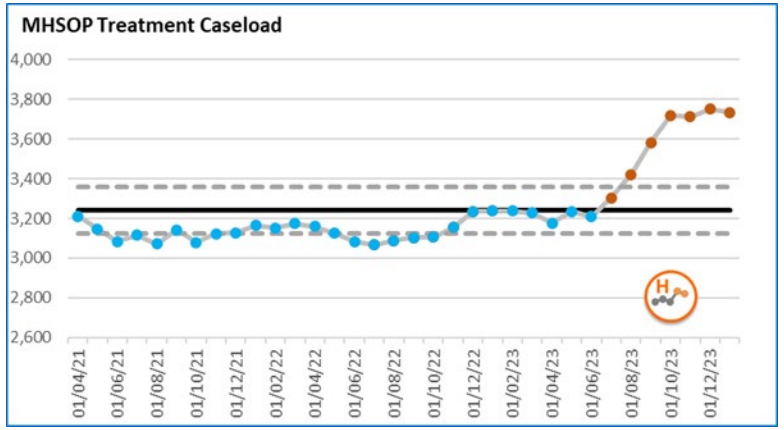


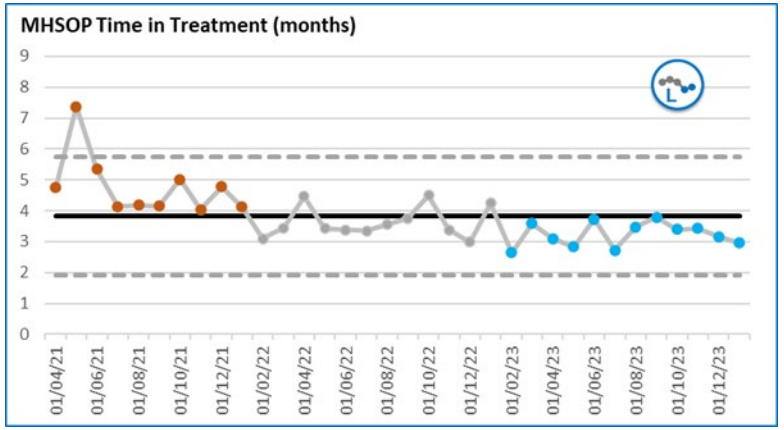


ICB Area	What the charts tell us	Issues	Actions
Adult Community Mental Health Services Herts & West Essex Herts data includes ADHD patients with the exception of the KPI. ADHD is excluded from the WE data	• Referral demand is stable, but remains high across the ICS • Demand in Herts fell slightly due to seasonal variation in December, but returned to pre-Christmas level in January • Community caseload dropped slightly in Hertfordshire for the first time since August 2023, but was static over the last two months in West Essex • Initial assessments within 28 days of referral showed significant improvement as part of the Hertfordshire recovery work – 87% in January against a 95% standard • EPUT continue to meet the 28-day referral standard • Overall time spent on treatment pathways remains stable	• Good progress has been made in Herts towards the recovery of the 28 day to assessment indicator. Full recovery of the 95% target is expected in March / April 24 • Increased referrals for adult ADHD diagnosis continue to impact on capacity, which is a recognised trend across the NHS • 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 • Herts 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 • Recovery of 28-day referral standard on track for March/April 2024 in Hertfordshire • 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



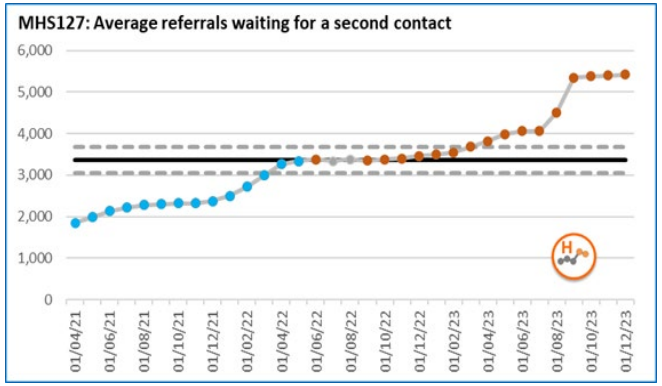


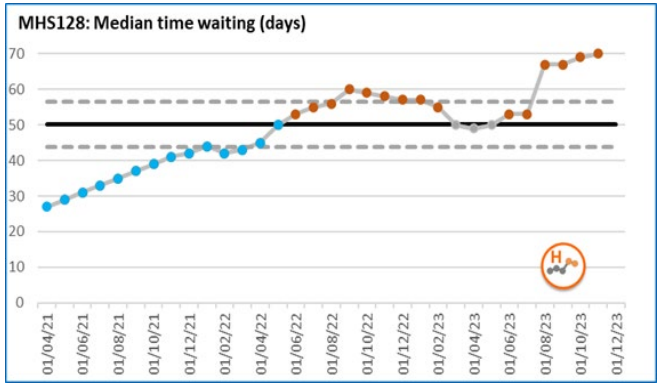


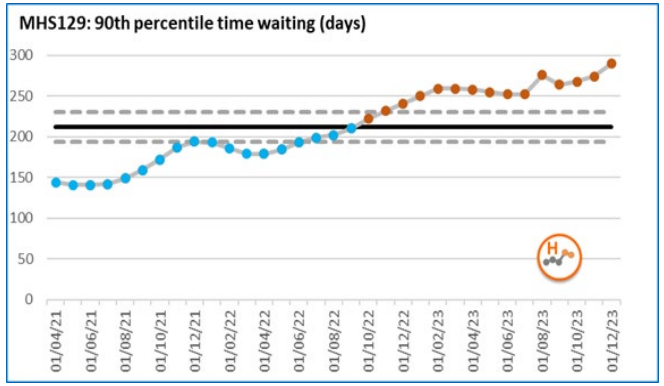
ICB Area	What the charts tell us	Issues	Actions
Older Adult Community Mental Health Services Herts & West Essex	• Demand is variable and remains within expected common cause variation limits • Rising caseload in Hertfordshire has stabilised and starting to see some reduction • Overall time spent on treatment pathways has improved for the last four months	• 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	• 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



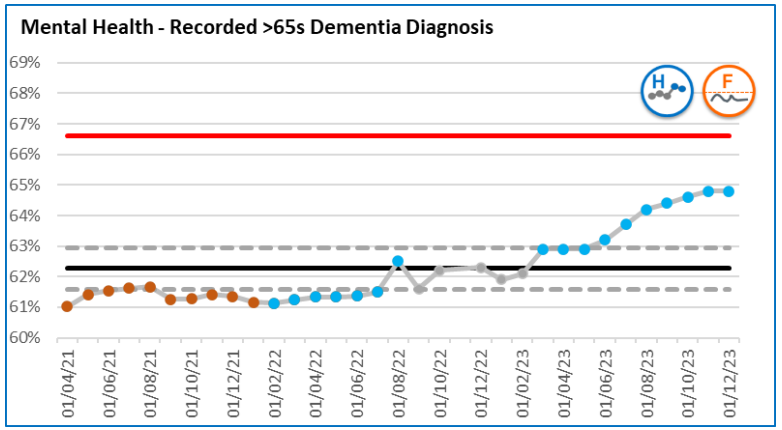


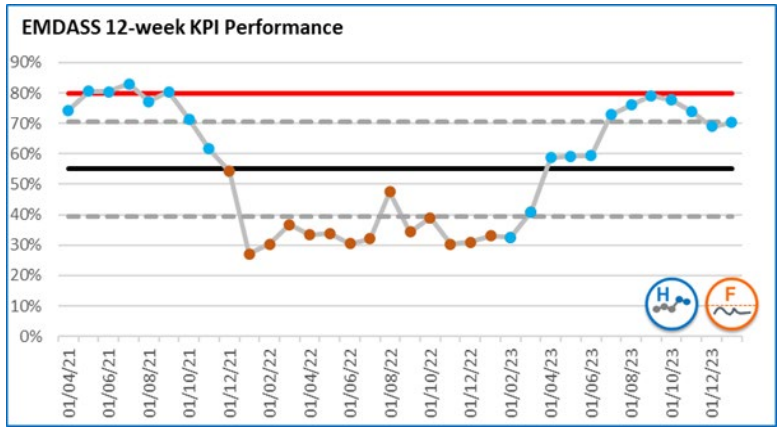


ICB Area	What the charts tell us	Issues	Actions

Hertfordshire & West Essex	• Median waiting times for a 2nd appointment increased slightly to 78 days
	• 78 days benchmarks well against the national average of 118 days, however there is a long-term trend of variation above the historic norm
	• Within the system there is variation of between 62 & 90 days:
	  • East & North Herts 62 days
	  • South & West Herts 90 days
	  • West Essex 66 days
	• 90th percentile waits increased to 290 days
	• 290 days benchmarks well against the national average of 703 days, however again there is a long-term trend of variation above the historic norm
	• Within the system there is variation of between 231 & 306 days:
	  • East & North Herts 231 days
	  • South & West Herts 306 days
	  • West Essex 303 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

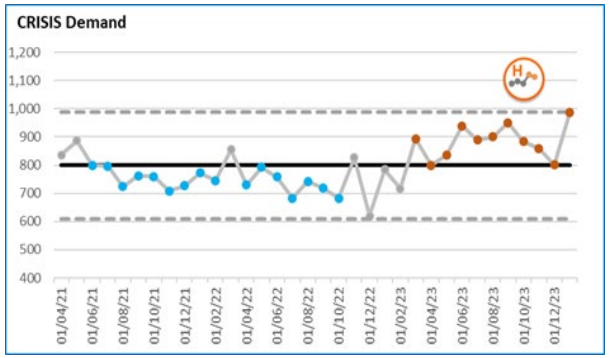


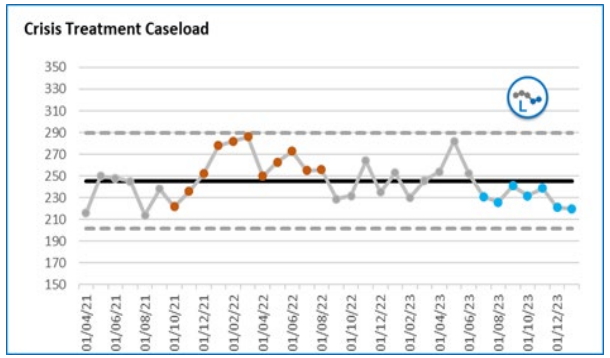


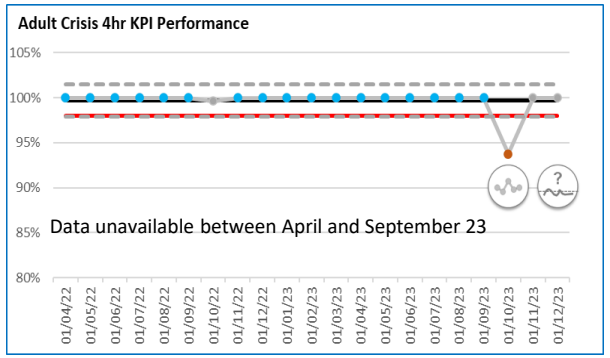
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
ENHCCH	59.4%	59.7%	60.2%	60.2%	60.2%	59.5%	59.3%	59.5%	59.2%	59.0%	58.8%	59.2%	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%
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%
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%
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%

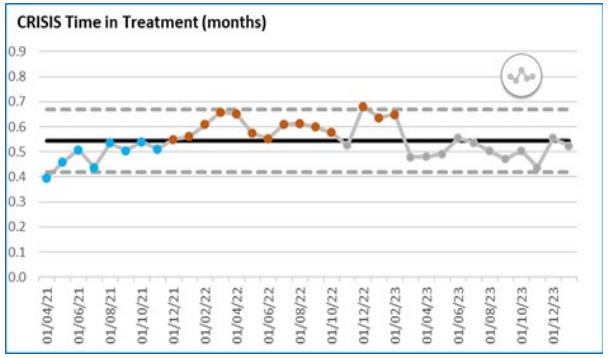
ICB Area	What the charts tell us	Issues	Actions
Dementia Diagnosis in Primary Care **Herts EMDASS Service**	• Dementia diagnosis rate across Herts & WE continues to gradually improve, but is not yet achieving overall national target of 66.7% • West Essex continues to exceed the target, with 71.5% being achieved Dec 23 • East and North Herts achieved 63.7% in Dec 23; West Herts achieved 62.3% • EMDASS service (Herts only) continues to recover and recently met the 80% KPI target in Sept 23. Performance has since dipped slightly but is now increased again. Significant recovery programme has been underway, but demand for memory assessment remains very high	• 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	• Recovery actions currently remain in place which include an Enhanced MDT and additional clinic appointments at weekends • Twice monthly MD led meetings continue to monitor progress. Weekly performance report is produced • HPFT plans underway to look at revised pathway, bringing Primary Care nurses in house under EMDASS structure to increase capacity. These plans have been presented and discussed at 2x contract meetings • Continue with recovery actions to consistently meet the 80% standard

Mental Health – Adult Crisis Services



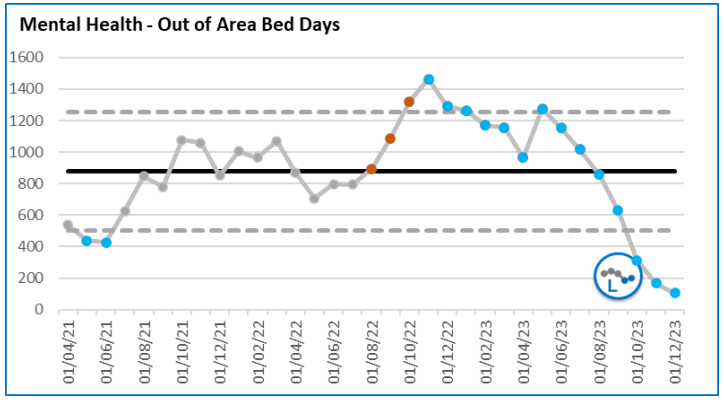






ICB Area	What the charts tell us	Issues	Actions
• Crisis Services – Adults and Older Adults • West Essex data is not included in the caseload chart as the service does not hold a caseload	• Crisis demand remains high. There was an additional spike of referrals in Dec 23, however, the caseload has reduced slightly • 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 December and January • The average time in treatment remains stable	• 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

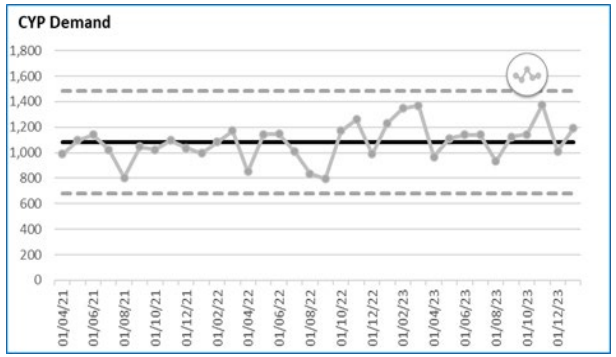
Mental Health – Out of Area (OOA) Bed Days

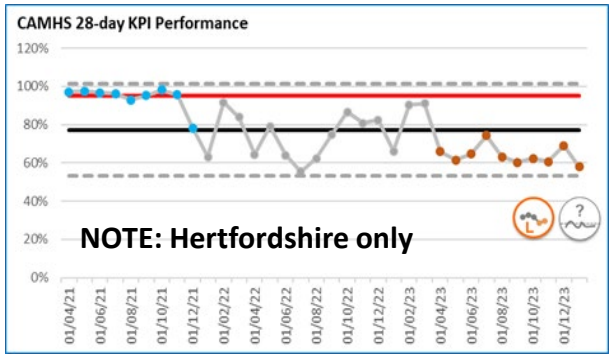


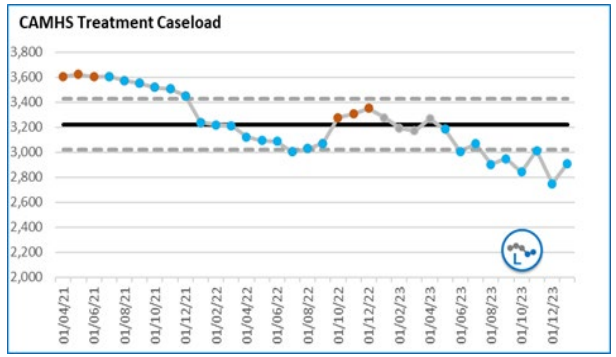
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Hertfordshire	452	337	336	574	834	759	936	745	674	779	830	987	767	691	775	757	817	1034	1177	1221	1080	1062	1003	966	650	980	938	863	632	430	171	25	11
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
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

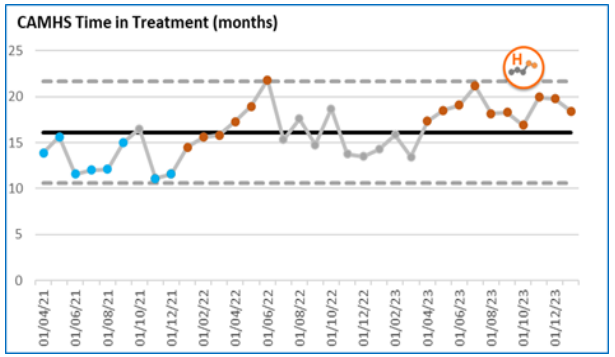
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Out of Area Bed Days remain challenged and at higher than pre 23/24 • The 95 bed days December position was however the lowest since September 22	• A national shortage of MH beds and increased pressures on service use of inappropriate OOA beds is very likely to continue	• Review of Essex bed stock continues with system partners and the Essex wide risk share contract continues with system partners System mapping due end of January 2024 • Review of West Essex Community Rehab requirements remains ongoing. This 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	• Out of Area Bed Days have reduced for the last 7 months due to the provision of additional block beds	• 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	• 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





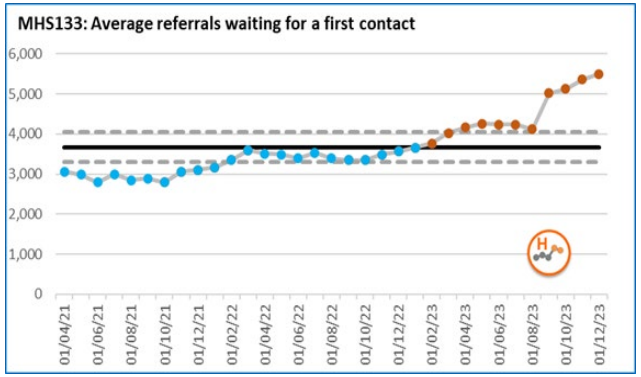


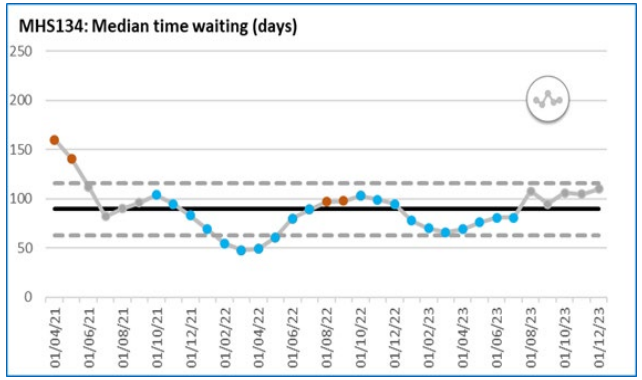


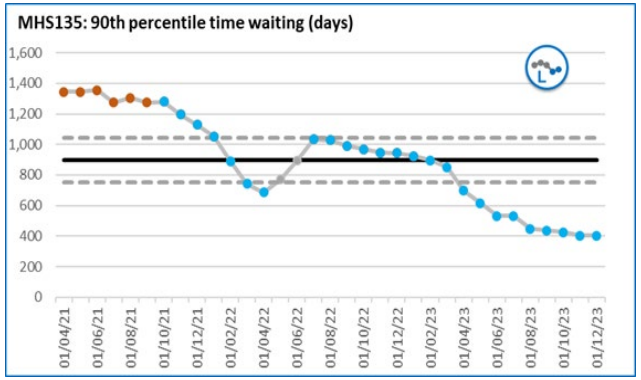
ICB Area	What the charts tell us	Issues	Actions
CAMHS Herts and West Essex. The CAMHS 28-day KPI Performance target relates to Herts only	**West Essex** • West Essex does not have a formal KPI for 28 days, but this is monitored at monthly provider meetings • Demand at SPA remains high, with seasonal downturn showing in December • CAMHS caseload remains on an improving trend through 23/24 **Herts** • Demand in December remained at a similar level to 22/23 • Caseloads (Community Quadrant teams including ADHD with open referrals & 2 contacts) continue to fall on previous year, following a caseload cleansing exercise • 28 days from referral to initial assessment in Hertfordshire remains below standard for Q3 at 53% • Time in treatment remains above 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 Herts the East Quadrant is beginning to see a slow recovery, following some successful recruitment. Vacancies in West Quadrant remain challenging, and we continue to see an impact on waiting times • Both teams 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 aimed to recover the 28-day KPI by end of Q4, however continuing vacancies have meant that the recovery prediction has moved to Q1 24/25

Mental Health – Community Waits

Children – time still waiting for a first contact



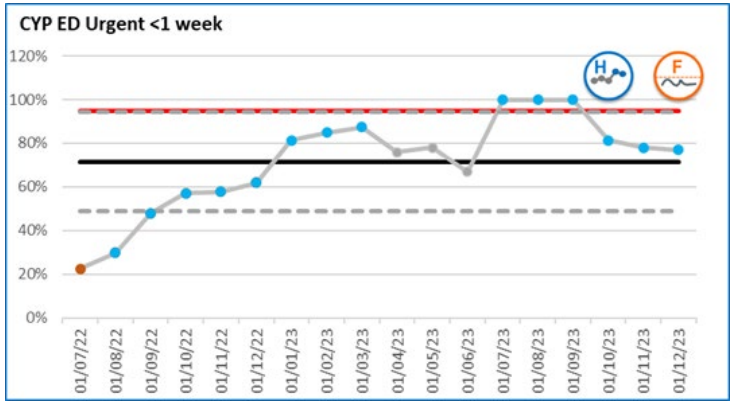


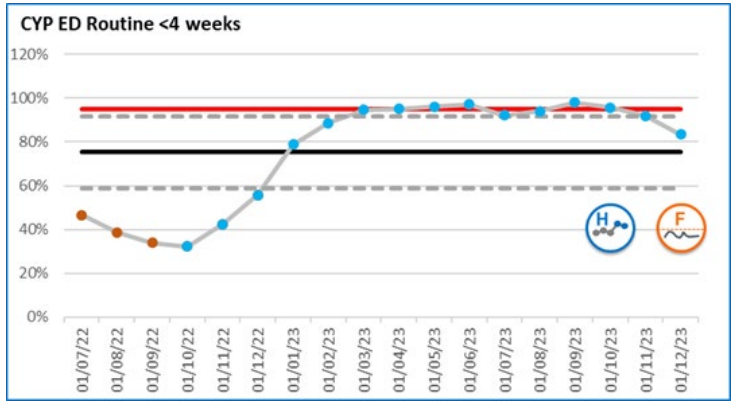


ICB Area	What the charts tell us	Issues	Actions

Hertfordshire & West Essex	• Median waiting times were up slightly at 110 days, but within expected common cause variation
	• 110 days benchmarks well against the national average of 186 days
	• Within the system there is variation of between 42 and 137 days:
	  • East & North Herts 42 days
	  • South & West Herts 137 days
	  • West Essex 83 days
	
	• 90th percentile waiting times were down to 404 days, and on a long-term trend of improvement
	• 404 days benchmarks well against the national average of 696 days
	• Within the system there is variation of between 306 & 430 days:
	  • East & North Herts 306 days
	  • South & West Herts 430 days
	  • West Essex 306 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



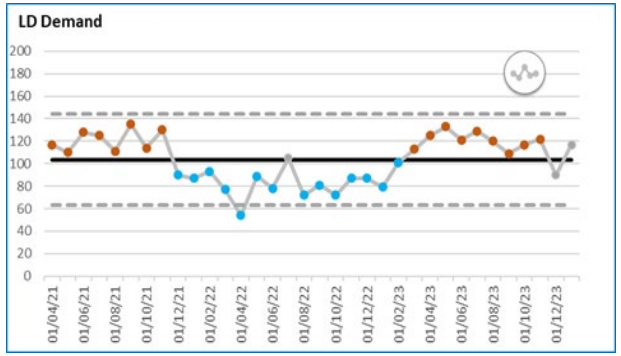


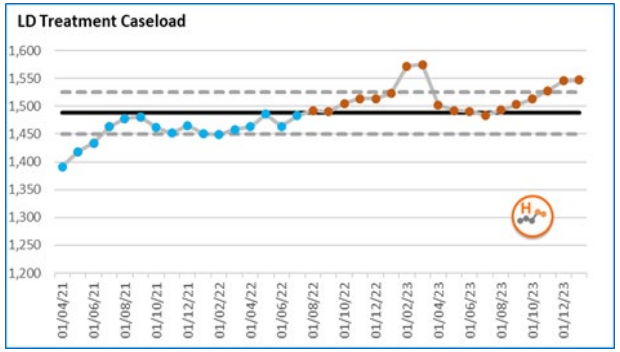
Description	Target		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
CYP ED Urgent <1 week	95%	Herts	12%	20%	43%	53%	54%	58%	80%	83%	86%	76%	78%	67%	100%	100%	100%	80%	77%	76%
		West Essex	92%	92%	92%	100%	100%	100%	100%	100%	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%
		West Essex	97%	97%	97%	96%	96%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	90%	90%

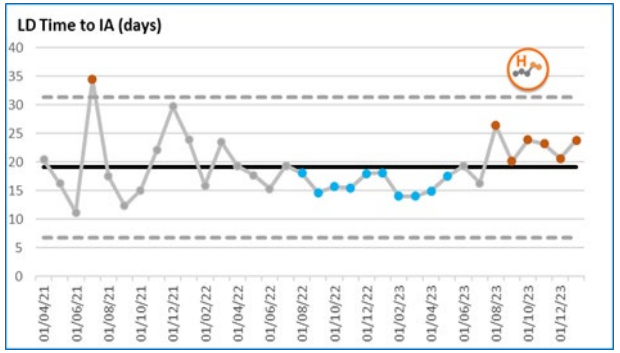
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Urgent 1 week standard consistently achieved in West Essex • Performance dropped to 90% in Q3 for routine referrals	• West Essex data from NELFT not currently flowing through MHSDS	• Commissioners working with NELFT and NHSE to secure more current data, as well as to flow data through the MHMDS

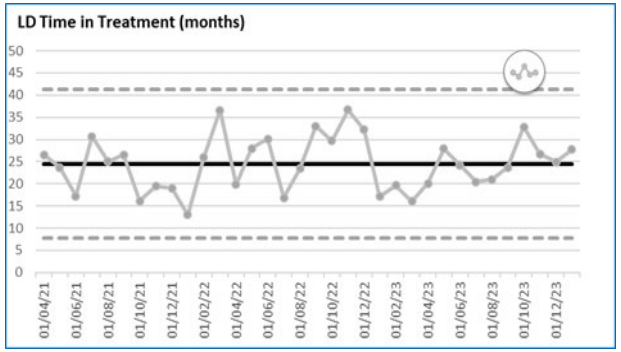
Herts	• The Eating Disorders Team had been performing consistently until a spike in referrals in Oct-Dec, coupled with an increase in vacancies
	• A number of breaches (urgent & routine) in December were due to patient choice
	• There are small numbers of urgent referrals. In December only 1 breach = 78% performance
		• The increase in referrals Oct-Dec is a seasonal factor and mirrors previous years
		• 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

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 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 • The 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

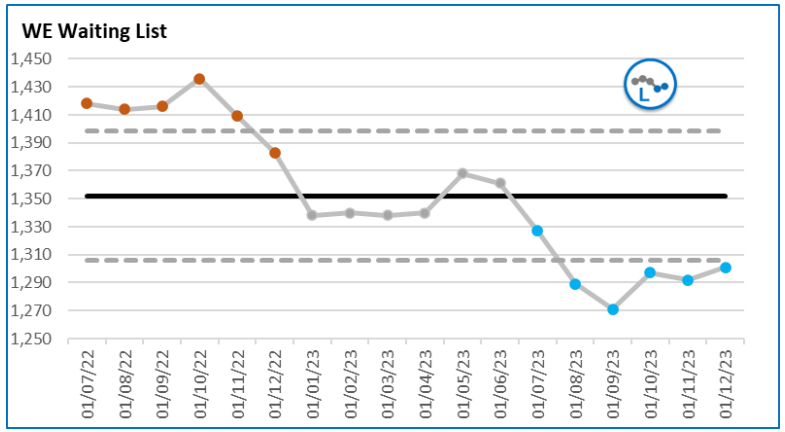
LD Health Checks December 2023	Total LD Register (age 14+)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks *	Comparison to December 2022
NHS Hertfordshire and West Essex ICB	**8,297**	**3,422**	**77**	**4,798**	**41.2%**	**47.8%**
East & North Hertfordshire	3,480	1,421	38	2,021	**40.8%**	**50.4%**
South & West Hertfordshire	3,570	1,544	28	1,998	**43.2%**	**48.6%**
West Essex	1,247	457	11	779	**36.6%**	**37.7%**

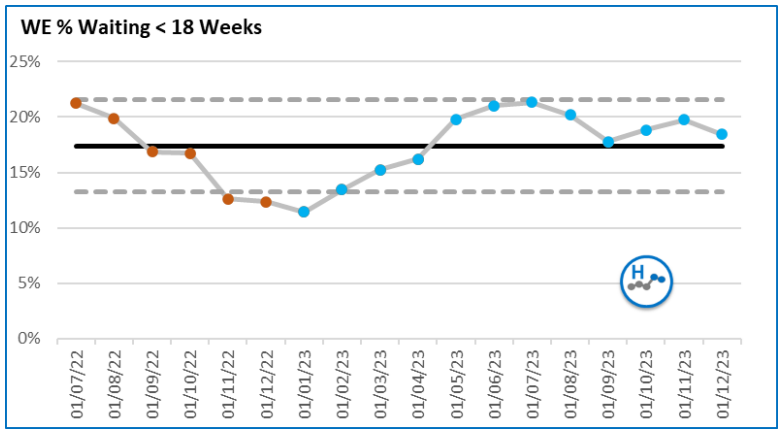
*** 75% Year End Target**

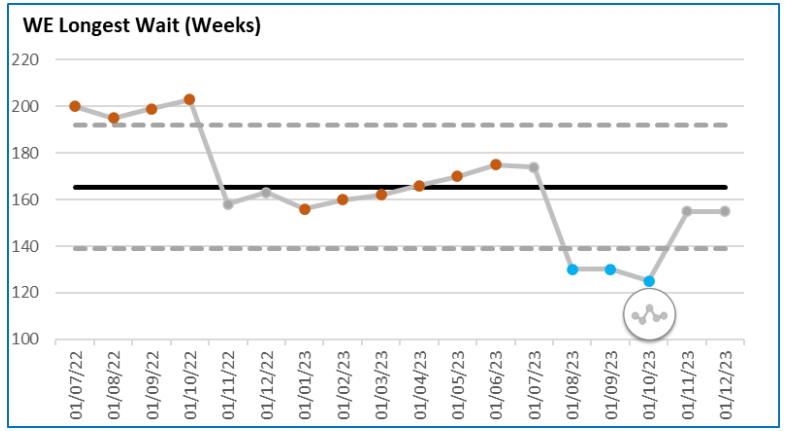
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• As of December 2023, the ICB is 6.6% behind the equivalent 2022 position. This is an improvement from a 7.6% gap in November • Indicative local data for January suggests further improvement • East & North Herts is 9.6% behind its 2022 position • South & West Herts is 5.4% behind • West Essex is 1.1% behind	• There is a national issue with LD read codes that may be inflating denominators for this performance metric • Percentage achievements may therefore be understated • 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	• National resolution of LD read codes was expected by end of January, but has been delayed • 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	1292	1301	↑	19.74%	18.45%	↓	155	155	→	December



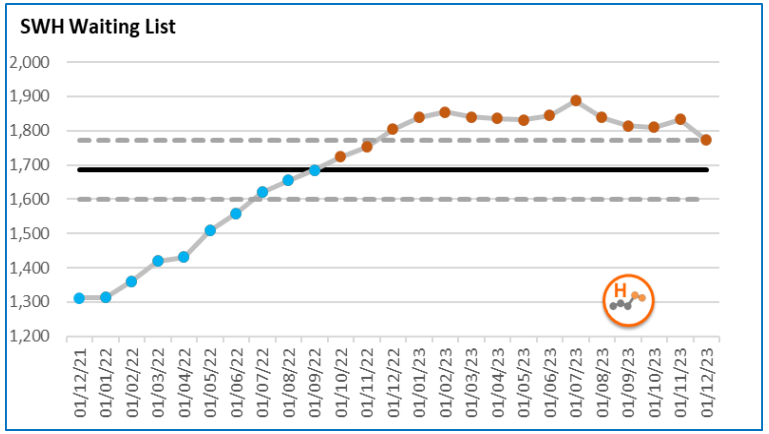


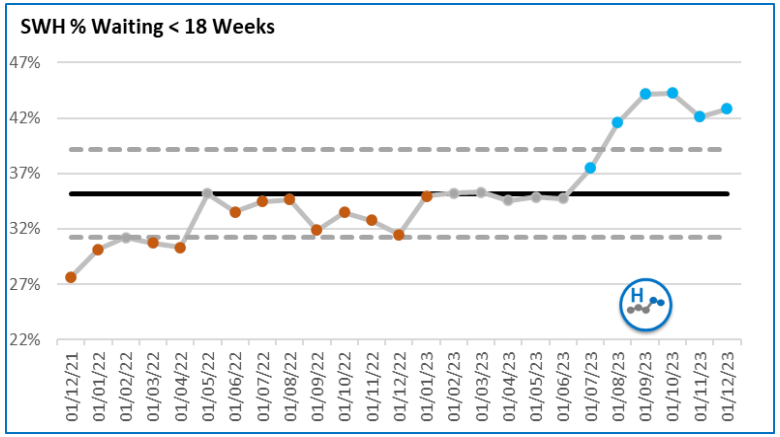


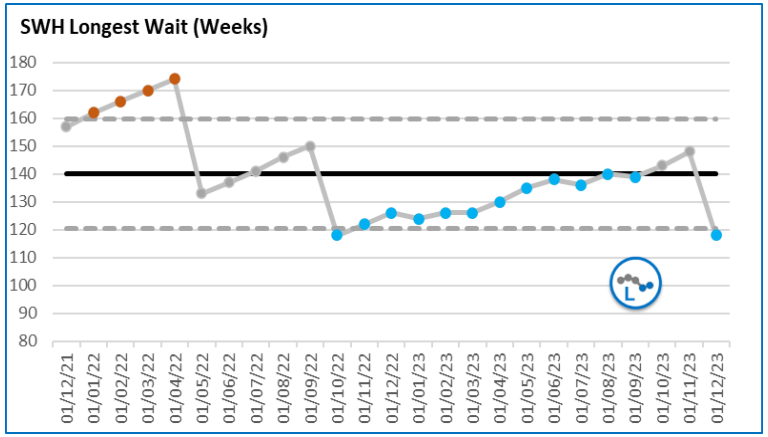
ICB Area	What the charts tell us	Issues	Actions
West Essex	• The ASD waiting list has been broadly flat for the last 5 / 6 months. Whilst still below the historic mean, the December position is 168 behind the agreed recovery trajectory • The % of ASD waiters < 18 weeks continues to fluctuate between 18-20% • There was one child at the end of December with a 155 week wait. They have since been seen, with the current longest wait now c.130 weeks	• Average monthly referral rate for Q3 was 67, against commissioned capacity of 40 assessments per month • Growth funding used to offset additional prescribing costs for ASD / ADHD. No additional funding so support ongoing in year additional capacity	• 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, but levels of available funding will still 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 Herts partners on applying a Neurodiversity Segmentation Model. Although this is similar to that already in place under the WE JADES model and requires additional resource to be effective. Therefore, likely limited impact for WE

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	1833	1773	↓	42.12%	42.81%	↑	148	118	↓	December

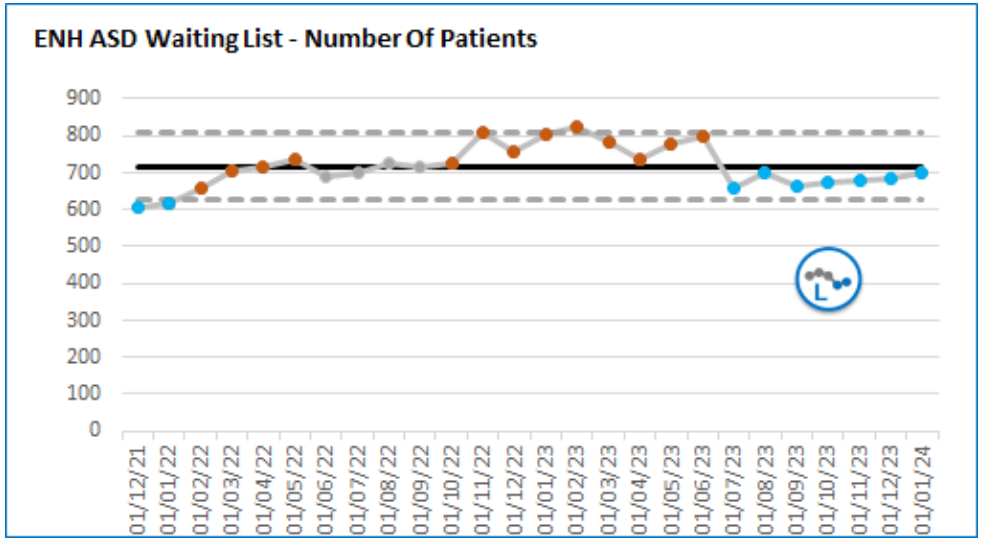






ICB Area	What the charts tell us	Issues	Actions
South & West Herts	• The overall waiting list remains consistently above the historic mean, but did improve in December • The % of ASD waiters < 18 weeks was largely unchanged in December, but the trend is one of improvement • The longest wait reduced by 30 weeks in December to 118 weeks	• 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	• Significant additional diagnostic assessments have been delivered in year through outsourcing • There is some 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 centred around supporting children and young people to understand their diagnosis and improve their mental wellbeing • EPs allocated to clinics with SLTs for quality check assessments • Clinicians have agreed future best practice Neurodiversity Model for Hertfordshire. This has been signed off through the HCT clinical governance and agreed by operational teams to inform business case that will be developed in Q1 2024 • Expression of interest submitted for Partnership for Inclusion of Neurodiversity in schools (PINs programme) on behalf of Herts and West Essex ICB

Autism Spectrum Disorder (ASD) – East & North Hertfordshire

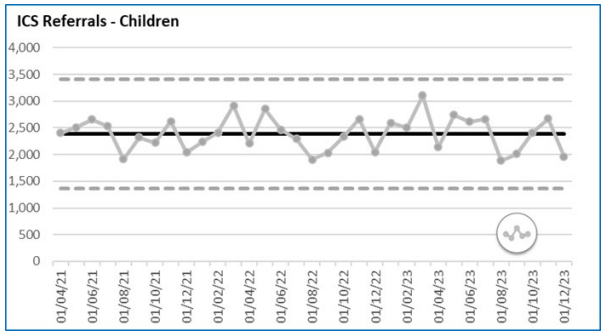


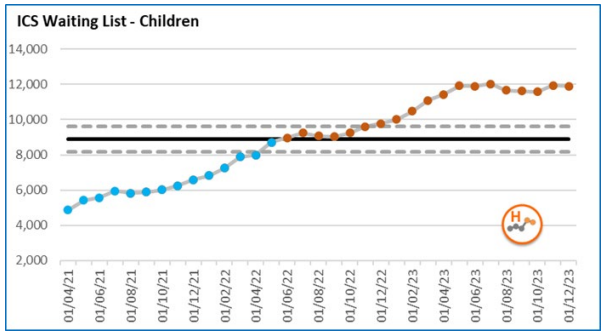
- In ENH patients have a first appointment with Community Paediatrics. If the clinician then considers that the patient requires an ASD assessment then they are added to the ASD waiting list.
- Data is available on the waiting times for the first community paediatrics appointments and also for ASD assessments 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):

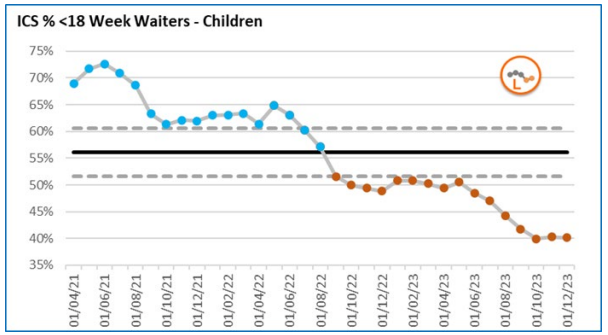
Waiting list bucket	Number of patients (Nov-23)	Number of patients (Dec-23)
<18 weeks	100	103
18 – 65 weeks	422	443
66 – 78 weeks	46	88
>78 weeks	111	86

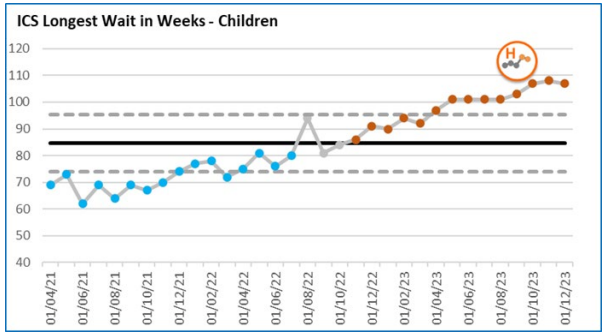
ICB Area	What the charts tell us	Issues	Actions
East & North Herts	• The ASD waiting list continues to fluctuate within the normal range of 600-800 patient • However, since July, the number of waiters has been below the mean in every month • The number of patients waiting >65 weeks has been relatively stable over the last three months, with 174 patients >65 weeks at the end of Dec-23 • 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	• Significant additional diagnostic assessments have been delivered through outsourcing to the Owl Centre. Funding ended in December 2023 • 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 centred around supporting 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 the HCT clinical governance and agreed by operational teams to inform business case that will be developed in Q1 2024 • Expression of interest submitted for Partnership for Inclusion of Neurodiversity in schools (PINs programme) on behalf of Herts and West Essex ICB

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	2673	1966	↓	11933	11900	↓	40.30%	40.14%	↓	108	107	↓	December

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	380	272	↓	1092	1057	↓	70.42%	71.52%	↑	43	46	↑	December
ENH	AJM/Millbrook	22	29	↑	121	129	↑	75.21%	73.64%	↓	32	36	↑	December
ENH	ENHT Community Paeds.	307	228	↓	4987	5054	↑	17.73%	17.12%	↓	108	107	↓	December
ENH	**All**	**709**	**529**	↓	**6200**	**6240**	↑	**28.13%**	**27.50%**	↓	**108**	**107**	↓	**December**

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	1370	1051	↓	4754	4672	↓	45.23%	46.58%	↑	76	78	↑	December
SWH	AJM/Millbrook	24	13	↓	110	107	↓	71.82%	71.03%	↓	32	36	↑	December
SWH	**All**	**1394**	**1064**	↓	**4864**	**4779**	↓	**45.83%**	**47.12%**	↑	**76**	**78**	↑	**December**

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	22	12	↓	33	31	↓	96.97%	96.77%	↓	20	19	↓	December
WE	HCRG / Virgin	548	361	↓	836	850	↑	96.17%	91.65%	↓	26	52	↑	December
WE	**All**	**570**	**373**	↓	**869**	**881**	↑	**96.20%**	**91.83%**	↓	**26**	**52**	↑	**December**

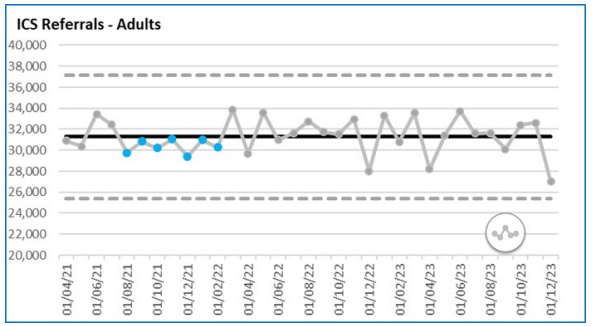
NOTE: ENHT Community Paediatrics data is included above to give a full picture for Children's Services, but is also included in the Planned Care position described in Slides 16 & 17

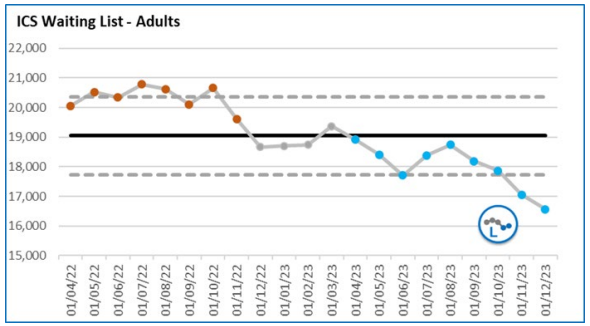
Community Waiting Times (Children)

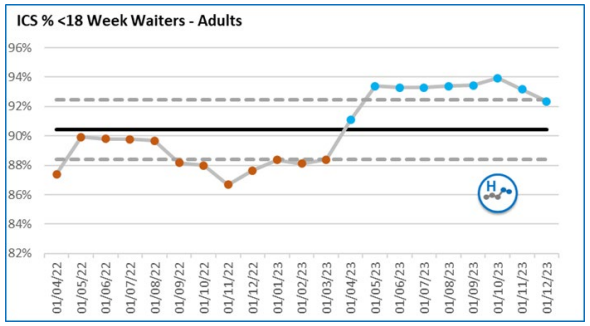
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services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

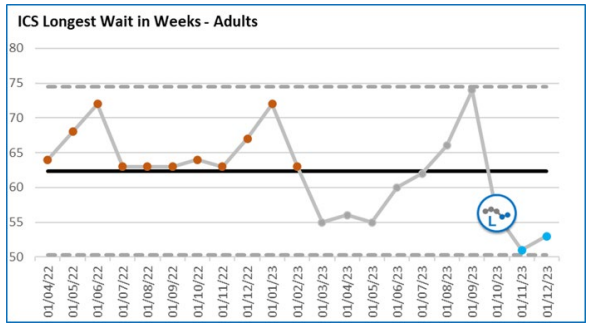
ICB Area	What the charts tell us	Issues	Actions
ICB	• Referrals were low in December but within expected common cause variation • The total number of children on waiting lists remains very high, but has plateaued at c.12,000 • The % of children waiting less than 18 weeks remains of concern at c.40%, compared to the national average of 56.7% • The longest waits are within the ENHT Community Paediatrics Service at 107 weeks. There are also long waits of up to 78 weeks within HCT services in South & West Hertfordshire • Consultant led 18-week RTT performance: SWH Community Paediatrics – 44.8% SWH Children's Audiology – 25.7% ENH Community Paediatrics – 17.1% WE Community Paediatrics – 93.6% • The ENHT Community Paediatrics position is described within the Planned Care and ASD slides of this report	**Hertfordshire** • Referrals to HCT children's specialist services in have increased by 33% YTD compared to 2019/20, with the majority of 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 2019/20, but referrals have increased by c.30% • There are continued waiting time pressures in Paediatric Audiology in SWH. 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 % has fallen further to c.92% • Waits for first appointments have increased as HCRG have targeted longest waiting follow ups in recent months • The volumes on the Community Paediatrics waiting list is increasing as a result • Admin exercise to review / discharge long waiters – completion delayed to February	**Hertfordshire** • For HCT services the number of over 52-week waits has reduced from 605 in July, to 362 in January, and continues to improve in the most recent data • 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. Analysis for workforce business case has resulted in increased capacity, with recruitment successful to two posts • Children's Therapies – increasing capacity through successful recruitment, waiting list initiatives and outsourcing • EHCP dashboard developed to improve waiting list management **Community paediatrics ENHT** • New clinical model agreed by all providers: HPFT, HCT and ENHT • Herts Mental Health Learning Disability and Autism Care Partnership developed capacity model to be populated with input parameters from the providers in order to develop the business case • Target date for the business case is April 2024; dependent on populating capacity model • Single point of access / single referral form expected to be in place by Apr-24 • Target implementation date for the new model is January 2025 • Providers have forecast investment levels to continue with outsourcing / backlog work in 2024/25. Neurodiversity Directors Group to review / agree; then governance process to be agreed • ICB / HCC has agreed to expand the Neurodiversity Support Centre across Herts. (staffed by experts by experience). Diagnosis not required to access the support. External evaluation completed and the feedback is extremely positive. Full evaluation will be available in the next two months **West Essex (WE)** • WE Community Paediatrics Business Case: Additional in year funding and annual growth for future years now agreed, although not at the requested levels. Funding this year is being utilised to offset prescribing overspend • New Community Paediatrician in post from January. Staffing now at full establishment • 24/25 plans in discussion, but levels of available funding will still leave a capacity gap

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	32620	27017	↓	17052	16562	↓	93.17%	92.35%	↓	51	53	↑	December

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	9210	7445	↓	7595	7751	↑	91.63%	90.61%	↓	51	53	↑	December
ENH	AJM/Millbrook	83	91	↑	481	457	↓	73.80%	71.55%	↓	47	46	↓	December
ENH	**All**	**9293**	**7536**	↓	**8076**	**8208**	↑	**90.56%**	**89.55%**	↓	**51**	**53**	↑	**December**

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	6347	5523	↓	2124	1627	↓	95.01%	91.64%	↓	39	39	→	December
SWH	Connect	3689	2816	↓	3339	3172	↓	99.55%	99.75%	↑	34	34	→	December
SWH	HCT	949	734	↓	1007	988	↓	88.38%	87.65%	↓	36	40	↑	December
SWH	AJM/Millbrook	110	119	↑	505	495	↓	72.28%	72.73%	↑	44	46	↑	December
SWH	**All**	**11095**	**9192**	↓	**6975**	**6282**	↓	**94.58%**	**93.62%**	↓	**44**	**46**	↑	**December**

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	12141	10208	↓	1893	1979	↑	98.78%	99.70%	↑	31	22	↓	December
WE	EPUT - Wheelchairs	91	81	↓	108	93	↓	98.15%	97.85%	↓	19	25	↑	December
WE	**All**	**12232**	**10289**	↓	**2001**	**2072**	↑	**98.75%**	**99.61%**	↑	**31**	**25**	↓	**December**

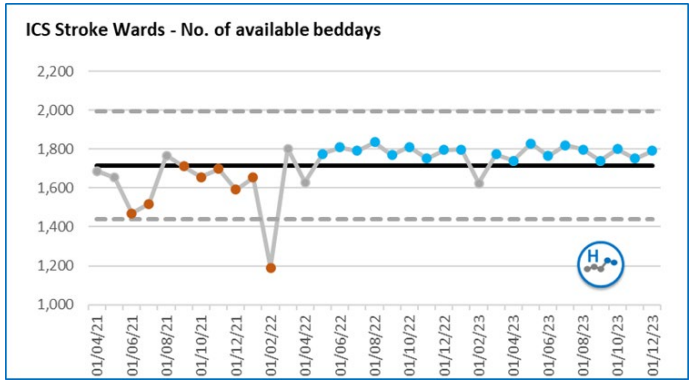
Hertfordshire and West Essex Integrated Care System

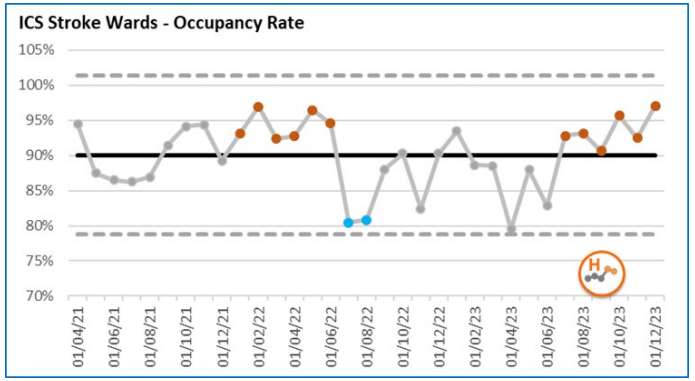
Community Waiting Times (Adults)

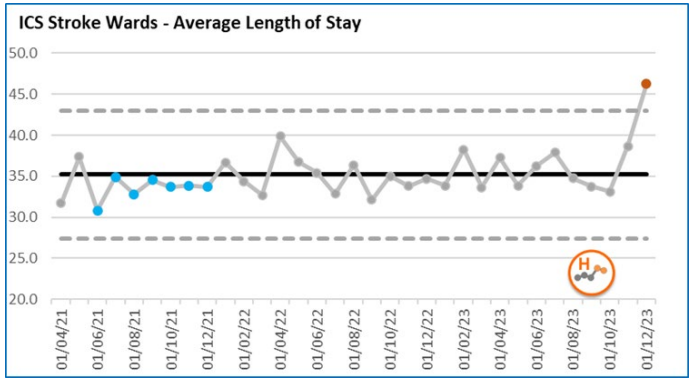
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Adult community services this include Skin Health (ENH), Respiratory (S&W), and Podiatric Surgery (WE). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services 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 were low in December but within expected common cause variation • The % of patients waiting less than 18 weeks has dipped but remains strong at 92.4%, compared to the national average of 84.1% • The total number of adults waiting on waiting lists decreased for the 4th consecutive month • Longest waits are within HCT services in East & North Hertfordshire – up slightly to 53 weeks • Consultant led 18-week RTT performance: ENH Skin Health – 86.7% SWH Respiratory – 88.1% WE Podiatric Surgery – 100%	**East & North Hertfordshire (ENH)** • Referrals have increased by 14% compared to 2019/20 (and are also up compared to last year, but overall 'waiting within target' performance continues to be more favourable when compared to the pre-pandemic baseline **South & West Hertfordshire (SWH)** • Overall decrease in number of referrals from previous month. Good progress continues to be made in reducing waiting list numbers • Longest waiter remains within the Neuro Rehab service (ABI patient waiting for psychology input) • Candidate for psychology post has now withdrawn application. Recruitment restarted • Good progress has been made on MS and PD nursing caseloads where longest waiters have reduced to 14 weeks and 11 weeks **West Essex (WE)** • Reduced capacity / workforce in Pulmonary Rehab • Small number of wheelchair breaches due to supplier delays and ordering of bespoke equipment	**East & North Hertfordshire (ENH)** • All waits are closely monitored and are 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 **South & West Hertfordshire (SWH)** • External provider continuing to support with PD and MS nursing caseloads. External provider also approached to support with ABI patients whilst service recruits to post • External provider now supporting with Lymphoedema follow up patients to improve capacity within the service to focus on 1st appointments • External provider now also supporting with planned care therapy waits • Plans being put in place for additional external support for NETT, Lymphoedema and Community Therapy • 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 recruitment – challenged as applicants withdrew at short notice impacting trajectory for recovery. Improvement in wait times not expected until Quarter 1 2024/25 • Wheelchair temporary equipment supplied where impact from supplier delays and bespoke equipment delays

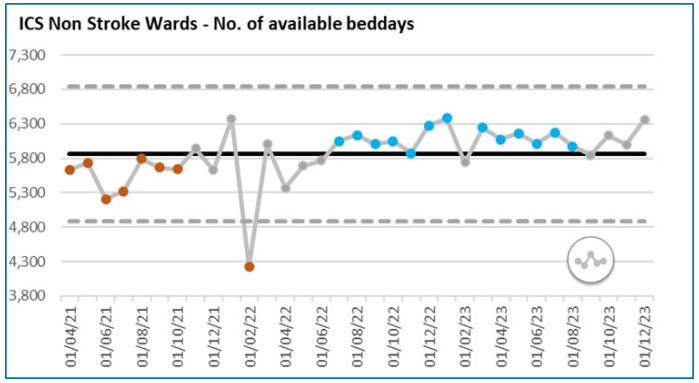
Community Beds (Stroke & Non-Stroke)

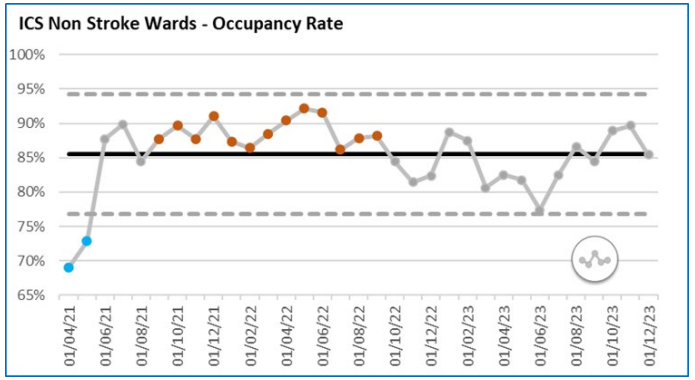


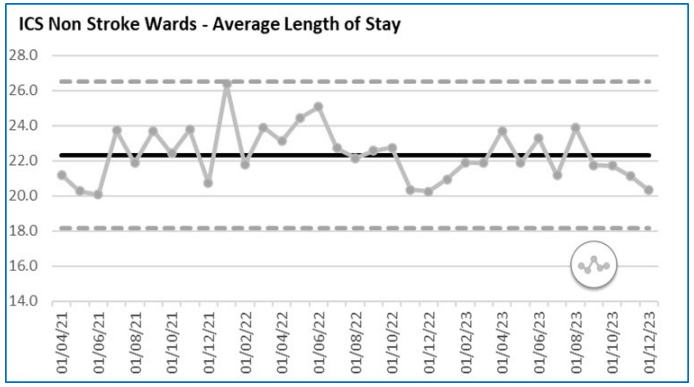




Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	720	744	↑	83.33%	92.88%	↑	37.9	31.6	↓	December
SWH	CLCH	611	614	↑	98.20%	100.00%	↑	44.9	38.2	↓	December
WE	EPUT	420	434	↑	99.76%	100.00%	↑	31.0	81.0	↑	December
ICS	**All**	**1751**	**1792**	↑	**92.46%**	**97.04%**	↑	**38.7**	**46.3**	↑	**December**





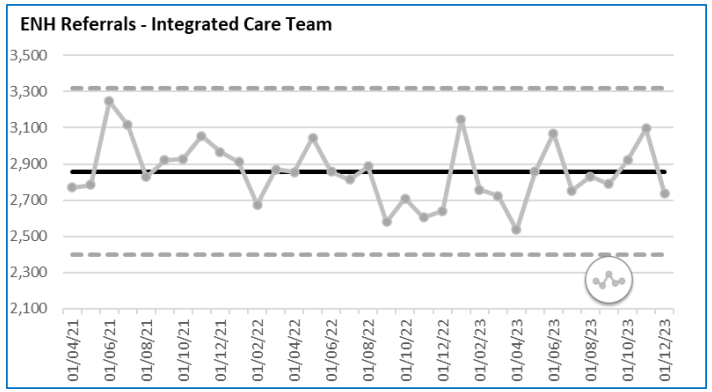


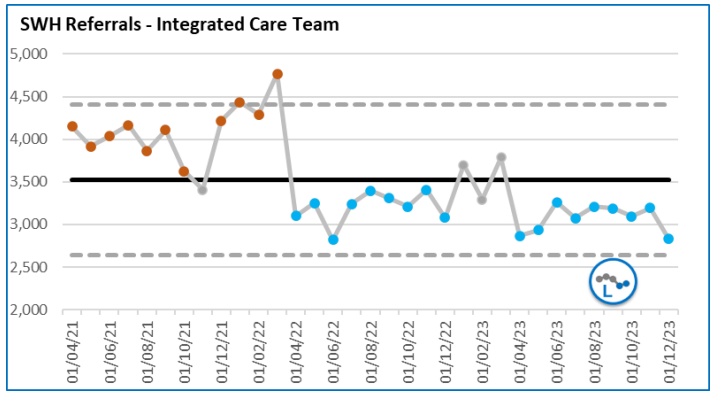
Non-Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	1590	1691	↑	87.11%	74.28%	↓	24.6	24.3	↓	December
SWH	CLCH	2216	2405	↑	85.65%	84.99%	↓	24.4	23.8	↓	December
WE	EPUT	2190	2263	↑	95.57%	94.17%	↓	15.9	14.7	↓	December
ICS	**All**	**5996**	**6359**	↑	**89.66%**	**85.41%**	↓	**21.1**	**20.3**	↓	**December**

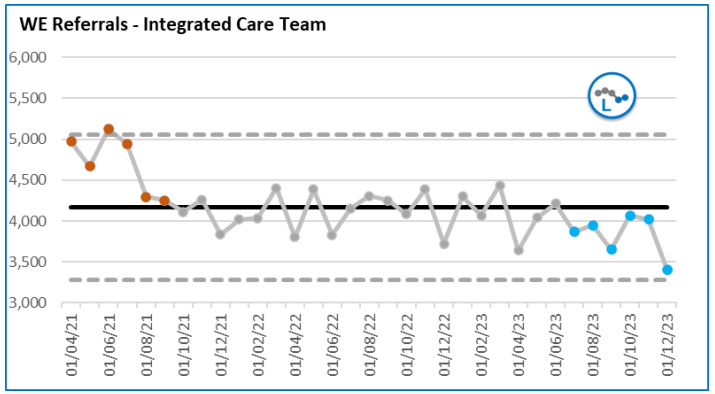
Community Beds (Stroke & Non-Stroke)

ICB Area	What the charts tell us	Issues	Actions
ICB	**Stroke Beds Days** • Available stroke bed days remain consistently higher than the historic mean • Overall occupancy rates continue on an upward trend, reaching 97% in December. CLCH and EPUT were both at 100% • Overall length of stay increased significantly in December as a result of a number of long stay patients at EPUT in West Essex **Non-Stroke Beds Days** • Available non-stroke bed days remain consistently higher than the historic mean • Overall occupancy rates across the system are within common cause variation limits. Occupancy is lowest in East & North Hertfordshire at 74.3% • Overall length of stay has reduced in recent months but remains within common cause variation limits	**East & North Hertfordshire (ENH)** • Bed occupancy remains highest at Danesbury with an average of 92% over the past 12 months. Herts & Essex and QVM have an average occupancy of 80% and 82% respectively. • Average length of stay for Herts & Essex shows normal variation with an average of 24 days. For QVM (24 days) following a period of lower average length of stay (ALOS), there is now normal variation • At Danesbury, there is now normal variation for ALOS following a trend of a reduced length of stay with an average of 33 days. Danesbury is achieving the contractual target for stroke beds, which is < 42 days • Following a period of increased admissions into Danesbury over the winter period at the beginning of 2023, there is now normal variation. Admissions into community hospitals show no significant change in trend in recent years for Herts and Essex and QVM. • Danesbury has the least admissions with an average of 18 a month, with QVM averaging 20 and Herts & Essex averaging 30 **South & West Hertfordshire (SWH)** • Stroke bed occupancy remains high 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)** • Lack of specialist dementia nursing placements • High volume of bed days lost in December due to delays in transfers to care home placements • Four long stay stroke patients awaiting placements significantly increased December length of stay to 81 days. Now resolved and January length of stay has reduced to 41 days	**East & North Hertfordshire (ENH)** • Safe staffing measures fully configured in PowerBI **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)** • All patients awaiting Care Homes reviewed on daily social care escalation call

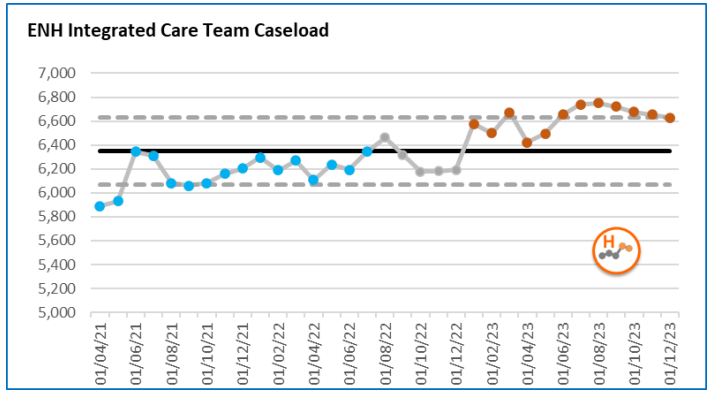
Integrated Care Teams (ICT)

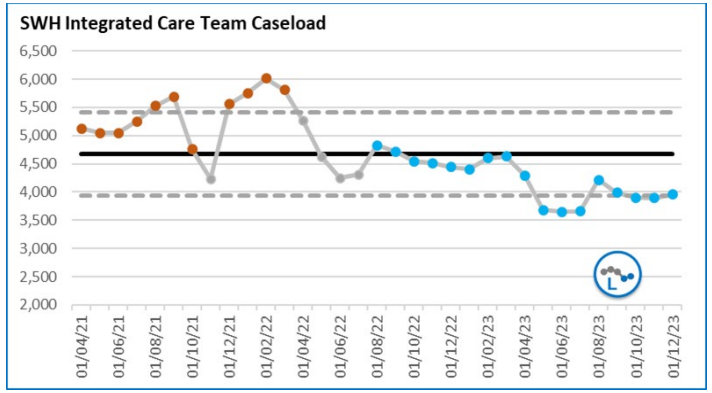


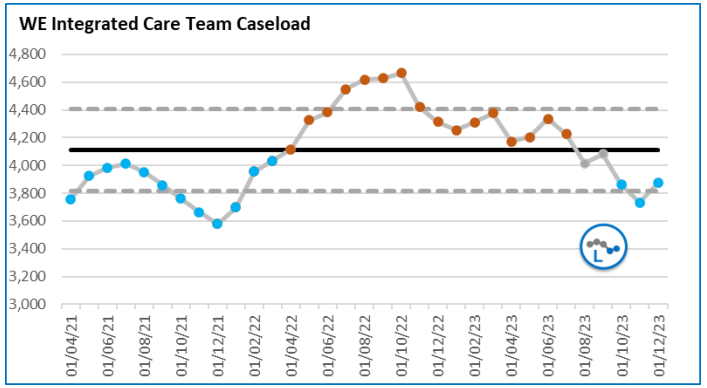




			Referrals			Referral Rate per 1,000 Population			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	3096	2739	↓	4.9	4.4	↓	December
SWH	CLCH	All	3196	2832	↓	4.7	4.1	↓	December
WE	EPUT	All	4021	3408	↓	12.1	10.3	↓	December
ICS	**All**	**All**	**10313**	**8979**	↓	**6.3**	**5.5**	↓	**December**





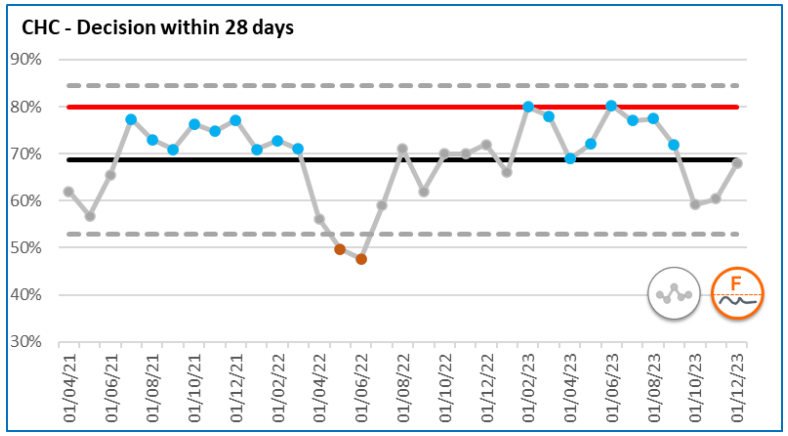


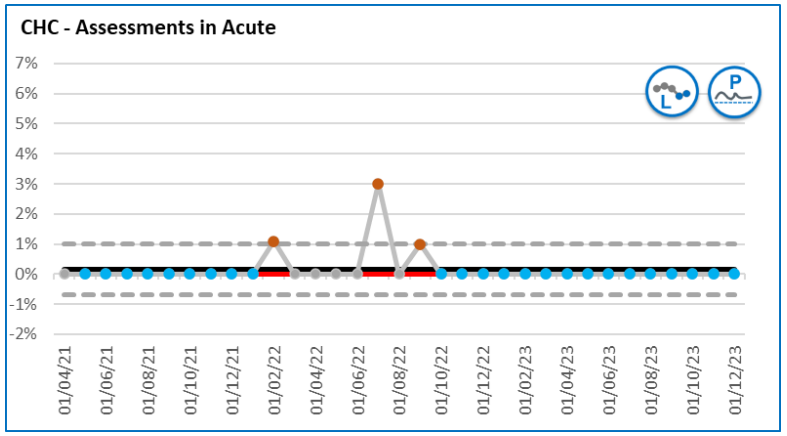
			Caseload			Caseload per 1000 population			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	6654	6628	↓	10.6	10.5	↓	December
SWH	CLCH	All	3896	3952	↑	5.7	5.8	↑	December
WE	EPUT	All	3732	3874	↑	11.3	11.7	↑	December
ICS	**All**	**All**	**14282**	**14454**	↑	**8.7**	**8.8**	↑	**December**

Integrated Care Teams (ICT)

ICB Area	What the charts tell us	Issues	Actions
ICB	• Overall referral volumes to Integrated Care Teams have been consistently reducing since the restoration of services post-Covid • Integrated Care Team caseload in East & North Hertfordshire remains high and above the historic mean, but has been steadily in recent months • The West Essex caseload has been consistently reducing and now shows a trend of an improving nature • The caseload in South & West Hertfordshire remains consistently below the historic mean	• The 3 Provider BI teams have completed a review to understand the reasons behind the referral and caseload variances seen between the three places. Due to internal recording differences, looking at unique patients in contact with ICT Teams is a better reporting measure, and ratios align with expectations given the relative population sizes. New reporting will be rolled out in the next report **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 increasing 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	• Implement change of reporting next month to the volume of unique patients in contact with ICT Teams • 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 COO • Various recruitment initiatives underway • A comprehensive support programme in place focused on workforce, wound care and diabetes management with the ICT **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
East & North Herts	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%
South & West Herts	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%
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%
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%

	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
East & North Herts	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%
South & West Herts	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%
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%
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%

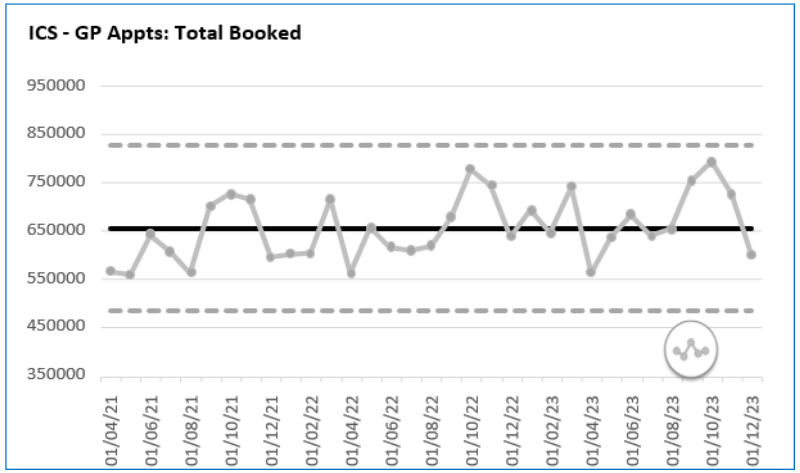
	What the charts tell us	Issues	Actions
HWEICB	• The CHC decision within 28 days standard continues to present a significant challenge, most notably in South & West Hertfordshire • Indicative data for January suggests further slippage to c.44% across the ICS • The 80% standard was achieved in East & North Hertfordshire and West Essex in December, but likely to be missed in January • The assessments in an acute setting <15% standard continues to be routinely achieved	• The SWH service identified a backlog of 422 nursing home notification forms that had not previously been processed in line with guidance and included in the CHC work stack • The notifications date back to January 22 and are now being urgently check listed, directly impacting performance against the 28-day standard	• Additional resource is being commissioned to complete the initial pathway from checklist to Decision Support Tool (DST) for the current 28-day backlog • 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 • A further comprehensive layer of management control and support has been implemented within SWH to significantly improve work allocation, daily analysis of completed work, case status and risk identification

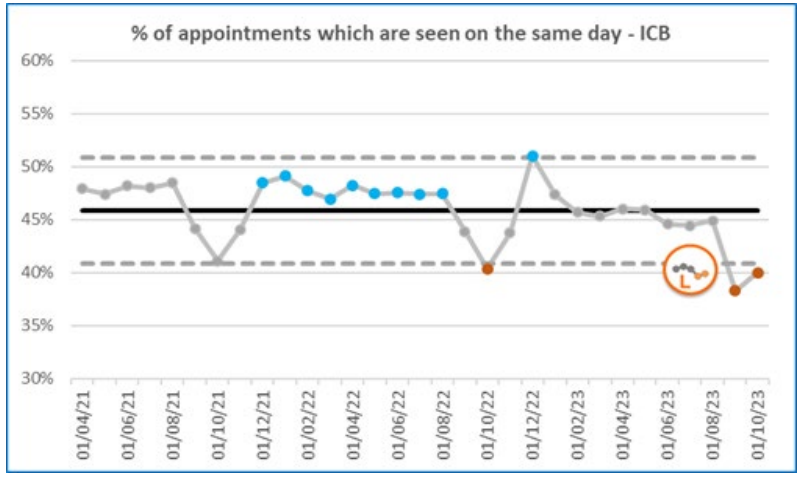
Primary Care – performance summary

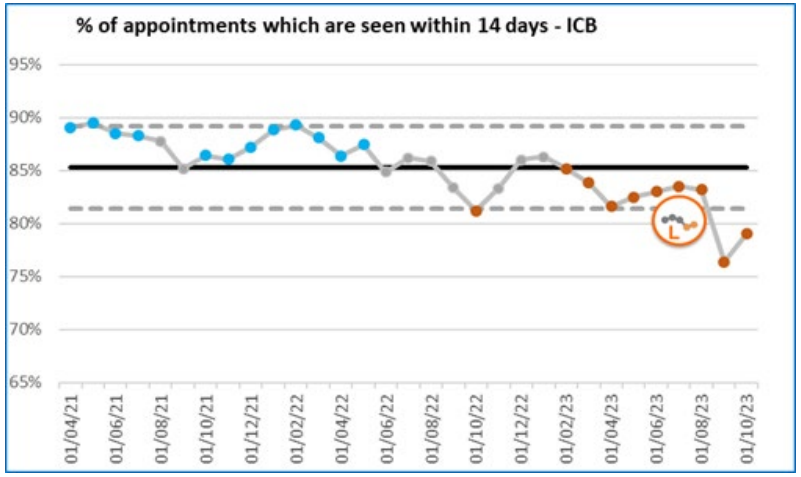
Current Performance Period vs Prior Period

Area	Indicator	Type	Prior Mth	Current	Change	Movement	Period	ICB	ENH	SWH	WE
								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	4,703	4,304	(400)	↓	Nov-23				
	% of appointments which are seen on the same day	Monthly	40.0%	43.8%	3.8%	↑	Nov-23				
	% of appointments which are seen within 14 days	Monthly	79.0%	83.4%	4.4%	↑	Nov-23		79	34	50
	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	↑	Q3 23-24				
	S037a: Percentage of patients describing their overall experience of making a GP appointment as good	Annual	70.5%	54.5%	(16.0%)	↓	2022	31			
	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	22.4%	29.8%	7.4%	↑	Oct-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%	↑	Q1 23/24	7	27	45	24
	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	1.143	1.132	(0.011)	↓	Sep-23	28	56	20	80
	S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	8.52%	8.51%	(0.01%)	↑	Sep-23	33	80	83	67

Primary Care – key indicator trends







What the charts tell us

- GP appointments fell below the historic mean in December, but remain within expected common cause variation limits
- The % of appointments which were seen on the same day noticeably decreased in Sep-23 and Oct-23, with both months are below the lower process limits. However, historically, September and October are usually low months due to flu vaccinations which won't be same day appointments
- The % of appointments which were seen within 14 days has been consistently below the mean for the last nine months, reflecting a steadily reducing trend over the last two and half years. In October (latest data available), <80% of primary care appointments were seen within 14 days of booking

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 • New 23/24 contractual requirement for an offer of assessment, an appointment, signposting to occur when the patient contacts the practice	**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 • 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 also 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 **Winter Pressure Funding** • No additional national funding for winter pressures this year specifically aligned to Primary Care. However, HWE have continued with local primary care funding to commission additional activity in primary care at the same level as last year • £1.43 per weighted patient is subject to PCN plans being appropriate to meet the local and national priorities. This capacity should support surges in practices in PCNs when reaching OPEL 3 or 4. PCNs requested to consider partnership working, same day access & phasing over the winter period • Additional funding agreed through double lock panel to support additional capacity in Primary Care during Industrial Action **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. Local UTI service to close 29 Feb 24

Performance v. 23/24 Operational Plans

		M7 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	37,898	42,244	11.47%	4,346	↑	291,168	286,836	-1.49%	-4,332	↓
EM11a	Number of specific acute non-elective spells in the period with a length of stay of zero days	3,544	3,095	-12.67%	-449	↓	24,538	20,700	-15.64%	-3,838	↓
EM11b	Number of specific acute non-elective spells in the period with a length of stay of one or more days	6,327	6,688	5.71%	361	↑	43,144	46,570	7.94%	3,426	↑
EM10a	Elective day case spells	9,754	10,221	4.79%	467	↑	61,475	67,460	9.74%	5,985	↑
EM10b	Elective ordinary spells	1,284	951	-25.93%	-333	↓	7,949	6,145	-22.69%	-1,804	↓
EM32g	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance	46,177	43,555	-5.68%	-2,622	↓	300,938	290,650	-3.42%	-10,288	↓
EM32h	Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance	54,195	68,003	25.48%	13,808	↑	365,552	445,582	21.89%	80,030	↑
EB20	The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 65 weeks or more	2,364	3,727	57.66%	1,363	↑	17,831	22,411	25.69%	4,580	↑

ICB Issues and escalations

- Performance v. plan data above has not been updated due to reporting issues in the Month 8 Freeze and Month 9 Flex positions
- Resolution is being progressed and we expect a return to normal reporting in the next report

Appendix A – Performance Dashboard

December 2023

Area	Activity	Target	Herts & West Essex ICB (Commissioner) 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	Provider ENHT	Trend *1	WHTHT	Trend *1	PAH	Trend *1
111	Calls answered < 60 seconds	95%	32.7%	December 23	-57.26%		F	59.46% (Worse)	46.40% (Worse)	4th lowest	32.7%	-128.77%						
	Calls abandoned after 30 seconds	5%	22.4%	December 23	45.96%		?	9.14% (Worse)	14.88% (Worse)	4th lowest	22.41%	79.47%						
A&E	% Seen within 4 hours	76%	67.8%	January 24	7.629%		F	70.28% (Worse)	68.49% (Worse)	13th lowest	67.77%	7.63%	70.23%	8.02%	69.52%	3.47%	61.76%	14.67%
	12 Hour Breaches	0	348	January 24	44.83%		?	54,308 (0.64%)	4,149 (8.39%)	5th highest	348	44.83%	73	-13.70%	63	77.78%	212	55.19%
Cancer	31 days	96%	93.1%	December 23	0.18%		?	91.13% (Better)	89.83% (Better)	20th highest	96.40%	1.66%	96.70%	0.83%	97.73%	3.40%	91.84%	3.31%
	62 days	85%	68.3%	December 23	2.37%		F	65.90% (Better)	62.97% (Better)	17th highest	72.06%	2.03%	82.22%	-4.96%	70.86%	-6.55%	55.75%	26.63%
	28 days Faster Diagnosis	75%	76.6%	December 23	3.70%	L	?	74.16% (Better)	70.39% (Better)	13th highest	77.24%	3.42%	80.50%	2.85%	74.61%	7.93%	77.00%	-1.17%
RTT	Incomplete Pathways <18 weeks	92%	53.3%	December 23	-3.00%	L	F	56.58% (Worse)	52.64% (Better)	9th lowest	49.52%	-3.61%	50.33%	-3.62%	48.38%	-3.14%	50.19%	-4.71%
	52+ weeks	0	11,797	December 23	-4.26%	H	F	337,450 (3.50%)	55,408 (21.29%)	5th lowest	9,777	-3.68%	5,612	-1.28%	2,246	-10.77%	1,919	-2.40%
	65+ weeks	0	4,136	December 23	3.36%	H	F	98,374 (4.20%)	18,359 (22.53%)	5th lowest	3,596	2.25%	2,332	1.67%	434	-7.37%	830	8.92%
	78+ weeks	0	1,387	December 23	13.99%	H	F	13,164 (10.54%)	3,317 (41.81%)	1st lowest	1,334	12.37%	1,190	11.09%	8	12.50%	136	23.53%
Diagnostics	6 week wait	5%	31.3%	December 23	18.90%		F	26.82% (Worse)	33.19% (Better)	14th lowest	36.13%	19.04%	46.70%	19.68%	35.12%	23.46%	15.95%	-4.57%

Area	Metric	Target	Herts & West Essex ICB (Commissioner) 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	Sub-ICB East & North Herts	Trend *1	South & West Herts	Trend *1	West Essex	Trend *1
111	Calls answered < 60 seconds	95%	32.7%	December 23	-57.26%		F	59.46% (Worse)	46.40% (Worse)	4th lowest	N/A		32.86%	-57.73%			31.85%	-55.60%
	Calls abandoned after 30 seconds	5%	22.4%	December 23	45.96%		?	9.14% (Worse)	14.88% (Worse)	4th lowest			22.48%	46.09%			22.10%	45.43%
Mental Health	Dementia Diagnosis rate	66.6%	64.8%	January 24	0.00%	H	F	64.60% (Better)	62.90% (Better)	20th highest			63.70%	-0.16%	62.30%	0.32%	71.50%	0.00%
	OOA placements	0	106	December 23	-59.43%	L	F	n/a	n/a	n/a			11	-127.27%			95	-51.58%
CHC	% of eligibility decisions made within 28 days	80%	67.9%	December 23	11.05%		?	76.45% (Worse) *2	79.06% (Worse) *2	10th lowest *2			80.00%	3.63%	47.50%	3.58%	92.90%	23.79%
	% of assessments carried out in acute	15%	0.0%	December 23	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:**	**22/03/2024**			
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]**	< Please identify from the five ICB Strategic Objectives and list below > ▪ *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:								
Executive Summary:	**ICS Year to Date Position (YTD) – Month 11** In month 11, the HWE System reported a YTD position of £7.6m deficit, ahead of plan by £11.7m. The ICB has distributed funding made available by NHSE to support the system and for industrial action, as well as from the financial recovery plan. The favourable variance represents distribution of funding and delivery of financial recovery plans one month early. **ICS Forecast Outturn Position (FOT)** The full outturn position forecasts the system will break-even, in line with plan. The position for each organisation has moved, reflecting the distribution of funding by the ICB. **Planning 2024-25** The System submitted its first formal high-level plan on 29th February, which showed a £97m deficit across the system, efficiency programme of							

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

	£130.4m (4%) and an underlying exit rate from 2023-24 of £146.1m deficit. **Capital** Capital reporting for month 11 is not available at the time this report was written. In month 10 the HWE system reported YTD capital spend of £38.7m against a YTD plan of £54.0m, with the full allocation of £79.2m forecast to be spent by the end of the year. NHSE provided additional information, stating it would provide capital cover to meet all IFRS16 obligations as reported in month 10. They will look to true up this position in month 11 if sufficient capital cover is available and required.
Recommendations:	The Board is requested to: ▪ Note the financial position and development of a financial recovery plan, outlined in the report. ▪ Note the capital position for the ICS and the recommendation that capital spending is not cut.

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

22nd March 2024

Working together
for a healthier future

HWE ICS – Financial Report for Month 11 2023/24

Executive Summary

ICS Year to Date Position (YTD) – Month 11

In month 11, the HWE System reported a YTD position of £7.6m deficit, ahead of plan by £11.7m. The ICB has distributed funding made available by NHSE to support the system and for industrial action, as well as from the financial recovery plan. The favourable variance represents distribution of funding and delivery of financial recovery plans one month early.

ICS Forecast Outturn Position (FOT)

The full outturn position forecasts the system will break-even, in line with plan. The position for each organisation has moved, reflecting the distribution of funding by the ICB.

Planning 2024-25

The System submitted its first formal high-level plan on 29th February, which showed a £97m deficit across the system, efficiency programme of £130.4m (4%) and an underlying exit rate from 2023-24 of £146.1m deficit.

Capital

Capital reporting for month 11 is not available at the time this report was written. In month 10 the HWE system reported YTD capital spend of £38.7m against a YTD plan of £54.0m, with the full allocation of £79.2m forecast to be spent by the end of the year.

NHSE provided additional information, stating it would provide capital cover to meet all IFRS16 obligations as reported in month 10. They will look to true up this position in month 11 if sufficient capital cover is available and required.

System Position Month 11

HWE ICS – Financial Report for Month 11 2023/24

Orgn '£m	Revised H2 Plan YTD	YTD Actual Mth 11	Variance to Plan
ENHT	2.0	2.6	0.6
HCT	0.7	0.7	(0.1)
HPFT	0.4	0.9	0.5
PAH	(5.6)	(5.8)	(0.2)
WHHT	(12.3)	(14.0)	(1.7)
ICB	(4.6)	8.0	12.6
ICS	**(19.3)**	**(7.6)**	**11.7**

Orgn '£m	Annual Plan Reported	Revised H2 Plan	Forecast Outturn Reported
ENHT	(2.5)	3.2	3.2
HCT	0.0	0.7	0.7
HPFT	(1.8)	2.0	2.0
PAH	(5.1)	(6.1)	(6.1)
WHHT	0.0	(9.3)	(9.3)
ICB	9.4	9.4	9.4
ICS	**0**	**0.0**	**0.0**

In month 11, the HWE System reported a YTD position of £7.6m deficit. This takes account of system support funding received from NHSE (£9.5m), together with additional industrial action funding (£6.8m). This, together with funds delivered to the ICB through the financial recovery programme has been distributed to Trusts and the positions above reflect this distribution.
The position is ahead of plan due to the delivery of some financial recovery plans one month early, for example the unmitigated scheme of £7.6m and some additional SDF.

The full outturn position forecasts the system will break-even and represents the revised plan for delivery, following redistribution of the surplus previously held in the ICB.

Additional funding for Industrial Action and HWE System Support – Month 11 2023/24

The total value of the cost of Industrial Action (IA) undertaken during November, December and February are shown in the table to the right. For HWE ICS, the total cost was £14.1m.

Using the national formula to calculate the reimbursable costs of IA, the ICS required £11.6m to be funded, however the national funding received by HWE ICS was £6.8m. The regional team recognised this contribution was insufficient and further £4.8m of support was provided.

HWE ICS Industrial Action Costs	ENHT £'000	HCT £'000	HPFT £'000	PAH £'000	WHTH £'000	ICB £'000	TOTAL £'000
Cost of cover	1,404	28	956	1,220	1,666	417	**5,691**
On the day costs avoided	(477)	0	0	(221)	(288)	0	**(986)**
Lost Efficiency	196	0	0	0	2,960	0	**3,156**
Mitgating actions	(203)	0	0	0	0	0	**(203)**
Loss of Elective Recovery (ERF) income	2,859	0	0	1,055	2,528	0	**6,442**
Total Industrial Action Costs	**3,779**	**28**	**956**	**2,054**	**6,866**	**417**	**14,100**
NHS England - Funding provided for Industrial Action	(4,422)	(28)	(431)	(2,504)	(3,803)	(363)	**(11,551)**
Balance of Industrial Action Costs	**(643)**	**0**	**525**	**(450)**	**3,063**	**54**	**2,549**

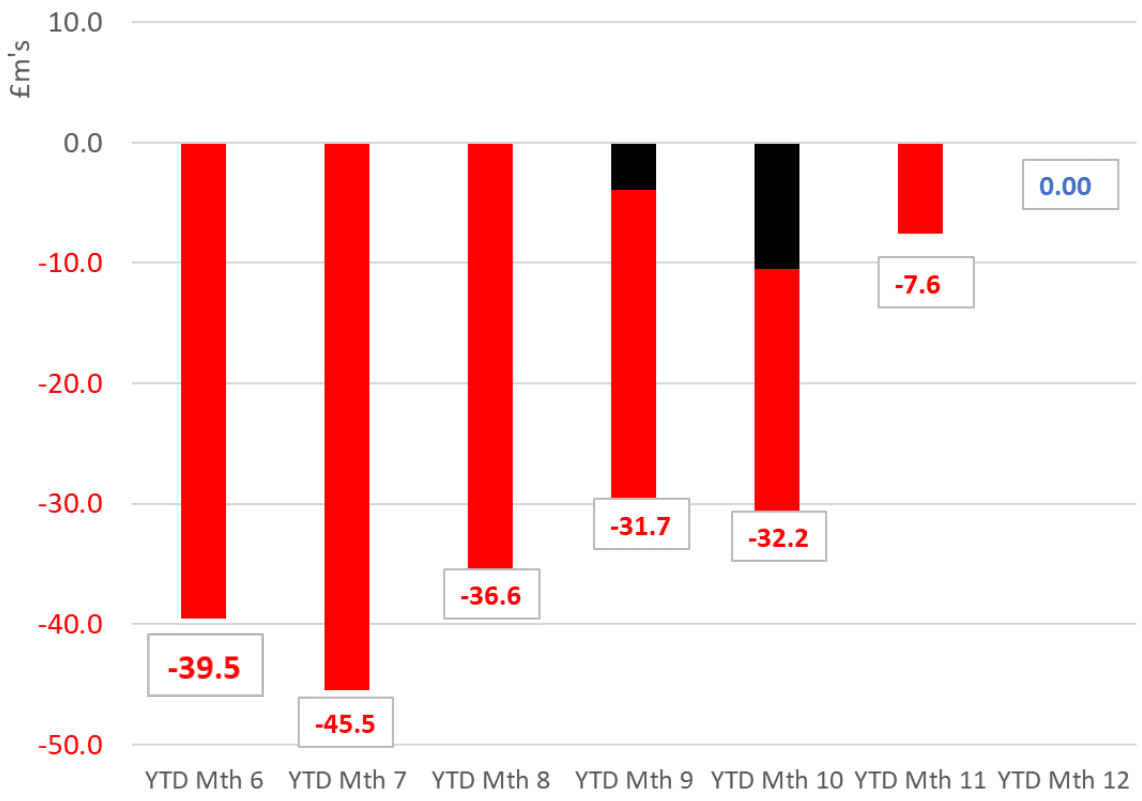
HWE ICS System Support		£'000
H2 Financial Plan - planned distribution		27,900
Less:	SRS income directly received by HPFT	(1,100)
Plus:	Additional support from the regional NHSE	2,047
Total value of HWE ICS System Support		**28,847**

The final value of the HWE ICS System Support is £28.8m, which has increased by £2m from additional support from the regional NHSE and reflects the fact that SRS income of £1.1m was directly received by HPFT and therefore was not available to the ICB to distribute.

The ICB Board has agreed that the ICS System Support will be distributed on a fair shares basis, with a cap in place to ensure that no Trust moves into a surplus position higher than 5% of their total expenditure. The full value of the System Support has been reported in the ICS' Month 11 position.

HWE ICS System Support	ENHT £'000	HCT £'000	HPFT £'000	PAH £'000	WHTH £'000	ICB £'000
Distribution of ICS System Support	8,684	2,054	5,610	5,116	7,383	(28,847)
Implementation of 5% cap (Option 2B)	(5,460)	(1,305)	0	2,769	3,996	0
Total System Support Funding	**3,224**	**749**	**5,610**	**7,885**	**11,379**	**(28,847)**

HWE System Profile 2023/24



The profile of the system position is shown above, worsening through the early part of the year and then improving in month 8, reflecting the first funding for industrial action being received. Further system support was received from NHSE in month 11, together with industrial action income. This was distributed to Trusts, alongside funds from the financial recovery programme.

Elective Recovery Performance – as at Month 8

NHS England has published the Elective Services Recovery (ERF) performance as at Month 8 2023/24. This position reflects the reduction of the ERF target by 4% and includes the impact of Industrial Action to the end of November 2024.

There has since been further Industrial Action from December 2023, each month to February 2024.
This will have affected ERF performance over the period. We expect to receive month 9 ERF figures before the end of the financial year and organisations will need to include a proxy for the last quarter of the year.
NHSE have suggested four options for calculating ERF in the final quarter, all of which are based on past performance The performance in HWE has improved as the year has gone on and the System has responded to NHSE, requesting that a higher performance figure is included for quarter 4, based on the upward trend to date and the strong performance of the Value Weighted Activity (VWA) reporting – (although this did drop back slightly towards the end of January – see next slide.)

HERTS & WEST ESSEX ICB COMMISSIONED ERF ACTIVITY

	Baseline	Target %	Target	Actual	Financial Adj	Actual %	Apportion A&G	Provider
Month 08 Year to Date								
The Princess Alexandra Hospital NHS Trust	£37,283,330	99.0%	£36,910,496	£35,854,188	-£1,056,308	96.2%	£348,222	-£708,086
West Hertfordshire Hospitals NHS Trust	£59,650,619	99.0%	£59,054,113	£61,247,423	£2,193,310	102.7%	£1,934,453	£4,127,763
East And North Hertfordshire NHS Trust	£57,485,712	110.0%	£63,234,284	£70,988,921	£7,754,638	123.5%	£1,498,900	£9,253,537
Independent Provider	£30,560,204	100.0%	£30,560,204	£34,385,855	£3,825,651	112.5%		£3,825,651
Non HWE Provider (API)	£80,683,721	103.6%	£83,558,240	£80,090,158	-£3,468,082	99.3%		-£3,468,082
Non HWE Provider (LVA)	£1,185,808	127.4%	£1,510,430	£1,241,894		104.7%		£0
Advice & Guidance				£3,781,575	£3,781,575		-£3,781,575	£0
TOTAL	**£266,849,394**	**103.0%**	**£274,827,767**	**£287,590,013**	**£13,030,782**	**107.8%**	**£0**	**£13,030,782**
Unallocated								£3,437,859
OVERALL ICB TOTAL	**£266,849,394**	**101.6%**	**£271,121,372**	**£287,590,013**	**£16,468,642**	**107.8%**		**£16,468,642**
Non HWE ICB Commissioned Activity								
The Princess Alexandra Hospital NHS Trust	£2,037,211	98.1%	£1,999,456	£2,235,526	£236,069	109.7%		
West Hertfordshire Hospitals NHS Trust	£6,982,920	98.2%	£6,854,610	£3,925,212	-£2,929,398	56.2%		
East And North Hertfordshire NHS Trust	£16,510,459	101.5%	£16,749,918	£17,561,229	£811,311	106.4%		
Total Non HWE ICB	**£25,530,589**	**100.3%**	**£25,603,984**	**£23,721,966**	**-£1,882,018**	**92.9%**		

Elective | System and Provider VWA Trend

NHS England

SUS (est)	10-Dec-23	17-Dec-23	24-Dec-23	31-Dec-23	07-Jan-24	14-Jan-24	21-Jan-24
EAST OF ENGLAND	**110.1%**	**112.4%**	**115.0%**	**115.3%**	**110.9%**	**107.6%**	**104.8%**
MID AND SOUTH ESSEX ICB	***109.0%***	***109.3%***	***113.2%***	***113.8%***	***106.9%***	***105.3%***	***100.1%***
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	109.7%	109.9%	113.7%	114.1%	107.3%	105.6%	100.6%
BEDFORDSHIRE, LUTON AND MILTON KEYNES ICB	***117.2%***	***118.2%***	***119.4%***	***117.9%***	***114.8%***	***112.5%***	***113.5%***
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	106.7%	108.7%	108.4%	109.2%	108.7%	105.4%	108.5%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	145.9%	147.0%	151.7%	143.8%	135.9%	134.5%	132.7%
SUFFOLK AND NORTH EAST ESSEX ICB	***106.3%***	***106.7%***	***112.3%***	***113.1%***	***110.3%***	***111.5%***	***106.5%***
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	106.5%	106.5%	112.6%	113.5%	112.5%	114.3%	108.0%
WEST SUFFOLK NHS FOUNDATION TRUST	116.9%	116.4%	119.8%	119.5%	109.1%	107.2%	106.2%
HERTFORDSHIRE AND WEST ESSEX ICB	***111.2%***	***118.2%***	***118.5%***	***117.1%***	***112.3%***	***105.0%***	***103.4%***
EAST AND NORTH HERTFORDSHIRE NHS TRUST	123.7%	120.4%	119.4%	117.2%	112.7%	113.2%	113.6%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	107.4%	110.3%	112.7%	111.5%	106.9%	101.5%	97.9%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	106.6%	155.4%	157.0%	157.0%	154.7%	104.5%	101.3%
NORFOLK AND WAVENEY ICB	***107.0%***	***107.7%***	***110.3%***	***110.9%***	***108.4%***	***105.4%***	***102.1%***
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	121.4%	115.6%	117.4%	115.2%	110.6%	112.3%	113.4%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	104.9%	106.6%	106.7%	108.5%	104.2%	102.5%	101.2%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	97.2%	99.8%	108.3%	106.5%	102.4%	98.2%	87.5%
CAMBRIDGESHIRE AND PETERBOROUGH ICB	***122.8%***	***126.3%***	***127.6%***	***128.5%***	***123.6%***	***113.8%***	***112.1%***
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	117.4%	122.9%	123.2%	123.8%	117.9%	110.4%	109.5%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	117.2%	119.6%	120.2%	121.9%	118.5%	110.6%	109.7%
ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	94.7%	95.0%	100.9%	99.5%	97.5%	95.8%	91.6%

NOTE: Please note fluctuations may be due to changes in either the current activity or the baseline position and both should be investigated to understand any unexpected change in VWA %

Source: SUS / Faster SUS

ERF Forecast Based on Month 8

Using Mth 8 Performance for M9-12							A&G	
The Princess Alexandra Hospital NHS Trust	£55,060,685	99.0%	£54,510,078	£55,469,594	£959,516	100.7%	£453,345	£1,412,861
West Hertfordshire Hospitals NHS Trust	£88,376,927	99.0%	£87,493,158	£91,086,540	£3,593,382	103.1%	£2,521,945	£6,115,326
East And North Hertfordshire NHS Trust	£85,824,697	110.0%	£94,407,166	£107,259,533	£12,852,367	125.0%	£1,957,162	£14,809,529
Independent Provider	£44,980,287	100.0%	£44,980,287	£51,052,990	£6,072,702	113.5%		£6,072,702
Non HWE Provider (API)	£119,671,304	103.6%	£124,038,788	£119,178,174	-£4,860,613	99.6%		-£4,860,613
Non HWE Provider (LVA)	£1,751,022	137.9%	£2,414,997	£2,002,304		114.4%		£0
Advice & Guidance				£4,932,452	£4,932,452		-£4,932,452	£0
TOTAL	£395,664,922	103.1%	£407,844,475	£430,981,587	£23,549,806	108.9%	£0	£23,549,806
Unallocated								£5,432,681
OVERALL ICB TOTAL	£395,664,922	101.6%	£401,999,101	£430,981,587	£28,982,487	108.9%		£28,982,487

Non HWE ICB Commissioned Activity						
The Princess Alexandra Hospital NHS Trust	£3,001,975	98.1%	£2,946,146	£3,261,675	£315,530	108.7%
West Hertfordshire Hospitals NHS Trust	£10,546,722	98.2%	£10,354,798	£6,151,903	-£4,202,895	58.3%
East And North Hertfordshire NHS Trust	£24,396,663	101.5%	£24,770,458	£27,051,960	£2,281,501	110.9%
Total Non HWE ICB	£37,945,359	100.3%	£38,071,402	£36,465,538	-£1,605,864	96.1%

The System would record ERF delivery of £29m, using month 8 performance for the final quarter. If the upward trend continues into month 9, it is expected this could increase further.
Once the ERF month 9 position is known, the System will request consideration of the most optimal performance.

The ICB Position – Month 11

HWE ICB Year to Date Position

- The ICB's year to date position is showing an underspend of £8.022m, which is £7.109m ahead of 2023/24 financial plan as at Month 11.
- Due to the deployment of the Industrial Action Funding (£11.6m) and the HWE System Support (£28.8m) to the ICS Providers in Month 11, the ICB has reverted back to the original 2023/24 financial target of £9.4m underspend, with the ICS Providers' improving their financial positions and the HWE System remaining in financial balance. The annual budgets reflect the adjusted values established in the Half Two (H2) financial plan.
- The phasing of the £9.4m planned underspend was established at the beginning of the financial year and is set to deliver £1m of underspend over Months 1 to 11, with the balance of £8.4m to be delivered in Month 12. The ICB is reporting that it is ahead of this plan and is therefore only required to deliver £1.4m of underspend next month.
- The £6.9m underspend in Other Commissioned and Programme Services relates to the Service Development Funding (SDF) slippage identified as part of the H2 efficiencies. The Delegated Primary Medical Services (GPs) is shown as overspending year to date, as the underspend on ICB Primary Care Services, which usually offsets the cost pressure, has been utilised to support the HWE System financial balance.

Summary ICB Expenditure Position as at Month 11 (February) 2023/24

		Year to Date		
Annual Budget £'000	**Expenditure Category**	**Budget £'000**	**Actual £'000**	**Variance £'000**
1,656,583	Acute Services	1,521,074	1,519,814	1,261
171,138	Continuing Healthcare Services	158,715	158,799	(84)
299,591	Community Services	275,325	275,351	(26)
323,744	Mental Health Services	298,852	298,675	177
264,000	Delegated Primary Medical Services (GPs)	243,891	247,563	(3,672)
133,583	Delegated Pharmacy, Ophthalmology & Dental (POD)	121,739	121,153	586
49,609	ICB Primary Care Services	44,427	43,655	772
242,837	Prescribing	226,237	225,760	478
30,875	Corporate Services (Running Costs)	28,474	28,793	(319)
24,729	Other Commissioned and Programme Services	9,348	2,467	6,881
11,551	Industrial Action Funding	11,551	11,551	0
28,847	System Support	28,847	28,847	0
10,578	Reserves	1,109	53	1,056
3,247,666	**Total Expenditure**	**2,969,589**	**2,962,480**	**7,109**
9,400	Planned Underspend	913	0	913
3,257,066	**Total Expenditure**	**2,970,502**	**2,962,480**	**8,022**

HWE ICB Forecast Outturn Position

- The estimated position for HWE ICB at the end of the year is £9.4m underspent, which is in line with the original 2023/24 financial plan.
- There are several areas of note within this position:
- Continuing Healthcare Services continues to experience increasing costs of packages of care, and also the start of two expensive placements. 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.
- Reserves hold allocations which were received in Month 11. These allocations are fully committed and will be moved into the relevant expenditure category for Month 12.

Expenditure Category	Annual Budget £'000	Expected Outturn £'000	Variance £'000
Acute Services	1,656,583	1,655,100	1,483
Continuing Healthcare Services	171,138	173,699	(2,561)
Community Services	299,591	300,248	(657)
Mental Health Services	323,744	324,587	(843)
Delegated Primary Medical Services (GPs)	264,000	266,561	(2,561)
Delegated Pharmacy, Ophthalmology & Dental (POD)	133,583	131,856	1,727
ICB Primary Care Services	49,609	49,143	467
Prescribing	242,837	245,363	(2,526)
Corporate Services (Running Costs)	30,875	31,286	(411)
Other Commissioned and Programme Services	24,729	19,903	4,826
Industrial Action Funding	11,551	11,551	0
System Support	28,847	28,847	0
Reserves	10,578	9,522	1,056
Current Forecast Outturn	**3,247,666**	**3,247,666**	**0**
Planned Underspend	9,400	0	9,400
Expected Position at Year End	**3,257,066**	**3,247,666**	**9,400**

Capital at Month 10 2023-24

System Capital Positions Month 10 – System and GPIT Capital

Capital reporting is unavailable for month 11 at the time of writing this report and an update is provided relating to month 10. Month 11 will be available 15th March, in line with the usual reporting time-table.
The ICB has a capital allocation available in 2023/24 of £2.5m, which will be used to support GPIT as part of a continuing rolling programme over time. The capital assets are recorded in NHSE accounts and not in the ICB's and as such are held entirely separately from system capital which is described below.

The net system allocation for provider capital in 2023-24 is £61.9m, with a bonus of £7.3m for breaking even in 2022-23. A further allocation of £10m has been provided for ENHT to replace Linear Accelerator (LINAC) machines in Mount Vernon. System total available capital is therefore £79.2m.

The £7.3m bonus capital cover has been deployed as follows:

- £3.1m will support the vascular surgery network in ENHT
- £2.9m will be spent by WHHT on the elective care hub
- £1.3m will be invested in the Mental Health Crisis Assessment Centre that was approved by the Board in September 2023.

System capital of £61.9m will be invested by Trusts on replacement cycle, back-log maintenance and smaller capital projects.

YTD spend against the planned capital allocation is £38.7m, which is behind plan by £15.4m (28%).

The full year forecast is over plan by £428k in PAH, with a small underspend in WHHT. System CFOs will seek to balance this position, to meet plan by the end of the year.

Orgn	YTD				FOT		
	Plan	Actual	Variance	Variance as % of Plan	Plan	Forecast	Variance
	£'000	£'000	£'000		£'000	£'000	£'000
ENHT	15,002	6,913	(8,089)	-54%	28,389	28,389	(0)
HCT	3,848	3,775	(73)	-2%	4,556	4,556	0
HPFT	8,033	8,083	50	1%	10,299	10,299	0
PAH	11,731	5,205	(6,526)	-56%	14,297	14,725	428
WHHT	15,402	14,685	(717)	-5%	21,653	21,646	(7)
Total	**54,016**	**38,661**	**(15,355)**	**-28%**	**79,194**	**79,615**	**421**

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

System Capital Positions Month 10 – National Capital

National Schemes	FOT					
	ENHT	HCT	HPFT	PAH	WHHT	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Screening - Diagnostics Programme	0	0	0	0	182	182
Community Diagnostic Centres	0	0	0	5,225	5,016	10,241
Elective Recovery/Targeted Investment Fund	0	0	0	0	3,600	3,600
Endoscopy - Increasing Capacity	0	0	0	0	900	900
Mental Health	0	0	0	0	92	92
Front Line Digitisation	771	0	1,942	8,136	0	10,849
NHP	0	0	0	2,760	24,596	27,356
LED Lighting	1,141			390		1,531
STP Wave 4	5,996	0	0	0	4,150	10,146
Total	**7,908**	**0**	**1,942**	**16,511**	**38,536**	**64,897**

Additional national capital is made available by NHSE for specific initiatives, often awarded after Trusts bid for funds. The table above shows the value of national capital projects receiving capital cover across the system.

Within PAH and WHHT, capital cover has been made available for community diagnostic centre, elective recovery and endoscopy investments. Both Trusts report they will be unable to utilise all the capital in the current year. Historically, the national team have been unable to show flexibility in moving capital between years.
We have been asked by NHSE, to carry forward capital by brokering with local system capital between 23-24 and 24-25. Both WHHT and PAH have confirmed they have been able to do so, by bringing forward system capital spend from 24-25. This will create headroom in 24-25, to cover the national capital not spent in 23-24.

System Capital Positions – IFRS 16

New accounting regulations relating to the International Financial Reporting Standard (IFRS) – IFRS16, were implemented in 2022-23. This means that leased assets have to be capitalised when acquired and when leases are remeasured and both score against capital budgets. During the first year this impact on capital budgets was managed at a national level.

In 2023/24 however, it was confirmed that the capital budgeting aspect would be devolved to Systems with each receiving a capital allocation. The capital allocations for Systems were only announced on 29 November 2023. The allocation for HWE is £11.9m.

The most up to date assessment of the HWE capital impact is £34.2m, almost entirely made up of remeasurement of existing leases. This impact is high because inflation has been high. This includes the impact from many leases where the lessor is another body within the Department of Health and Social Care (DHSC) group. It is therefore likely that in at least some of these cases the impact on capital nationally would be cost neutral.

NHSE have recently confirmed it will make capital cover available, based on month 10 reporting, even if this is above the capital allocation made available (£11.9m). It has removed the requirement for systems to contact Lessors who are within the DHSC group, to assess whether they agree that capital can be netted off between themselves as the Lessor and the HWE system as the Lessee, neutralising the capital cover requirement at a national level.

Any additional IFRS16 requirements received in month 11, will be considered, but additional capital cover may not be available for this.

This has substantially reduced the risk of overspending our IFRS16 capital allocation.

The capital cover will be made available at the end of month 12.

Guidance for 24-25 planning for IFRS16 has not yet been published.

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 next slides shows the expected distribution of the Core and SDF Allocations across Trusts within the HWE System and also shows values for System Partners.

Depreciation funding is capped at £6.7m, which is dependent on the values of depreciation charges that the ICS Trusts are planning for.

HWE ICS Allocations	**£'000**
Core Allocation	2,680,262
Additional Discharge Funding	12,179
Additional Physical and Virtual Ward Capacity Funding	22,542
Elective Recovery Funding (ERF)	63,417
COVID Testing Funding	2,056
Service Development Funding (SDF)	45,651
Adult Long COVID Funding	2,234
Ambulance Capacity Funding	6,930
Allocation baseline reset (limited Public Health exercise)	2,496
Charge Exempt Overseas Visitor (CEOV) and UK cross border adjustment	(1,392)
Microsoft License Funding Transfer	(498)
Learning disability and autism FTA	(153)
Total Core Allocation	**2,835,724**
Delegated Primary Medical Care	272,628
Delegated Pharmacy, Ophthamology and Dental (POD)	142,404
Delegated POD Elective Recovery Funding (ERF)	2,524
Delegated Specialist Commissioning	tbc
ICB Running Costs	25,265
TOTAL OF HWE ICS ALLOCATIONS	**3,278,545**

2024/25 Baseline for HWE ICS Core Allocation

Using the uplifts indicated in last year's guidance, this table shows how the estimated ICS Core Allocation value is likely to be distributed, including Service Development Funding (SDF). Please note: this table shows allocation and not spend and does not reflect the significant financial planning gap for the ICB and Trusts.

Funding Source	%	ENHT	HCT	HPFT	PAH	WHHT	CLCH	EPUT - Comm	EPUT - MH	EEAST	Other NHS Trusts	ISP	ICB CHC	ICB Presc	ICB	Not Yet Deployed	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	298,669	0	2,759,557
Less: ERF - Core		13,788	0	0	8,505	13,712	0	0	0	0	17,944	6,129	0	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	0	14,021
Less: UEC Capacity		782	0	0	1,000	4,759	0	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	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	0	8,100
Less: SDF		0	1,351	10,900	0	0	1,780	670	0	0	0		0	0	33,684	0	48,385
Less: Other adjustments		0	1,232	11,676	0	0	0	0	0	0	0	0	0	0	1,227	0	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**	**262,758**	**0**	**2,604,552**
Inflation (net of efficiency)	0.80%	2,702	670	1,688	2,202	3,085	471	302	244	693	3,195	361	1,274	1,850	2,032	0	20,766
ERF - Core		13,898	0	0	8,573	13,822	0	0	0	0	18,088	6,178	0	0	0	2,858	63,417
Other Growth - Capacity	0.60%	2,027	0	0	1,651	2,313	0	0	0	520	2,396	270	0	0	0	0	9,177
Other Growth - Acute	1.70%	5,742	0	0	4,679	6,555	0	0	0	0	6,789	766	0	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	0	4,758
Other Growth - Mental Health	3.24%	0	0	6,835	0	0	0	0	989	0	0	0	0	0	0	0	7,824
Other Growth - Ambulance	2.17%	0	0	0	0	0	0	0	0	1,879	0	0	0	0	0	0	1,879
Other Growth - CHC		0	0	0	0	0	0	0	0	0	0	0	9,397	0	0	0	9,397
Other Growth - Prescribing		0	0	0	0	0	0	0	0	0	0	0	0	5,157	0	0	5,157
Other Growth - Other	1.70%	0	0	0	0	0	0	0	0	0	0	0	0	0	2,808	0	2,808
Convergence	-1.09%	(3,767)	(942)	(2,388)	(3,069)	(4,300)	(662)	(424)	(345)	(970)	(4,453)	(503)	(1,849)	(2,592)	(3,120)	0	(29,385)
Physical & Virtual Ward Capacity		2,050	4,414	0	0	2,466	0	4,091	0	0	0	0	0	0	1,000	0	14,021
UEC Capacity		782	0	0	1,000	4,759	0	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	0	2,056
Additional Inflationary Uplift		0	0	0	0	0	0	0	0	0	0	0	5,522	6,937	0	0	12,459
Additional Discharge		0	0	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	0	6,930	0	0	0	0	0	0	6,930
Public Health reset exercise		1,326	0	0	0	1,171	0	0	0	0	0	0	0	0	0	0	2,497
SDF		0	1,351	10,900	0	0	1,780	670	0	0	0	0	0	0	30,951	0	45,651
DWP Employment Advisors		0	0	863	0	0	0	0	0	0	0	0	0	0	0	0	863
Health Inequalities		0	0	3,426	0	0	0	0	0	0	0	0	0	0	857	0	4,283
TOTAL DEPLOYMENT OF ALLOCATIONS		**363,033**	**91,414**	**232,275**	**290,677**	**416,014**	**61,957**	**43,342**	**31,404**	**95,664**	**425,909**	**52,136**	**173,622**	**242,595**	**297,285**	**17,016**	**2,834,342**

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.

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:**	**22/03/2024**		
Report Title:	**ICB Committee Summary Reports**				**Agenda Item:**	**12**		
Report Author(s):	Governance Leads, HWE ICB							
Report Presented by:	Committee Chairs / Executive Leads							
Report Signed off by:	Michael Watson, Chief of Staff							
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:	N/A							
Report History:	N/A							
Executive Summary:	Each ICB Sub-Committee has produced a summary document providing an update from the last meeting.							

Committee	Date of meeting	Chair
Audit and Risk Committee	15 January	Catherine Dugmore
Performance Committee	17 January	Thelma Stober
People Board	18 January	Ruth Bailey
Primary Care Board	25 January	Nicolas Small
Finance and Investment Committee	22 February	Nick Moberly
Population Outcome and Improvement Committee	06 March	Gurch Randhawa
Quality Committee	07 March	Thelma Stober

Commissioning Committee	14 March	Gurch Randhawa
Patient Engagement Forum	12 March	Alan Bellinger

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

ICB Committee Summary Document

NHS Hertfordshire and West Essex Integrated Care Board

Audit and Risk Committee, 16th January 2024	
Signed off by Chair and Executive Lead:	**CD, MW**
Key items discussed: ***(From agenda)***	• Governance Update • Risk and Board Assurance Report • Information Governance/SIRO report • Overview of Phishing Exercise • Year End Timetable and Progress • Review of tender waivers, procurement register. Losses & special payments • Internal Audit 23/24 Plan • Local Counter Fraud Report • External Audit Update
Key points made / Decisions taken:	• The committee noted the good progress on Risk Management and looks forward to reviewing Corporate Risks by Directorate on a rotational basis. It was acknowledged that our ambition should be to continue to develop our approach to system wide risks. • The committee noted the report on the 22/23 Phishing Exercise with recommendations, committee would support the adoption of cyber security mandatory training for the ICB. • Year End Timetable and planning guidance still awaited from NHSE • WECCG audit finalisation awaited. • ICB audit opening balance for ICB and further sampling on accruals needed in order to complete ICB 22/23 accounts audit
Forward plan issues:	• To add mandatory training compliance report (+FTSU modules) on a quarterly basis • To add a review of the ICB policy register on a 6 monthly basis • Indicative external audit plan to March committee • ICB Phishing Exercise report for 2023 to come to committee once concluded
Date of next meeting	Tuesday 19th March 2024

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

ICB Committee Summary Document

Performance Committee – 17 January 2024	
Signed off by Chair and Executive Lead:	**Thelma Stober and Frances Shattock**
Key items discussed:	• The Committee was quorate and meeting held virtually. • Declarations of Interest – members and regular attendees reminded to ensure that submitted declarations are up to date. No additional declarations raised for specific agenda items. • Minutes from 08 November 2023 – noted and approved by the Committee as a true reflection of the meeting. • Deep Dive: Planned Care, including Outpatients – the Committee noted work which is being carried out through the ICS Outpatient Transformation Group and future actions for Outpatients; including the 2023/24 ICS High Level Plans for Referral Optimisation, Digital/Remote Consultations/Portals, and Patient Initiated Follow-up. • UEC Performance Update – the Committee was assured of the progress on the programmes of work: - Falls Programme – Long Lie Pathway implemented with no issues reported, Implementation of a patient who falls when on anticoagulant pathway has been approved, - HWE Unscheduled Care Hub – Access to the Stack community referrals are high, reliability of Call Before Convey data is under review, - C2 Validation (C2 Segmentation) - Learning from/impact of PAH IUATC model, a new system is being purchased which will allow full data reporting against UTC requirements, outcomes, etc. • Performance Overview – noted areas that have shown improvement and supports the areas identified as high risk where performance is currently challenged; Improvement: - Mental Health – Adult Crisis 4-hour wait has continued to improve and moved down the low risk category, new KPI's added for CYP Eating Disorders (low risk category), Community MH CYP Waits for 1st Appointment (variable risk category), CAMHS 28 Day Standard and Community MH Adult Waits for 2nd Appointment (high risk category),

	- Primary Care – new KPI's added for % of on the day GP Appointments and % of <14 day GP Appointments (high risk category), currently in line with national average, - Cancer – 28 Day Faster Diagnosis has been escalated to the high risk category, new KPI added for 31 Day Standard (variable risk category), impact of industrial action remains on elective waits and cancer backlogs. despite this performance against the 62-day cancer standard continues to be ahead of regional and national average. Challenge: - Urgent and Emergency Care (UEC) – 4-hour standard and elective recovery of 78, 65 & 52 week waits remain as areas of highest risk, ambulance handover performance continues to not meet targets, 2 Hour Urgent Community Response (UCR) has been escalated up to the variable risk category. - Community – Children's community services remain as an area of highest risk, CHC Assessments <28 Days has been escalated to the high risk category, new KPI added for Autism Spectrum Disorder (high risk category). • Performance Risk Register – It was agreed that the current performance risks [Community Waits (Children's), Cancer, Elective Recovery, UEC, Mental Health, Diagnostics] accurately reflect the current position and mitigating actions in relation to risk areas as discussed in the Performance Overview. • Committee Workplan – The following updates were agreed regarding the scheduling of deep-dives: - Remove – EPRR, Health Inequalities, Community Services, Call before convey access to the stack, - Add – Mental Health, Primary Care.
Committees to note:	• The Committee is to note the discussions and decisions above. • The Board is to note the discussions and decisions above, particularly the performance challenges. • All ICB Sub-Committees Terms of Reference and Workplans remain under review for 2024/25 – being checked for potential inclusion of items concerning newly delegated areas for the ICB and changes in Committee structure.
Forward plan issues:	• N/A
Date of next meeting	• 13 March 2024

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document

NHS Hertfordshire and West Essex Integrated Care Board

People Board: 18th January 2024	
Signed off by Chair and Executive Lead:	**Ruth Bailey / Tania Marcus**
Key items discussed: ***(From agenda)***	**Programme Report**– system is currently supporting a consistent approach of Re-banding of Band2/3 HCAs may result in significant backpay. Other systems agreed backpay to 2021. Prepared a bid for WorkWell which will support people living with long term sickness and disability into the workplace. HPFT in cohort 2 of Pathfinder programme, looking at PAH for Cohort 3 to build on the successes of WHHT in Cohort 1. System will be participating in the NHSE flexible working leadership development programme to equip leaders to champion flexible working. AHPs will pilot E-Job Planning, procurement group set up. UoH will be developing a SLT degree apprenticeship starting September 2025, diagnostic and therapeutic radiography programmes also being commissioned. System AHP Lead clinical role will bring focus to issues of quality, safety, operational delivery and workforce development. HWE integrated programme launch with UoH was successful almost 100 participants. Operational Plan submission on 21st March 2024 further submission in May tbc. focus will be on skill mix. Significant ongoing work relating to establishment control, temp staffing, recruitment of medical consultant posts and impact on future agency spend. Nursing Council being set up and keen to connect with Social Care nursing and private sector nurses supporting nursing homes. **Social Care Deep Dive**; SC provides a mix of practical and personal care support, but it also includes a focus on enabling and empowering people to developing skills and confidence to identify what's important to them and return to their quality of life, some of the more subtle aspects of social care often unseen and unrecognized. It also relates to things like GP Appointments and hospital pressures. With the Care Certificate becoming a formal qualification - there is great depth and breadth of skills within the sector. 1.6 million people employed in social care compared to 1.3 million people in the NHS. £21.2 billion goes into adult social care compared to £125.1 billion within the NHS. Estimated 20-25% home care and 36.7% of care home places are self funded. 2022/2023 vacancy rate was 9.3%, turnover was 30.3% and 63% of recruitment was from adult social care. Remote monitoring will not replace personal care. Care Ambassadors being recruited to try and drive the promotion of careers in care. System working with EPUT and PAH to create an occupational therapy rotation. Priorities are: Recruitment, Retention, Growth & Wellbeing. Robust discussions took place relating to system integration of training and development, joint recruitment campaigns, career passports and shared investment planning (pay rates). System looking at increasing SC use of health and care academy, widening participation in ADDS and ESL programmes, consideration of transfer acceptance routes to review resource burden of interviewing staff moving within the system. Need further focus on equality and inclusion, different workforce demographics including covid experience, poorer health outcomes etc. ASC Services are culturally confident. In the next iteration of the People Strategy, considerations of how SC colleagues have a voice with focus on

	one or two high impact areas. LM referred to the report: 'Why people leave social care' (30%) left their last role in ASC due to poor workplace culture or communication. (20%) mentioned burnout or stress. 16% reported low pay to be the reason for leaving. Younger workers significantly more likely to leave because of poor workplace culture/communication. The importance of relationships and a positive working culture were noted frequently in the qualitative interviews (23%) intended to leave current employment within the next 2 years, (53%) had no plans to leave. Main reason for considering leaving their current role was pay (25%). Joint working can be really effective but much more challenging re pay. **University of Hertfordshire Health and Care Enterprise Area** JB highlighted call for funding applications relating to workforce and for the Health & Care Enterprise Area. UHICS partnership programme is a multi org group looking to solve complex issues in the ICS to benefit services and staff and residents, create new impactful approaches to system challenges maximising University resources, including research, academic expertise, facilities and knowledge exchange. There are three broad strands to the programme: Workforce Development, Community and Population Engagement, Service Innovations. Programme steering group reports into the ICB Population Outcomes Improvement Committee and UoH Knowledge Exchange Advisory Board. Projects for the Programme are: Elective Care – Decision Support Tool (DST), Social Value Tool (SVT) and Artificial Intelligence and Machine Learning for Healthcare Systems and Patients Management. JB to return to People Board to update on outcomes and insights. RB highlighted that we need to determine what are our population health needs, what are our current set of skills. This is a longer-term risk and a really interesting piece of work that we just need to think through how we can do that and if we can get that the University program to potentially help with that. **Deep Dive into (Education) Talent and Leadership** A F2F workshop was held in Autumn 2023 where we fleshed out some priorities including: Improving culture and leadership, greater focus on talent with a new Talent Lead starting in April 24. Collaboration on areas providing the greatest value to our workforce and organisations, Shared leadership programmes, development opportunities, regular success sharing and utilising the health and care academy as a central point of information, ensuring that EDI is considered throughout. The system is running: ADDS, Mary Seacole from March24, Emerging system leaders, GMTS and Inclusive career development. Discussion focused on mapping to the transferrable skills throughout the ICS to ensure we're reaching and relevant for the whole workforce (i.e. Primary Care) Need to build a culture of acceptance change in the talent culture, how we build people and mechanisms that allow movement/cross shadowing opportunities and also utilise digital technology. **People Board Risk Register;** Risks discussed and reviewed, risks relating to Vacancies and recruitment, establishment growth and productivity have been updated. We need to incorporate the band 2/3 back pay risk element and give some broader consideration to governance arrangements and the elements of the financial recovery programme and how that feeds across the system. The risk relating to staff retention has been downgraded as the turnover figures continue to reduce. Meetings are to be held with Kate Chand regarding aligning the quality aspect and

	also a meeting with Joyce Sweeney and Nicolas Small re Primary care. Now more broadly aligned so collaboration on band and agency usage and recurrent funding, will review in the next risk review meeting to ensure correctly articulated. A horizon risk is incorporated into our access to workforce data planning and modelling may further consideration with additional stakeholders. To ensure BAF risks highlighted with in the pack and agreed need to have granular understanding of particularly difficult to recruit roles to understand where there are long-term risks that the system can support with.
Board to note:	Tom Hennessey invited members/Board to spend half a day in social care environment i.e. domiciliary care, social care provider visit, meals on wheels to understand the impact and value of ASC more deeply.
Forward plan issues:	• Future agenda item relating to supporting better levels of retention and career development for recognised hard to recruit areas across the system • Deep dive into health and wellbeing staff experience.
Date of next meeting	21 March 2024

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

ICB Committee Summary Document

Primary Care Board – Thursday 25 January 2024	
Signed off by Chair and Executive Lead:	**Nicolas Small and Avni Shah**
Key items discussed: ***(From agenda)***	• **Questions from the public:** • One question received – How is PCB going to assess progress of access and delivery and the GP contract? A formal response has been provided to the patient. See appendix 1. • **Directorate highlight report:** • Report provides detail of Covid vaccination rates, noting it was lower than previous years, but all vulnerable cohort targets (care home residents and the elderly) had been met. • MMR: Analysis of gaps in vaccination rates would be identified and targeted. • National Vaccination Strategy: this had been published in December; delegation of section 7.a services would be commissioned by the ICB from April 2025. Learnings from the transfer of commissioning for POD would be collated and applied. • Pharmacy First: launch date 31 January. Over 200 community pharmacists have opted into this service which will cover the treatment of seven common health conditions. • Orthodontic services: A proposal had been submitted to the Primary Care Commissioning Committee to commission orthodontic services across HWE. Work is progressing with the development of the needs assessment following by going through PSR. • Recruitment and retention focus within primary care had been widened to include POD, health care professionals and nursing -this includes testing initiatives such as enhanced fellowships in ARRS and nursing, and development of community pharmacy clinical lead programme. • Good progress being made against the digital road map. 2024/25 work on scoping POD digital needs of integration are key priority for 2024/25. • **Progress on recommendations to date from Healthwatch reports:** • The board heard about the progress made against the recommendations from the Healthwatch report on community pharmacy. It has been agreed as these reports are commissioned by the ICB to ensure there is a formal way of reporting progress against the recommendations and providing progress. This is built into the primary care delivery plan. One of the key actions in relation to the community pharmacy report is to promote the wider services that community pharmacy offer through local comms and social media campaigns to completement the national campaign.

	• Promotion of the NHS App and training for community pharmacy staff for repeat prescription requests. • **Primary Care Strategic Delivery Plan progress update including transformation reports (see attached):** • Since publication of the Primary Care Strategic Delivery Plan end of July 2023, the board received a 6 month update on progress against the key delivery actions across the plan together. Some of the key highlights are attached to the board report to provide an update through each place. • **Primary Care Risk Register:** • New risks identified: POD workforce – robustness of workforce as well as training and education opportunities. • The ICB risk policy was in the process of being finalised, once this had been completed, the team would review the PC Risk Register against the new policy. • **Primary Care System Access Improvement Plan – progress update:** • The board heard about the progress made on the range of areas outlined in the Primary care Access Recovery Plan including implementation of cloud based telephony, modern general practices, further development of workforce including capability and integration of digital tools and progress against key areas of reducing bureaucracy working with secondary care. An interface group had been established between PC and the three acute providers to speed up and refine referral pathways. • **Dental Access Review:** • The board heard about detail review of dental access across HWE including the gaps in oral health, pockets where access is poor for dental care. This review further reinforces the workplan and priorities under dental which have been developed. The board will receive regular update on progress against key areas of priorities. • The commissioning of orthodontic services is one of the areas of work and as outlined in the directorate report, progress being made on commissioning future services across HWE. • **Enhanced Commissioning Framework for General Practice 2024/25:** • Report provides the main findings from the ECF 22/23 and year to date 23/24, including impact on care and health outcomes, outlining the ECF specification for 2024/25. The ECF provided just one component of a whole system wide approach to holistic health care and also provided different treatment regimes for patients (within the national guidance). • **Primary Care Digital – Progress Update** • Website reviews are ongoing, the website provided the main point of access for patients and best practice had been shared by NHSE to assess against. Cloud based telephony: a call back function had been introduced. • Digital inclusion: this remained high on the team's agenda; access for the digitally excluded needed to be maintained.
Forward plan:	Future deep dive: Community Pharmacy
Date of next meeting:	Thursday 28 March 2024

South West Herts Place Primary Care Update December 2023

Key Information:

16 PCNs
52 practices
4 INTs
645,513 Raw Population
597,798 Adjusted

Examples Of Best Practice

- 100% eligible care home patients have received autumn 2023 COVID vaccination

Modern general practice (MGP)

- 45 practices have submitted transition funding bids -39 approved
- Total triage in place within 8 practices, 1 more from Jan 24

Primary care recovery and winter planning

- All PCNs have submitted Capacity & Access Plans continue support with delivery of these plans
- 14 practices signed up to GP Improvement Programme & 3 PCNs
- Active encouragement for remaining practices to join Cohort D & E
- 1 practice without cloud-based telephony, supporting via procurement hub who are now contacting practices; contracts to be signed by 15.12.23
- Winter additional capacity agreed with all PCNs 43,502 additional appts.
- PCN community pharmacy integration leads support with increased CPCS uptake
- Promotion of virtual hospital to maximise capacity as part of winter planning

Health Checks

- **LD Health Checks –** Q2 achievement is low - number of health checks performed in September lower than expected and all localities falling below achievement from last year.
- 5 SWH practices highlighted as low achievers – ongoing work with practices to ensure this continues to be high on the agenda and we continue to meet the national target in Q4 as in 22/23.
- **Dermatology** – review of low and high referrers to start in Jan 23

Long term conditions

- 4 SWH PCNs and 1 practice interested in providing asthma/Feno hubs
- NHSE funding secured for the ICB to invite practices to provide an enhanced review with patients 18-39yrs old with type 2 diabetes (971 patients). Request for Expressions of interest gone out to practices.

Workforce (Progress of recruitment/Retention of workforce at PCN/Locality level)

- Oct workforce plans received. PCNs planning to use OVER 100% of 23/24 budget
- 411 ARRS claimed for October 23; high level of WTE Clinical Pharmacists & Care Coordinators
- Recruitment & Retention challenges exacerbated by competing with London Weighting & Locum use
- Writing to all PCNs, advising budget forecast and asking them to feedback on projected spend vs budget

Enhanced Commissioning Framework

- ECF Dashboard (monthly data) to be shared at Locality Forums Bimonthly
- Four practices identified for support to increase hypertension detection and management. Meetings held with all 4; targets agreed, and CVD chosen as ECF disease detection area, ICB to review in March 24

Vaccinations

- **Flu** – 23/24 YTD (Dec 17th 23) uptake is 35% for patients aged 6 months plus, which is higher than 22/23 (33% same week last year) (possibly slightly higher uptake when missing practices' data included)
- **MMR 2-30** – Sep 22-Aug 23 uptake is 74% compared to 56% for previous 12 months (possibly slightly higher uptake when EMIS data included)
- **COVID booster** – uptake higher for all eligible cohorts (48%) compared to last year (42%)

Same Day Access

- St Albans IUCH appt only ANP led service-initiated Nov 22
- Offers 490 appts per week – to date has seen 18k pts 98% seen & treated within 2 hours.
- OPEL reporting regularly exceeds 60% and provides measure for informal discussions with practices re access

Anything else to share

- Support to migrants – HWE financial model being revised to align with budget
- Developing approach for Support Level Framework visits – high priority practices are The Grove in Hertsmere, Verulam and Woodhall Farm in Dacorum
- UTI pathway launched – 45 Community Pharmacies to provide the service
- St Albans & Harpenden support for Gypsy Roma & Traveller Communities – support those who need to access healthcare – traveller's champion – Integrated with Public Health & County Council.

Health Inequalities

Integrated neighbourhood teams and proactive care

- **Hertsmere**: Complex Mental Health INT set up - an integrated approach to improving Health Checks uptake especially in deprived areas, Urgent Care Same day minor illness bookable hub expected to start April 2024, cancer screening (see below)

- **Dacorum**: Proactive Care Model (Beta & Delta PCNs as pilot sites) Clinical Design Group meeting weekly to develop model and develop business case for funding in Feb 24. Dacorum INT working collaboratively with WHTHT and Dacorum Borough Council to identify priorities and ensure less duplication and integrated working.

  Dacorum INT is also scoping Childhood Obesity, Cancer Screening, Heart Failure, COPD.

- **St Albans and Harpenden** : Scoping Obesity, Heart Failure – potential INT project with St Albans Council utilising healthy weight Shape support (linking to Obesity- practices to be identified, no of patients to be confirmed)

- **Watford & Three Rivers** : Scoping 3 INT projects: High Intensity Users, Mental Health, Obesity.

Cholesterol lowering project at Schopwick in Hertsmere

- Schopwick undertook a 6-session pilot, using lifestyle changes to lower cholesterol in 10 patients - aged 40-55 years and non-smokers.
- Total cholesterol and LDL-cholesterol were lowered in 7 patients, non-HDL cholesterol and triglycerides were lowered in 6; and HbA1c was lowered in 5 patients.
- The programme involved whole families in some sessions, and results indicate that the entire family made sustainable lifestyle changes.

Cancer screening uptake project in Hertsmere

- Joint (primary care, local councils, Communities First) project to call up non-responders to cervical, breast and prostate cancer screening invites.
- Started Dec 2022.
- Breast screening coverage has increased from 62% to 72% - the increase in cancer screening uptake across all practices and highest in those with lowest uptake and most deprived.
- Prostate: Texts sent to encourage PSA testing, and in GP Practices where follow up calls have been made to encourage PSA, these have been successful with a booking rate of 70%
- Cervical screening coverage has increased from 64% to 76%.

West Essex Place primary care update

Nov/Dec 2023

Key Information:

6 PCNs
30 practices
6 INTs
330,324 registered population
322,017 weighted population

Modern general practice (MGP) transition funding

- 28 practices submitted bids
- 26 approved (2 awaiting more detail)
- 2 practices not submitted, will prioritise for SLF visit
- Total triage in place within 4 practices and 5 moving to
- Prioritisation developed for Support Level Framework visits
- Sharing GPAD data to support practices to meet IIF indicator (90% appts within 2 weeks) and accurately map appointments
- 13 practices have option to express an interest in CBT

Primary care recovery and winter planning

- Continue to support PCNs with delivery of their capacity and access plans and support to move to modern general practice
- 5 practices doing GP Improvement Programme (Eden and Nuffield completed, Lister and John Tasker House underway, Crocus signed up)
- 2 practices without cloud-based telephony, supporting via procurement hub who are now contacting practices (Thaxted, Old Harlow)
- Winter additional capacity agreed with all PCNs 25,856 additional appts planned
- Targeted work with practices who have not referred to CPCS this year
- Engaging PCN community pharmacy integration leads to support with CPCS uptake
- Promotion of virtual hospital to all localities and INTs to maximise capacity as part of winter planning

Health Checks and prevention

- **40+ health checks** 11 practices have accepted support from Provide which should support with increased delivery of health checks over the next few months, bringing us closer to the ECC target for the year. Achievement has improved when comparing to 22/23 (although other Essex ICBs have improved more).
- **LD Health Checks** – Q2 achievement is often dis-proportionately low. Continued work with practices to ensure this continues to be high on the agenda and we continue to meet the national target in Q4 as in 22/23. ECC project funding available to enhance support – 5 PCNs taken up. NHSE coding for LD register has inaccurately inflated register so Nov/Dec/Jan data should be disregarded (NHSE resolving)
- **Improving Hypertension detection and management** – visits have been held with our outlying practices (Limes, Loughton Surgery, Forest, Sydenham) to support with improvements

Same Day Access

- UTC in Harlow live from 1st November and mobilisation successful. Providers working very well together on a daily basis to manage demand and revise approaches and workforce accordingly. Waiting times very low. Patient satisfaction good. Provider collaborative now focused on phase 2.
- LB&C PCN enhanced/same day access hub – flexible to support with demand e.g. OPEL 3 and 4 practices
- NUTTs PCN – shared locum workforce
- OPEL reporting from practices remains high c80%+ and provides measure for informal discussions with practices re access/MGP

Workforce (Progress of recruitment/Retention of workforce at PCN/Borough level)

- Oct workforce plans received. PCNs planning to use c90% of 23/24 budget
- Some PCNs focusing recruitment on urgent care to improve access

Vaccinations

- **Flu** – 23/24 YTD uptake (21.95%) in line with 22/23 (21.72%) (possible slightly higher uptake when EMIS data included)
- **MMR 2-30** – 23/24 YTD uptake (76.9%) in line with 22/23 (76.2%) (possible slightly higher uptake when EMIS data included)
- **COVID** – uptake slightly lower (38.85%) compared to same period last year (42%)

Health inequalities

- Range of projects within PCNs, with some continuing with the small-scale, targeted approaches developed in 2022/3,; as EFN PCN focusing on COPD patients with financial issues in a specific area with high deprivation – working with Epping Forest DC and Epping Forest CAB.
- Other PCNs participating in broader areas of work that reflect Core20+5 national priorities (health checks, cancer screening, waiting list support centred on PAH, Harlow).
- PCN HI leads and CVSs considering £7k funding available to meet the needs of a local patient group – promoting in PCN CD 121s

Integrated neighbourhood teams and proactive care

- Continued engagement across INT leadership teams
- Proactive care MDTs underway in 5 INTs
- PCN estate is facilitating INT working eg LB&C (links with acute) and NUTTs (links with whole INT)
- OD programme underway with Leadership team members
- LB&C Care home hub pilot (pooled resources

Long term conditions

- 3 PCNs interested in providing asthma/Feno hubs
- NHSE funding secured for the ICB to invite practices to provide an enhanced review with patients 18-39yrs old with type 2 diabetes (460 patients across WE).

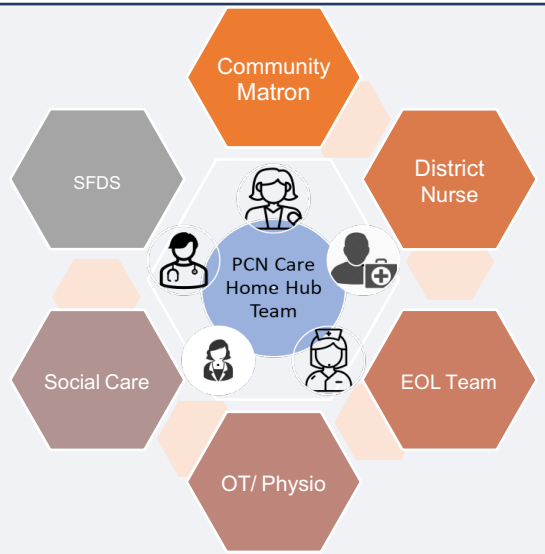
Community Pharmacy Integration

- CPCS referrals in Nov tripled from 78 in Oct to 238 in Nov putting WE on a par with Herts for the first time
- UTI pathway launched – 16 CPs in WE providing the service and good spread across WE.

Examples of good practice

Loughton, Buckhurst Hill & Chigwell PCN Care Home Hub

- The PCN is piloting pooled resources to support 6 care homes across the PCN (4 practices and 252 care home beds)
- The service will provide increased consistency of support to care homes, especially where patients in a care home are registered with more than 1 practice
- Aims = Better patient care, better integration with system partners and reduced A&E attendances and admissions (10% over 12mths)
- Proactive care using MDT approach – in the care home and review of impact on monthly basis
- Personalised care and support including better EOL planning
- Use of WHZAN to help monitor and identify early deterioration of patients
- Funding from existing sources (ARRS, EHCH, LES, GP fellowship scheme) and Essex County Council Intermediate Care Fund
- Key project of the LB&C Integrated Neighbourhood Team
- The project will be test and learn approach with a view to sharing learning across other INTs in the future



Protected learning time – recent examples

Epping forest North - review of ARRS workforce to inform future working. ARRS staff and practices completed a short survey before the day. The ARRS staff gave an overview of the work they do in each practice, similarities/differences/ideas for the future. Practices also considered how the ARRS staff are embedded within the practice teams, ideas for the future and future recruitment plans

Loughton, Buckhurst Hill and Chigwell – Mary Seaman provided training to all staff to support patients with Learning Disability

South Uttlesford – Staff health and well being focus with support from guest speakers covering personal well-being and menopause. Over 100 staff attended and it was well received by all.

Harlow North - Paediatric focus with attendees across the PCN team and community teams.

Loughton, Buckhurst Hill & Chigwell blood pressure check evening

- The PCN held a dedicated evening session at New City College, Debden for patients to have a blood pressure check
- Over 160 patients attended – most were prebooked, but walk-in slots were also available
- This services was to support an increase in hypertension detection and management, as part of the PCN's health inequality project delivery
- This service offer aimed to attract those patients who don't normally come forward for blood pressure checks
- Patients' height and weight measurements were also taken and there is a process for relaying these readings back to their GP practices
- Stalls were set up for their PCN social prescribers, Active Essex, local leisure centres and other organisations to engage with patients directly.
- The PCN are reviewing the format, with a view to holding a future event on a Saturday.

North Uttlesford PCN vaccination clinic and support to patients with learning disabilities

- The PCN held a flu/covid clinic on 21 st October
- 2hrs of the day was dedicated time for LD patients
- Purpose - to generate a calm environment where clinicians could take additional time with the patients
- LD nursing team also present during the clinic to support people with any additional requirements or anxieties.
- Gave opportunities for patients and their carers to ask questions and learn more about services available to them.
- Feedback from the LD team was really positive and they are keen to be involved in this process again next year.
- The PCN also plans to undertake a survey with LD patients to understand how they wish to access health and wellbeing services with the aim to improve health outcomes.

East & North Herts Place primary care update

Dec 2023

Key Information:

12 PCNs
48 practices
2 INT (at early planning/ development stage)
Actual patient list - 624,692
Weighted

Primary care recovery and winter planning

- Individual meetings held or scheduled for PCN's to discuss progress with capacity & access plans & required support
- Daily reminder emails implemented for OPEL reporting with an improved % compliance rate
- GP improvement programme – numbers signed up as of 22.12.23 – 7 practices & 4 PCN's
- GPAD data update received and being reviewed with PCN's & practices to support IIF

Workforce (Progress of recruitment/Retention of workforce at PCN/Locality level)

Work continues with PCN's around recruitment challenges & any over and under spends challenges of ARRS budget which includes forecasting of allocations for 24/25
Icknield PCN Mental Health Practitioner recruited

Vaccinations

- **Flu** – 23/24 YTD uptake = 28.7% of total population, slightly lower than 22/23 which was 33.9% at the same point in the season (week 15).
- **MMR 2-30** – 23/24 YTD uptake (76.9%) in line with 22/23 (76.2%)
- **COVID** – ENH uptake slightly lower (48.4% of eligible population) compared to same period last year.

Enhanced Commissioning Framework

We have been working with the BI team to improve the reporting/supporting process re ECF. BI have now agreed to extract Ardens Manager data on a monthly basis, (previously quarterly) from which we will collate and RAG rate each PCNs' member practices' ECF achievements and use this to steer discussion in practice meetings. This will allow us to highlight good progress and identify work to do for the final quarter of the year.

Same Day Access Hubs

- Stevenage North & South PCN's same day access hubs have now been established and relevant reporting metrics to monitor the effectiveness of these in supporting the wider system will be reported monthly
- In view of East & North Herts Trust (ENHT) recent decisions around changes at their Urgent Treatment Centre(s) (UTC's) discussions are happening to ensure that primary care and community services are integrated at Phase 2, clarification being sought on timelines for this. Also being worked on via the Health and Care Partnership Transformation group.

Integrated neighbourhood teams and proactive care

The Integrated Neighbourhood Team programme is progressing well: Welwyn Garden City PCN has now held three workshops to develop its Integrated Neighbourhood Teams (INTs). The PCN have drafted a 'plan on a page', conducted local patient searches, and agreed to establish core working groups to develop logic models for each of the three priority cohorts to inform next steps.

- Broxbourne and Hoddesdon PCN postponed its second workshop to allow for further engagement with colleagues in advance.
- Stevenage PCNs have indicated their willingness to be in the next 'tranche' of INT development. Initial discussions are on-going, and this is likely to start in January.

- The partnership's proposed culture programme to support Integrated Neighbourhood Team development has been finalised.
- There is widescale enthusiasm for a programme of work to look at saving clinicians, professionals, and patients time across the partnership. This will be scoped in January.

Modern general practice (MGP) transition funding

- 44 practices have submitted bids with 96% approved
- Have compiled a list of practices who will be considered for SLF prioritisation
- Cloud based telephony upgrade roll out continues with 13 practices now in the upgrade process as part of the phase 1 offer to those with analogue systems and a further 5 offered an upgrade of their low-level CBT to provide them with compliant, equitable systems in phase 2.
- Showcase visits planned to practices in the New Year who have recently implemented Total Triage to help support learning and cascade

Anything else to share

- Presentation to Hertfordshire Carers Network updating on INT Development. ARRS roles & update on access recovery
- SLF- NHSE facilitated SLF session with Stanmore Medical Centre & ICB colleagues attended in the background for learning. The session was very well received
- Secondary and Primary Care Interface meeting held with Consensus document approved with E&NHT.
- Community and Primary Care Interface meeting held with Herts Community Trust with two areas agreed for action on Electronic Referral Service and personal Direct Access to Integrated Care Team for GP's, pilot work underway with results of this being shared in February 2024.

Examples of good practice

North Herts locality; Hitchin & Whitwell PCN continue to see good attendance and feedback at their Carer's Café, which is offering support from a variety of partners – voluntary sector, hospice, Sadie Centre, practice care coordinators who are available to schedule health checks. Clinical staff on hand to offer BP checks, opportunistic health care and vaccinations. Also peer support from other carers in the area – a positive movement offering a break and a cuppa! This café is held in a local church hall.

Lower Lea Valley locality; The Dementia Strategy Plan and five priority areas has been highlighted for feedback from area stakeholders. Healthy Memory Café still running on the last Friday of the month but looking at ways through stakeholder engagement at improvement.

A very successful volunteer fayre was held in October 2023, the event was attended by over 100 members of the public and 25 professionals from various local organisations, including health and social care services and the voluntary sector. The event also provided a valuable opportunity for professionals to network and learn from each other. Participants were able to exchange ideas, share best practices, and identify potential areas for collaboration. This initial event has become a model for proactive community engagement. Addressing the increasing demand for local holistic support services, it paves the way for a healthier, more connected, and resilient community. As the initiative evolves, organisers remain dedicated to building a comprehensive support system that prioritises the well-being of the Broxbourne and Cheshunt community. A full report has been drafted on the event including photos, which can be shared for more information. A further event is planned in April 2024.

Upper Lea Valley locality; Two PCNs are working together to provide a respiratory hub for all of their patients.

Hertford and Rurals & Ware and Rurals PCNs have opened a weekend respiratory hub where patients from all practices within the two PCNs can been seen for any respiratory conditions.

The hub is located within Dolphin House Surgery in Ware offering a central location for all practices within the PCNs.

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document

NHS Hertfordshire and West Essex Integrated Care Board

Title: Finance and Investment Committee (Extraordinary) Meeting, Date of meeting: 22/02/2024	
Signed off by Chair and Executive Lead:	**Nick Moberly and Alan Pond, 04/03/2024**
Key items discussed: ***(From agenda)***	• Interim Draft Planning Assumptions for 2024/25 • HWE System (System Position Month 10 and System Planning 2024-25)
Key points made / Decisions taken:	**Interim Draft Planning Assumptions for 2024/25** 1. The official planning guidance has not been released due to ongoing negotiations between NHS England, the Department of Health, and the Treasury. However, interim draft planning assumptions have been shared to aid in planning efforts. 2. Organisations are instructed to plan under the assumption that there will be no industrial action in 2024/25, to simplify planning processes. If industrial action occurs, NHS England and the Treasury will assess impacts and provide funding accordingly. 3. Performance Requirements and Service Improvements: • Primary and Community Services: Emphasis on improving access and reducing long waits, with an expectation of growth funding directed more towards community services than acute services. • Dental Services: A ringfence for dentistry funding is reinstated, expecting no underspend and a focus on utilising existing funds to address dental service delivery. • Urgent and Emergency Care: Standards are to be maintained or slightly improved, with specific targets for emergency department performance and ambulance response times. Capacity must be maintained without reducing bed numbers. • Elective Care: The Elective Recovery Fund continues, targeting over 65-week waiters and eliminating over 78-week waits, with the activity target set at 107% of the 2019/20 levels. • Cancer Services and Diagnostics: Goals include improving wait times for diagnostics, with an unspecified target for improvement. • Mental Health: Focus on improving access, specific targets for physical health checks and talking therapies, and improving patient flow to reduce pressure on crisis and acute care. 4. Workforce Management: There is no expectation of an increase in workforce numbers, with a push towards reducing reliance on agency staff from 3.7% to 3.2%. The emphasis is on maintaining capacity, managing the workforce effectively, and improving productivity. 5. Financial Sustainability:

- Efficiency and Productivity: The need to deliver financial balance with a target efficiency gain factored into the tariff deflator, plus a convergence factor requiring savings to offset perceived overfunding.
- Savings Requirements: Systems may need to deliver more than the identified efficiency savings due to funding reductions and increasing pressures, with some systems potentially needing to achieve around 5% savings.

Financial Position for Month 10:

1. Original Financial Plan had a year-to-date deficit of £18m. Rapid planning exercise in November created a revised plan with year-to-date deficit of £23.6m and financial balance by year-end, albeit with £7.6 million in unidentified savings pushed to Month 12.
2. Current Deficit and Impact of Industrial Action: The actual year-to-date deficit is £32 million, partly due to £10.5 million in unexpected industrial action costs. Without these costs, the deficit would have been £22 million, slightly ahead of the revised plan.
3. Improvements and Forecast: There was an improvement in the deficit from Month 9 to Month 10, and the H2 plan suggests achieving the financial targets if industrial action costs are funded. The organisation is also analysing its spending and efficiency compared to regional forecasts.
4. Specific Challenges and Actions: Industrial action costs varied among organizations. The ICB incurred costs due to investments in primary care and NHS 111 services to reduce hospital demand.
5. Efficiency Losses and Financial Recovery: The ICB faces challenges in lost efficiencies, particularly from the West Herts Trust, impacting its financial recovery. There may be a case of inflated figures for lost efficiencies due to industrial action, seen as an excuse for not meeting efficiency targets.
6. Future Financial Balance: Despite challenges, there's optimism about achieving financial balance by the end of the year, helped by additional funds and allocations from NHS England. The aim is to reach balance without impacting future financial years.
7. Elective Activity Recovery: The ICB and its providers have been working on recovering elective activity, with performance above targets leading to additional funding, indicating a positive direction in managing and recovering from the financial deficit.

System Planning 2024-25:

8. Funding Uplifts: The ICB receives less growth funding than the national average due to slower population growth, with specific rates of 4.05% for the ICB versus 4.20% nationally.
9. Convergence and Overfunding: The ICB's convergence rate is higher (1.09%) than the national rate (0.88%), indicating it is more overfunded relative to its target allocation. This overfunding is around 5% for the ICB compared to 3% nationally.
10. Financial Gaps: Although likely to achieve financial balance in 2023-24 this has largely been through non-recurrent measures. The underlying position remains a significant financial gap, in excess of £100m, similar to the medium term financial outlook, highlighting the need for strategic planning and difficult decisions on service provision.
11. Operational Strategies: Discussions emphasize the need for transformational changes and efficiency improvements, including managing workforce growth and productivity.

	12. The HWE ICS position is mirrored across the country. There is a call for realistic and honest discussions about financial positions, with ongoing dialogue with NHS England about funding efficiency and service delivery priorities.
Committees to note:	• The need for awareness of election year impacts, ongoing financial challenges, and the critical importance of system transformation focusing on patient outcomes. The necessity of using System Development Funding effectively and having difficult conversations about service sustainability and prioritization was highlighted. • The necessity of a balanced approach that considers both the difficult decisions of service reduction and the exploration of all possible opportunities for efficiency, income generation, and better utilization of existing capacities within the health system. • Risks and concerns about how expanding patient choice through accrediting independent sector providers might affect NHS trusts' ability to manage elective care backlogs and the broader financial and operational implications for the health system. • Leveraging the potential opportunity to increase income by reclaiming services from non-Integrated Care System (ICS) providers, suggesting an opportunity to bring back income while managing patient choice risks. • The need for managing transformational priorities despite their early-stage development. The challenge of progressing these priorities while managing the current tense position was emphasised, highlighting the importance of gaining traction on transformational initiatives.
Forward plan issues:	• Information request for planning: there is a request for information from various stakeholders regarding what they consider to be investment needs for the year 2024-2025. This process aims to identify priorities and halt work on initiatives that are unlikely to proceed. • Flash Reporting is due on the 29th of February. This submission focuses on providing exit run rates, other pertinent issues, financial positions, workforce details, and a bit on activity and performance. It's not a full submission but targets specific areas of interest. • FIC meeting is scheduled for mid-March, around the 12th, indicating another step in the review and decision-making process. • First Full Submission is due on the 21st of March. This submission will likely include refined and more detailed plans based on the initial flash reporting and subsequent discussions and analyses. • The Board meeting is scheduled for shortly after the first full submission, around the 22nd of March, where the submissions and plans will be reviewed, and further actions decided.
Date of next meeting	12 March 2024

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document

NHS Hertfordshire and West Essex Integrated Care Board

Population Outcome and Improvement Committee – 6th March 2024	
Signed off by Chair and Executive Lead:	**G. Randhawa (Chair)** **B. Flowers**
Key items discussed: ***(From agenda)***	• Quorate meeting until 09:45*. • Minutes from 8th January 2024 approved. No declarations declared. • Research, Innovation and Evaluation Strategy – Committee received presentation. Key points raised: When we make requests for commissioning funds, that is supported by evaluation evidence; If putting in a bid, keep a percentage back for evaluation; If you cannot find evidence for something – that promotes call for research; Once you get the mindset, the process and support – embed discipline; Return on investment – direct benefits – do need to risk of double counting on evaluation, counting benefits twice; Moving away from a system where evaluation happens after everything has been completed and those that have delivered the service so have a vested interest. Update provided over the work currently being undertaken with the University of Hertfordshire. Discussion over how this can become a key part of the ICB decision structure. Reference made to linking this work with the ICBs Joints Forward Plan, plus evidencing that will be sought. Request by the committee to ensure the strategy is implemented in a holistic way. Request for this strategy to be owned by the ICB and give the benefit to our residence. Proposal that this strategy is presented to the Commissioning Committee. • *Population Health Management (PHM) Strategy – identified links to mindset change within the ICB and drawing resources/advice from core colleagues. Identified PHM needs to be everyone's business. Identified linking this as a key enabler of the delivery of our ICS strategy and Joint Forward Plan. • Update on work of VCFSE Alliance and Health Creation Strategy – item deferred to next meeting as apologies from those presenting. • Governance update – As part of the wider ICB Governance Review - update provided and that for the 1st May 2024 this Committee will be known as the Strategy Committee. At that point a draft Terms of Reference will be presented with proposed work plan. Agree for sub-group to meet prior to 1st May to develop this work, whilst also considering the wider system voice.
Key points made / Decisions taken:	• As detailed above.
Committees to note:	• Governance Review – with Committee development.
Forward plan issues:	• VCFSE Alliance and Health Creation Strategy – deferred to 1st May 2024.

	• Sub-group to meet prior to 1st May – to consider developing scope of this Committee for the population of a revised Terms of Reference and Workplan.
Date of next meeting	1st May 2024

Hertfordshire and West Essex Integrated Care System

Draft ICB Quality Committee Summary Document

NHS Hertfordshire and West Essex Integrated Care Board

Quality Committee – 07 March 2024	
Signed off by Chair and Executive Lead:	**Thelma Stober and Natalie Hammond**
Key items discussed: ***(From agenda)***	• ICB Quality Committee Workplan, including Nursing & Quality transition planning and future Quality and Performance Committees • ICB Quality Dashboard • ICB Quality Escalations Report (inc. National Patient Safety Strategy update) • ICS Quality Strategy Delivery Plan and updates against ICB key quality priorities • ICB Continuing Healthcare Report • ICB Risk Register (Nursing & Quality) and Strategic and Corporate Risk Register (Quality related) • ICB Quality Improvement update: System QI Network Progress Report • Deep Dive – Medication Safety • Feedback from Patient Subgroup • Minutes/Summary from sub-groups • New risks and escalations from Committee • Reflections and feedback from the meeting on assurance and on addressing equality and diversity issues in reports
Key points made / Decisions taken:	• **Nursing and Quality transition planning** – A new Directorate structure has been developed to provide a clear leadership in the provision of safe, patient centered and quality care. There will be close working with the health and care partnerships to deliver clinical transformation at place as well as quality oversight and improvement at system level, using quality improvement methodologies and digital technologies, innovation and learning. • **ICB Quality Dashboard** – The new dashboard builds on the previous model and has continued to grow and evolve in areas which will be built upon over the coming months. This will focus on the link between quality and performance, arising issues, and monitoring progress against key areas of the ICS Quality Strategy as well as developing suggestions and feedback from the Quality Committee. • **Quality Escalations Report** – Key headlines: ongoing ophthalmology improvement work at provider and system level; improvement work continues at ENHT for paediatric audiology with initial pathways due to recommence in March 2024. Work is underway to develop and finalise the aligned SEND Quality Assurance Framework and implement in partnership with health and social care providers. • **Quality Strategy Delivery Plan** – the report provided the progress against the Year One deliverables, which combine specific areas of work within the Nursing and Quality Team as well as areas within other strategies developed by the ICB ie. Primary Care Strategy and Digital Strategy, that align to the Quality Principles. 39 individual measurables out of 41 have been fully delivered or are on track to be delivered by end of March 2024 with 2 being carried over to year 2.

	• **ICB Nursing & Quality Risk Register** – There are currently 7 risks on the Nursing and Quality Team Risk Register. There is one new risk added to the risk register relating to Safeguarding Adults. • **Continuing Healthcare Report** – The Committee acknowledged the honesty and transparency in the report which highlighted the progress, ongoing challenges and pressures the CHC team is facing while delivering a full service and full transformation. • **Quality Improvement update** – A face to face Quality Improvement Network event is being planned with providers and system partners to focus on PSIRF and Quality Improvement. NHS Impact is working with all ICBs to understand how the national team can support continuous improvement at system level. • **Medication Safety Deep Dive** – The ICB Pharmacy and Medicines Optimisation Team (PMOT) provided the report; items covered: good medication safety management and governance, system-wide implementation of medication safety alerts and response to medicines shortages, high risk areas: transitions of care, overprescribing/inappropriate polypharmacy with a focus on anticholinergic burden, medication waste and stockpiling, reducing medicines related harms, antimicrobial stewardship – reducing inappropriate antibiotic prescribing. The Committee recommended approval of the Memorandum of Understanding between NHS England and Integrated Care Boards on the Safe Management and Use of Controlled Drugs • **Feedback from Patient Subgroup –** Members are bringing a large range of issues to the group as potential material for a workstream in terms of patient issues linked to quality of services. Work is ongoing to support development of the patient group, helping to determine a clear purpose of the group, and how patient involvement can support implementation of the quality strategy and lead to improved quality and experience for the population.
Committees to note:	• As above
Board to note:	• **Medicines Safety** - The Committee acknowledged that the Medication Safety Deep Dive is a compelling document which aims to raise awareness of what the ICB Pharmacy and Medicines Optimisation Team is individually and collaboratively doing to improve medication safety and making it a priority for our system as a whole with the aim of reducing errors and patient harm. The Committee strongly recommended that this document should form part of a presentation to Board along with sharing with the HCP System Frailty Board and other forums.
Forward plan:	• In light of the new governance structure coming into place resulting in the combination of the Performance Committee and the Quality Committee with the inaugural combined Committee due to commence in July 2024; members will be part of the new Committee development process providing input and opinion, evaluating the previous year to understand how we need to develop going forward. **Some areas to consider:** • Combining two significant agendas, reforming the schedule of business, having a pacier review process to understand Committee effectiveness. • Some items previously brought to this Committee will be heard at 'Place' within the Health and Care Partnerships (HCPs) forums.
Date of next meeting	• Thursday 2 May 2024

Hertfordshire and West Essex Integrated Care System

ICB Meeting Notes and Actions

NHS Hertfordshire and West Essex Integrated Care Board

Patient Engagement Forum – 12 March 2024		
Signed off by Chair and Lead:	**Patient Chair: Alan Bellinger** **Michael Watson, Chief of Staff**	
Members and Attendees:	**Patient representatives** Leighton Colegrave (ICB Primary Care Board Citizen representative, East and North Herts) Claire Uwins (Patients Association task and finish patient representative) Alan Bellinger- patient Chair (ICB Buddy Scheme patient representative) Justin Jewitt (Patient Safety Partners and Quality Committee patient representative) John Wigley – Vice Chair (shared South and West Herts Health and Care Partnership Co-production Board patient representative) Leigh Hutchings, West Herts Hospital Trust co-production board (new Member) Paul Campion (Quality Committee Patient Group)	**Herts and West Essex Integrated Care Board staff** Michael Watson (Chief of Staff) Lauren Oldershaw (Senior Communications and Engagement Officer) Louise Manders - Deputy Head of Communications and Engagement Paul Opoku – Children and Young People's Participation Lead **Apologies:** Fiona Corcoran (Deputy CEO Healthwatch Herts) Kevin minier Heather Aylward (Engagement Manager)
Key items discussed: ***(From agenda)***	The main focus of the meeting was two presentations, and subsequent discussions from: • Paul Opoku, the ICB's Children and Young People's Participation Lead, on the development of its Youth Council which was launched last year and how the PEF could potentially work with its Youth Ambassador members. • Anthony Power, Head of Patient Care and Experience for Herts Community Trust, who spoke about the patient care experience and the PALs team and its work. It was agreed communicating with patients and gaining their understanding of how they can give feedback / make a complaint was a big issue and PEF members would support the team in reviewing their strategy for this. **Updates from the PEF working Groups:** • **Primary Care** – (The- final report on the Patient Association project to develop patient groups will be presented on Monday 18 March and will include details of all those surgeries who do / do not have groups as well as information about	

	the successful buddying scheme. This work will end with PA at the end of this month and the Primary Care Citizens and steering group will look at how we take this work forward) • **Mental health** – (Kevin currently away but this group is making some good progress including meetings with the MHLDA HCP) • **Secondary care and community** (John Wigley shared a paper updating members about how the group is developing and laying foundations) • **Networking –** (work continues to establish an online platform with Facebook and Linked in currently being looked at)
Agreed Actions:	• Agreed to review the Terms of Reference and aim to agree any modifications / changes by the end of the week. • to find some way to openly collaborate with the Youth Council, led by Paul Opoku and hear their patient voice. Suggestion, to start with, this could be having a standing item at each PEF meeting to hear from the Youth Council about any critical issues impacting on their patient experience. They can stay for the whole meeting afterwards or leave at their own convenience. • For Anthony Power to return to the group for feedback on its review of HCT's Patient Experience Strategy
Date and time of next meeting:	Tuesday 9 April, 6 – 7.30pm

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document - Public

NHS Hertfordshire and West Essex Integrated Care Board

Commissioning Committee – 14th March 2024	
Signed off by Chair and Executive Lead:	• **Gurch Randhawa** • **Elizabeth Disney**

Key items discussed:
(From agenda)
	• Minutes from 11th January 2024 noted with no amendments sought – approved.
	• Action Log – noted and discussed with updates received.
	• Governance Review update:
	  • Confirmed program for Terms of Reference development, and mirroring committees at Health Care Partnership level.
	  • For the May meeting to continue as is, with new Strategic Finance and Commissioning Committee to start in July.
	  • Further, for a meeting to take place prior to the May meeting between core colleagues such as Chair, Executive, Governance lead and so forth – to further development the draft Terms of Reference that has already been shared and consider the future workplan. This work would then be presented to the May committee.
	  • L/A requested to be part of this conversation – confirmed they were, also linking work currently taking place with s.75 agreements and linking governance.

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:	Key items referenced above.
Board to note:	A noted above.
Forward plan issues:	Further updates on governance review.
Date of next meeting	16th May 2024

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:**	**22/03/2024**		
Report Title:	**Green Plan, progress and future roadmap**				**Agenda Item:**	**13**		
Report Author(s):	Mark Spriggs, Sustainability Programme Manager, HWE ICB							
Report Presented by:	Mark Spriggs, Sustainability Programme Manager, HWE ICB							
Report Signed off by:	Alan Pond, Chief Financial Officer							
Purpose:	**Approval / Decision**	☒	**Assurance**	☒	**Discussion**	☐	**Information**	☒
Which Strategic Objectives are relevant to this report **[Please list]**	**Priority 1: give every child the best start in life** **Priority 2: support our communities and places to be healthy and sustainable** **Priority 3: support our residents to maintain healthy lifestyle**							
Key questions for the ICB Board / Committee:	▪ The programme is understandably trying to balance the issues between the requirement to meet the net carbon zero agenda versus the finance/ affordability/ economics or other factors that could be a detriment to patient care or services operation. Could the Board outline its appetite to this regard?							
Report History:	▪ N/A							
Executive Summary:	The ICB following on from its members, and under the Health and Care Act 2022 was required to produce and adopt a “Green Plan”. Which we included for board members to read. Along with this there is an update on where we believe this plan to be in view of the work alongside members, and the next steps being taken to provide greater monitoring and assurance of the programme leading up to the completion of member’s green plans in January 2025, followed by the completion of the ICB plan by the end of March 2025. Which will be brought back to the Board for ratification and report.							
Recommendations:	▪ Presentation of the ICB Green Plan ▪ Acknowledgement of the progress made. ▪ Acknowledgement of roadmap to March 2025							
	Indirect	☐	***Non-Financial Professional***	☐				

Potential Conflicts of Interest:	***Financial***	☐	***Non-Financial Personal***	☐
	None identified			☒
Implications / Impact:				
Patient Safety:	*This work goes towards the positive impact on patient safety and health improvements as being a preventative measure to improve health overall.*			
Risk: *Link to Risk Register*				
Financial Implications:	*No direct funding implications*			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	N/A		
	Quality Impact Assessment:	N/A		
	Data Protection Impact Assessment:	N/A		

1. Executive summary

In accordance with a mandate from NHS England and the Health & Care Act 2022 Hertfordshire and West Essex along with all ICBs and Trusts were required to produce a Green Plan in order to meet the "Net Carbon Zero" commitment on the NHS.

ICB Green Plan prepared in 2022 can be viewed here:

hertfordshire-and-west-essex-ics-sustainability-action-plan (hertsandwestessexics.org.uk)

It is also noted here some of the progress and challenges that exist in supporting this programme and the ICS's work to achieve the targets for 2032, 2040 and what may be considered to 2045.

There is a roadmap of elements over the next 12 months that the Board should be aware of that are laid out here which outline some of the progress that will be made and viewed in terms of the monitoring and assurance.

2. Background

The NHS launched its campaign For a Greener NHS in 2020, setting out a practical, evidence-based path to a Net Carbon Zero (NCZ) NHS. This work resulted in the publication of '*Delivering a Net Zero National Health Service*'. This is underpinned by the acknowledgement that climate change itself undermines good health, exacerbating cardiovascular disease, asthma, and cancer. Tackling the issues around net carbon zero also reduce the burden of disease from air pollution, obesity, and poor diet whilst directly addressing health inequalities experienced across the country. The Green Plan sets out the strategy to engage this, predicated on two specific targets:

- Net zero by 2040 for the emissions the NHS controls directly.
    - Target to achieve 80% of this target by 2032
- Net zero by 2045 for the emissions the NHS has some ability to affect.

The NHS makes up 5% of the UK's carbon footprint, approximately 25million tonnes per annum. The HWE ICS figure is about 535,000 tonnes per annum on a 2019/20 baseline, just over 2% of the whole NHS total.

On page 8 of the green plan, in figure 2, you will see how the emissions are broken up in the area, scope 1,2 and 3 along with those which the NHS have indirect influence over. Scope 1 is defined as direct greenhouse emissions, fossil fuels, facility consumption, anaesthetics and the NHS fleet & leased vehicles which generate that which the System produces. Scope 2, electricity is an expression of what the trusts, ICB and primary care consume in their day-to-day delivery of services. Scope 3 is

areas of consumption which may or may not be under the different elements of NHS provision's control. Things such as water and waste, business travel and inhalers make the first part of this while ICT and medical devices, medicines and food, construction and manufacturing, freight and staff commuting as well as business services and external commissioned services. Each of these elements make up the ICS's carbon footprint and post 2040 patient and visitor travel will also be something that will be directly required to be addressed in our system.

On page 9, figure 3, this is illustrated more clearly in terms of how these elements make up the whole of the picture in HWEICS. It is also though clearly stated from the top-down carbon footprint provided at this point in time that 89% of our Service's carbon footprint is made up of the scope 3 elements and as such will be more challenging to identify and make changes to.

Since the Health and Care Act 2022, there has been some good progress made, such as performing the world's first net zero delivery and surgery, launching the first zero emission ambulance along with the specifications for future units which will be the only units that can be procured from 2030; embedding the response to climate change into the governance and strategy of every Trust; and investing over £550 million in energy efficiency and renewable energy as part of the Government's Public Sector Decarbonisation Scheme., The act also places new duties on the whole NHS, to contribute towards the reduction in emissions and energy consumption as well as environmental targets. The commissioners and providers are required to address:

- The UK net zero emissions target.
- The environmental targets within the Environment Act 2021
- To adapt to any current or predicted impacts of climate change identified within the 2008 Climate Change Act.

Since the green plan was produced, we can highlight positive outcomes that have been achieved.

- The Trusts and Local Authorities within Herts and West Essex all have their green plans or Carbon Reduction Plans (LAs) in place and are working to deliver their action plans individually and as a service.
- In December no desflurane was procured by anybody within the East of England region, Bedford, Luton and Milton Keynes being the last to stop this. The medicines workstream reported in September 2023 that East and North Herts, Princess Alexandria and West Herts Hospital Trusts had achieved complete removal from their sites of this gas.
- The Sustainability Leads within the region meet fortnightly, the ICS representatives meet bi-monthly as a working group, bi-monthly with the ICB lead, and as part of the various work streams focusing on different areas.
- Essex have launched an app to support residents improving their contribution to tackling climate change.

- HWE ICS Procurement Service are working with Trusts to improve appropriate use of procurement and equipment. Using funding to employ a nurse to make this clinical applicable. The reduction in couch rolls and trays has, with the support of Directors of Nursing, generated savings of more than £120k across two trusts and without 100% compliance. The procurement work stream will be presenting to the working group in March to clarify their work and roadmap.
- Lister Hospital and Princess Alexandria have received £1.4m funding from NHSE between them for the installation of LED lighting within this financial year. Langley house has installed LED lighting, solar panelling and air source heat pumps to reduce their energy consumption.
- Working closely with Council colleagues to integrate our approaches across the ICB areas, joining with our fellow ICBs in Essex, SNEE and MSE, as part of the anchor group.
- EPUT have reduced their greenhouse gas emissions from 35.11kg CO2e/m2 in 2019 to 22.13kg, a reduction of 37%, by 2022/23. This has been as substantial move in the face of increased staffing and service delivery over the same period.

3. Issues

Within 2024/25 there are a number of issues that need to be faced within the programme:

Renewing the Green Plans – whether this is the whole strategy and action plan, or just purely the action/ delivery plan going forward will be a matter for discussion. No guidance from NHSE has been released so far, and the timing may be impacted by the election schedule later in the year. We have planned a deep dive exercise between all members in September's working group to support this process.

Estates Infrastructure Strategy – ensuring that within this document, not only is Sustainability discussed and included in a notional manner but is a golden thread that is reflected in all due consideration. Sustainability is now positioned within the Estates team and will support this ongoing aspiration.

Monitoring and Metrics – get an agreed suite of measures in place that are being monitored on a bi-monthly basis per ICS member which will then be reported upwards to give assurance as to the direction of travel towards the 2032/2040 deadlines.

Re-establishing ICS workstreams to address various aspects of delivery across all members. Covering medicines management, procurement, estates (adaption and energy), and travel and transport.

NHS Travel and Transport Strategy – develop and integrate over the next 18 months into green plans. The rationalisation, planning and preparation for the change to procurement rules regarding purchasing exclusively zero emissions vehicles for NHS Trusts by 2027, and zero-emissions ambulances by 2030. This seen in the light

of the requirement to build in the electric vehicle chargers' network and upgrade the grid requirements to facilitate the need.

Biodiversity Net Gain (BNG) – impact of this not only in a positive way towards the environment, but also the challenge to the programme of delivery of new buildings underway for our area, in achieving the 10% (or more) increase in the net gain within the financial envelope of capital works. This will include the New Hospitals Programme and any new builds within the primary care work.

Reporting to the Environment Agency – The UK emissions trading scheme. Currently the EA apply a cap on the consumption of energy by businesses. The cap is going down to ensure businesses, which the NHS is included, are becoming more efficient, and the fines for breaches are going up. Currently six trusts have been required to pay fines worth around £400,000 in the last year, within the East of England region, only one within our service. This may change over time if we do not continue to drive down consumption and become more effective at being more efficient.

4. Resource implications

N/A

5. Risks/Mitigation Measures

The risks around the area of sustainability need to be reviewed, reassessed and expanded to meet the requirements for clarity and mitigation for the management of these risks.

Within this area we must cover the risk appetite involved in the decision making over sustainability vs cost/quality vs other elements such as economics and procurement. Guidance needs to be requested to cover this element, as we need to consider such things as inhalers, the shift from single use, which has a material impact on sustainability but there is a cost implication which must be reconciled.

6. Recommendations

Acknowledge the progress and challenges of the last 18 months.

Confirm the roadmap of delivering milestones towards the revision of the Green Plans in "January 2025" for Trusts and "March 2025" for the ICS.

7. Next Steps

The ICS Sustainability Working Group will continue and develop the support network and the agreed challenge to work with each other to develop our outcomes and outputs towards net carbon zero. The working group will also have greater resilience to ensure on going forum to discuss and deliver the progress desired.

Reinvigorate the sustainability work streams to deliver change management in their environments across the range of members.

Identify local metrics to consistently measure, monitor and assure the ICB of overall progress of the ICS and its individual members.

Work through subjects in depth to prepare for the delivery of the work streams, new green plans, travel and transport strategies and bio-diversity net gain etc but also embedding sustainability into the Estates Infrastructure Strategy.

Look to embed sustainability into the thinking of staff and managers as a key cornerstone of the corporate due diligence of our members.

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:**	**22/03/2024**		
Report Title:	**HWE Joint Forward Plan - Refresh Update**				**Agenda Item:**	**14**		
Report Author(s):	Stephen Madden, Associate Director for Strategy and Transformation, HWE ICB							
Report Presented by:	Beverley Flowers Deputy Chief Executive & Director of Strategy, HWE ICB							
Report Signed off by:	Beverley Flowers Deputy Chief Executive & Director of Strategy							
Purpose:	**Approval / Decision**	☒	**Assurance**	☐	**Discussion**	☒	**Information**	☒
Which Strategic Objectives are relevant to this report? **[Please list]**	< Please identify from the five ICB Strategic Objectives and list below > ▪ Tackling unequal access, experience and outcomes ▪ Improving physical and mental health across our population ▪ Enhancing productivity and value for money; and ▪ Helping the NHS to support broader social and economic development.							
Key questions for the ICB Board / Committee:	▪ Is the Board content with the approach to the refresh of the Joint Forward Plan? ▪ Is the Board willing to approve the draft plan for publication, noting the outstanding updates that are required?							
Report History:	▪ A draft version of the refreshed JFP was taken to both HWE ICB Population Outcome and Improvement Committee and HWE ICB Operational Executive Team meeting in February 2024. The JFP is being updated based upon feedback received. ▪ The current version of the Joint Forward Plan was taken to Board in May 2023 and signed off virtually in June 2023. ▪ The updating of the plan has been discussed with both the Essex and Hertfordshire Health & Wellbeing Boards							

Executive Summary:	Our current Joint Forward Plan, which covers the period 2023-2028, was completed and published on the ICB website on 30th June 2023 Hertfordshire and West Essex Joint Forward Plan 2023 - 2028 – Hertfordshire and West Essex NHS ICB. The plan sets out how we will meet our 17 specific statutory requirements, which is a mandatory requirement of the JFP, as it will be used as part of ICB assessments/CQC inspections to determine delivery of our duties. Our current JFP also outlines our plans for supporting the delivery of the 6 ICP Integrated Care Strategy priorities, as well as the priorities of the ICB strategic Framework that do not align to these priorities: Improve access to health and care services' and 'Achieve a balanced financial position annually, and 'improved cancer outcomes'. The Health and Care Act 2022 outlines expectations that the JFP be reviewed and refreshed each year with a refreshed version of our current JFP, to cover 2024-29, to be published by 31st March 2024. The HWE JFP has been refreshed for 2024-25, given that the current iteration of the JFP was published 9 months ago the approach to the refresh has been relatively light touch and is based upon what we are hoping to deliver based upon current planning assumption. The refresh has focussed on the following areas: • Providing an update on progress so far • Updating proposed deliverables for 2024-29. • Providing greater clarity on our priorities including links to the Medium-Term Plan (MTPP. • Improving the accessibility of the document. • Splitting out the core elements of the plan and its delivery/implementation plans into separate documents. Given the ongoing planning work and financial uncertainty it is proposed that we publish a draft of the refreshed JFP by 31st March, with the delivery element of the current plan published at a later date. Further work would then be undertaken to update and revise the delivery plan aligned to the planning process and our emergent Medium-Term Plan (MTP). This enables us to have more time for wider engagement and it is proposed that a draft would come to Board to review in May. This approach is supported by NHSE.

	The version included with this report is the draft 'core' plan and highlights areas that require further update before publication.			
Recommendations:	▪ To agree publication of an interim JFP at the end of March with delivery plan to follow later in the year. ▪ To agree to proposals for the finalisation and approval of the 2024-29 JFP refresh			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	< Provide details here - review the Register of Interests (Board/relevant committee membership), and highlight any potential conflicts, which the Chair needs to manage or state N/A if none >			
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:***		***Equality Impact Assessment:***	
	Quality Impact Assessment:		***Quality Impact Assessment:***	
	Data Protection Impact Assessment:		***Data Protection Impact Assessment:***	

1. Background

The Health and Care Act 2022 sets out the requirement for the ICB and our partner organisations to prepare a 5-year Joint Forward Plan (JFP) before the start of each financial year. Our first Joint Forward Plan, which covers the period 2023-2028, was completed and published on our website on 30th June 2023 Hertfordshire and West Essex Joint Forward Plan 2023 - 2028 – Hertfordshire and West Essex NHS ICB.

Our current JFP sets out how we will meet our 17 specific statutory requirements, which is a mandatory requirement of the JFP, these are outlined below in Figure 1. It also outlines our plans for supporting the delivery of the 6 ICP Integrated Care Strategy priorities, as well as the two priorities of the ICB strategic Framework that do not align to these priorities ('Improve access to health and care services' and 'Achieve a balanced financial position annually') and 'improved cancer outcomes'. The Joint Forward Plan will be used as part of ICB assessments/CQC inspections to determine delivery of statutory duties.

Legislative Requirement	Describe the health services for which the ICB proposes to make arrangements	Duty to promote integration	Duty to have regard to wider effect of decisions	Implementing any Joint Local Health and Wellbeing Strategy
	Duty to improve quality of services	Duty to reduce inequalities	Duty to promote involvement of each patient	Duty to involve the public
	Duty to patient choice	Duty to obtain appropriate advice	Duty to promote innovation	Duty in respect of research
	Duty to promote education and training	Duty as to climate change, etc	Addressing the particular needs of children and young persons	Addressing the particular needs of victims of abuse
	Financial duties			
Other Recommended	Workforce	Performance	Digital / Data	Estates
	Procurement / Supply Chain	Population Health Management	System Development	Supporting wider social and economic development

Figure 1: ICB Statutory duties

The JFP was led on by the ICB Strategy Directorate with contributions from across the ICB and ICS. These included the ICB, Nursing and Quality, PMO, Planned Care, Primary Care and UEC teams. There were also contributions from each HCP, which were co-ordinated by the ICB's Place Directors and were included under the 'levelling up' section of each plan.

To support the development of the JFP a resident survey was undertaken with over 1,100 responses received and additional engagement information was utilised from the development of the Integrated Care Strategy. The JFP also was also endorsed by both Essex and Hertfordshire Health and Wellbeing Boards.

Our current JFP was reviewed by NHSE following publication who confirmed that it met our statutory commitments and felt that it had a "concise and succinct narrative", linked well to NHSE targets and demonstrated clear collaboration and partnership working across the HCP's. They did also suggest that it could be improved by having more clearly defined milestones and trajectories, more long-term targets, better alignment of priorities and the vision of the ICP with that of the ICB so that there is a single narrative and also, so it reads less like a project plan.

Under The Health and Care Act 2022 the ICB is now required to review and update its JFP before the start of each financial year (31st March 2024). Updated Guidance for the refresh from NHSE was published in December 2023, with no significant changes from the original guidance that was published in 2022.

<u>2024 Refresh</u>
The refresh of the JFP began in November 2023 and has incorporated and tried to address the feedback from NHSE, and local stakeholders. Leads involved in the development of the original JFP were contacted for an update on progress to date and to review their future deliverables and measures for determining success and milestones. This information has been collated and included in an initial draft which has been shared with both the ICB Population Outcome and Improvement Committee and HWE ICB Operational Executive Team meeting during February 2024. Feedback from them included ensuring the JFP made sense to the public and reflected our priorities and should not be finalised until the operational and financial plans for 2024-25 are agreed.

Feedback from the ICB's communications team has also been acted on so that the content has been redesigned so that it is more 'accessible'. To support this the plan will also be reviewed by a resident reader panel prior to publication.

Work is also ongoing to refine the performance indicators within the JFP to ensure that there are clear and succinct population outcome targets and proxy measures in place, aligned to the ICB's outcome framework.

2. Issues

Operational and financial planning for 2024-25 is still to be concluded and therefore the full JFP including implementation plan, for this period is not able to be completed, however the ICB is required to publish an updated core JFP by 31st March.

Work remains on going to ensure better alignment between the current priorities outlined in the JFP, the ICP/ICS strategy, ICB strategic framework and the evolving Medium-Term Plan (MTP).

3. Options

It is proposed that in line with other ICB's, that we separate out the delivery aspect of our Joint Forward Plan into a separate delivery plan for the Joint Forward Plan. The remaining core document is then published in line with our legal requirements by 31st March 2024. The attached version of the document reflects this separation, and its publication will enable us to meet the statutory deadline, whilst allowing additional time to refresh and develop the delivery plan for the next five years to capture the key actions from the 2024-25 operational plan as well as alignment with the ICB Medium Term Plan that is being developed. This approach is supported by NHSE.

4. Resource implications

No specific issues identified – the plan is based upon our current planning assumptions. It assumes that we will continue to deliver the national requirements within our existing financial framework and also our local priorities where funding is in place.

5. Risks/Mitigation Measures

Risk:	Detail	Mitigation:
If the 2024-25 financial plan is not sufficient for us to deliver the activity required against our priorities, then we will be unable to achieve the outcomes required for our population and fully deliver our JFP resulting in the ICB and its partners being unable to deliver the proposed outcomes	The JFP currently includes our current work plans and delivery of all national asks utilising our current projected resource allocation	EQIA's to be completed for any decisions to change our plans to minimise any impact of any changes.

6. Next Steps

Task		Timeline
1.	JFP Update to be taken to both Essex and Hertfordshire Health and Wellbeing Boards	March 2024
2.	Core JFP to be reviewed by ICB Patient Reader Panel	March 2024
3.	Core JFP document to be finalised and published	28th March 2024.
4.	Delivery plan for 2024-29 to be updated and finalised	March- April 2024
5.	Updated delivery plan to be shared with Executive leads to review and approve	April 2024
6.	Updated delivery plan taken to ICB Patient Reader Panel for review	April – May 2024
7.	Updated delivery plan taken to ICB Board for Review	May 2024
8.	Finalised plan taken to ICB Board for sign off	June 2024.

7. Recommendations

To agree to proposal for finalising and publishing our JFP.

Hertfordshire and West Essex Integrated Care System

DRAFT

NHS
Hertfordshire and West Essex
Integrated Care Board

Hertfordshire and West Essex Joint Forward Plan 2024-2029

Working together
for ahealthier future

Foreword

Since the Hertfordshire and West Essex Integrated Care Board (ICB) was formed in July 2022, we have made progress together across a number of areas, some of which are set out in this plan.

However, as a system we are facing an unprecedented demand for many of our services and a constrained financial situation. Alongside this we have projected changes in the demographics of our communities which will make both of those challenges greater.

Our Joint Forward plan sets out the key actions we plan to take, together with our partners, over the next five years and has been endorsed by both Essex and Hertfordshire Health and Wellbeing Boards

Our plans have in part been guided by our Medium Term Operational and Financial Plan which will be published later this year. This will set out the significant changes we need to make to our model of care and our key areas of focus, as we seek to ensure we are a sustainable health and care system that delivers the best for its residents.

Both the Joint Forward Plan and the ICBs Medium Term Plan are based around the changes we need to make as a system to:

- Reduce health inequalities
- Have a more anticipatory, community-based model of care
- Deliver true integration of our services
- Support patients to engage in self-management and collaborative care planning
- Deliver annual financial plans which will ensure we are able to sustainably maintain and improve our services whilst delivering our wider priorities.

With the commitment, expertise and resources of the Hertfordshire and West Essex Integrated Care System behind us, we are confident that we can deliver on our ambition, to help build a brighter and healthier future for everyone who lives and works in our area.

Dr Jane Halpin
Chief Executive

Hertfordshire and West Essex Integrated Care Board (ICB)

Rt. Hon. Paul Burstow
Chair

Hertfordshire and West Essex Integrated Care Board (ICB)

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(Authors Notes: Reformat once content finalised)

1. About us

The Hertfordshire and West Essex Integrated Care Board (ICB) was established on 1 July 2022, following the introduction of the Health and Care Act 2022.

Our role is to plan and oversee how NHS money is spent to support our 1.6 million residents. We have a budget of £2.8 billion and our role is to join up health and care services, improve health and wellbeing and reduce health inequalities across our area.

The board is one of two key components of our area's 'Integrated Care System' (ICS). The second is the Integrated Care Partnership (ICP), a statutory joint committee, established jointly by Hertfordshire County Council, Essex County Council and the ICB. It was formally constituted on 1 July 2022 and is made up of representatives from the following organisations:

- Elected members and executive directors from Hertfordshire and Essex County councils
- Chief executive and Chair of the Integrated Care Board
- Council leaders and Chief Executives from district and borough councils
- Directors and Chairs of the Health and Care Partnerships
- Leads from the VCFSE Alliance
- The Care Providers' Association
- Healthwatch
- Police, Fire and Crime Commissioners

Our vision for Hertfordshire and West Essex is one 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 is accessible in a timely manner
- No patient is treated in a hospital setting when it would have been possible for them to receive their treatment at home or in the community
- The health experience and outcomes of all Hertfordshire and West Essex residents matches the experience and outcomes of those who with the best outcomes
- We are a proactive system that is as focused on interventions to prevent illness and reduce the risk of hospitalisation, as we are on the management of illness.
- Decisions about health and care services are based on the needs of the population and are taken as locally to the end user as possible, except for where there is a clear benefit to doing something at scale.

We have a number of statutory duties that the ICB and its partner trusts are required to fulfil by law. Throughout this document we demonstrate how we are fulfilling these duties, Appendix 1 provides further details of these duties and compliance.

The NHS Long Term Plan (2019) (LTP) sets the direction for NHS organisations delivering care to patients across the country. Delivering the ambition of the NHS LTP to ensure that the NHS can achieve the ambitious improvements needed for patients over the next ten years; the LTP sets out how the challenges that the NHS faces can be overcome such as staff shortages and growing demand for services by:

Doing things differently: we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as 'primary care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.

Preventing illness and tackling health inequalities: the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

Backing our workforce: we will continue to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

Making better use of data and digital technology: we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

Getting the most out of taxpayers' investment in the NHS : we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly used products for cheaper, and reduce spend on a

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2. Our Population

Our Integrated Care System provides health and social care to 1.6 million people living in Hertfordshire and west Essex.

A high proportion of our residents are in good health and life expectancy is longer than the national average.

However, although the health and wellbeing of our population is similar or better than in England as a whole, there is considerable variation within our area. In some communities, life expectancy is relatively low, with people struggling to live with the health and wellbeing impacts of deprivation. The average healthy life expectancy for our residents, which is the average number of years that a person can expect to live in full health, is 65.4 years for males and 65.7 years for females, compared with life expectancy of 81 for males and 84 for females.

Key partners across the system recognise 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.

In addition, we know that changes to the demographics of our population 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 welcome news, but it does mean that our services and approach will need to change to match the changing demographics of our residents.

We also recognise that pockets of deprivation and health inequalities exist within our system. Any plan that covers the remainder of this decade must consider the role that the Integrated Care Board should have in bringing the experience and outcomes of the residents in our most deprived areas up to the level of those in our communities with the best outcomes.

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.

A health overview of our Integrated Care System population can be found here: Health needs of the Hertfordshire and west Essex (HWE) population. Assessments of the needs of the whole of Hertfordshire and Essex can be accessed using these links: Hertfordshire Joint Strategic Needs Assessment Essex Joint Strategic Needs Assessment

This plan has been informed by detailed information about our population including our local Joint Strategic Needs Assessments (JSNA) and the health and social care needs of our communities. We have used this information to assess the health of our communities in comparison with each other, and against the national average, identifying the areas where the needs are greatest.

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. The affordability of housing poses an ongoing financial challenge to our residents and

workforce and the rising cost-of-living is increasing this pressure.

2.1 Learning from people and communities

The views of our residents, patients, staff and communities have informed and shaped the development of this plan.

Using an approach guided by our policy and best practice - including a wide-ranging literature review, focus groups, stakeholder engagement events and surveys - we have explored what makes healthy living tough, particularly for people facing inequalities.

More than 1,100 people shared their personal experiences and recommendations for action in a survey specifically commissioned to support this plan, supported by our Healthwatch partners. You can read in detail about our learning **here** which outlines the six priorities identified for our system, and how we will deliver on them.

2.2 Supporting our places

Our system includes most of the county of Hertfordshire, with its 10 district and borough councils (with the exception of Royston in the north of Hertfordshire) and the three district and borough councils to the west of the county of Essex.

The Integrated Care System also falls under two county council areas (Essex and Hertfordshire) and is a key partner of both Essex and Hertfordshire Health and Wellbeing Boards and the delivery of their health and wellbeing strategies that cover 2022/26.

- Essex Joint Health and Wellbeing Strategy 2022 - 2026
- Hertfordshire Health and Wellbeing Strategy 2022 – 2026

Our area has a number of hospitals and in-patient units to meet people's physical and mental health needs. Watford General Hospital, Lister Hospital in Stevenage and Princess Alexandra Hospital (PAH) in Harlow are our three biggest 'acute' hospitals. Both Watford General and PAH are part of the nationally funded New Hospital Programme with new hospitals to be put in place by 2030, which will transform the services provided by these hospitals.

Residents in our area can also access care and support from mental and community health organisations such as the

- Essex Partnership University Foundation NHS Trust (EPUT),
- Hertfordshire Community NHS Trust (HCT),
- Central London Community Healthcare NHS Trust (CLCH) and
- Hertfordshire Partnership University NHS Foundation Trust (HPFT).

An overview of the main providers of our Healthcare services is provided below in Figure 1.

Within Hertfordshire and West Essex we have four Health Care Partnerships (HCP's). Three of these are based around geographical areas (places) covering west Essex, south and west Hertfordshire and east and north Hertfordshire. These partnerships are a collaboration of NHS, local authority and voluntary and community organisations that help to design and deliver services together in a way that meets the needs of their local communities. Below in Figure 2 is an overview of the geographic coverage of our three place-based HCPs.

Provider	East & North Hertfordshire	South & W
Acute services	East & North Hertfordshire NHS Trust (ENHT)	West Hertford Hospitals NHS
Community Services	Hertfordshire Community NHS Trust (HCT)	Central Londo Healthcare NH
Mental Health Services	Hertfordshire Partnership University NHS Foundation Trust (HPFT)	Essex Partnership University NHS Foundation Trust (EPUT)

111/Integrated Urgent Care	
Emergency and non-emergency transport services (including 999 services)	E
GPs; Pharmacy; Opticians; Dentists	135 GP practices serving our 295 community pharma 225 optom 243 dental practices

Figure 1: A summary of the main commissioned providers of healthcare in our area.

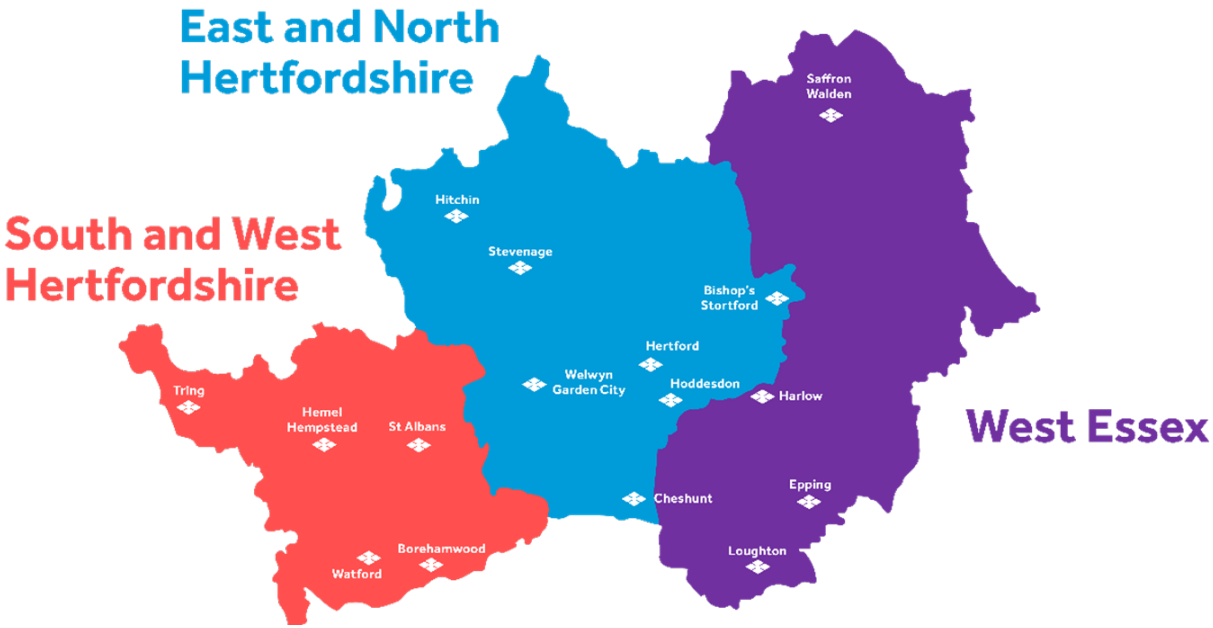


Figure 2: An overview of our Health Care Partnerships' areas

Figure 5: An overview of our Health Care Partnerships' areas.

The Hertfordshire Mental Health, Learning Disability and Autism Health and Care Partnership (HMHLDA HCP) brings together the local organisations with a responsibility for supporting people living with a mental illness, autism and learning disabilities in Hertfordshire, to support them to live longer, happier and healthier lives. Essex is served by three Integrated Care Boards, and an integrated adult mental health strategy is currently being developed to serve the greater Essex area.

The local Voluntary, Community, Faith, and Social Enterprise sector (VCFSE) consists of many thousands of organisations, from small volunteer-led charities and community-based faith groups to large social enterprises employing hundreds of staff and serving thousands of people. Our VCFSE Alliance is a network of these organisations which works closely with the NHS, councils, and other partners within the Integrated Care System to help make sure everyone can find the right support, when and where they need it. The Alliance has recently developed a strategy to value, promote and enhance the VCFSE sector in promoting health and wellbeing and addressing the wider determinants of health across our system.

2.3 Building our operating model

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 a Memorandum of Understanding (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.

The main task of our HCPs during 2024-25 will be to develop and implement delivery plans around our five priorities for the year (see section 5).

In April 2024, our HCP's 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
- All of the work of the HCPs will be underpinned by a Population Health Management approach underpinned by the new data platform.

3. The principles that underpin the shift in care we will see over the next decade.

Nationally, collaboration within and between local and national organisations and working towards an agreed number of shared priorities are widely agreed as being fundamental principles for any system that wants to achieve a healthier future for their population.

We recognise that to meet the changing nature of our population and create a sustainable health and care system we need to build our model of care around the following principles:

1. Integration of health, care, and wellbeing services

We will prioritise **opportunities for integrated planning, commissioning and delivery of health, care, and wellbeing services** so that people's experience of support and services is more joined up. We recognise that it is routine for health and care staff to work together across teams and between organisations. This strategy is about the big strategic changes where a more joined-up approach will bring local authority, NHS, and voluntary sector services much closer together to improve health and wellbeing at every opportunity.

In addition to this and to support our Medium-Term Plan ambitions we will encourage a shift in our care model to an improved model of continuous integrated NHS care with a strong emphasis of join up of NHS services to provide our residents with the best possible outcomes. ***See sections 4 and 5 for further detail***.

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

We will prioritise **prevention and early intervention**, reflecting the evidence that it is better to identify and deal with needs earlier rather than to respond when difficulties have become complex, which will then require intensive action by services.

Preventative services are particularly effective in improving the longer-term life chances of children, young people, and their families. We will look at how we can shift investment across our system so that we can support the priorities we have set ourselves for early intervention and prevention, at the same time still striving to improve services for those who need our help now.

As a key partner of the Integrated Care Strategy we are focussed on prevention and early intervention. ***See sections 4 and 5 for further details.***

3. Targeted work to reduce health inequalities

We will prioritise targeted work to **reduce health inequalities** across our population and across all services and settings, reducing avoidable and unfair differences in health between different groups in society. We will use local intelligence including population health management systems to enable health and care staff to identify people most at risk of ill health. We will identify areas where health inequalities are greatest to ensure that resources are targeted at people with the greatest needs. ***See section 5 and 6 for further details.***

4. Involving our residents and our workforce

We will involve our residents, their carers, our communities, and our staff - engaging with them at the earliest stages of service design, development, and evaluation. We recognise that those with 'lived experience' of a particular issue or condition, their families and carers, and the staff that support them are often best placed to advise on what support and services will make a positive difference to their lives. We will work with our residents to improve our services, listen to what they tell us, and respond to their needs. ***See Section***

***2.1* for further detail.**

4. Our priorities

In alignment with our principles, our JFP is aligned to the six priorities of our Integrated Care System (ICS) and our local health and wellbeing strategies. The ICS comprises different organisations from across Hertfordshire and West Essex including both Essex and Hertfordshire County Councils, healthcare providers and the Voluntary, Community, Faith, and Social Enterprise sector (VCFSE) Alliance.

The Integrated Care System brings together these organisations to design and implement joined up health and care services, and to improve the lives of its residents. The six priorities for the Hertfordshire and West Essex ICS, which are shared by all partners, are:

Priority 1: give every child the best start in life: *We will ensure that children in Hertfordshire and west Essex have the best opportunity to be safe and well and to reach their potential at school and beyond.*

Priority 2: support our communities and places to be healthy and sustainable: We will work with our communities to improve our residents' health and wellbeing by reducing health inequalities and taking action on the wider determinants of health including housing, employment and the environment.

Priority 3: support our residents to maintain healthy lifestyles: We will support people to be physically active, eat healthily and maintain a healthy weight, and we will provide support and advice to prevent tobacco, alcohol and substance misuse.

Priority 4: enable our residents to age well and support people living with dementia: We will ensure our residents are supported to age healthily, with access to advice and services that enable them to live well and independently for as long as possible.

Priority 5: improve support to people living with life- long conditions, long term health conditions, physical disabilities, and their families: We will support people living with lifelong conditions, long term health conditions, physical disabilities and their families, assisting them to take more control of their health and live a good quality of life.

Priority 6: improve our residents' mental health and outcomes for those with learning disabilities and autism: We will provide early help to our residents to prevent mental illness and support the health and wellbeing of those with a Severe Mental Illness (SMI), learning disabilities or autism.

Figure 3: The Hertfordshire and West Essex Integrated Care Strategy

5. The role of the ICB

In its Medium Term Plan the ICB sets out its priorities for 2024-2030. These priorities set out the role it will play in achieving the priorities of the wider NHS system (figure 4), with a focus on:

- Increasing healthy life expectancy and reducing inequality
- Giving every child the best start in life
- Improving access to Health and Care Services
- Increasing the number of citizens taking steps to improve their wellbeing.

The ICB will manage its budget and resources to focus on delivery across these areas. It will work directly to deliver improvements in the areas within its remit, such as access to services, and then in partnership for those priorities that need a whole system partnership approach to be successfully delivered.

In addition to the priorities set out above, the Integrated Care Board has an 5th priority, which is the need to successfully deliver our financial plan each year.

The ICBs Medium Term Plan has more detail on how it will deliver these priorities.

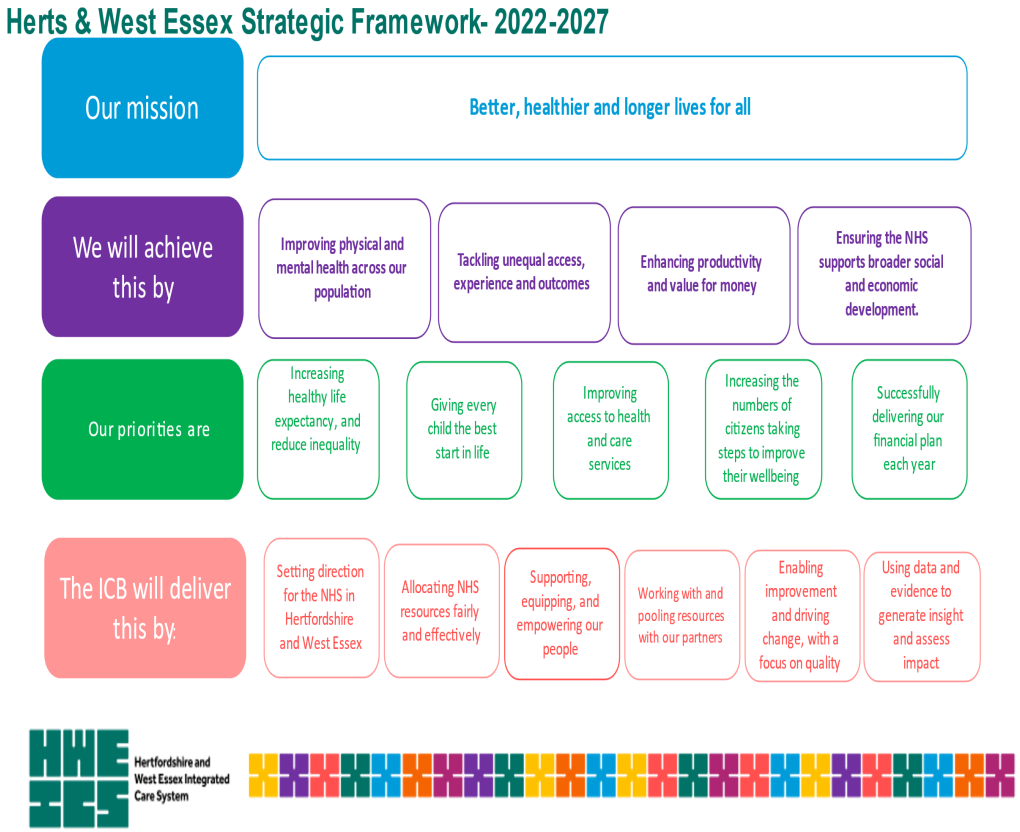


Figure 4: HWE ICB Strategic Framework

In 2023-24 the ICB agreed 5 key areas of short-term focus with our NHS partners for 2024-25 which will support the delivery of our strategic principles and priorities, these are outlined below:

1. Reduce inequality with a focus on outcomes for CVD and hypertension: we are seeing a fall in life expectancy through conditions including heart disease and widening health inequality. Through better detection and treatment it should reduce unwarranted life expectancy gaps through reducing Myocardial infarction (MI) known as “heart attack”, strokes and reduce related admissions.

2. Improve Urgent and Emergency Care (UEC) through more anticipatory and more Same Day Emergency Care: By enhancing our UEC services we should improve outcomes for our frail residents, such as deconditioning and provide better support closer to home. This will also improve ambulance handovers, reduce attendance, admissions and decrease our system spend on surge and escalation beds. It will also support our growing older population to stay healthy for longer.

3. Better care for Mental Health crises: Improving our crisis support should provide better care and outcomes for our residents by reducing long waits, Section 136 demand, reducing out of area placements, preventable admissions and suicides.

4. Elective Care Recovery: By further supporting the recovery of elective care we aim to reduce waiting times and the number of people waiting for treatment, as well as reduce unwarranted variation across clinical networks. This focus will improve our achievement of the national cancer standards, provide improved patient outcomes and experience by reducing the number of days our patients have to wait and improving quality and safety of our services.

5. A reduction in the backlog for Childrens Care: This can be achieved by developing improved and integrated for children and young people’s services including special educational needs and disability (SEND). Success would improve equity in access to services, enable the waiting times for community paediatric services and Attention Deficit Disorder (ADHD) assessment to be reduced and improve outcomes for children to support giving them the best start in life.

6. Delivering our priorities – to be updated:

To support the delivery of our Joint Forward Plan we will develop an updated delivery plan outlining our key plans for the next five years. Within this we will link our plans to the health needs of our population, and the challenges faced by our communities, along with feedback we have received from residents. This will be published in the summer of 2024.

To ensure that these deliverables are focused on the right areas, they are aligned to our Integrated Care Strategy and our ICB's strategic priorities and MTP. Our plans incorporate work with our ICS partners as well as a focus on the things we directly act on to support the delivery of wider system priorities. They will also support us to achieve the outcomes that are outlined below in Figure 5 over the next 5 years, with the indicators being used to demonstrate progress:

ICB Priorities	1. Reduce inequality with a focus on outcomes for CVD and hypertension	2. Improve Urgent and Emergency Care (UEC) through more anticipatory and more Same Day Emergency Care	3.Better care for Mental Health crises	4. Elective Care Recovery	5. A reduction in the backlog for Childrens Care
Indicators	1. Improved detection rate of hypertension in underrepresented groups year on year. 2. Increase in Percentage of patients with GP recorded hypertension in whom the last blood pressure reading was within target range 3. Reduction in Under 75 mortality rate for Cardiovascular disease per 100,000	1. Reduction in the Emergency admission and re-admission rate for people aged 75+ with a stay of <24 hrs per 100,000 age-sex weighted population 2. Decrease rates of +75s emergency admissions for falls within the community 3. Increase the % of patients with a high eFI who have a clinical frailty score recorded in the last 15 months 4. Reduced percentage of patients aged 75+ years with 3 or more admissions in last 90 days of life	1. Increase in Mental Health crisis follow up <72 hour 2. A reduction in Out of Area Placement Mental Health Bed days	1. Reduce elective long waits with essential actions to increase day case rates to 85% 2. Reduce elective long waits with essential actions to increase theatre utilisation to 85% 3. By March 2025; 95% of patients who need diagnostic tests will be seen within 6 weeks	1. Reduction in wait for community paeds services to 65 wks. by April 25. 2. Reduction in ED attendance and admission rates for children and young people by 5% by 2028
Expected Outcome	Reduce under 75 mortality from long-term conditions	Reduce the rate of ambulatory care sensitive emergency hospital admissions (Reduce unwarranted ED attendances & admissions)	Increase in the provision of early help to prevent mental illness and support the health and wellbeing of those with a Severe Mental Illness (SMI), learning disabilities or autism.	Reduction in the numbers waiting for elective activity and diagnostics (reduced PTL size).	All children will have the best start and live a healthy life

Figure 5: Expected outcomes and indicators

7. Supporting Change:

The following areas and initiatives will support the delivery of our strategic priorities and improve health outcomes for our residents.

Armed Forces Community

The Armed Forces Act 2021 required public sector bodies to take account of the unique needs of the armed forces community and legislation came into effect in November 2022.

We have worked closely with our two upper-tier local authorities (Hertfordshire and Essex County Councils) as well as our voluntary sector including both Healthwatch organisations, who provide specific Joint Strategic Needs Assessments for our armed forces community, which includes serving personnel and reservists, veterans and their families.

We work closely with both Counties Armed Forces Covenant Boards and chair a Health subgroup of the Hertfordshire Armed Forces Community Board.

We are focused on four key areas:
1) Social prescribing – we run a community Single Point of Contact (SPOC) across the ICB which supports serving and reservist families as well as veteran's and their families.
2) General Practice - accreditation with the Royal College of General Practitioners as 'veteran friendly'.
3) Local NHS Trusts and the Veteran Healthcare Alliance to gain accreditation as 'veteran aware' as well as achieving Employers Recognition Scheme accreditation
4) Improving the identification and coding of veterans and the armed forces community in our commissioning and service delivery.

Our 5-year vision is to help deliver locally the national vision of England being the best place to be a veteran, with a fully integrated system wide approach to improve outcomes for our armed forces community.

Climate Change and Sustainability

The delivery of our Green Plan 2022 – 2025 will support the ICB and our partners to deliver against the national NHS net-zero targets. The sustainability agenda will be embedded into the Estate Infrastructure Strategy, as well as addressing the newly released Biodiversity Net Gain requirements and NHS Travel and Transport Strategy in the revised Green Plans, which will emphasise the delivery and monitoring of progress across the ICS.

Each of these elements will also help to mitigate the health harms of climate change, for instance air pollution alone contributes to 1 in 20 deaths in the UK and increases the number of cases of cancer, heart disease and asthma.

We will continue to share and learn from our colleagues, such as the Cheshire 10-point plan, outlined in Figure 6, to support general practices to reduce their environmental impact in line with the NHS net zero ambitions, by adopting similar approaches in our estates planning and procurement.

Figur General

In add en Pla e tners are co ger, gree communities and working to reduce their environmental impact through reducing resource consumption in support of delivering the national Net Zero NHS targets. Each of our providers within our HCPs have published their sustainability commitments and Green Plans to deliver their individual goals. All business cases that are considered by each HCP must demonstrate its commitment to achieving our green goals as part of the governance process.

Key Deliverables:		
ICS Green Plan	2024-25	• Implementation and delivery against action plans • Co-ordinate communications and launch system wide campaign • Review and communicate our progress against actions • Measurement and reporting of system carbon reductions – targets will be fully embedded across all partners with supporting policies and procedures • Review of Green Plan reflecting on changes and new guidance, such as strategic estates, travel and transport strategy and bio-diversity net gain, creating a new 5-year plan across the ICS partners. • Ongoing communications and engagement, including training and carbon literacy (Mandatory training)
	2025-26	• Focus on hard to deliver and outstanding actions • Reflect on what is working and what can be improved moving forward
Key Performance Indicators		
• Leads assigned to each workstream. • System wide campaign launched.		
Milestones		
• Creation and ratification of refreshed ICS green plan – March '25 • Strategic Estates Plan – Sustainability section		

Clinical Leadership

We are committed to local implementation of programmes aimed at clinical and care professional leadership, as identified in Chapter 4 of the NHS Long Term Plan.

In keeping with system objectives with a greater emphasis on partnership working across health, inside and outside the NHS, and the broader public sector, the following are three key components in our plan for clinical and professional leadership:

a. Broadening the clinical and professional backgrounds of those in clinical and professional leadership positions.
b. Promoting clinical and professional leadership at all levels of seniority, including but not limited to, leadership for quality improvement, development of future senior leaders and encouraging practice at the top of one's licence.
c. A multidisciplinary forum, similar to a Clinical Senate, which establishes broad-based clinical and professional oversight of the above activities and other appropriate multi-professional initiatives such as medicines management and research.

Digital

We agreed our 10-year Digital Strategy in 2022 which focuses on digital improvements that will help us to improve patient care. We have identified five key themes as our digital strategy mission, covering new technology, strengthening our digital skills as a workforce, helping our residents access online services, and collaborating and sharing information to improve care. Our key plans for digital improvements include:

- Replacement cancer solution for the cancer network i.e. single solution across all 3 acute trusts (24/25)
- Advanced care plans deployed for a to be confirmed cohort of patients likely EOL (24/25)
- New EPR in PAH and ENHT (24/25)
- Increased uptake of NHS App usage across HWE especially in an OP setting.
- Fully deployed e-consent solution across 3 acute trusts.
- 80% of all CQC registered care home providers will have digital care records.
- Enhancements to Shared care record capabilities however this is currently unfunded and we need to find the funding source.
- Advanced cloud-based telephony in GP primary care estate.

Estates

We recognise the need to ensure our buildings are fit for purpose, suitable to meet the health and care needs across our geographical footprint, now and in the future.

Estates transformation and modernisation is a critical enabler of our strategic priorities and provides an opportunity to improve access, deliver efficiencies across our health and care system. We will build on our estates plans to include additional and flexible capacity in primary care; development of integrated neighbourhood care hubs; and acute hospital estate improvements. This will build on existing organisational and system estate plans, including our work on a major capital investment at Epping and Bishop's Stortford to improve community diagnostic treatments.

To deliver our ambitions, we are working in collaboration with NHSE national and regional colleagues, building on our previous strategies

and learning, incorporating the outputs from the National Primary Care Network Estates Toolkit.

There are exciting plans in development to improve hospital provision for the benefit of patients in our area through the New Hospitals Programme, which include funding for a new Princess Alexandra Hospital in Harlow and a new Watford General Hospital. This investment in our hospital infrastructure will be welcomed by communities and staff – and make it easier to deliver the modern, integrated health and care services that we all want to see.

Core ICB capital allocations for 2022/23 to 2024/25 have already been published and remain the foundation of capital planning for future years. These allocations broadly cover operational lifecycle costs and equipment replacement, with limited scope for major strategic change. Capital funding for large scale programmes is currently retained by NHSE for targeted allocation.

Finance – to be updated

Information about the ICB's financial duties is included in **Appendix 2**.

NHS England has issued two-year revenue allocations for 2023/24 and 2024/25. At national level, total ICB allocations [including COVID -19 and Elective Recovery Funding (ERF)] are flat in real terms with some limited additional funding available to expand capacity.

The national planning assumption was that to deliver a balanced net system financial position for 2023/24 and to achieve the core service recovery objectives, efficiency and productivity improvements equivalent to 2.2% would be required in 2023/24 with at least the same again in 2024/25. In reality the likely requirements for the next 2 years are closer to 4-5% efficiency and productivity improvement. Whilst future allocations beyond 2024/25 are still to be published, it is to be expected that future year efficiency and productivity targets will be at least 2% per year.

In order to deliver such improvement the ICB and its providers are working together on a series of plans that are outlined in section 5.7.

Longer term the system will need to be more transformative and increase investment on prevention services to deliver the triple aim – optimising health system performance through the simultaneous pursuit of three dimensions:

1. improve population health,
2. improve quality,
3. improve value for the system.

To support the delivery of financial balance, the ICB and partner trusts work together as a single system, but also in Place-based collaboratives to explore clinical and service delivery models and opportunities for transformation of services. Whilst each individual organisation agrees through its own governance processes an operational and financial plan for its organisation, this plan does reflect the spirit of the duty to collaborate.

Risk management remains a vital part of system planning and system plans take account of financial risks and how they will be

managed. A key aspect of the system's approach to risk and performance management is the regular sharing of data in a transparent way. This helps to identify any increasing likelihood of risks crystallising and affecting underlying financial performance. This allows for peer review and discussions on the opportunities to mitigate emerging financial problems. To support this the Finance Directors across the system meet regularly to review performance and agree actions to be taken.

The ICB's Finance and Investment Committee regularly sees financial performance information relating to the ICB and also for each of the partner trusts mapped to the ICS. The protocol for changes to in-year revenue financial forecast, published by NHSEI in November 2022, is followed with the Finance and Investment Committee taking a leading role in the oversight of partner trusts where necessary.

Broadly, this means that where organisations are performing consistently with submitted and approved plans, they may have limited engagement on their own operational financial matters. However, where an organisation within the system is departing from their plan, or is forecasting a divergence from plan, engagement would be increased.

Patient Choice and Personalised Care

Personalised care represents a shift in focus from traditional medical models to approaches that enable people to have greater choice and control over the way their care is planned and delivered, based on what matters to them and their individual strengths, needs and preferences.

We are working hard to improve opportunities for people to make choices about their care. We want to ensure that all patients can discuss with their GP or healthcare professional the different options available including pros and cons, and where appropriate, whether to have treatment. By enabling choice of provider and services that best meet people's needs, we will uphold people's legal rights in line with statutory requirements and guidance.

Patient choice has both constitutional and legal commitments which are embedded in key policy drivers within the NHS, including the NHS Long Term Plan and Universal Personalised Care. Choice is also highlighted as a key enabler of elective care recovery within the Delivery Plan for Tackling the COVID-19 Backlog of Elective Care.

The ICB has a Choice policy statement available on our website and we will engage with healthcare providers and professionals to promote choices available to ensure patient awareness, and information on patients' legal rights to choose is publicised and promoted.

Population Health Management (PHM)

Within the next five years we expect the ICS will have built the capabilities to utilise Population Health Management information to drive a data led focus on person-centred care. This should enable us, through our partnerships, to begin to see an impact of improved population health outcomes described within our outcomes framework and deliver our overarching system level outcomes. This is described in more detail in our recently developed PHM Strategy.

Our PHM strategy, which has been developed through a series of collaborative work across Hertfordshire and west Essex, will enable

our workforce to understand the needs of the population and the opportunities for improvement. This will therefore support improvements in population outcomes and health inequalities through the development of right services/high impact interventions for the right cohort of individuals at the right time. Adopting this approach will help ensure that proactive care models are considered across the system and our services are responsive to be able to meet the needs of the population. The strategy summarises our key activities over the next five years to help us achieve our ambitions.

The delivery of our PHM data platform and tools enable identification of needs and opportunities including scenario modelling, measurement of the impact of evidence based high impact interventions and support new financial models and incentive schemes. The tools described above will be implemented in 2024, through close working with the University of Hertfordshire and the ICS expects to develop key analytical capabilities to develop our workforce. This will support the ICS to develop its 'Intelligence Function' as described within Integrating Care: Next Steps to building strong and effective integrated care systems across England. Our PHM resources can be accessed here: Population health management – Hertfordshire and West Essex Integrated Care System (hertsandwestessexics.org.uk)

Procurement

The procurement regulations for healthcare services have recently changed with the introduction of the Provider Selection Regime (PSR). New procurement legislation which will become law in October 2024 will introduce significant changes to the way in which non-healthcare services are procured. The ICB is developing systems and processes to implement PSR and planning for the legislative changes in October 2024.

The ICB is also undertaking a detailed review of the local contracts and services during 2024/25 to develop future commissioning and procurement plans and recommendations that will support the decision making that is being delegated to the HCPs during 2024/25. The review will also explore and identify opportunities to improve efficiency, productivity, optimise spending, and shape the procurement plan for 2024/25 and 2025/26. The reviews are being aligned with the pathway and service model work streams under the following areas:

- Long Term Conditions.
- Planned Care.
- Urgent and Emergency Care.
- Out of Hospital Care (Community Services & End of Life).
- Continuing Health Care.
- Children, Young People and Maternity.
- Mental Health / Learning Disabilities.

Quality

Our goal is to set out a single vision of quality in our system based on the need to provide high quality personalised and equitable care for all now and into the future, ensuring that quality is central to planning and decision making within our health and care system. To meet our ambitions and support deliver, we will adopt the National Quality Board (NQB) 'Seven Steps' outlined in Figure 7:

1	**Setting clear direction and priorities** To deliver a new service model for the 21st century, which delivers better services in response to local needs, invests in keeping people healthy and out of hospital, and is based on clear priorities, including a commitment to reducing health inequalities.
2	**Bringing clarity to quality** setting clear standards for what high quality care and outcomes look like, based on what matters to people and communities.
3	**Measuring and publishing quality** Measuring what matters to people using services, monitoring quality and safety consistently, sharing information in a timely and transparent way, using data effectively to inform improvement and decision-making.
4	**Recognising and rewarding quality and learning** Recognising, celebrating and sharing outstanding health and care, learning from others and helping others learn, recognising when things have not gone well.
5	**Maintaining and improving quality** Working together to maintain quality, reduce risk and drive improvement.
6	**Building capability for improvement** Providing multi-professional leadership for quality; building learning and improvement cultures; supporting staff and people using services to engage in coproduction; supporting staff development and wellbeing.
7	**Staying ahead** By adopting innovation, embedding research and monitoring care and outcomes to provide progressive, high-quality heath and care policy.

Figure 7: the National Quality Board (NQB) 'Seven Steps'

In 2023 the ICS Quality Strategy was developed with quality leads, a range of system partners and with valuable contributions from members of our communities. Five quality principles (as outlined in Figure 8) were agreed as areas of focus across the system for the next 3 years and a range of defined actions have been taken and aligned to evidence our progress and successes against each of those principles.

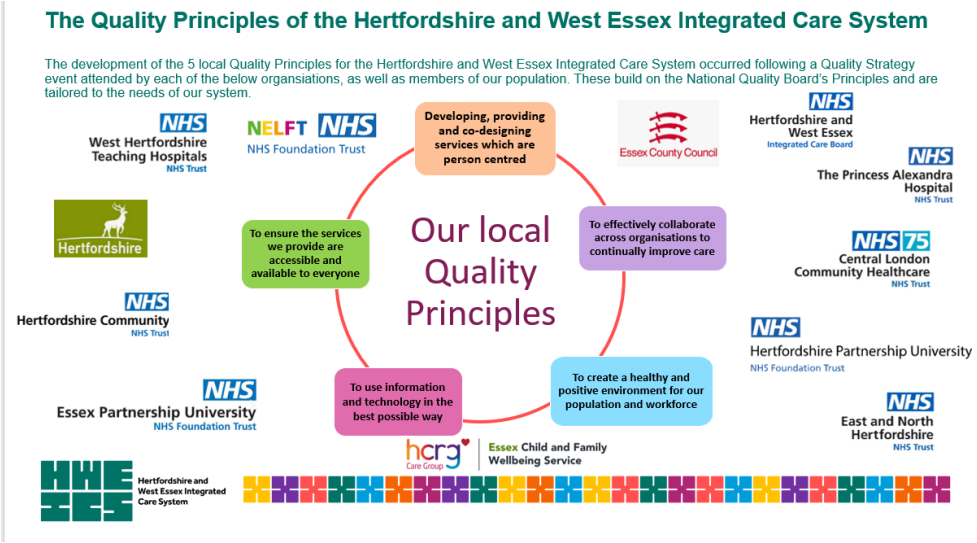


Figure 8: HWE Five Quality Principles

Below lists a sample of the key actions taken or plan to be taken:

- To have a fully developed system in place to gather feedback from our GP colleagues regarding feedback they, or their patients, want to give regarding NHS services. This is to understand where important quality improvement work can be focussed.
- To establish systems and processes to learn from deaths across the health and care system to improve patient safety.
- To create ways to understand family and carer feedback following end of life care.
- To explore how to effectively share key pieces of information to and for our communities, initially via GP practice websites, whilst being mindful of those who are digitally excluded.
- To increase the promotion of Freedom to Speak Up Guardians to ensure they are accessible and available to all staff.

Progress against all the actions has begun and will remain closely monitored whilst also considering potential further opportunities for improvement that can be aligned to the Quality Principles.

The Quality Strategy, as well as an easy-read version, has been published on the ICB's website. Following feedback from members of our community regarding simplicity a Quality Strategy Plan on a Page has also been developed to condense all the essential information on one page. This will be shared with colleagues across the ICS.

Reducing Health Inequalities

Our continued 5-year plan sets out its ambition to improve health equity, in line with our Integrated Care Strategy and principles of the NHS LTP. This plan sets out the approach we will take in closing the gap in variances of outcomes for people that may be due to ethnic background, circumstances in which they live or factors outside of their control. In the first year of the plan, we will work to clarify our performance in the Core20Plus5 framework for adults and Children and Young People. This plan outlines the ambition to ensure performance metrics are clear in respect of Core20Plus 5 for adults and CYP and will also assure that ICB is meeting is responsibilities in respect of its legal duties to tackle health inequalities.

We will continue to deliver an overall picture of health needs including wider determinants for the population of the ICS, targeting specific groups such as ethnically diverse groups, those who may be unpaid carers, veterans and members of the Gypsy, Roma Traveller community, refugees and migrants, victims of domestic violence and those living with a serious mental health issue or learning disability. In collaboration with system partners, an outcomes framework is being developed with clear performance metrics and tiered outcomes, that will identify areas where modifiable risk factors can be better prevented through the use of asset-based community development, community connectors and social prescribing.

In Hertfordshire and west Essex we have areas of significant deprivation and inequalities Through partnership work with colleagues including the VCFSE sector we aim to narrow the gap in varied outcomes, building longevity into actions, ensuring they are sustainable and benefiting our communities.

To achieve this aim, we will need to collaborate with partners to better understand their data, ensure data collected and categorised is correct allowing for better and easier data manipulation and interrogation. Working with our Population Health Management team and system partners, we will develop an in-depth understanding of the local population needs and areas of inequity, supported by the continued development of system partnerships.

During the coming year of the plan and beyond, we will continue to work to drive down inequalities in outcomes for members of communities most at risk Through enhanced neighbourhood working between PCNs and VCFSE partners, enhancing current partnership working with sustainable models for engagement, communication and delivery.

The PHM team will build reporting from the linked record data through our new data platform so progress in achieving outcomes will be viewable by geography, age, population segment and other cohorts, supporting for example inequalities work such as the Core20Plus5.

Research and Innovation

Hertfordshire and west Essex has well established research capabilities embedded within our provider organisations. The Health and Care Act 2022 enables our ICS to develop an integrated approach to research and ensure this capability and capacity aligns with the delivery of our key priorities. The ICB has appointed a Head of Research and Innovation and is working with the University of Hertfordshire to mobilise a Research & Innovation hub to further strengthen our research and innovation capacity and capability across our ICS.

The ICS has developed a Research Strategy which incorporates the findings of a recent project to understand our systems research capacity and ensure representation in research for our whole HWE ICS population. Its guiding principles are:

1. Embed the benefits of research, innovation and evaluation to better meet the needs of the health and social care system and enable the delivery of the Joint Forward Plan

2. Ensure that research, evidence, innovation and evaluation underpins the way we enhance, transform or devise services using a well governed approach to manage risk, ensure patient safety and public confidence.

3. Ensure that the voice of all our residents inform all we do, promoting inclusion, and represent good value for our taxpayers.

4. Make the HWE ICS a national exemplar for the use of research, innovation and evaluation to meet the needs of our residents and workforce and deliver the integrated care strategy to improve population health outcomes.

5. Aim to achieve financial sustainability by 31st March 2026.

Safeguarding Specific Research and Innovation

Over the next five years the safeguarding team will provide leadership through innovative practice through collaborative research, including

1. Evaluative research to test effectiveness of Learning and Improvement in Practice. (Hertfordshire University, Hertfordshire Safeguarding Adults Board, HSAB /Hertfordshire Safeguarding Children's Partnership HSCP).
2. Improve the life chances for infant and children through the collaborative research into the cause and prevention of suicide. Findings from the Child Death Overview panel (Essex Safeguarding children Board ESCB /Bedfordshire University/HSCP/ Public Health.
3. Collaborative working between Child Death Overview Panel (CDOP) Essex and Hertfordshire to reduce child death linked to unsafe sleeping.
4. Contributing to the Innovative Domestic Abuse Perpetrator programme in collaboration with University of Bedfordshire safeguarding children partnership and community safety partnerships.
5. To reduce non accidental death and traumatic injury in childhood through the introduction and innovative practice of Infant Crying - ICON fathers and partners and bespoke learning events.
6. Leading on national development for Primary Care Community of Practice, to strengthen learning and innovative

practice.

7. Supporting the national drive for Domestic Abuse Community of Practice to develop research-led intersection of risk assessment.

Safeguarding

Legislation, statutory guidance, multiagency policies and procedures support organisations, practitioners, drive the agenda of safeguarding children and adults. These include Working Together 2023, the Children Act 19896/2004; The Mental Capacity Act, 2005; The Care, Act 2014; The Children and Social Work Act, 2017; Domestic abuse Act, 2022; The Health and Care Act, 2022. The recent legislation on Domestic Abuse Act 2021, Serious Violence duty January 2023 is driving our system to embed practice to meet these legislative requirements.

In Essex we continue to work collaboratively with Suffolk & North East Essex, (SNEE) and Mid and South Essex (MSE) to develop an evidence based Strategic Needs Assessment and operational plan. HWE is also committed to reducing inequalities identified within the national agenda to address the disproportionate amount of Violence Against Women and Girls. Including, those impacted by serious violence, going beyond the scope of domestic abuse with specific focus on children as victims in their own right. There is work to strengthen the application of research on the support for perpetrators.

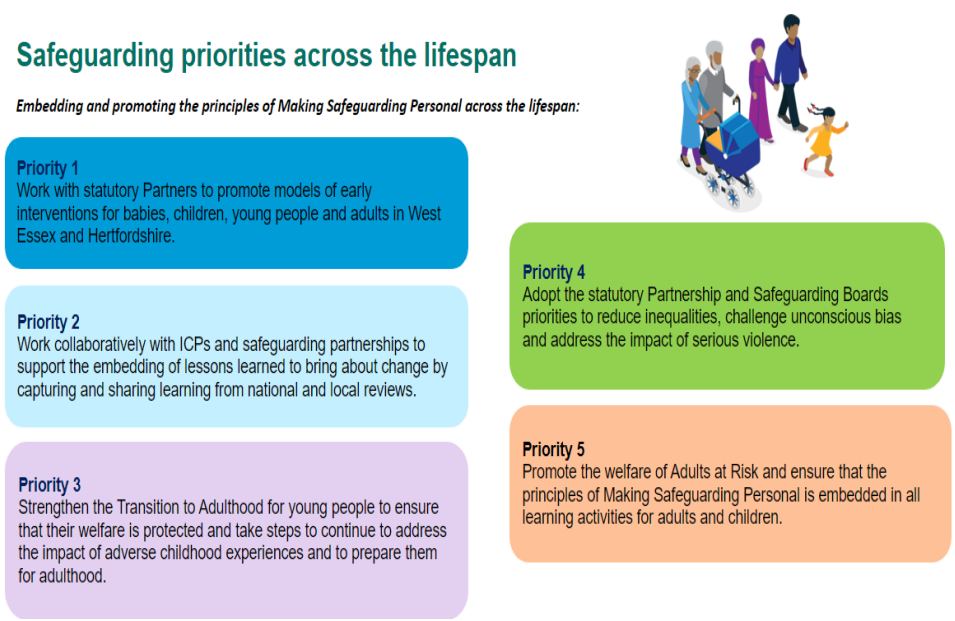
The HWE ICB continue to work with partners to ensure that the application of the Mental Capacity Act 2005 is consistently applied for people aged 16 and above, who are or who need to be deprived of their liberty in order to enable their care or treatment, and lack the mental capacity to consent to care and arrangements are supported in the most proportionate, least restrictive way ensuring legislative requirements are met. We are using findings from Statutory reviews to work in partnership to ensure that the principles of the MCA and making safeguarding personal is embedding in the planning and delivery of care for the local population, both children and adults.

Our safeguarding teams work in partnership with our local authorities' children's and adult services to promote the health and welfare of children and support adults at risk and promote a learning culture to act as a preventive measure towards improving the lives of all of our communities This work is supported by several partner safeguarding plans and strategies including Hertfordshire 2022-2024 for adults, strategic priorities 2023-2025 for children and Essex Children Board plan 2022-27, Southend Essex Thurrock Domestic Abuse Board strategy 2020-2025, Hertfordshire Domestic Abuse Strategy 2022-2025 and our HWE ICB Safeguarding Strategy for children.

The safeguarding teams will drive leadership to improve the safety of looked after children in residential settings in response to the national review phase one, and two of the Hesley report 2022 and 2023 to ensure that safe efficient and appropriate provision for children with disabilities and complex needs are aligned with local inclusion plans when planning for care through regional care cooperatives. We will also work to strengthen and improve access for adults with complex physical, and mental health needs.

We monitor and share with partners safeguarding children and adult Key Performance Indicators (KPIs) on a quarterly basis to understand trends in referrals to children's and adult services,

domestic abuse referrals by health, local authorities and police so we can respond to emerging trends and themes to promote and support safe care. We will use the findings of current evaluative research to strengthen the way we deliver learning from local, national and wider reviews. The ICB as part of Corporate Parenting Board have prioritise the lived experience of Care Leavers and children with care experience. This includes strengthening opportunities for employment and further education through the Deed of Covenant for Looked After Children. The aim is to improve equity, access to employment and further education and to reduce health inequality for this cohort of the population.



Supporting wider social and economic development – Part of our role as an 'anchor institution' is to support the NHS to develop broader social and economic development. We will use all the levers at our disposal and partners support as anchor institutions to improve the economic wellbeing of residents as one of the key determinants of health and wellbeing. This includes improving employment outcomes for our residents and improved social value through our commissioning and procurement activities. We are developing our role to support this in several ways, which are outlined below:

- **Anchors Network** - 30 public sector organisations in Essex, including the West Essex Health & Care Partnership, have come together as the Essex Anchor Network (EAN) to drive greater prosperity and a better quality of life for their local population – through employment and workforce strategies, procurement and supply chain policies, investments and use of estates. This is with an aim of raising aspiration within a community, by engaging with schools and mentoring people.

  The west Essex Anchors Group within this network is currently focusing on bringing employers and colleges closer together to specify skills needed for the future. The group is also looking to improve opportunities for work placements and apprenticeships.

  Building on the learning from Essex, the University of Hertfordshire has been working with partner organisations across Health, Local Authority and the Voluntary Sector to help identify early system priorities that would benefit from delivery in partnership. These areas are focused on positively impacting our Workforce, Research and Innovation and our communities. Following on from the official programme launch attended by over 100 representatives of the wider Hertfordshire and West Essex system partners, this year we will focus on developing and articulating a strategic plan to

capture both the early benefits of the agreed work and agree how ambitious the future plan for partnership working across Health and Care partners can be.

- **VCFSE sector and the VCFSE Alliance** - This sector is worth more than £1bn and is a large employer. The website Working Herts has three functions, all of which will develop further during year 1 of the JFP. The first is to promote working in the VCFSE sector in Hertfordshire, the second is to provide free promotion of jobs to encourage more people into the sector, and the third is to provide an easy way for registered partners to fill short term and part time roles by drawing on the capacity of those currently working in the sector who wish to build a portfolio.

  It also uses thousands of volunteers, with positive impacts for the volunteer's wellbeing and, where appropriate, their acquisition of new skills and employability. The VCFSE Health Creation strategy has a workstream on further developing volunteering roles to fit 21st Century lifestyles and to encourage Anchor Institutions to offer their staff opportunities to contribute to their communities too. This sector is also crucial in helping the most disadvantaged residents' access full benefit entitlements and other help. The Herts Cost of Living Group and the Better Life Chances partnership are forums where VCFSE and statutory sector work together to maximise the impact on those facing the greatest financial challenges.

- **Unpaid Carers** - A significant segment of the working population has caring responsibilities including 30% of the national NHS workforce. The pressure on social care is making it harder for many carers to work and care. We have been awarded 'Accomplished' (level 2) status by Employers for Carers for our work to support carers who are juggling their unpaid carer role with being employed by the ICB. Work with local authority partners also focuses on helping carers to stay in or return to work where possible.

Workforce

Our workforce continues to be recognised as a key enabler in delivering both the broader Integrated Care Strategy and Joint Forward Plan. Our system-oriented workforce transformation programme continues to seek to strengthen collaboration ensuring the most effective and efficient delivery of health and care services for our population. The programme is supported by wider activities of the system's Primary Care Training Hub and Allied Health Profession Faculty.

We have seen substantial progress in meeting our People Strategy priorities over the first year of the Joint Forward Plan.

Additionally, we have seen the publication of the national NHS Long Term Workforce Plan and associated regional priorities. These actions fall into three priority areas:

- Train: increases to education, training apprenticeships and alternative routes into professional roles. Development of new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.
- Retain: ensure we keep more staff by supporting people throughout their careers, improving flexible working options as well as the wider culture and leadership across organisations.
- Reform: improving productivity by working and training in different ways, building flexible skills, and ensuring staff have the right skills to take advantage of new technology.

Key to the delivery of our People Strategy and Joint Forward Plan will be an improvement and triangulation of workforce data. We are working with colleagues within performance, quality and across the system, to improve our understanding, analysis and forecasting of workforce requirements across health and social care.

Within the first year of delivery we have achieved the following areas of progress against our People Strategy aims and ambitions, which are monitored and governed by the systems' People Board, and directed by respective sub- committees:

1. **We will produce a long-term workforce plan for the whole system, based on the needs of our population and accounts for the skills required to deliver those services.**
   - We are developing a system to improve access and analysis of workforce data across health and care.
   - Pilot projects reviewing Allied Health Professionals workforce and establishment review.

2. **We will create communities empowered and enabled to provide the best possible care through innovation and integrated working.**
   - Working with IBM and our stakeholder organisations we are seeking to apply new technological HR solutions.
   - We are also seeking to implement the national digital staff passport to enable easier transfer of staff across organisations.

3. **We will develop sustainable workforce attraction strategies, particularly through domestic supply routes, to reduce system vacancies.**
   - We have supported targeted recruitment to care support worker roles and have improved vacancy rates in those areas.
   - We continue to provide long-term strategic support to the system through the use of the Health and Care Academy.
   - We have introduced a 36-week NHS and Care Cadet Scheme along with a dedicated campaign to attract young people into a career within the Health Service or Social Care

8. 2023-2024 Progress

Our first Joint Forward Plan was published in June 2023, since its launch we have seen the following progress against our ICB Priorities, which also support our ICS Integrated Care Strategy ambitions:

Reduce inequality with a focus on outcomes for CVD and hypertension

- **CVD**: The trend in both diagnosis and control of hypertension in HWE is improving. We have increased the proportion of people with hypertension who have had a blood pressure check and whose last blood pressure reading is below the age specific threshold.

  The number of people submitting home blood pressure readings have also increased significantly.

- **Stroke:** improvement in the Sentinel Stroke National Audit Programme (SSNAP) rating for East and North Hertfordshire Trust to a 'B' in September, from previous longstanding 'D' rating

Improve Urgent and Emergency Care (UEC) through more anticipatory and more Same Day Emergency Care:

- **Falls**: We have successfully implemented a 'Long lie' pathway (a long lie fall is when a person who has fallen spends a prolonged period of time on the floor because they are unable to get up) supporting those who have had a fall in the community.
- **Leg-Ulcers**: A revised leg-ulcer service has been introduced to deliver equitable management provision, both specialist and non-specialist, for all registered Place patients.
- **End of Life:** East and North Hertfordshire have continued rollout of ReSPECT documentation for patients in the last year of life and advanced care planning. This supports greater understanding, awareness, leading to reduced number of inappropriate and avoidable admissions resulting in patients dying in hospital rather than their preferred place of death
- **Primary Care:** in 2023-24 there was a 3.7% increase in GP appointments in 23-24 compared to 24-25.

  Integrated Neighbourhood Teams have been established on all place footprints and clinical priorities are being agreed and are already in place for some.

ICB Priority: Better care for Mental Health crises: to be updated

- **Children and Young People:** We have increased CYP mental health access by 44% year on year and have increased support in Early Help by 54%.
  We have achieved the national Eating Disorder RTT 28-day standard ambition.
  Herts CYP mental health services successfully procured a digital access portal, to enable functionality including automated referrals, an Advice and Guidance 'Passport', secure instant messaging and live updates.
- We have exceeded the Mental Health Support Team (MHST) target of 23% by 23/24 with Herts and west Essex having 90% SEND MHST coverage across schools.

ICB Priority: Elective Care Recovery

- Clinical networks established for urology, gynaecology, theatres and perioperative care, musculoskeletal (MSK) and children and young people. Resources secured for Elective Hub planning, mobilisation underway and building work has now commenced. The new QEII Community Diagnostic Centre (CDC) is fully operational

- Extended access for MRI, Audiology is live at Epping Community Diagnostic Centre, with ultrasound available at the Bishops Stortford CDC.
- Theatre productivity rates improved to top quartile nationally (81.7%).

A reduction in the backlog for Childrens Care:

- **SEND:** We have reviewed and made the necessary changes to our skill mix of our therapies teams and we have appointed new education leads.
  Additional clinics have been offered on Education, Health and Care Plans (EHCPs) to reduce waiting times for assessments; we have launched the new children and young people's integrated therapy services website. We have also completed a number of specifications focused on speech and language therapy and occupational therapy and physio and our new prioritisation framework is enabling resources to target children with the highest need.
- **Engagement:** A ICB Health Youth Council was established, providing a structured and consistent framework to hear the voices of children and young people and undertake co-production, to complement this work helping patient groups understand what young people need from healthcare a series of 8 short videos have been produced and shared across multiple platforms.

Other updates supporting wider system ambitions:

- **Maternity** Work is underway and on track to deliver 70% compliance in line with the Year 5 Maternity Incentive Scheme (MIS) by February 2024; our aim is to reach 100% compliance by March 2024 aligned to the Three-year Single Delivery Plan.
  The Local Maternity and Neonatal System (LMNS) has been successful in delivering the year 5 Maternity Incentive Scheme (MIS), which supports the delivery of safer maternity care, designed to improve the delivery of best practice in maternity and neonatal services.
- **Respiratory:** We have established an asthma board to oversee asthma improvements, including delivery of the National Childrens' Asthma Bundle of Care sharing learning across our system. Children and young people asthma clinical leads are in post. We have provisional funding to provide our Trusts with children and young people diagnostic equipment and we have launched Asthma Friendly Schools across our system

  We have increased the proportion of children with an asthma care plan and there has been a decrease in the rate of Children attending Emergency Department for Asthma
- **Kidney Disease:** In East and North Hertfordshire the evaluation of Virtual Chronic Kidney Disease (vCKD) pilot has shown that the service has significantly increased the number of patients who are able to be safely managed within primary care in the community (98%), and that the Lister Hospital First appointment wait is down from 14 weeks to 6 weeks due to coverage by vCKD
- **Autism**: The Autism Outreach Service has been successfully commissioned, with the launched expected in May 2024; the planning and roll out of the Autism in Schools programme implementation will continue in 2024-2025. The ASD Psychoeducational Resource Project was also launched across Essex, Southend and Thurrock for parents, carers and young people.

- **Digital:** Links established with the wider NHS, Universities, Academic Health Science Networks and others aligned to exploring and testing new technologies for care in line with the NHS Long Term Plan
- **Obesity:** We have increased referrals into the national Digital Weight Management Programme, with Hertfordshire and west Essex now in the top 10 for highest eligible referrals.
- **Smoking Cessation:** We have implemented the national Tobacco Dependency Programme pathways, in maternity, acute inpatient (in limited) but high impact specialities; community inpatient and mental health inpatient settings.

Appendix 1 – ICB Statutory Duties

As an ICB we have a number of statutory duties that it is required to fulfil by law. This Joint Forward Plan includes details as to how these duties will be delivered. We will exercise our statutory duties with the aim of:

- **Meeting our population needs** through commissioning of healthcare services and working with our partners in health and social care to deliver services that meet the needs of our population. ***See sections 1 and 2 for further details.***

- **Promoting integration** within our system by working with our providers as well as our health and social care partners to build on existing integration and collaboration to better align and integrate our services to create efficiencies and benefits for our residents. ***See section 3 for further details.***

- **Having regard to the wider effects of healthcare decisions** through our governance and decision-making processes at system, place and neighbourhood levels. Ensuring that the NHS triple aim is considered in our decision making and evaluation processes. The triple aim being better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing), better quality of NHS health care services (including by reducing inequalities with respect to the benefits obtained by individuals from those services), more sustainable and efficient use of resources by NHS bodies. ***See sections 2, 3 4, 5 6 and 7 for further details.***

- **Achieving a balanced financial position**: To support delivery of financial balance the ICB and partner trusts work together as a single system, but also through our Health Care Partnerships to explore clinical and service delivery models and opportunities for transformation of services. So, whilst each individual organisation agrees through its own governance processes an operational and financial plan for its organisation, this plan reflects the spirit of the duty to collaborate. ***See section 7 and Appendix 1 for further details.***

- **Improving the quality of services** in line with our duty to continually improve the quality of care and outcomes and to deliver the ambition set out for us within the National Quality Board Guidance – 'A Shared Commitment to Quality' and the Long-Term Plan's ambition for quality in the NHS. Our goal is to provide high quality personalised and equitable care for all now and into the future ensuring that quality is central to planning and decision making within our health and care system. Also that it is aligned with Public Health and Adult Social Care, the NHS Patient Safety Strategy and the People Plan. ***See section 7 for further details***.

- **Reducing health inequalities** across our population and across all services and settings, reducing avoidable and unfair differences in health between different groups in society. We will utilise local intelligence including population health management systems to enable health and care staff to identify people most at risk of ill health and identify areas where health inequalities are greatest to ensure that resources can be targeted at people with the greatest need. We will also work in an integrated way to reduce the factors that contribute towards health inequalities. ***See sections 2, 5 and 6 for further details.***

- **Promoting involvement and patient choice** of each person by expanding the choices and control that people have over their own care. Through social prescribing the range of support available to people will widen, diversify and become accessible across the area. Enhanced digital capabilities will ensure that people are empowered and will have the ability to access, manage and contribute to digital tools, information and services. articulated throughout our JFP. ***See sections 2, and 7 for further details.***

- **Involving our residents** who use our services, their carers, and communities, along with our staff that deliver our services. We will engage with them at the earliest stages of service design, development, and evaluation. We recognise that those with 'lived experience' of a particular issue or condition, their families and carers, and the staff that support them are often best placed to advise on what support and services will make a positive difference to their lives. We are committed to working with our residents to improve our services and will listen to what our

residents tell us and respond to their needs. ***See section 2 and 7 for further details.***

- **Addressing the needs of victims of abuse** by ensuring that the proper systems are in place to help. We will continue to develop best practice to safeguard children who are subject to abuse and neglect, including victims of criminal or sexual exploitation. Adults or older people with greater vulnerabilities or complex needs will have specialist integrated drugs and alcohol support. Specialist support recognises and tackles the complexity of vulnerable adults' needs such as victims of domestic abuse or sexual assault, sex workers, homeless people, veterans and older people. We will develop effective pathways to integrated services for domestic abuse victims and perpetrators. Agencies will collaborate to help everyone in the family affected by domestic abuse. The Serious Violence Duty (January 2023) will drive the ICS to embed practice to meet the legislative requirements. ***See section 7 for further details.***

- **Obtaining appropriate advice** to enable us to successfully discharge our functions through our ICB governance arrangements that incorporate expert advice and also through broader engagement of the public (as outlined in section 2 and throughout this document). Also by strengthening relationships with national and regional clinical networks, academic health science networks and our local university to support with innovation and review pathways. ***See section 7 for further detail.***

- **Supporting delivery of our local health and wellbeing strategies** through alignment with our plans and strategy detailed in our JFP and also with the Integrated Care Strategy***. See sections*** 4 ***and 5 for further details***.

- **Promoting innovation** by utilising and realising the benefits of innovation to enable positive change in the way that we deliver our services. We will look to use innovation to improve our interactions with the public, patients and their families and develop new improved models of care. We will also look to advancements in technology to improve the management and delivery of care and deliver new treatments. ***See section 7 for further details.***

- **Promoting education and training** through the delivery of our ICS People Strategy we will strengthen our health and care workforce and enable career development by embedding a culture of training and development across the system. This will be done by developing a system-oriented career and leadership pathway, ensuring staff from all backgrounds can access appropriate training and development opportunities and developing a system-led talent management process. We will also work with educational institutions to develop training and placement opportunities to address key skills gaps. ***See section 7 for further detail.***

- **Utilising, facilitating and promoting both local and national research** – we have well established research capabilities embedded within our provider organisations. Through research engagement network development (REND) funding will build on initial progress to develop an ICS research strategy. ***See section 7 for further details***.

- Delivering against our targets to **tackle climate change** by building on our initial progress and delivering our ICS Green Plan 2022-25 in collaboration with our partners. ***See Section 7 for further details.***

- **Providing children and young people with the best start in life** irrespective of where they were born and live. Our aim is to improve the health and care system to ensure that services are joined up and easy to access when and where they are needed and to ensure that the voice of the child is at the heart of all we do. Over the next 5 years we want to see improvements in the health of children and young people as a result of the work we do across the ICS, and with our neighbouring partners across Essex. ***See section 4, 5 and 6 for further details.***

- **The Public Sector Equality Duty (section 149 of the Equality Act 2010) (PSED) -** requires that public bodies should place considerations of equality, where they arise, at the centre of formulation of policy, side by side with all other pressing circumstances of whatever magnitude. The general equality duty not only applies to general formulation of policy, but also applies to decisions made in applying policy in individual cases. The views of our residents, patients, staff and communities in west Essex and Hertfordshire have informed and shaped the development of this plan. This was done using an approach that includes a wide- ranging literature review, focus groups, stakeholder engagement events and surveys. What our residents have said is included in each of the priorities covered in this plan. We acknowledge that our responsibilities under the Public Sector Equality Duty are ongoing, and any work undertaken to deliver on the priorities will ensue that the views, and needs, of the nine protected equality groups will be included, where appropriate.

Appendix 2 – ICB Financial Duties - to be updated

As set out in section 223M of the National Health Service Act 2006 ("the 2006 Act") (as inserted by section 29 of the Health and Care Act 2022), each ICB and its partner trusts must exercise their functions with a view to ensuring that, in respect of each financial year:

- local capital resource use does not exceed the limit set by NHS England
- local revenue resource use does not exceed the limit set by NHS England.

Furthermore, under section 223L of the 2006 Act (as amended) NHS England may set financial objectives for ICBs and their partner trusts, and each ICB and its partner trusts have a duty to seek to achieve those objectives. NHS England has set the objective that each ICB, and the partner trusts whose resources are apportioned to it, should deliver a financially balanced system, which may be referred to as a 'duty on breakeven'.

ICBs also have a duty to deliver financial balance individually (section 223GC of the 2006 Act). This is to promote careful financial management and to reflect legislation that requires NHS England and ICBs to manage within a fixed budget. Where an ICB considers it necessary to deliver overall system financial balance but with a deficit in the ICB itself, NHS England should be notified at the

earliest opportunity. Additionally, each ICB should ensure it does not exceed the running cost allocation limit, which will be published as part of ICB allocations.

Under the legislation, the system financial duties rest on each ICB and its partner trusts. As each trust may be the partner of more than one ICB, the legislation provides for NHS England to apportion a trust's resource use for these purposes to one or more ICBs. NHS England has apportioned the revenue and capital resources of all trusts exclusively to a single principal ICB. The objective of this approach is to ensure that the ICB and trusts' mutual responsibilities are clear, e.g. to meet system financial balance, and to provide stability and continuity in planning relationships.

While the measure of system financial balance will be based on the mapping of a trust to a principal 'host' system, this does not change the requirement for all commissioners to work with the providers of their commissioned services to support financial sustainability and agree contractual terms that underpin this. Likewise, trusts that are formal partners of more than one ICB are required to confirm that their operational and financial plans are compatible with and align to all relevant system plans.

Given the requirement for systems and ICBs to seek to deliver a breakeven position each year, they should not plan for any in-year surplus or deficit. Any system or ICB that is overspending is expected to take all necessary steps to correct its rate of expenditure to address the overspend. In the event a system does overspend against its allocation for the year, the amount of the overspend will be carried forward and maintained as a cumulative system position. Cumulative system overspends will need to be repaid.

Access to any historical surplus for non-recurrent expenditure will be aligned with performance through the NHS Oversight Framework, and subject to national affordability. Any approved drawdown must be used for non-recurrent investment. The brought forward balance from the former CCGs within the system is £16.7m.

In response to the COVID-19 pandemic, the NHS adopted emergency payment arrangements from the start of 2020/21. Those arrangements included the establishment of nationally calculated block payments, with the balance of funding to support system breakeven issued as a 'system top-up' through a host clinical commissioning group (now ICB) for each system. As a consequence, although individual trusts received the totality of funding available either through their individual contract arrangements or system top-up flowing from their host ICB, funding did not necessarily flow to the trust from the appropriate responsible commissioner (ICBs or NHS England).

To address this issue, a short exercise was run during 2022/23 to correct material issues with contract values and allocations.

Glossary of Terms

Acronym	Full Term
ARRS	Additional Roles Reimbursement Scheme
AFC	Armed Forces Community
AHP	Allied Health Professionals
CAMHS	Children and Adolescent Mental Health Service
CETRs	Care, Education and Treatment Reviews
CVD	Cardiovascular disease
CYP	Children and Young People
CPCS	Community Pharmacy Consultation Service
DNA	Did not Attend
DSR	Dynamic Support Register
EAN	Essex Anchor Network
EEAST	East of England Ambulance Service
ENH	East and North Hertfordshire
FH	Familial Hypercholesterolaemia
FIT	Faecal Immuno Testing
FDS	Faster Diagnosis Standard
FSM	Free School Meals
GIRFT	Getting it Right First Time
HCP	Health Care Partnership
HEE	Health Education England
HIU	High Impact User
HMLDA	Hertfordshire Mental Health, Learning Disability and Autism
HWE	Hertfordshire and West Essex
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
INT	Integrated Neighbourhood Teams
JFP	Joint Forward Plan
JSNA	Joint Strategic Needs Assessment
LDCT	Low-Dose Computed Tomograph
LD	Learning Disabilities
LoS	Length of Stay
MDT	Multi-Disciplinary Team
MHST	Mental Health Support Teams
MOU	Memorandum of Understanding
NDDP	NHS Diabetes Prevention Programme
NQB	National Quality Board
ND	Neuro Diversity
OPA	Outpatient
OPFA	Outpatient First Appointment
PCN	Primary Care Network
PHM	Population Health Management
PROMs	Patient Reported Outcome Measures
PTL	Priority Target List
SDEC	Same Day Emergency Care
SMI	Severe Mental Illness
SWH	South and West Hertfordshire
TLHC	Targeted Lung Health Check
UCR	Urgent Community Response
UEC	Urgent & Emergency Care
UDA	Units of Dental Activity
UTC	Urgent Treatment Centre
WE	West Essex

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:**	**22/03/2024**
Report Title:	**HWE ICS Urgent and Emergency Care Strategy**		**Agenda Item:**	**15**
Report Author(s):	Dr Holly Jenkins, Associate Medical Director, ICB Input from key stakeholders across the ICS			
Report Presented by:	Dr Elizabeth Disney, Executive Director of Operations, ICB			
Report Signed off by:	Dr Elizabeth Disney, Executive Director of Operations, ICB			

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:	▪ Is the Board happy to approve the HWE ICS Urgent and Emergency Care Strategy as a final version and for the document to be now disseminated across the ICS.
Report History:	The development of the HWE ICS Urgent and Emergency Care Strategy was presented and discussed at the ICB Board previously (May 2023). Following this, continued co-design with system partners has been undertaken to further specify the strategic priorities. ▪ Presented and discussed at the ICB UEC Board (May/November 2023, Jan/Feb 2024) ▪ Engagement with public through a local survey to understand peoples' experiences of using UEC services in HWE (August 2023) ▪ ICB Patient Engagement Forum (September 2023) ▪ System UEC leadership and programme area leads co-development of UEC priorities and proposed deliverables (October 2023) ▪ ICS wide engagement and further development of the strategy with our four health and care partnerships (HCPs), system resilience groups (SRG)/local delivery board (LDB) acute, community, and ambulance providers, primary care colleagues (including community pharmacy), and other health and care partners and VCFSE leaders (November 2023 to February 2024)

Executive Summary:	The HWE ICS Urgent and Emergency Care Strategy outlines the direction of travel for urgent and emergency care transformation across Hertfordshire and west Essex from 2024 to 2029. The strategy encompasses the national UEC recovery delivery plan and performance improvement requirements, it also aligns with a number of local strategies and priorities as outlined within the document. The strategy sets out six core strategic objectives: ➢ Understand and predict our population needs in order to support those at greatest risk and deliver tailored population-based approaches. ➢ Partners within the system work together to ensure joined up and coordinated care, including improved flow and early supported and safe step-down from services. ➢ Prevention and proactive, personalised care is embedded across the system to empower people to live and age well avoiding the need for services wherever possible. ➢ When people need same day or urgent care they can easily and rapidly access the right care ➢ Effective and efficient emergency care pathways that are appropriate, safe, and closer to home. ➢ Focus on children and young people, mental health crisis response, and frailty and end-of-life care. These strategic priorities will be supported by a number of key enablers, we will: ➢ Ensure an integrated workforce operates flexibly across the urgent and emergency care system, empowered to innovate and embrace new and alternative pathways of care. ➢ Make better use of digital technology to enable self-care, convenient access, remote monitoring, and care with smooth data interoperability and sharing between system partners. ➢ Empower our population to make informed decisions when accessing same day and urgent care. ➢ Deliver clinical and professional leadership for transformation change with a culture of innovation, evaluation, and sharing best practice. The strategy outlines key deliverables over the next five years within each of these strategic priorities. Each year, drawing on the whole of the ICS resources, we will produce in partnership, a prioritise ICS UEC delivery plan which will progressively implement the intent of this strategy, including meeting the needs of the annual operational planning process. Each delivery plan will need to deliver on the annual operational plan requirements, taking balanced consideration to improving clinical outcomes, experience, performance, operational

	delivery, and financial sustainability. Due to current financial challenges, it is likely that initial years implementing this strategy will be focussed on initiatives that clearly deliver improved efficiency, productivity and outcomes, and where ongoing investment leads to prevention of cost expenditure elsewhere in the system or releases financial savings. Reflecting our whole-system approach, there are other relevant activities, programmes of work and Strategies across the ICS that will contribute to achieving our strategic priorities and the overall UEC Plan. The UEC Programme Board will oversee the delivery of this system strategy, monitoring progress of work, resolving issues, and managing interdependencies between activities by drawing together different partners responsible for delivery and providing a cross-system view of the projects. This should provide some central coordination of both the core UEC work and wider areas of change delivered across the ICS. Should the HWE ICS UEC Strategy receive Board approval, we will: • coproduce an annual delivery plan to progressively implement the intent of this strategy. • measure success of this UEC strategy through population-health outcomes and impacts on our system performance, progress will be tracked at UEC Programme Board and any issues escalated to UEC Board. • hold ourselves to account on our strategic intent with continued quality oversight of the strategy delivery through a 'UEC Strategy Implementation Group', this group will have a diverse membership from across the system, including patient and public involvement. • work with the ICB Communications Team to ensure everyone, including those with sensory or cognitive disabilities can access and are able to understand the key information contained in the document.
Recommendations:	▪ The Board is asked to approve the HWE ICS Urgent and Emergency Care Strategy

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

Implications / Impact:		
Patient Safety:	*[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]* The paper supports improvement in patient safety and mitigates risks to patient safety.	
Risk: *Link to Risk Register*	The HWE ICS Urgent and Emergency Care Strategy links to specific risks laid out in the SCC Clinical Safety Risk Register	
Financial Implications:	*[State funding costs and potential savings]*	
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	Attached for information
	Quality Impact Assessment:	<Yes / No / N/A >
	Data Protection Impact Assessment:	N/A

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Hertfordshire and West Essex
Urgent and Emergency Care Strategy

2024 - 2029

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Abbreviations

ACP	Advance Care Plan
ACSC	Ambulatory Care Sensitive Condition
A&E	Accident & Emergency
ARI	Acute Respiratory Infection
CAS	Clinical Assessment Service
COPD	Chronic Obstructive Pulmonary Disease
LTC	Long term condition
LTP	NHS Long Term Plan
MDT	Multidisciplinary Team
MIU	Minor Injuries Unit
OOH	Out of Hours
PAH	Princess Alexandra Hospital NHS Trust
PCN	Primary Care Network

Hertfordshire and West Essex Urgent and Emergency Care Strategy 2024 - 2029

Executive Summary

A case for change

Providing the medical help needed in an urgent or emergency situation is a core function of the NHS. But our urgent and emergency health care services are under extreme pressure and busier than they have ever been. People are waiting longer for ambulances to arrive, more people are being admitted to hospital in an emergency, the numbers of people attending our emergency departments (ED) continue to rise and since Covid-19 more people are accessing urgent appointments with their GP or NHS 111.

We urgently need to improve access to high quality urgent and emergency care services to meet this unprecedented demand and to support our staff in making the safest decisions for all patients across the system.

Our health and care teams work hard to manage the challenges of busy urgent and emergency care services every day, and while we deliver excellent care, the system remains under extreme and continued pressure and retaining and recruiting staff is difficult. Growing the workforce is not enough, we need to develop the skills and expand our capacity to deliver care closer to home whilst supporting people living well for longer.

Purpose of this strategy

This strategy sets out how the health and care system in Hertfordshire and west Essex will transform over the next five years in order to deliver safe, sustainable urgent and emergency care for all who need it.

This recovery and transformation can only be successful if the whole system works together in a different way to meet our changing population demands, improve performance in waiting times and ensure when our residents have urgent and emergency care needs that they get the right care, in the right place, the first time they try to access it.

What is the strategy?

In five years, our ambition is that people in Hertfordshire and west Essex will experience urgent and emergency care as close to home as possible to avoid harm of hospital stays and minimise disruption to their lives. The care they receive will be consistently high quality and safe and they will have confidence that they will receive the right care, first time and be supported in managing their health.

The six priorities presented in this strategy have been developed in response to information which shows where our population urgent and emergency care needs are greatest. The priorities are:

1	Understand and predict our population needs in order to support those at greatest risk and deliver tailored population-based approaches
2	Partners within the system work together to ensure joined up and coordinated care, including improved flow and early supported and safe step-down from services.
3	Prevention and proactive, personalised care are embedded across the system to empower people to live and age well avoiding the need for services wherever possible.
4	When people need same day or urgent care they can easily and rapidly access the right care.
5	Effective and efficient emergency care pathways that are appropriate, safe, and closer to home.
6	Focus on children and young people, mental health crisis response, and frailty and end of life care.

How we will deliver the strategy

This strategy sets out the intentions for urgent and emergency care recovery and transformation across Hertfordshire and West Essex Integrated Care System over the next five years. Each year a prioritised delivery plan will progressively implement the intent of this strategy. A UEC strategy implementation group consisting of diverse membership will be

empowered to review whether we are delivering work to meet our ambition. The strategy will be updated and reviewed regularly.

Introduction

Urgent and emergency care (UEC) services perform a critical role in keeping people healthy, supporting patients of all ages to receive the right care, by the right person, as quickly as possible according to patient clinical need. The distinction between urgent and emergency care is detailed in table 1.

Table 1: Urgent and emergency care definition

Emergency	• Life-threatening illnesses or accidents which need immediate, intensive treatment. • Services that should be accessed in an emergency include ambulance (via 999) and emergency departments.
Urgent	• An illness or injury that needs urgent attention but is not a life-threatening situation. • Urgent care services include a phone consultation through the NHS111 Clinical Assessment Service, pharmacy advice, in- and out-of-hours GP appointments, and/or referral to an urgent treatment centre (UTC). • If the user isn't sure what service is needed, NHS111 can help to assess and direct to the appropriate service/s.

Source: NHS website x

A case for change

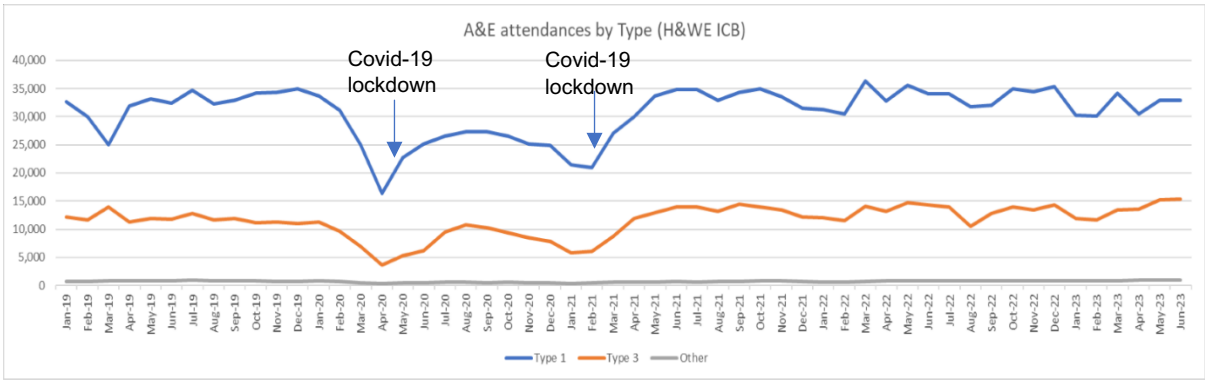
Managing increased demand

Health and social care are under extreme pressure, all services across the system are facing the immense challenge of both high demands, and limited capacity and resource. In recent times, more and more people have used our urgent and emergency care (UEC) services. The waits for ambulances and time people spend in the emergency department (ED) is unprecedented. Emergency admissions have steadily increased over the last 20 years, except during Covid, and hospitals are fuller than they were before the Covid-19 pandemic. Not only are UEC services stretched and overrun, but planned elective care, primary care, community care, mental health, and social care are all operating at full capacity.

During the pandemic the demand for ED and GP services changed. ED attendances dipped during lockdowns and a greater proportion of GP appointments were conducted by telephone during this time to manage infection control measures. NHS111 operating hours expanded beyond out-of-hours to be a 24/7 service and attendance at community pharmacy for healthcare needs increased. ED activity has since recovered, and attendances not only surpass pre-pandemic levels, but continue to steadily rise as they have done for the last 20 years (figure 1). GP appointments are again delivered face-to-face at rates similar to before

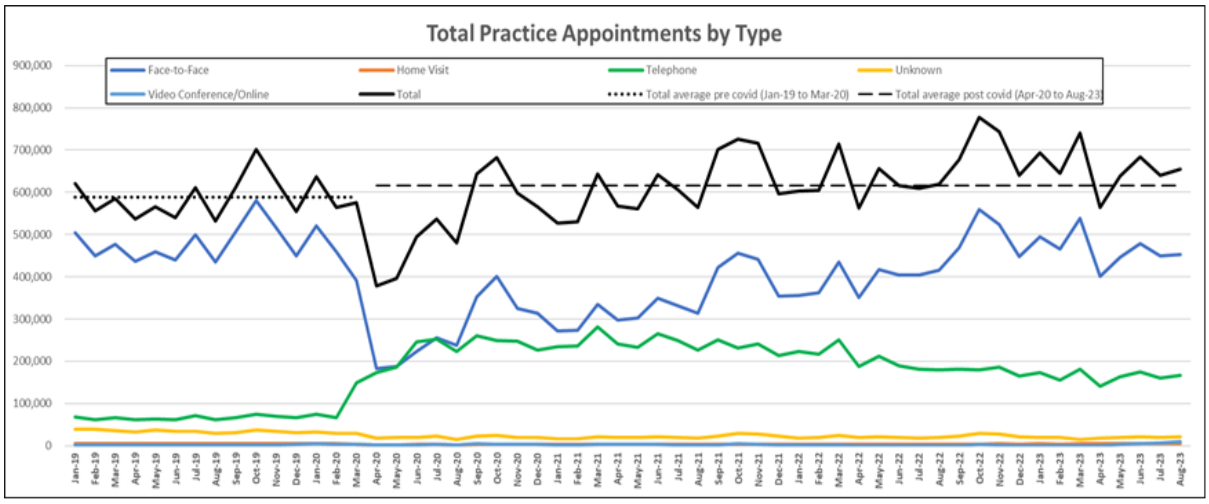
Covid-19, but this is coupled with the substantial increase in telephone GP appointments (almost treble the number delivered pre-pandemic)[1]and introduction of online consultations (figure 2). NHS111 activity remains consistently high both in- and out-of-hours. More people are using emergency services or same day access services than ever before, and c ommunity services have seen increasing referrals over recent time and with demographic changes, demand challenges and technological developments, staff are managing increasing levels of acuity in people's homes and community-based settings (NHS Providers, 2023).

Figure 1. Graph of ED attendances in HWE ICB, by type, Jan 2019 – Jun 2023



*Type 1 ED dept is consultant-led 24-hour with full resuscitation facilities, Type 3 is Urgent Treatment Centre, Minor Injury Units, Walk-in Centres, Urgent Care Centre

Figure 2. Graph of total GP practice appointments, in HWE ICB, by type, Jan 2019 – Jun 2023.



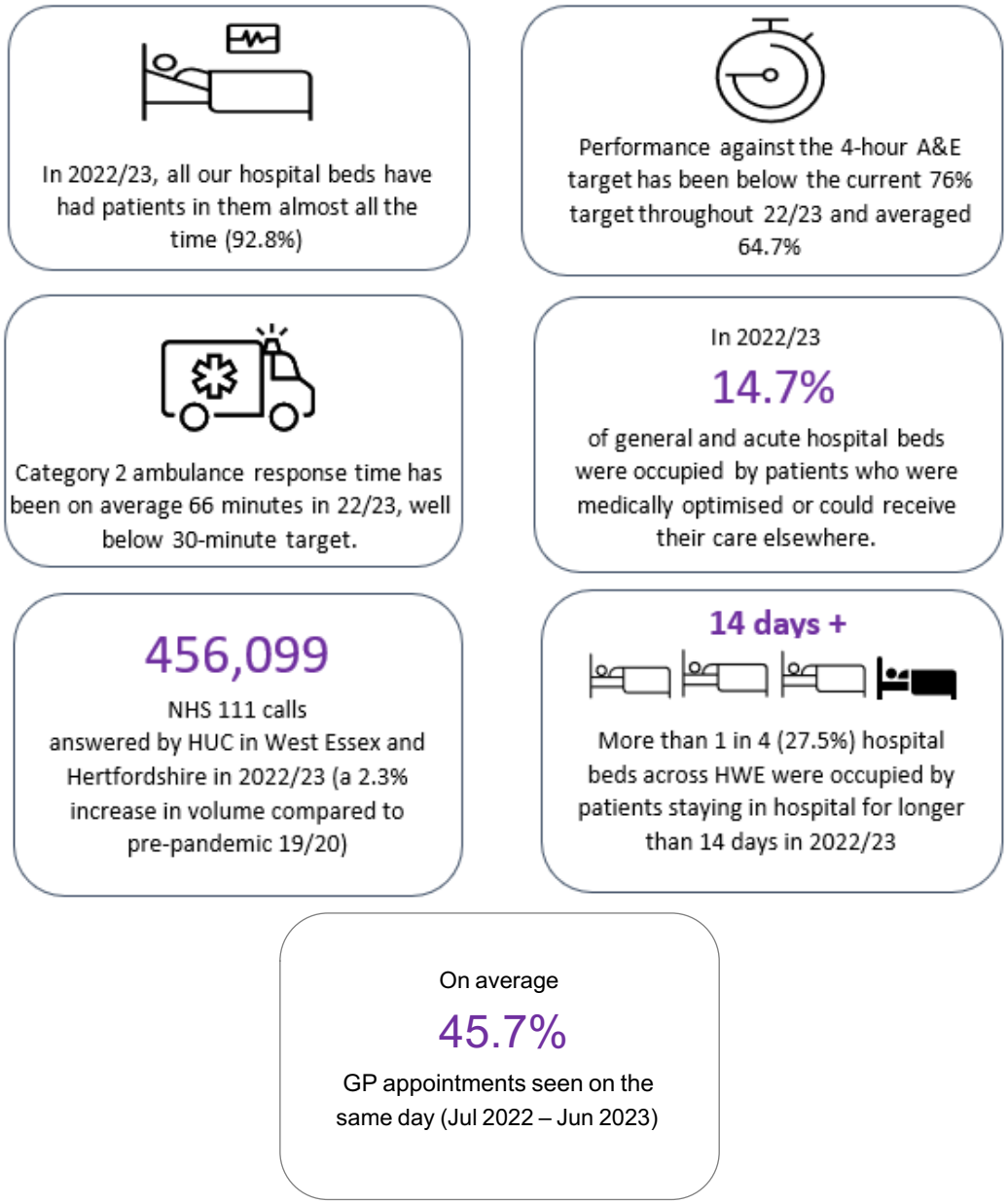
Note: this does not include Extended Access activity delivered through PCN hubs and Additional Roles Reimbursement. Scheme (ARRS) activity delivered through PCNs prior to 2023/24.

Our health and care system works hard to manage the challenges of busy urgent and emergency care services every day, but while our staff deliver excellent care, they remain under extreme and continued pressure. This high demand is impacting our ability as a UEC system to be as responsive, and risks compromising safe care and good outcomes for

[1] Figure 2 demonstrates that pre-Covid, on average the total number of practice appointments per month was 588,010, post-Covid this rose to 615,547 per month, 4.7% higher.

patients. Full hospitals mean there are significant waits for admission from ED, and busy EDs impact the ability for ambulances to handover, so ambulances are queuing outside of departments meaning they are unavailable to be dispatched to other emergency calls. Evidence clearly shows that hospitals work most safely and effectively at bed occupancy levels no higher than 85% but in 2022/23 bed occupancy levels in HWE were 92.8%.

Figure 3. UEC performance metrics in HWE in 2022/23



Recovery requires the whole system to work together in a different way to meet the demand, improve our performance in seeing people quickly in ED and ambulances getting to patients quicker, and most importantly to ensure patients get the right care, in the right place, whenever they need it to improve outcomes for our population.

Mitigation of clinical risk

There will be increased clinical risk if people in the community with serious or life-threatening emergencies wait longer than recommended for an ambulance to respond (AACE, 2021; HSSIB, 2023), and with increased pressure on urgent and emergency services, it is necessary to change our approach to managing risk across the healthcare system. System risk arises when increasing operational pressure results in heightened operational and clinical risk, at a system level. Effectively managing system risk when our healthcare system is under pressure involves prioritising services to where there are higher proportional risks.

Healthcare professionals, managers and clinicians regularly make challenging decisions, balancing and prioritising patient care in the context in which they work. However, their decision-making abilities are constrained by the immediate situations, risks, and consequences they see directly before them. Without visibility to all, of the clinical risk across the system, decision-makers in one care setting may be unable to understand and appreciate how other care settings hold risk and lead to decisions without holistic understanding of the impact on other care providers, which in greatest operational pressure leads to increased likelihood of harms occurring.

Sustainability of UEC services

NHS England's spending to provide services for unplanned or urgent care is approximately £21.5 billion per year (NAO, 2023). Productivity growth of the NHS was high but since the onset of the Covid-19 pandemic has fallen (NAO, 2023). Nationally, general and acute (G&A) hospital bed capacity had been on a long-term downward trend since 2010, reaching a low of 92,559 G&A beds in the early stages of the Covid-19 pandemic. Bed numbers have since risen but only back to pre-pandemic levels with occupancy rates at record levels (NAO, 2023)

To be more sustainable we need to deliver care differently, moving care upstream, harnessing technological advancements to reduce administrative burdens, and delivering opportunities to upskill and retain our staff.

Nationally, the number of NHS staff including GPs, ambulance staff and doctors in EDs have increased by 30% in the last 10 years (NAO, 2023). However, healthcare need driven by ageing and increasing morbidity, as well as changes to healthcare seeking behaviours means demand is outstripping the growth in the workforce. There is and will continue to be a shortfall of staff available across NHS organisations, most pronounced in GPs, paramedics, critical care nurses, community nurses, and mental health and learning disability nurses. In HWE we have high turnover of staff in our ambulance service and a higher proportion of ambulance staff leaving the NHS than the national average.

Growing the workforce is not enough to meet the challenges. We need to grow the skills and capacity to move care further upstream, delivering care closer to home (for example virtual wards and intermediate care) and supporting people to keep well for longer. We need professionals with generalist skills who can work effectively in multidisciplinary teams (NHSE 2023), We need to build upon and increase the changes commenced in general practice where new roles within the multidisciplinary team enable more people to have their needs

met via improved access. Additional roles in these teams, working alongside GPs include care co-ordinators, social prescribing link workers, mental health practitioners, and paramedics amongst others.

Purpose of this strategy

The purpose of this UEC strategy is to set out the short, medium, and long-term intentions for the next 5 years for UEC recovery and transformation in the Hertfordshire and west Essex (HWE) Integrated Care System (ICS). It articulates our ambition and provides a framework for change over multiple years. Each year a prioritised delivery plan will be produced in partnership which will progressively implement the intent of this strategy and sit alongside a medium-term operating plan. This strategy applies to the whole HWE population, including all ages.

Who we are and what we do.

HWE ICS is a partnership of the NHS, the councils (county and district), the voluntary, community, faith, and social enterprise (VCFSE) sector, and professional bodies[2] that have a shared purpose of ensuring people living in HWE have the best opportunities to live happy and healthy lives, and get the support they need, when they need it.

Operating as an ICS enables us to tackle complex challenges. Working collaboratively at neighbourhood, place, and system level we can improve UEC and population health outcomes by harnessing all system resource for greater preventative action and address the fragmentation and gaps in existing pathways through more effective integration of organisations.

The Integrated Care Board (ICB) is the local NHS organisation that plans and oversees how NHS money is spent in HWE and makes sure health services work well and are of high quality. There are three geographically based Health and Care Partnerships (HCPs); East and North Hertfordshire (ENH), South and West Hertfordshire (SWH) and west Essex (WE) and the Hertfordshire Mental Health, Learning Disability and Autism (MHLDA) HCP. HCPs bring together health, social care, and voluntary sector organisations across our ICS to work as one and lead detailed design and delivery of joined-up services across communities.

The ICB will support in setting the strategic direction for UEC and at place, HCPs will work together as system partners to transform and deliver on priorities of the UEC strategy.

[2] Professional bodies include Hertfordshire Local Medical Committee (LMC), Essex LMC, Hertfordshire Local Pharmaceutical Committee and Community Pharmacy Essex, Hertfordshire Local Optical Committee and Essex Local Optical Committee

Figure 4. Hertfordshire ICS map

Place: East and North Hertfordshire (ENH)

Acute: East and North Hertfordshire NHS Trust (ENHT)
Lister Hospital – Emergency Department (ED) but no Urgent Treatment Centre (UTC)
New QEII Hospital – UTC
Hertford County Hospital

Community: Hertfordshire Community NHS Trust (HCT)

Mental Health: Hertfordshire Partnership University NHS Foundation Trust (HPFT)

Place: South and West Hertfordshire (SWH)
– previously known as Herts Valleys

Acute: West Hertfordshire Teaching Hospitals NHS Trust (WHTH)
Watford General Hospital– ED and UTC
Hemel Hempstead Hospital – UTC
St Albans City Hospital

Community: Central London Community Healthcare NHS Trust (CLCH)

Mental Health: Hertfordshire Partnership University NHS Foundation Trust (HPFT)

Place: West Essex

Acute: Princess Alexandra Hospital NHS Trust (PAH)

Community: Essex Partnership University NHS Trust (EPUT)

Mental Health: EPUT and North East London NHS Foundation Trust (NELFT)

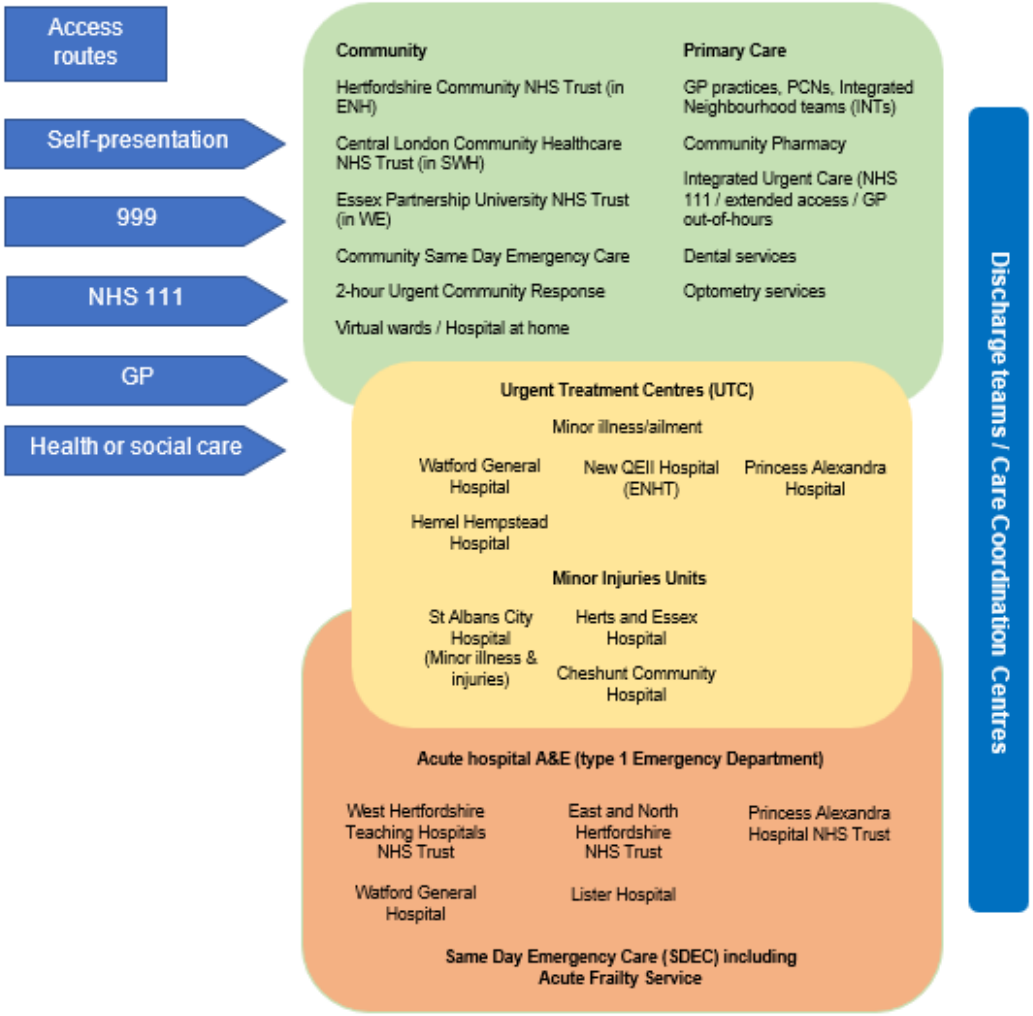
How current UEC services are organised and delivered.

The UEC system is complex with multiple organisations contributing to the design, planning, and transformation of UEC services and numerous providers responsible for delivery of UEC across HWE.

We currently have a large range of services and pathways being delivered to meet our population's urgent and emergency care needs. Figure 5 shows the different services and providers, and how services can be accessed.

The ICBs System Coordination Centre (SCC) principal function is to act as a central co-ordination service across the Hertfordshire and west Essex (HWE) Integrated Care Board (ICB) footprint, with the aim of supporting patient access to the safest and highest quality of care possible. The SCC will use its position within the ICB to support proactive co-ordination of a system response to operational pressures and risks and will utilise available information and intelligence to assess and validate local assurance submissions with regards to planning for events that impact on UEC and wider system pathways.

Figure 5. UEC services and access routes



It should be acknowledged that 25% of our unplanned activity takes place outside the ICS footprint and therefore not all our population's UEC needs are met by the services in Figure 5. We therefore need to ensure our neighbouring UEC services are better incorporated into our work programmes. It is expected that HCPs will work with a full range of providers to achieve this.

East of England Ambulance Service NHS Trust (EEAST)

East of England Ambulance Service NHS Trust (EEAST) provides a 24 hour, 365 days a year service for those in need of emergency assessment, treatment, and transport. They also provide non-emergency patient transport services.

Acute Trusts: West Hertfordshire Teaching Hospitals NHS Trust, East and North Hertfordshire NHS Trust, Princess Alexandra Hospital NHS Trust

Across HWE there are three acute trusts with a type 1 ED which is a consultant-led 24-hour service with full resuscitation facilities to deal with emergencies and designated accommodation for the reception of accident and emergency patients. All three offer a same day emergency care (SDEC) service.

There are also doctor or nurse-led urgent treatment centres (UTCs)[3] that are open at least 12 hours a day, every day, and equipped to diagnose and deal with most common ailments or minor injuries (e.g., sprains). These are either co-located (Watford General and PAH) or located on different sites (QEII in ENHT, Hemel Hempstead in WHTHT). Herts Urgent Care (HUC) provide a nurse-led, referral only St Albans Integrated Urgent Care Hub (IUCH) service located at St Albans City Hospital to increase same day access for health concerns that are urgent minor illness and injuries. HUC also provide Cheshunt Minor Injuries Unit (MIU) for adults and children over the age of 12 months who have a minor injury such as a cut, burn, scald or suspected fracture.

Mental health trusts: Hertfordshire Partnership University NHS Foundation Trust (HPFT), and Essex Partnership University NHS Trust (EPUT).

HPFT and EPUT work in partnership with VCFSE and independent sector organisations to deliver services such as Host Families scheme and Street Triage team. In addition to several adult mental health inpatient sites, the Crisis Resolution and Home Treatment Team units offer therapeutic interventions to people in crisis as an alternative to admission and to facilitate early discharge and a 24/7 mental health liaison team is in operation in the acute trusts.

Community Trusts: Hertfordshire Community Trust (HCT), Central London Community Healthcare NHS Trust (CLCH), and Essex Partnership University NHS Trust (EPUT)

Community services cover support to people with long term conditions (LTCs) to keep them well, treating and managing acute illness, supporting people who are near the end of life, and supporting people with frailty to live in their own home. EPUT and CLCH are cross-border. Community services have been working innovatively to expand out of hospital care to avoid admissions. Urgent Community Response (UCR) includes services that deliver urgent crisis response care within two hours and/or reablement care within two days[4], and early intervention vehicles (EIV)/falls car to support those who have fallen if non-injurious. Virtual wards and hospital at home[5] have been expanded and all three places provide at least a frailty, acute respiratory infection (ARI) and heart failure virtual ward.

Integrated Urgent Care

Our integrated urgent care (IUC) service incorporates NHS 111 and GP out of hours (OOHs) and is delivered by HUC. The IUC clinical assessment service (CAS) provides access to urgent care via NHS 111 (telephone or online), triage by a Health Advisor and consultation with a clinician and either direct booking post-assessment into a face-to-face service where necessary (including OOH treatment centre), electronic prescription or self-help information. The OOH treatment centres are in:

- SWH: Borehamwood, Bridgewater House Surgery, Hemel Hempstead Hospital, Hertford County Hospital, St Albans Hospital
- ENH: Lister Hospital Stevenage, QEII Hospital Welwyn Garden City
- WE: Dunmow Community Clinic, Lister Medical Centre Harlow, St Margaret's Hospital Epping

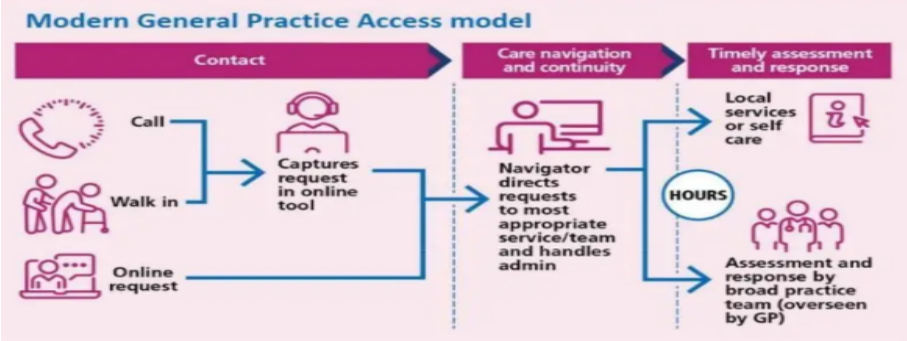
[4] UCR cares for people with non-injurious falls, decompensation of frailty (e.g., UTI), reduced function or deconditioning or mobility, palliative or end of life support, urgent equipment provision, confusion or delirium or acute worsening of dementia.
[5] Virtual wards, and hospital at home are often terms used interchangeably for a continuum of care provision in conjunction with remote monitoring. Hospital at home is when care needs are often higher and most of the care is face-to-face, whereas virtual wards use more remote monitoring. We will now refer to both as virtual ward in this document.

Primary care

Primary care includes general practice, community pharmacy, dentistry, and optometry. There are 129 GP practices working in 35 primary care networks (PCNs), 261 community pharmacies[6], 184 opticians and 229 dental contracts and 4 urgent dental contracts (excluding specialist services).

Primary care is changing the model of access for urgent healthcare needs, implementing the 'modern general practice model[7]'as a way of organising work in general practice to tackle the 8am rush. It enables practices to see all patient need and understand need through structured information gathering, to then prioritise and allocate need safely and equitably, and make best use of other primary care services and the multidisciplinary team (figure 6)

Figure 6. Modern General Practice Access Model



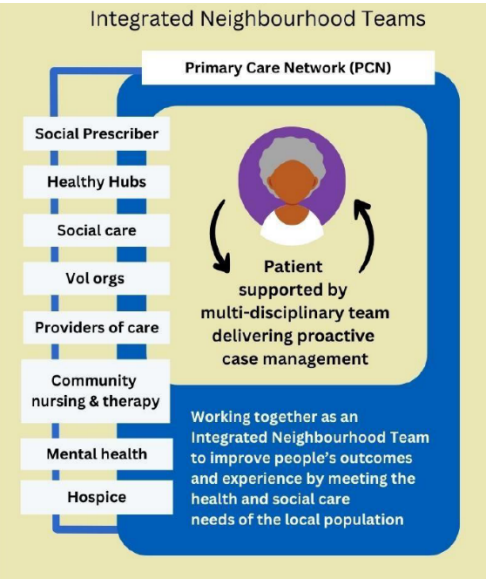
Source: Manor View Practice https://manorviewpractice.co.uk/reception-area/patient-triage/

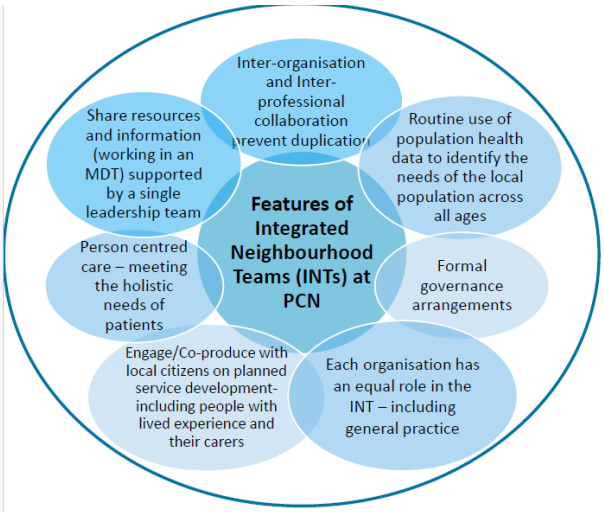
The dental OOH service is interlinked with NHS 111 to see patients with urgent dental needs weekday evenings and weekends, this and urgent and emergency eye services are to be reviewed to inform new commissioning plans. As the 'front door' of the NHS, primary care plays an essential role in preventing ill health and tackling inequalities and works with partners across health and care to deliver primary, secondary, and tertiary prevention. Integrated neighbourhood teams (INTs) are being created to deliver person centred care through partnerships between NHS, social care, primary care, voluntary sector, and community. A proactive approach to managing chronic disease and complex care is delivered through INT working, with proactive care planning, care delivery and management of complex patients, preventing escalation of need and delivering timely urgent response and

[6] 274 contracts of which 261 are Community Pharmacies, 3 Dispensing Appliance Contractors (DAC), 10 distance selling. Note this is accurate as of February 2024 but numbers are likely to change.
[7] NHS England » Modern general practice model

crisis support at a local level (figure 7). Proactive management through INT working is being implemented across HWE and their associated outcomes including impact in reducing unnecessary hospital admission, where this has been a designated area of focus will be evaluated to identify and share best practice. INTs can use population health management approaches to identify patients at risk of unplanned care and support these patients through coordinated and proactive models of care to prevent deterioration and escalating need and subsequent unplanned care use.

Figure 7.





Locality Leadership with PCN delivery of INT through collaboration in the Health and Care Partnerships

Source: HWE Primary Care Strategic Delivery Plan

Social care

Social care is a key partner in multidisciplinary teams supporting acute and community hospital discharges, as well as continuing healthcare, safeguarding, people with complex needs, mental health needs, those over 65 years of age, or who require multiagency risk assessments.

In Hertfordshire, adult care services (ACS) host in partnership with providers, an integrated health and social care prevention of admission service to prevent deterioration in health or social circumstances to the extent where hospital or long-term bed-based residential or nursing care is required. This includes the EIV, UCR, and virtual ward/hospital at home as well as the social care community rapid response team (ENH) and social care prevention of admission team (SWH) which offers rapid social care assessment, support, and interventions in the community for people at risk of an imminent hospital inpatient or residential admission to help them remain independent and safe in their usual place of residence.

In west Essex, the care coordination centre (CCC) MDT includes adult social care and manages all adult referrals to and from west Essex health and care services to help avoid acute admissions, ED attendances and delayed discharges. West Essex is trialling new ways of working with the voluntary sector, including placing social prescribers in the acute hospital to provide support to adults being discharged ('Ticket Home' as below).

VCFSE sector

In Hertfordshire, for patients over 65 discharged on a pathway zero (no obvious need for support) calls are made within 48 hours and again at 5 days by the Hospital and Community

Navigating Service. Almost 1 in 10 patients are found to have unmet needs, two-thirds of these are addressed by social prescribing and VCFSE sector interventions. In west Essex 'Ticket Home' provides similar support.

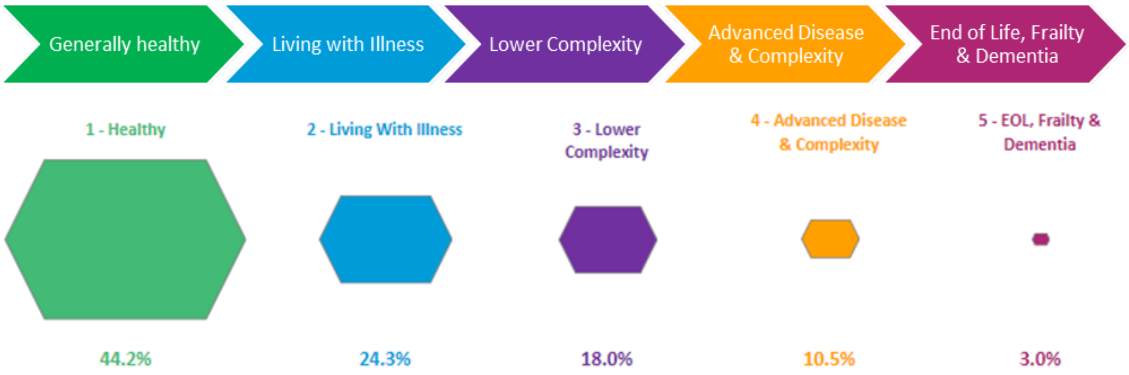
Mind West Essex, Mind Hertfordshire Network, Mind Mid Herts provides crisis cafes to keep people with mental health crisis out of hospital, and 'Rebound' to support discharge. Other organisations include the British Red Cross, and the Centre for Voluntary Service (CVS) who support community transport.

Strategy development

Underpinning our strategy is an analysis of our population's urgent and emergency care needs.- this can be found here. Numerous workshops with stakeholders from across the system were conducted to define the scope of the work, prioritise key questions, and build consensus around what the key issues in UEC are.

Epidemiological approaches were used to build a comprehensive picture of who is accessing UEC services in HWE, and for what reasons. Population segmentation[8] was used to group individuals with similar health needs to help us understand how different cohorts interact with our acute UEC services and understand who may be better cared for in alternative settings, services, or pathways of care. Benchmarking our local data with other areas and national averages highlights unequal access, unwarranted variation in services and inequalities in population health outcomes across the life course.

Figure 8. HWE Population segmentation cohorts



Machine learning models were used to understand and predict patients at the highest risk of ED attendance. Triangulation of data with missed opportunity audits, clinical deep dives, insights, and evidence review informed an integrated view of those at high risk of preventable admissions, potentially inappropriate use of UEC services, the opportunities, and recommendations for the strategy. An overview of the main findings and opportunities for the strategy is detailed in 'where are we now' and referenced throughout the strategic objectives. The needs analysis findings underpin the development of this strategy and supported our system UEC leaders to identify priority areas of focus. These were

[8] Segmentation is a tool to help us understand the population need by dividing the population into more manageable chunks, where each segment has relatively similar healthcare needs and priorities. The population segmentation model used in HWE drew on large, linked datasets from primary care, secondary care, community care and mental health services and allocated individuals in our population into one of five main segments considering their physical and mental health, and social factors. The segments range from a cohort of individuals who are generally healthy and have no known health conditions, to the frailest patients and those at the end of life.

subsequently developed to form core strategic priorities (figure 13, page 26) and enablers.

In the initial phase of development various discussions, forums, and workshops were held with system leadership, transformation teams, clinicians, and health and care partners. The vision and strategic priorities were shared with the ICB Patient Engagement Forum including patient representatives, members from Healthwatch, and other patient networks, and VCFSE organisations (appendix a). The second phase of engagement with broader system partners took place over a few months and we are grateful for their support and engagement in developing this strategy. The organisations and groups that we met with and/or received feedback from were:

- Urgent and emergency care system leaders
- East of England Ambulance Service NHS Trust
- East and North Hertfordshire NHS Trust
- West Herts Teaching Hospitals NHS Trust
- The Princess Alexander Hospital NHS Trust*
- Hertfordshire Partnership University NHS Foundation Trust
- Hertfordshire Community Trust
- Essex Partnership University Hospital NHS Trust*
- Central London Community Healthcare NHS Trust*
- Primary care colleagues across Hertfordshire and west Essex (via primary care transformation, and PCN meetings)
- Community Pharmacy Hertfordshire – and contractors
- South and West Hertfordshire System Resilience Group
- East and North Hertfordshire System Resilience Group
- West Essex Health Care Partnership
- South and West Health and Care Partnership
- East and North Health and Care Partnership
- Mental Health, Learning Disability and Autism Health and Care Partnership
- HUC*
- Hertfordshire Crisis Care Partnership
- Hertfordshire County Council
- Essex County Council
- Hertfordshire Care Providers Association
- Healthwatch shared with leaders of community and voluntary groups.
- Voluntary Community Faith and Social Enterprise Organisations
- ICB Patient Engagement Forum

*Present at UEC Board when the HWE ICS UEC Strategy has been discussed.

[9] sets out recovery of core services and progress in delivering the NHS LTP ambitions.

Strategic context

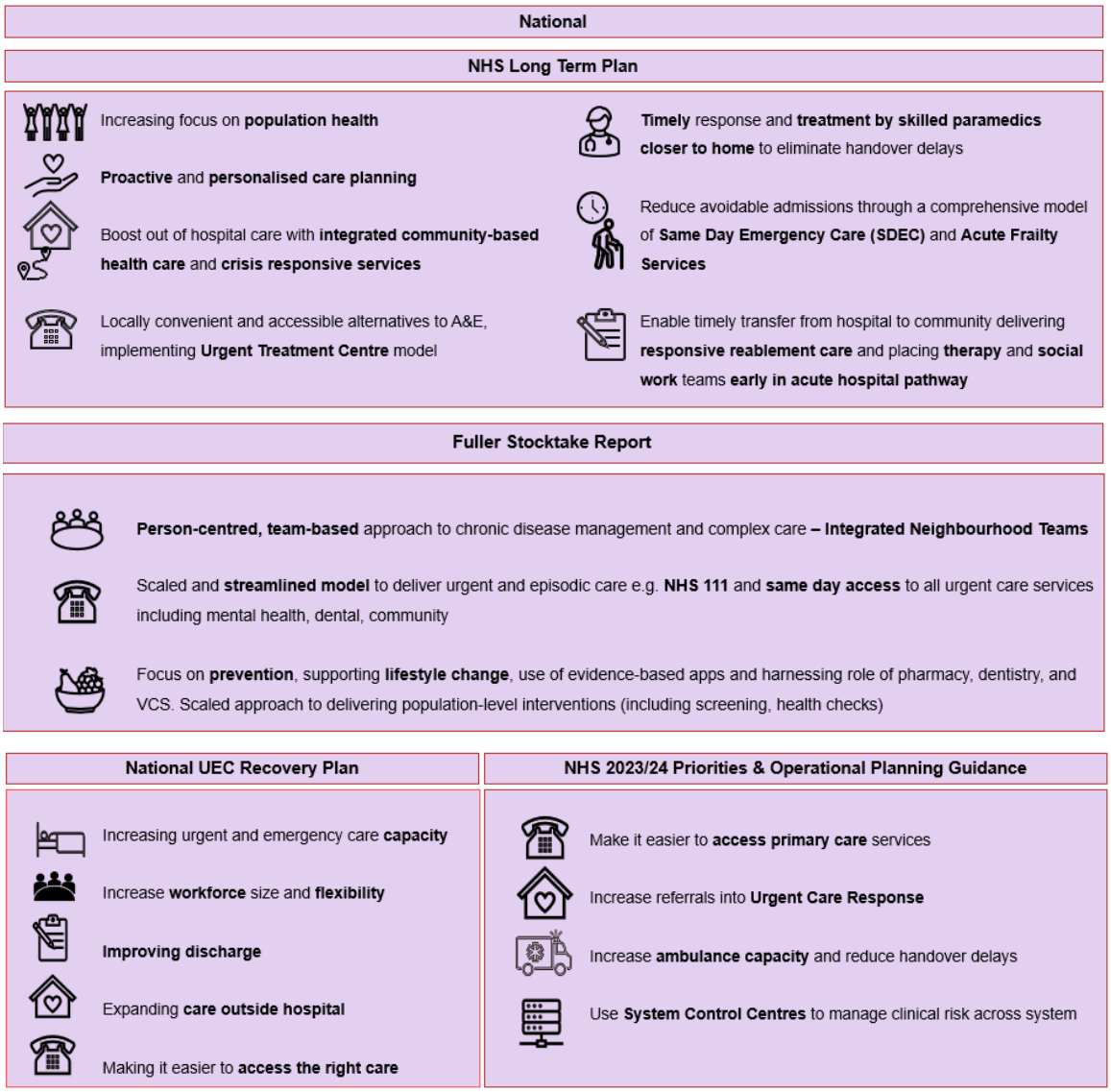
National context

Key drivers for change are set out in the NHS Long Term Plan (LTP) (NHSE, 2019) with an ambition to focus on our population's health and provide care closer to home. Our strategy is aligned to delivery of the LTP ambitions, including 2023/24 priorities and operational planning guidance[9] (NHSE, 2023a), and national UEC Recovery Delivery Plan (NHSE, 2023b), as well as the plans for delivering operational resilience across the NHS this winter which sets out the systems roles and responsibilities and evidence-based high impact

interventions to improve resilience. The Fuller Stocktake report (NHSE, 2022a) built a broad consensus on the vision for integrating primary care and described a framework to improve same-day access for urgent care. To achieve this vision, the NHS England Delivery Plan for Recovering Access to Primary Care (NHSE, 2023c) outlines plans to improve both same day access and wider access to primary care, these inform our strategy.

There is also synergy with other national strategies, including the NHS England Core20PLUS5 (NHSE, 2022b) which outlines an approach to focus action on reducing healthcare inequalities at a system level for adults and children and young people. The 'Core 20' (the most deprived 20% of our population) and underserved populations such as people with drug and alcohol dependence, people with a learning disability and autistic people, those that are homeless or victims of domestic abuse, experience significant health inequalities and are high users of urgent and emergency care.

Figure 9. National strategies and plans



Local context

This UEC strategy has been developed with reference and alignment to other local strategies and priorities as below. These include the HWE Integrated Care Partnership (ICP) Strategy 2023 – 2033, HWE Joint Forward Plan 2023-2028, and HWE Integrated Care Board Strategic Framework. This strategy also supports and will collaboratively enhance delivery of other priorities in the Acute Trust strategies, Primary Care Strategic Delivery Plan, MHLDA Physical Health strategy, children and young people (CYP) strategy, frailty and end of life strategy, and the long-term condition and mental health priorities, and the Integrated Care Board (ICB) clinical priorities below (table 2). There is alignment with HWE ICS quality strategy, digital strategy, population health management (PHM) strategy, and workforce transformation (people) strategy

The HWE Primary Care Strategic Delivery Plan 2023-2026 sets out three key transformation priorities; simplifying and enhancing access for urgent primary health needs, proactive management to support routine and complex care through INT working, and continued focus on prevention and health inequalities. This addresses the key requirements of the NHS England Delivery Plan for Recovering Access to Primary Care (NHSE, 2023c) which includes implementing modern general practice access, empowering patients to manage their own health, building capacity and developing the primary care workforce and cutting bureaucracy to reduce workload across primary and secondary care interface.

Following a community services review in HWE there is agreement to develop a shared strategic vision for community-based models of care. This will be key to delivering our UEC strategic vision and priorities through the work of our HCPs.

Figure 10. Local strategies and plans

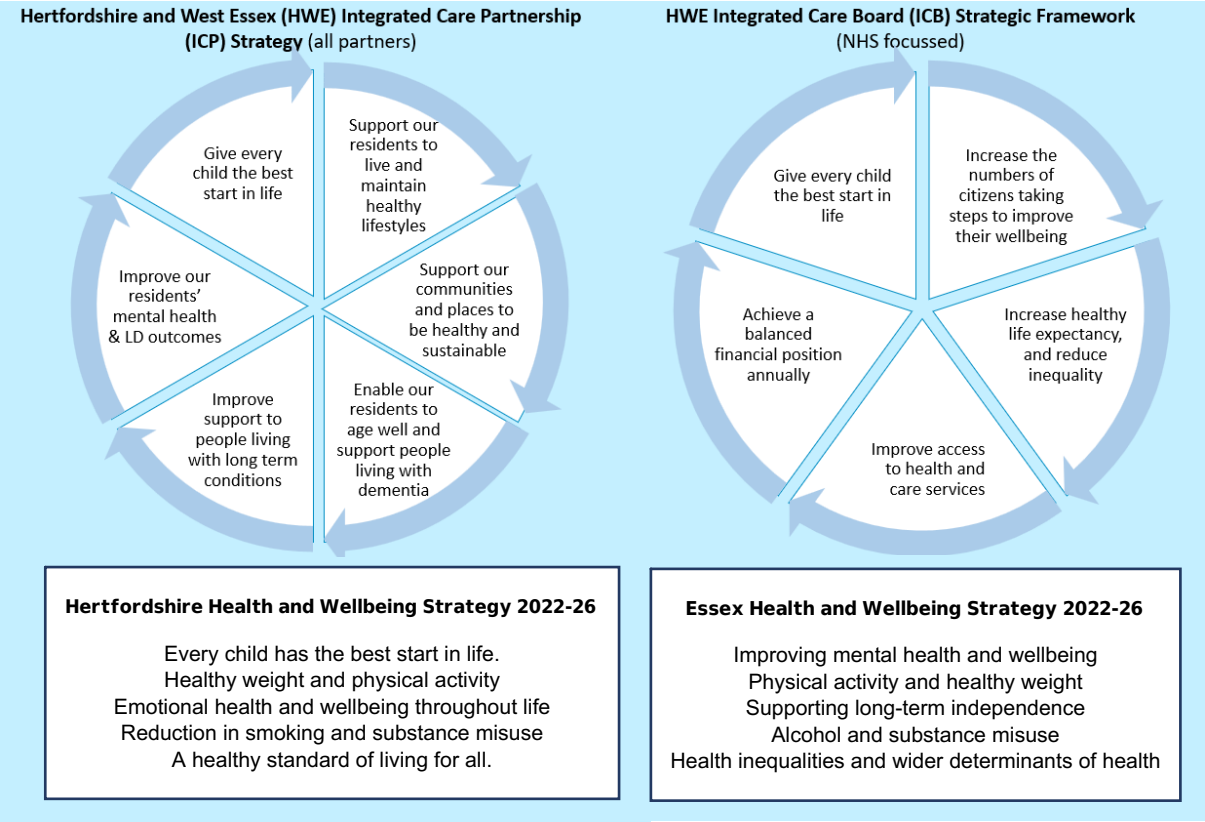


Table 2: HWE ICB Clinical Priorities

Area	Clinical Priority
CYP	Improve readiness for school in children eligible for free school meals. Reduce rates of childhood obesity Reduce unnecessary A&E attendances and admissions
Prevention and health inequalities	Reduce premature mortality rate for cardiovascular disease
LTC & frailty	Reduce attendance and admissions for falls, people with frailty and people in last of life. Development of more proactive, preventative care models for management of LTC frailty
Mental Health	Reducing suicide rates and attendances/admission rates for self harm Reducing rates of A&E attendances involving substance misuse and violence
Maternity	National recommendations to be implemented and linked quality issues with local providers requiring ICB clinical transformation support. Neonatal urgent care pathways

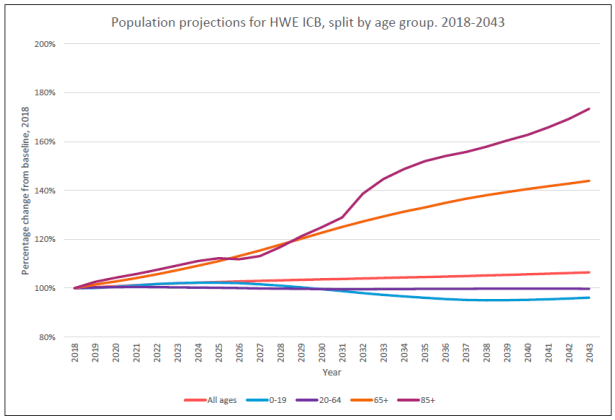
Where are we now?

Analysis of population need.

The UEC population needs analysis was conducted in 2022/23. Significant developments in the ICB operating model since this time are acknowledged and there is now greater prominence of HCPs and acknowledgement of their crucial role in delivering the UEC strategy. As such, we will ensure ongoing and future analysis be provided for HCPs to support the prioritisation and targeted delivery of recommendations to specific population geographies and cohorts, for example via the outcomes framework and support to integrated neighbourhood teams.

In HWE we face the challenge of meeting the needs of an ageing population and tackling health inequalities. A higher proportion of our population are aged 85 and over compared to England average, and we expect to see a sharp growth in this age group in the next 20 years (figure 11). These elderly, frail individuals have complex health and social care needs. Despite being a relatively affluent place to live, there are some communities struggling with deprivation and poverty and poorer health outcomes, particularly in districts such as Broxbourne, Harlow, Stevenage, Watford, and Welwyn Hatfield.

Figure 11. Population projections for HWE ICB 2018-2041



Over half a million people in HWE attend ED each year. ED attendance rates are highest in those aged 0 to 4 years and over 75 years. Approximately one third of all ED attendances

Patterns of inequality in unplanned care use can be seen across different groups of our population as outlined in the equality impact assessment (EQIA) [appendix c]. People from less affluent areas have higher rates of ED visits and hospital admissions. This 'social gradient' shows that health inequalities impact everyone across different socioeconomic levels. The rate of ED attendances for those living in the most deprived areas is nearly double that of those living in the least deprived areas, but this inequality exists at every level of the socioeconomic spectrum (ONS, 2021). The biggest differences in ED attendance were found for low acuity conditions. The odds of ED attendance increase with levels of deprivation across all age groups. Health differences play a role in explaining some of these differences in ED attendance, but not all, particularly in young populations. Residents of the most deprived neighbourhoods suffer 2.5 times as many preventable emergency hospitalisations as the least deprived (Cookson et al, 2016). Many emergency admissions affect people with LTCs and could be prevented by more effective primary care or outpatient care. Despite relative affluence of the overall HWE population, and better than national average emergency admissions, in certain districts, such as Harlow, Watford, and Stevenage, the rate of emergency hospital admissions for coronary heart disease (CHD) and chronic obstructive pulmonary disease (COPD) are both significantly higher than the national average. Wider action from all system partners, beyond just UEC services, is required to address these inequalities in health outcomes.

We identified characteristics of patients at high risk of attending ED through machine learning, across the life course these cohorts were:

- young children (less than 3 years old) who present with wheeze and breathlessness,
- working age adults with issues such as substance misuse, mental health problems, social complexity, and Med3 'not fit for work' letter, and
- older frail population with history of falls, pain management medications, stroke and memory or cognitive problems and end-stage disease

A mental health clinical deep dive highlighted fragmentation of the system with lack of joined up care between mental health, drug and alcohol, social services, and primary care which resulted in many patients ending up inappropriately in ED. To overcome the inequality in health outcomes and reduce the frequency of ED attendances in working age adults facing multiple disadvantages, there is a requirement for the system to work together to effectively tackle the wider social determinants of health.

The costliest ED attendances and largest volume of emergency admissions to hospital are amongst our older population who are living with significant and advanced illnesses, severe frailty, or dementia, and many of whom are in their last year of life. Common reasons for admission are exacerbations of underlying LTCs, infective causes, and falls and fractures. Analysis of emergency admissions for ambulatory care sensitive conditions (ACSCs) highlight potential cost savings and improved patient outcomes if, management of these LTCs in primary and community care could be optimised to avoid unplanned care use. The largest volume and highest cost of these admissions were amongst people with severe frailty and at end of life. Many of our most frequently admitted patients are admitted for acute ACSCs[10] which should not usually require hospital admission and with greater streaming to SDEC or an acute frailty service to manage the acute condition caused by the frailty, could avoid hospital admission. In certain districts there are significantly higher rates of emergency

[10] Many of acute ACSCs are infective and include urinary tract infection, lobar pneumonia, diarrhoea, and gastroenteritis of presume infectious origin, cellulitis, acute upper respiratory tract infections, and viral and other specified infections.

admissions due to falls injuries in older people compared to England average.

Many of the emergency admissions in older people result in lengthy stays in hospital. This is a concern given the risks of deconditioning (10 days in hospital leads to the equivalent of 10 years of muscle ageing in people over 80) (Gill et al, 2004). Hospital is most often not the patient's preferred place to die. Many patients are not being supported to die or be cared for in their preferred place, and whilst a downward trend of the proportion of deaths occurring in hospital, this proportion is higher in HWE compared to the rest of England.

Full summary of findings, opportunities identified to improve UEC pathways, and recommendations can be found in our needs analysis here.

Figure 12. Opportunities identified to improve UEC across the pathway for our different population cohorts.

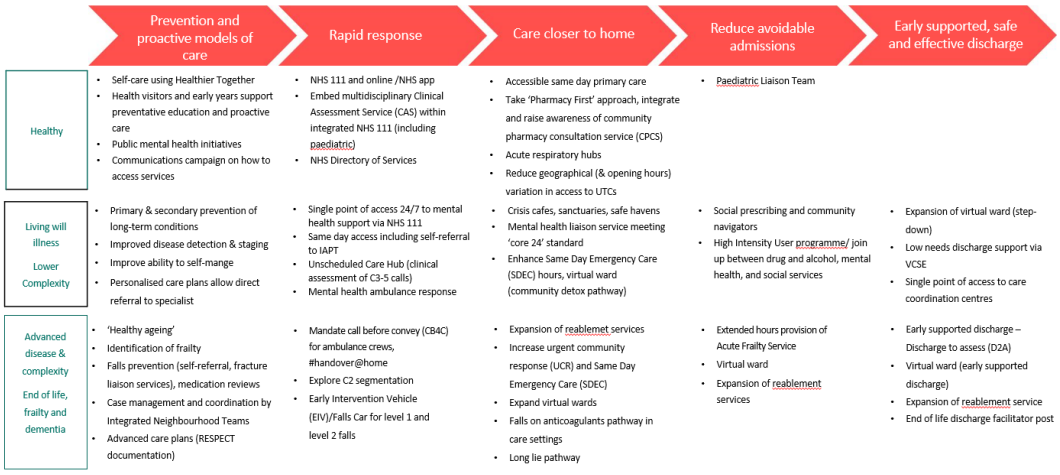


Table 3. Summary table of key findings from UEC population needs analysis to be addressed by the strategy.

Key findings from needs analysis to be addressed by the strategy
• One third of ED attendances resulted in no investigation or treatment. • Low acuity ED attendances highest amongst healthy young children
• Growing population of elderly, frail individuals who have highest rates of unplanned care and most at risk of harms of acute hospital admission (e.g., deconditioning)
• Inequalities in unplanned care use with higher rates amongst people living in more deprived areas. • Variation in health outcomes (higher emergency admissions for COPD and heart disease in certain districts)
• Adults with mental health, substance misuse and social complexity predicted high risk of ED attendance. • Clinical deep dive found a lack of join up between mental health, drug and alcohol services, social services, and primary care.
• Highest volume emergency admissions in frail older people for ambulatory care sensitive conditions (COPD and heart failure), and amongst those living with advanced disease and complexity.
• Higher rates of admissions for falls and fall-related injuries

- Frequent emergency admissions in people in the End of Life, frailty, and dementia segment

What else have we learned from our population?

National research (Ablard *et al*., 2020) found patients want a simplified UEC system which is easier to understand together with a single point of access that has clear and up-to-date information about what services are available to them locally. And they want equal access within the system regardless of where they live. Linked medical records to enable continuity of care and to negate the need to repeat their medical information were cited as important to achieving a more 'joined up' UEC system for patients.

We conducted a UEC local survey to understand the views and experiences from people who had used our UEC services in the past 12 months to further shape and inform our strategy (findings available in appendix b). There were over 800 responses, with respondents coming predominantly from an older age group and a white British background. Three-quarters of the respondents lived in ENH. Whilst this is not representative of our whole population, there are useful insights. Almost half of respondents understood 'urgent same-day care' to mean a GP appointment the same working day, and the second most common response understood this as seeing a clinician immediately. When asked about their UEC experiences, respondents most consistently reported what was good about their experience was the staff. The most frequent suggestions for improvements related to primary care access (many citing difficulties in obtaining a same day GP appointment, this may in part have been about obtaining a face-to-face appointment or preference to see their own GP) and the need for improved communication about waiting times, particularly in ED. Respondents reported that not knowing how long they would be waiting led to frustration, particularly in ED. This corroborates with reports from Healthwatch Herts (appendix a) and national studies (Ablard *et al.*, 2020) that suggest staff in UEC services could communicate more information about what is happening to patients and why, and the waiting times.

Almost a third of respondents reported they didn't know where to seek help for urgent or same day care, and 1 in 10 (n=68) felt services were confusing or hard to understand. Respondents were asked to rank what influenced their decision about where to go for medical attention on the same day. The highest ranked factors were ease of booking an appointment and guarantee to see someone face-to-face. Respondents who said if it was their child(ren) who was ill they would make a different choice, most often said they would choose somewhere with no waits or go to ED over other services. Suggestions to support people in deciding the best place to get help for UEC included: education to improve understanding of the urgency of conditions, more GP appointments, improvements to the NHS app or websites, and communications from their GP practice.

Table 4. Key findings from HWE local patient UEC survey

Key findings from local survey to be addressed by the strategy
• Most frequently cited issue was difficulties in obtaining a same day GP appointment
• Frustration in not knowing waiting times, particularly in ED

• Most cited factors influencing decision about where to seek help for same day care:
  • Ease of booking appointment
  • Face-to-face

• One third of respondents didn't know where to seek help for urgent or same day care. • Suggestions to improve understanding were: • Education to understand urgency of conditions.

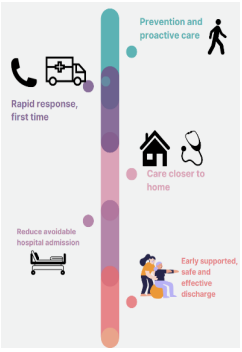
- More GP appointments
- Improvements in the NHS app or websites
- Communications from GP practices

Our future engagement on this topic area will make every effort to gather the views of those from a working age group and families with children, the Youth Council, residents from a Black, Asian, or other minority ethnic background, those who presented at ED with substance misuse or mental health needs, carers, and a more balanced representation from our three places, in particular WE and SWH. As part of our implementation plans, we will outline a phased approach to this engagement, including proposed engagement activities and timelines.

Where do we want to be?

Vision and ambition

Our vision for urgent and emergency care in Hertfordshire and west Essex is that everyone should understand and rapidly access safe, tailored, high quality, and sustainable urgent and emergency care which is received at the right place and time for them to remain well and independent.



In five years, our ambition is that people in Hertfordshire and west Essex will experience urgent care as close to home as possible to avoid harm of hospital stays and minimise disruption to their lives. The care they receive will be consistently high quality and safe and they will have confidence that they will receive the right care, first time and be supported in managing their health.

Our guiding principles

To achieve this vision, we will ensure that as a system we remain guided by the following principles during our recovery and transformation of UEC:

- Coordination and efficient use of resources to provide access to out-of-hospital providers (primary care, out of hours, community services, mental health, ambulance service, local authority, and VCFSE sector) to ensure patients get the right care, in the right place, first time.
- To meet patients' UEC needs move care as close to home as possible, where safe and appropriate.
- Prevention and targeted proactive, personalised care to specific populations backed by population health management (PHM) to move care where appropriate away from emergency admissions, crisis response, exacerbations, and ill-health.
- A sharp focus on reducing health inequalities in our population and unwarranted variation in services and access, experience, and outcomes.
- Maximise and coordinate system-wide digital solutions and technology-enablers.

- Use the skills of qualified health and care professionals in the most appropriate way to deliver services and develop innovative workforce models.

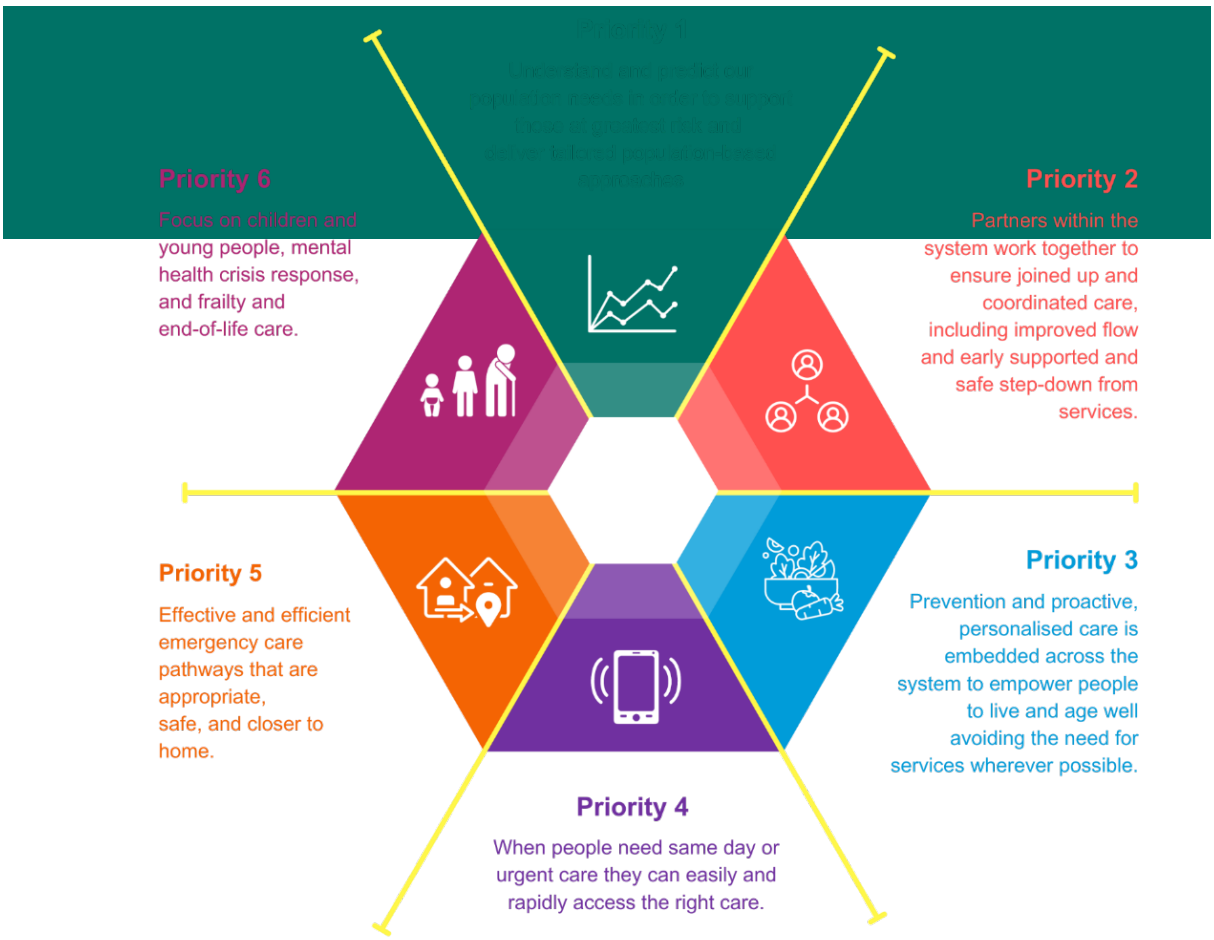
Six core strategic priorities

To deliver our vision, we have identified six core strategic priorities (figure 13) that look across the whole UEC pathway to capture the efforts and transformation required from partners across the system to meet the needs of our population in a different way.

These six core strategic priorities align with HWE ICP and ICB strategic frameworks. The first three core UEC strategic priorities emphasise prevention, targeted proactive and personalised care, using a PHM approach to promote resident wellbeing, reduce inequality, and avoid ED attendance. Partner coordination aims to improve access to services providing the right care, at the right time away from ED. When people do need to access our UEC services, the latter three priorities ensure these are responsive, enable care as close to home as possible, and provide positive patient experiences, and quality outcomes. Focus is given to key population groups identified by our population needs analysis.

The six core strategic priorities are explored in more detail below. For each, we outline a) why this is important considering our population needs and evidence of good practice, b) what we plan to do differently to achieve our vision, given the opportunities identified from our needs analysis and guided by our principles , c) the outcomes our population can expect from working differently, and d) what we plan to deliver as a system in the short-, medium-, and long-term to realise these strategic priorities and achieve our strategic vision.

Figure 13. Six core UEC strategic priorities



Priority 1: Understand and predict our population needs in order to support those at greatest risk and deliver tailored population-based approaches

We will work to understand and predict our population needs in order to support those at greatest risk of deteriorating health and deliver tailored population-based approaches to reduce health inequalities.

Why is this important?

The distribution of UEC need within our population is not uniform but patterned by age, geography, deprivation, and other demographic characteristics. Rates of ED attendance and emergency admissions are highest in young children aged 0-4 and adults over 75 years. Older people account for the greatest volume of emergency admissions in HWE, and care home residents are around 1.5 times more likely to be admitted as an emergency compared to older people living in their own homes (Lisk, 2015).

There is variation in UEC use across our geography (see full UEC population needs analysis here) with significantly higher rates of ED attendance in infants in west Essex and admissions to hospital for babies and children in East and North Hertfordshire compared to England rates. We need to understand the reasons for this variation to ensure all children and young people in HWE have equal health outcomes.

Social deprivation is the strongest predictor for ED attendance (Scantlebury et al 2015). Poor and unequal outcomes for people living with long term conditions exist too as people living in the more deprived neighbourhoods of HWE experience higher rates of emergency admissions for COPD, coronary heart disease and heart failure and worse health outcomes. People from minority ethnic backgrounds, living with disabilities, or from deprived neighbourhoods, are more likely to be on a long waiting list for planned care with subsequent deterioration in health culminating in what could have been a preventable emergency hospital admission. These inequalities in UEC activity are a proxy indicator for wider health inequalities in our population and reflect the need for our system to not only reduce the variation in access, experience, and outcomes for people of our health and social care but to also act on the wider determinants of health.

A small proportion of the population are at high risk of frequent use of our UEC services. These 'high intensity users' (HIU) often have a range of physical and mental health issues but also face social issues (deprivation, housing instability, social isolation, and substance misuse). Whilst there are a core proportion of HIUs that will continue to be so, many individuals who are identified as current HIUs of UEC in a snapshot of time will no longer be the high-cost individuals of the next year, even if we did nothing to intervene (Roland et al. 2005). Instead of identifying individuals based on their current high intensity use of UEC services, our analysis identified characteristics of those people with high predicted risk of future hospitalisation.

What will we do differently?

We will continue to develop an accurate view of the health and care needs of our communities to deliver more equitable and sustainable services for the future. We will use a PHM approach joining local data insights to make an iterative assessment of our population's UEC needs to understand who is experiencing poor and unequal health outcomes, and who is at greatest risk of deteriorating health, subsequent emergencies, and preventable admissions. We will use this to deliver population need-led transformation and service improvement and tailor evidence-based care to specific communities and cohorts. We will ensure that the analysis is provided for HCPs to support the prioritisation and targeted delivery of recommendations to specific population geographies. We will embed system-wide continuous improvement to ensure we deliver on our outcomes to address unwarranted variation and reduce health inequalities.

We will interrogate unequal and unwarranted variation in population outcomes and implement strategies with our system partners to tackle these inequalities, at both system and HCP level. We will work in partnership to engage with population groups facing inequality such as those living with mental ill health, learning disabilities, autism, and underserved groups to understand their needs and to -design tailored population-based approaches, using Experts by Experience and people with lived experience. We will ensure that we continually assess our population need and modify or pivot our tailored approaches accordingly.

We will use predictive models and techniques to identify those at risk of deteriorating ill health and future unplanned care. We will prioritise those with conditions amenable to upstream care (such as heart failure, COPD) so we can mitigate their risk through timely screening, early diagnosis, and proactive support. To enhance the impactability of these models we will work closely with our analytical teams, clinicians, and patients, to consider other factors when targeting case management for high risk (Steventon & Billings, 2017). A PHM approach supports enhanced planning and coordination of health and social care needs to ensure care is no longer fragmented.

What can our population expect?

- A local health and care system that uses data tools to better understand and pre-empt their urgent and emergency care needs.
- Local teams use data to identify patients whose condition might get worse and need hospital treatment, so we can put proactive care in place for them that stops them needing admission.
- To have access to a broad range of urgent and emergency care services across the health and care sector that are designed and developed using evidence of what works well from other areas and tailored to the local population.
- A local health and care system that seeks to learn and make improvements, working hard to ensure equal access and good health outcomes for all.

What we will deliver

- Conduct an urgent and emergency care population needs analysis using PHM approaches. Develop this iteratively to enable all partners to deliver transformation

and service improvement that better meets our population's urgent and emergency care needs.

- Learn from people in our communities, particularly those who experience health inequalities, by way of planned engagement through our HCPs utilising Experts by Experience and people with lived experience, including mental health service users, learning disabilities and autism groups, and other underserved groups to understand how their experiences may differ and how better to address their UEC needs.
- Using the PHM network, understand data available to use from providers across the UEC system, and ensure cohorts for evaluation are identifiable within data flows. A CORE20Plus5 lens is embedded to ensure routine data collection and reporting on these demographic characteristics, and ethnicity to make it easier to identify health inequalities and gaps in care.
- Evaluation of pilot interventions and transformation of UEC services (for example, virtual wards), considering impact and outcomes for different segments of our population to support a differentiated approach.
- Use the segmentation model to understand the profiles of high intensity users to understand, implement, and evaluate the different interventions required to optimise their care.
- Use predictive models and techniques to support identification of those at risk, or rising risk, of deterioration and future unplanned care to optimise delivery of proactive intervention and coordination of care. INTs will be supported to proactively design effective personalised and proactive care models to meet these needs. These data-driven methods will allow us to flag patients at risk of acute deterioration to be managed faster by specialist community services and avoid unplanned hospital admission.
- Move from reactive use of remote monitoring and health technology to a proactive use that enables prediction of patients at high-risk of future hospitalisation and targeted, earlier community care with enhanced monitoring and oversight to prevent deterioration and use of emergency care.
- Use our linked data sets and collective resource as an ICS to target efforts to protect certain populations through public health advice (for example targeted follow-up by health visitors of families following ED attendance), screening and testing (using NHS Health Checks holistically to enable earlier conversations around screening) and vaccination programmes to narrow inequalities in health outcomes.
- Understand why rates in ED attendances and emergency admissions amongst children and young people are different across our geography, including variation between areas, to inform development of services to address any unwarranted variation.
- To use the care home dashboard to identify any unwarranted variation in emergency admissions between care homes and offer homes differentiated and targeted support to reduce conveyance of residents to ED.
- Use our linked data sets to track patient journeys through the UEC system, undertake analysis of duplication and population characteristics to understand shortcomings and fragmentation of services to inform service improvements.

Priority 2: Partners within the system work together to ensure joined up and coordinated care, including improved flow and early supported and safe step-down from services.

We will work as partners within the system together to ensure, there are no barriers in coordinating care, and safe and supported transition from services for patients.

Why is this important?

Currently in HWE, ambulances are often unable to handover patients promptly in ED which means delays and a clinical risk to patients waiting for ambulances in the community. Our EDs are pressured with high volumes of attendances by people who may be better cared for in primary or community care. Drug and alcohol related presentations requiring medical attention can involve issues of challenging behaviour which can cause disruptions in ED and require additional staff support. EDs are often inappropriately designed to meet the needs of people in a mental health crisis, evidenced by long waits in noisy environments resulting in increased reports of violence and aggression towards staff. Our hospitals are stretched with bed occupancy rates over 90%. More hospital beds are not sufficient, we need to bolster our services outside of the hospital, including in our community services, primary care, and adult social care to improve people's health and reduce avoidable demand for hospital care.

Primary care plays a pivotal role with the largest share of contacts in the NHS, in 2022/23, in excess of 3.5 million same day urgent appointments were delivered by general practice in HWE. As the first point of contact in the healthcare system, a clinician in primary care seeing urgent or same day patients is a key plank in the management of clinical risk across the system, and, alongside community services, determine whether the patient can be managed appropriately with social support in the community, by acute specialist community services, or Same Day Emergency Care (SDEC) as alternatives to ED, or if they believe an ED assessment or admission is likely to be required.

When admitted patients spend too long in ED it can cause serious patient harm and deaths (RCEM, 2023). At present, the people most vulnerable to 'deconditioning syndrome'[11] are most likely to experience prolonged emergency hospital admissions due to the complexity of both clinical and social needs. Early step-down from services to care at home is important as we know patients are generally more satisfied when cared for in their own home (Shepperd *et al*., 2021), and they would rather be in hospital for as short a stay as possible. Over 50% of delays are caused by 'NHS factors' including discharge processes, or lack of hospital clinician understanding of community specialist resources resulting in underutilisation of such resources (Fernandes & Ray, 2023).

[11] 'Deconditioning syndrome' is the physical, psychological, and functional decline resulting from prolonged bed rest and associated muscle loss (Arora, 2019).

When long-term care needs assessments are performed in an acute hospital setting, this can lead to an over-prescription of care and support (Offord *et al*., 2017). A process of 'discharge to assess' means assessing a patient's needs after discharge, in the patient's own home rather than in hospital. This facilitates reduced length of hospital stay (average 5.5 to 1.2 days) (Offord et al 2017), no increase in readmissions and improved patient and family satisfaction (Botwinick, 2017). However, national research (Healthwatch, 2020) revealed many people had unmet needs in the community and were not receiving a home assessment after leaving hospital exposing the interdependence on community care, social care, and the voluntary sector for safe and effective discharge.

What will we do differently?

We will organise ourselves to provide join up at all levels; at system, between providers of services at place, and at patient-level to improve flow and patient experience and outcomes. System partners across all acute, community, mental health, primary care, social care services and the VCFSE sector will work together to understand and utilise all available capacity across the system enabling people to access the right care at the earliest opportunity. The ICB will play a pivotal role in this system leadership, coordination, and management of pressures. The System Coordination Centre (SCC) will exist as a central coordination service to providers of care across the ICB footprint to support patient access to the safest and best quality of care. The SCC will be responsible for coordinating an integrated system response using the Operating Pressure Escalation Level (OPEL) framework and keeping a focus on system's wider capacity including, but not limited to, NHS 111, primary care, intermediate care, and social care, urgent community response, and mental health services. Partners will work together to ensure emergency support is available in our system when it is needed most. We will get better at forecasting and predicting changes in demand to deliver a responsive and proactive UEC system.

Strong central leadership from the ICB will coordinate a system response to operational pressures and manage risk across the system. Acknowledging constraints of external factors such as workforce and funding, risk across the system will be better managed through identification of where the risk resides and ensuring this is visible to all. The SCC will work to improve visibility of operational pressures and help align this view with clinical risks. This will enable a collective, objective understanding of system risk, its relationship with pressure, and will support senior operational and clinical leaders in better decision-making and collective action to improve patient safety. This will be supported by our clinical and professional leadership fostering a culture of positive and dynamic decision-making across the system, taking into account risk levels in the community and acute hospital settings risks to minimise the overall, system clinical risk, ensuring individual clinicians feel safe and supported and overall clinical risk is reduced.

Health and social care services will work collaboratively and in a joined-up manner to ensure a single, timely and coordinated response to patients so that people receive the right care in the right setting. Care coordination centres will make the best use of scarce resources and assemble the right expertise and manage smooth transfers of care across the system. By working together as system partners, we can develop and utilise more community-based or same-day access services to meet the needs of patients. Given the pivotal role of primary care (including community pharmacy) plays in supporting people with their same day, urgent care needs, as well as proactive models of care, we will ensure joint collaboration in the design and delivery of integrated pathways and develop structures to support close working through operational management processes to mitigate clinical risk, and better integration as

a delivery partner of UEC in our HCPs.

When people are admitted to hospital, we will ensure discharge planning is commenced on the day of admission to support them to return to their usual place of residence (as the default) as soon as is safely possible and ensure ongoing care needs or appropriate end of life care as they require, as well as VCFSE interventions to address blocks to discharge such as lack of transport, or unsafe conditions at home. This will ensure safer care and improved patient outcomes, and reduce bed occupancy, bottlenecks, and delays in patient care.

What can our population expect?

- Shorter waits for ambulances and in EDs.
- To be able to access the right care, at the right time with connected teams and information so they do not have to repeat their story.
- To be discharged seamlessly from a hospital (acute, community, mental health) in a timely and effective manner with a 'home first' approach, equipping them to maintain independence. Plans for discharge will happen as soon as they are admitted, everyone is kept informed and the help they need to go home (including social care and ongoing treatment) is coordinated to ensure safe discharge.
- Shorter, more appropriate, hospital lengths of stay so that they are less likely to experience harms of an inpatient stay and people can make decisions about long-term care needs in their own familiar surroundings when out of crisis.
- To make sure hospital beds, including mental health inpatient beds, are available for people who need them.

What will we deliver?

- Ensure our care transfer hubs have appropriate staff, leadership, and processes to coordinate relevant health and social care partners to speed up decision-making about which pathway someone should access, facilitate rapid, safe, and appropriate discharge from hospital, and maximise access to rehabilitation and reablement services, as well as wraparound services (e.g., hospital and community navigator service and ticket home) to support discharge, recovery, and prevent unnecessary readmission. These care transfer hubs will be digitally enabled to manage daily flow and care coordination of patients.
- Work with system partners to develop a safe, high-quality framework to deliver a discharge to assess (DTA) model which promotes 'home first' principles, ensures prompt access to therapy, and is supported by community and primary care. Draw on real-time evidence from care transfer hubs to plan and appropriately resource sufficient intermediate care to align the right wraparound for rehabilitation and reablement to facilitate safe and timely discharge from acute and community hospitals.
- A clear understanding of the demand for intermediate care to ensure appropriate capacity to provide timely services that prevent reactive interactions and minimise emergency hospital admissions, and the right care types, positively impacting patient satisfaction, and maximising independent living.
- Re-define 'medically optimised' and link our integrated discharge teams with virtual wards/hospital at home so people who can receive their acute-level care by these services can also receive the short-term care and therapy at home needed to

facilitate early supported discharge.

- Develop system-wide principles for optimal discharge practice to reduce unwarranted variation, including early planning, improved communication to ensure the person and their carers understands what is happening, criteria led discharge, and daily reviews.
- Implementation of in-hospital (acute, community and mental health) efficiencies to improve flow and support early discharge guided by best practice interventions, consistently seven days a week.
- Embed a year-round 24/7 SCC that has oversight of system pressures and manages patient flow across the system in real time. Data will be shared with clinicians across the system at critical time points to support in decision-making on alternative pathways and mitigation and dispersion of clinical risk across the system that benefits the population. Consideration will be given to how pressures within primary care could become an even more integral part of these processes to improve identification and decompression of high strain points. All of these measures will help to ensure greater multi-partner, system-wide, dynamic management of risk.
- A subcommittee of the SCC will oversee and manage clinical risks within the system (with specific reference to UEC demand and capacity) and support the SCC with clear clinical escalation to agree mitigations.
- A system demand and capacity model that allows us to not only understand current levels of demand and capacity but is sufficiently developed to forecast and predict seasonal pressures and risks to pre-empt operational planning and enable proactive coordination by the SCC. We will use predictive analytics to predict when demand will exceed capacity and how this may change over time.
- Enhance whole system near-live monitoring of demand and system impacts and interdependencies using System Health Resilience Early Warning Dashboard (SHREWD). All our system partners (acute, mental health, community, primary, and social care) will be incorporated to allow effective management of capacity, improved performance, and its use retrospectively to inform system planning.
- A single ICS system-wide SCC standard operating procedure will be used alongside the new Operating Pressures Escalation Levels (OPEL) framework across all acute sites, including mental health, and primary care. This will ensure a view of pressures is shared across the system to understand where support is required to alleviate this pressure across the entire UEC pathway.
- Increase our use of statistical process control (SPC) for data driven insights for improvement action and to effectively identify trends and warning signs to enable early intervention.
- Understand and predict system performance using system dynamics modelling to identify where investment in the urgent care system could deliver the most improvement to flow and outcomes. This will allow us to model impact of proposed interventions at a system level, enabling future prioritisation and evaluation of initiatives.

Priority 3: Prevention and proactive, personalised care is embedded across the system to empower people to live

and age well avoiding the need for services wherever possible.

We will be proactive to prevent ill health and deliver personalised care across the system to empower people to live and age well, avoiding the need for services wherever possible.

Why is this important?

We need to take a long-term approach to urgent and emergency care, going beyond just dealing with emergencies in hospital.

It is estimated 51 million GP consultations per year nationally are for minor ailments alone which could be dealt with by self-care or self-management (PAGB, 2010). Self-care for minor ailments is effective in reducing dependency on UEC services (NHSE, 2013) and community pharmacy can support this, but there is often a lack of awareness amongst the public of the services available through pharmacies.

Healthy children accounted for the largest volume and cost of low-acuity ED attendances. Some of the greatest disparities in ED attendance between more deprived and less deprived populations are amongst children, this difference is even bigger for low-acuity attendances. Illnesses such as upper respiratory tract infections, injuries caused by accidents at home and poor oral health are leading causes of ED attendances in under 5s and linked to several factors connected to health inequality.

Under-served populations experiencing complex needs[12] include rough sleepers, those experiencing homelessness, and victims of domestic abuse face the greatest health inequalities. Other inclusion groups experiencing social exclusion include vulnerable migrants, Gypsy, Roma and Traveller communities, and those with drug and alcohol dependence. These populations have poorer health outcomes and are at greater risk of unplanned admission to hospital and care homes, ED attendance, street triage, and ambulance callouts.

Rates of emergency admissions for chronic ACSCs[13] vary widely across the geography. High-quality disease management, timely treatment, and appropriate referral of patients with chronic ACSCs, improve quality of life and help prevent avoidable emergency admissions. The highest volume and cost of these admissions are in patients with heart failure, COPD, and atrial fibrillation. Lower socioeconomic groups often have less access to self-management programmes, the focus should be on increasing 'patient activation' (knowledge, skills, and confidence a person has in managing their own health and health care) (Hibbard & Gilburt, 2014).

People living with severe frailty are at four times greater risk annually of future hospitalisation, care home admission, or death. If frailty is not identified, older people face poorer outcomes from their hospital care (for example, less successful surgical outcomes) (NHSE, 2023d). 'Frailty crises' such as a sudden loss of mobility, delirium, or falls account for most common presentations to ED in older people and significantly higher rates of admission due to falls (compared to England) occur in older people living in some of our districts in

[12] Complex needs defined as two or more needs affecting physical, mental, social, or financial wellbeing.
[13] such as asthma, diabetes, epilepsy, hypertensive disease, dementia, and heart failure

HWE. The cumulative effect of taking medications with anticholinergic activity, the 'anticholinergic burden', contributes to risk of falls. In HWE, a larger proportion of patients aged over 85 have a high anticholinergic burden compared to England average.

What will we do differently?

We will take a longer-term strategic view of UEC that looks beyond the 'highest risk' activity in our population occurring in ED and acute hospitals and takes a whole population approach to make a difference at scale. As an ICS we work collaboratively across local authorities, primary and secondary care, social care, the voluntary sector and beyond, to deliver our ICP strategic priorities and support our residents to live and age well. This UEC strategic priority aligns to delivery of this and other key strategies and priorities in HWE (e.g., Primary Care Strategic Delivery Plan, frailty and end of life, children and young people, long-term conditions).

Public health offers leadership in prevention and is well placed, in partnership with district and borough councils, and a wide range of VCFSE groups, to support residents to get the support they need. We will take action to tackle the wider determinants of health, such as housing, employment, or social isolation, and in line with the HWE ICS VCFSE Alliance health creation strategy, further develop our social prescribing offer to enable us to reach more people from the most deprived backgrounds and wrap the necessary support around them proactively to avoid unplanned care and reduce GP attendance.

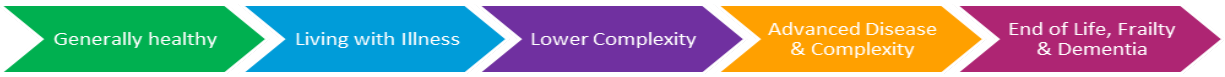
We will do more to coordinate, bring together and design services that are accessible to vulnerable people, many of whom currently face social exclusion. The role of the VCFSE sector will be critical in engaging with underserved cohorts of our local population who experience significant health inequalities and support in-reach and local approaches to ensure access to health and care services.

Our approach to prevention and proactive care will be tailored to different cohorts in our population (figure 14) including: primary prevention measures to keep people physically and mentally well; empowering our residents, families with young children to self-manage minor ailments; identifying those well but at risk through early identification such as screening programmes and annual health checks (particularly for those with learning disabilities to enable early identification and intervention), and improving mental health before it escalates; personalised care, and self-management and 'activation' for those living with illness and low complexity to stop or delay progression to complexity, frailty, and functional impairment. Those living with advanced disease and complexity, or frailty will be supported proactively through coordinated case management to provide continuity of care that is highly responsive, detecting early deterioration and urgent care needs with tailored advance care plans (ACP) in place. It should be acknowledged that advance care planning should be socialised and available to all, starting conversations with people before they are ill and frail.

Population-level frailty identification and stratification will help us to plan for future health and social care need, target ways to help people age well including falls prevention and medication reviews. We will embed a PHM approach in primary and community care, using risk stratification and targeted proactive and anticipatory care. We will align with the Core20PLUS5 approach, targeting those living in the most deprived communities, and inclusion health groups who experience barriers in accessing primary care and preventative services, and experience poorer outcomes.

We will increase our resilience as a system, drawing on our collective resource, including the VCFSE alliance to address the wider determinants of health, maximise use of our public health programs, and acknowledge the critical role of community pharmacy as part of primary care, to optimise existing services and pivot these to address unmet need.

Figure 14. Prevention and proactive care across our population segments



• Public awareness campaigns • Signposting (Healthier Together) • Early years settings/HV for accident prevention and minor illness advice • Immunisations • Community pharmacy for minor ailments • Primary care access • Healthy behaviours • Health checks • Screening • Healthy ageing • Self-referral into falls prevention	• Public mental health initiatives • Optimisation of patients living with LTCs e.g.: weight management, smoking cessation services • Self-management programmes e.g., for COPD, diabetes • Advance care planning	• Improve activation and self-management to stop or delay progression to complexity. • Medication reviews and investigations e.g., blood tests when needed. • Advance care planning	• Annual reviews • Treatment escalation plans/ Advance care planning • Identification of frailty • INT proactive care models	• Advance care planning • Identification of end of life

What can our population expect?

- To feel empowered to self- manage acute minor illnesses and some minor injuries.
- Support from all system partners to live longer, healthier lives through adoption of healthier behaviours, earlier identification, and proactive management of disease, mental health needs, and frailty.
- To have knowledge, skills, and confidence to understand the signs and symptoms of deterioration in their health and seek early and prompt intervention to manage their health condition and stay well at home.
- To be given the opportunity to plan for their future care so that it is focused on what matters most to them and that they die in their place of choice.

What we will deliver

- Consistent public physical and mental health awareness and prevention campaigns across the ICS. Ensure these are tailored and we design these with those at greatest risk and most vulnerable, using Experts by Experience and people with lived experience.

- Signposting resources e.g., Healthier Together and the NHS websites to support self-care and self-management of minor illness and some minor injury and share messages through various channels and family spaces, and with support from our VCFSE organisations to support these campaigns.
- Safe and effective plans for delivery of national health screening and immunisation programmes, and robust plans to reduce inequalities in uptake of vaccinations.
- Public mental health initiatives, including supporting system partners to build on suicide prevention, ensuring the autistic community and other groups with protected characteristics are considered, to achieve the system commitment of zero suicides, and developing mental health training and roll out to enable our workforce across all ICS partners to be more psychologically minded and achieve earlier identification of low-level mental health need, improved signposting, and early intervention (NHS Talking Therapies).
- Support the collaboration of primary care and system partners in HCPs in taking a PHM approach, using data and intelligence to identify need and deliver prevention activity and proactive care targeted to those with greatest need to reduce variation and inequalities. We will enact support, investment, redesign, and reprioritisation of funding where appropriate to increase patient participation in the most impactful ill health prevention initiatives such as NHS Health Checks, smoking and weight management services, particularly among communities that experience the greatest health inequalities to prevent or delay the onset of disease and support healthy ageing. We will invest in the VCFSE sector to support in-reach and flexibility to improve access to preventative and proactive primary care interventions for specific communities, and underserved populations.
- Joint work between relevant healthcare workers and system partners to achieve greater number of completed annual physical health checks and appropriate action plans are put in place for those with severe mental illness (SMI), learning disability (LD), and annual reviews for residents who are frail or at risk of frailty to support early identification of disease and early intervention.
- Further develop our social prescribing offer to help people find 'person-centred' support, allowing time to identify the challenges they face and how they may want to address them. Strengthen pathways for referral of high intensity users in UEC services to social prescribing and VCFSE organisations to tackle wider determinants of health.
- Pathways into drug and alcohol services that are accessible across all our UEC services. We will support hospitals with the highest rate of alcohol dependence-related admissions to establish hospital-based alcohol care teams with pathways to detox and community support for those individuals with repeated hospital admissions.
- Falls and fracture prevention, including promotion of self-referral into falls prevention services, stronger links with community-based falls prevention services and voluntary sector, and development of fracture liaison service. We will take a system-wide approach to identify those older people at risk of high anticholinergic burden, and support clinicians in assessment and deprescribing as necessary, to reduce risk of falls.
- Support INTs to use PHM approaches to identify patients at greatest risk of deterioration or hospital admission, enabling earlier intervention and effective case management and personalised care. Integration of care by MDTs with access to specialist advice and guidance facilitated through Consultant Connect.
- Test and learn from pilot services using digital technology remote monitoring and support such as early deterioration monitoring in care homes, and sensor devices in peoples' own homes to predict falls or early decline in functioning.

- Use data to proactively identify in real-time patients with COPD, heart failure and frailty who will benefit most from proactive case management so we can intervene earlier and provide an effective and efficient set of services to support people in their homes. WE will explore a learning model to identify patients in the days before crisis or hospital admission to reduce their risk of emergency admission.
- Embed advance care planning through work to 'start the conversation' across all cohorts and health and care sectors. Undertake systematic identification of adults who are likely to be approaching the end of their life and support these individuals to develop ACPs which set out the patient's preferences and priorities for clinical care in an emergency using consistent documentation, for example ReSPECT or PEACE[14] to enable sharing across the UEC system.

Priority 4: When people need same day or urgent care they can easily and rapidly access the right care.

We will ensure that when people need same day or urgent care they can easily and rapidly access the right care.

[14] Recommended Summary Plan for Emergency Care and Treatment (RESPECT) and Proactive Enhanced Advance Care plan (PEACE)

Why is this important?

Many people are accessing services that are not best suited to their urgent care needs. We know a third of ED attendances in HWE result in no investigation or treatment[15]. Several audits at our ED departments found that very few patients had tried to contact primary care before attending. These low-acuity ED attendances for urgent care needs could be better addressed by alternative same day access in primary care or integrated urgent care, freeing up capacity within ED to deal with true emergencies.

Primary care services play a central role in managing demand, particularly same day urgent care. General practice delivered in excess of 3.5 million same day appointments in 2022/23 and continue to provide increasing numbers of appointments. In a recent local public survey, respondents reported that better primary care access would improve their UEC experience. Many reported struggling to either access or navigate their way to a same-day appointment. In the HWE ICS GP National Survey, 11% went to ED when they couldn't get a GP appointment and 31% visited ED instead when the GP practice was closed (GP Patient Survey, 2023).

Our local patient networks considered effective triage as the key to supporting people to access the right care easily and rapidly by the most appropriate services. Evidence tells us that senior decision-making early on improves experience for patients and productivity (NHSE, 2013) and the core skill set of GPs in managing uncertainty and clinical risk results in fewer investigations and quicker management for urgent care needs (Uthman et al., 2018).

National research found patients wanted a simplified, joined up, and easier to understand UEC system with a single point of access, and equal access within the system regardless of where they live, and clear up-to-date information about services available to them (Ablard *et al.* 2020). If UEC services and clinicians trust the assessment of clinicians in other services (and can share care records), a 'joined up' system will add value to patient care, reduce waits and delays and negate the need for patients to repeat their medical information.

EDs are often inappropriately designed to meet the needs of people in a mental health crisis. Staff in EDs are often lacking training with the skills in supporting the people who present, and the estate does not lend itself to enable reasonable adjustments to be made to ensure that patients can deescalate their mental health crisis safely.

Analysis of the top 5% of patients with the most frequent emergency admissions found the reasons for admission often related to acute ACSCs e.g., urinary tract infection, pneumonia, cellulitis which could be amenable to SDEC avoiding admissions longer than 24 hours. Patients with SDEC-amenable conditions are most likely to be admitted during hours that extend later than opening hours of the current SDEC provision. Older people account for the greatest volume of emergency admissions due to ACSCs, highlighting an opportunity to provide greater same day emergency care, either through SDEC or acute frailty services for these patients, and avoid harms of admission.

What will we do differently?

[15] Includes type 1 and type 3 ED attendances.

We will ensure that when people need urgent same day care they can easily and rapidly access the right care, as close to home as possible. A coherent, streamlined, accessible, and convenient urgent care system will ensure ED is reserved for life-threatening emergencies and serious conditions.

Primary care is pivotal to transformation of same day access, urgent care. Simplifying and enhancing access for urgent primary healthcare needs, is a key priority within the HWE Primary Care Strategic Delivery Plan and by improving access to cost-effective primary care same day services we will provide patients with care that is convenient, close to home, and sustainable.

We will ensure that we better integrate community pharmacy with our other urgent and emergency care services through clear protocols and pathways and better communicate, to both patients and staff, the full range of capabilities in community pharmacy to deal with their urgent healthcare needs.

Models of same-day access urgent care will be tailored to meet the current and future needs of local populations to ensure equity in access, for example as we expect to see a growth in older people concentrated in our more rural communities there will be an increase in need for accessible same day urgent care in these areas due to frailty and limited travel options.

We will ensure an integrated urgent care pathway that operates 24/7 in the community to guarantee patients' same day and urgent care needs are met effectively, efficiently, and safely in an appropriate setting by appropriate staff. We will simplify access and further develop consistent effective triage and care navigation for patients with urgent care needs supported by digital triage tools, backed by population health data, and testing of artificial intelligence in navigation and referral direction. We will embed a 'trusted assessor' approach, service connectivity will ensure that patients can be efficiently and safely navigated to the most appropriate care without duplication of assessment and avoiding delays to receipt of care. This will make it easier for patients to navigate the UEC system and improve patient experience and satisfaction. There will be a universal offer, from any access point, for patients who need assessment, diagnostics and/or treatment the same day. This will make best use of all our UEC resource (GP in-hours, community pharmacy, dental, optometry, same-day/extended access hubs, mental health services, NHS 111, GP out of hours, urgent community response (UCR), urgent treatment centres (UTCs) and same day emergency care (SDEC) services) through effective triage and navigation to ensure the most clinically and cost-effective model of care, that is matched to patients' level of urgent care need. We will continue to empower our patients and carers to make informed decisions when accessing care by providing communications and education to help navigate the system.

A mental health urgent care centre has been launched on the Lister Hospital site. This, alongside a wider training and development programme for hospital staff will ensure that people who present with a mental health crisis are supported as effectively and efficiently as possible improving patient experience and the growing pressure in EDs.

What can our population expect?

- A less confusing urgent care system with clear, consolidated access points to empower individuals to make informed decisions about their urgent health needs and be guided seamlessly to the right care first time.
- Access to care for same day health needs, which is appropriate to level of need, convenient, and accessible 24 hours a day, 7 days a week.

- Reduced waiting times for assessment and treatment and no unnecessary visits to hospital.
- General practice surgeries with more time to support people if they are living with complexity and LTCs, frailty, social or psychological needs and benefit from relationship-based care.
- 999 and ED have enough capacity to respond quickly to people with serious or life-threatening emergency needs.

What we will deliver

- A shared understanding across the system (including patients and public) of what same day access means and a system-wide same day access strategy detailing our medium to long-term plans for transforming same day urgent care.
- Develop a simplified general practice access model, informed by trials and tests of telephony/e-consultation hubs, and artificial intelligence in navigation and referral direction.
- Provide a highly responsive integrated urgent care service so that people understand the value of seeking advice through first NHS 111 and NHS 111 online rather than using emergency services to address unanticipated urgent care needs. Scope new models such as possible integration of digital capabilities of NHS 111 and expertise of primary care to develop appropriate pathways to support same day access and use data-driven methods to effectively prioritise and navigate patients to the most appropriate local service 24/7 365 days a year, including identifying people who frequently use urgent care and finding a better way to support them.
- An integrated 24/7 urgent care service with primary care central. We will explore the potential for all UEC access points (including GP, NHS 111, 999, ED) to be effectively integrated into a single assessment service, using consistent initial assessment, and supported by a comprehensive, easily accessible, up-to-date Directory of Services (DoS)[16] to allow consistent signposting and referral for further care. This will ensure patients are treated promptly in the right setting. Those that require relationship-based care will be supported by their own GP whilst other patients benefit from broader capacity across the UEC system to find a service that is accessible and convenient. A trusted assessor approach will be embedded across the integrated urgent care pathways and digital interoperability to share records to ensure patients do not have to repeat their medical information.
- Ensure patients have appropriate and timely access to diagnostics, and expert advice regardless of where they access the system (primary care, NHS 111, 999, or ED), supported by virtual networking of ED, SDEC, UTC and MIUs.
- Locally led models of same-day access to improve resilience of our urgent care system that are outcome-led to ensure equity in access. These may include locality- or PCN-level same day access hubs matched to population need (particularly across priority areas such as Harlow, Stevenage, and Hertsmere) and that have integrated pathways with other services (NHS 111, ED, SDEC, UTC, and virtual wards) to support referrals, diagnostics, treatment, and monitoring. We will adapt these to respond to seasonal surges in demand, for example due to acute respiratory infection in all ages (particularly children).

[16] The urgent and emergency care Directory of Services (DoS) is a database of NHS services in England. It works with NHS Pathways, the decision support system behind 111 and some 999 providers, to provide real-time information for patients about the right place to go.

- Integrate community pharmacy into the UEC system so that low acuity conditions can be redirected to pharmacies for management via clear commissioned protocols and pathways. Patients will be supported in self-management of minor ailments through implementation of the Pharmacy First scheme and optimised use of the Community Pharmacist Consultation Service (CPCS) across the UEC system. We will conduct a comprehensive assessment of service offerings and capabilities and invest in training and support to expand community pharmacy capabilities.
- Ensure UTCs have consistent pathways of care and assess the optimum locations and opening times for these driven by population-need. We will test and learn from new integrated multi-provider service models to ensure ED has capacity to respond quickly to those with serious or life-threatening illness and we better 'close the loop' in people's care. Learning will be shared across the system as we undertake an UTC model review and spread.
- We will monitor, evaluate, and learn from a new Mental Health urgent care centre which offers a more appropriate alternative to ED for patients experiencing mental health crisis, with targeted crisis response and gatekeeping for mental health admissions.
- When people have an acute condition and no red flags, they can be managed via same day emergency care (SDEC) non-admitted pathways (these will include high volume and population needs-led pathways e.g., emergency admissions for ACSCs) for medical, surgical, orthopaedic, paediatrics and gynaecology. Operating hours will be matched to demand to enable greater streaming to SDEC from the front door, so patients are seen, treated, and discharged on the same day as arrival to hospital. SDEC will be accessible across all parts of the healthcare system including 111, 999, primary care, community care (including virtual wards), and mental health, and digitally enabled direct referral and booking slots will be available, including from single point of access (SPOA).

Priority 5: Effective and efficient emergency care pathways that are appropriate, safe, and closer to home.

We will ensure effective and efficient emergency care pathways that are appropriate, safe, and closer to home.

Why is this important?

National qualitative research has found patients are frustrated in having to repeat their medical information and want a more 'joined-up' UEC system that has linked medical records (Ablard et al. 2020). This lack of join up is experienced by staff too. Audits at the three trusts found ambulance crews have a lack of information on alternatives to conveyance pathways and primary care. There are delays in responding to category 2 ambulance calls. This is a broad category of calls and includes serious emergencies such as strokes, heart attacks and sepsis. Evidence from national pilots have found further breakdown of these category 2 (C2) calls to provide a different response has potential to support a proportion of those C2 calls through telephone advice or referral to an alternate service, protecting ambulance capacity to respond faster to the more serious emergencies.

As well as facing long waits for ambulances, older people also face longest waits in the ED. Those living with frailty, dementia, complex conditions, and at end of life are more likely to have investigations and treatment when brought to hospital, which may be unnecessary with incidental abnormal findings, leading to a decision to admit which does not align with individual wishes and is often not the safest, most appropriate setting. Older people are at high risk of adverse outcomes from these delays and the harms acquired directly from being in hospital, including rapid decline, deconditioning, increased risk of delirium, and loss of reserve. This can then result in longer inpatient stays, delays to discharge, and increased likelihood of readmission. Early discharge alone is insufficient though, research has shown that individuals with frailty who are discharged from hospital, even after short (<72 hours) admissions experience greater mortality and hospital use (Keeble et al, 2019). We need to avoid admissions to hospital through intensive community support to improve patient outcomes.

Our UEC pathways are not effectively supporting those patients at end of life either. People in the last year of life experience a high number of emergency and urgent care episodes, one in 14 people are admitted to hospital three or more times in the last three months of their life. Many people are not supported to die or be cared for in their preferred place. In HWE, there are a higher proportion of deaths occurring in hospital compared to England.

What will we do differently?

We will ensure that when people have urgent or emergency care needs, they are able to access appropriate and safe care close to home. Conveyance and admission to hospital will only occur when clinically necessary and most appropriate for the patient.

We will bolster out of hospital care, and local community services, including virtual wards for children and young people, and adults, support for mental health need and crisis, and end of life care. We will configure out of hospital urgent and emergency care services so that they are responsive to patients urgent, emergency, mental health and end of life care needs and ensure that wherever a patient accesses UEC they will benefit from multidisciplinary support in finding the most appropriate out of hospital care to meet their needs. This will be co-ordinated efficiently, reducing the number of clinical assessments, referrals and waits for patients and maximises the opportunities for them to receive safe, effective care at home.

We will support our workforce in using these admission avoidance services (including urgent community response, falls vehicles, virtual wards, and SDEC) navigating patients efficiently and effectively to receive urgent and acute level care at home. Rapid response to urgent and emergency mental health need, and crisis alternatives for adults and children and young people will be consistently available, priority 6 covers greater detail as to how we will deliver this.

What can our population expect?

- If they call 999 and have a life or limb-threatening illness or accident which requires immediate, intensive treatment, an ambulance is reliably dispatched within minutes, and they will be seen rapidly in ED.
- If they do not have immediate, life-threatening need they will be safely navigated to alternative out of hospital care that is comprehensive, coordinated, and effective to manage their urgent and emergency care needs and provide acute-level care at home.
- People will no longer need to repeat information to multiple different health and care professionals.
- Older people and those with complex health needs can expect to live independently for longer in their own homes and experience better health outcomes.

What will we deliver?

- Simple and efficient referral routes from primary care, NHS 111, community teams, 999 and paramedics on scene into a single point of access (SPOA) in the community staffed by a MDT of senior clinical decision makers (including mental health and drug and alcohol services) who can support in providing timely clinical advice and finding safe, alternative non-ED pathways of care to support patient UEC needs. This will include helping them remain at home, receive timely follow up care after accessing the ambulance service, or accessing the right setting first time (e.g., urgent community response, virtual wards, SDEC).
- Respond to time critical, life threatening and serious conditions by our ambulance service through proactive management of ambulance portal lists. We will automate redirection of certain category 3-5 calls, and proactively identify other suitable calls within this list for redirection to our community services who can coordinate an MDT response. We will also carry out segmentation of category 2 calls so people dialling 999 with non-time critical presentations can be supported through telephone advice or through SPOA referred to alternative community, mental health, primary care, or direct access hospital pathways.
- Access to the stack (live CAD) with EEAST clinicians in an unscheduled care hub to proactively identify appropriate calls for 'Call Before Convey' and initiate a clinical conversation with ambulance crew on scene to identify alternatives to conveyance. A sustainable workforce model will be developed to support this.
- Develop the unscheduled care hub to become a SPOA across the system with one single number and no boundary restrictions for ambulance crew at scene with a patient to access a multidisciplinary team, including acute consultants and advanced clinical practitioners, with specialty clinical advice lines for guidance to support in making informed decisions about the right setting or service to meet the patients' needs, embed this Call Before Convey service through digital prompts in ambulance

care records.

- Develop efficient pathways between ambulance service and acute trusts through direct referral pathways (e.g., fractured neck of femur, SDEC) and safely reducing conveyance to ED with established remote clinical support from senior clinical decision-makers.
- Expand our provision of rapid alternative crisis response (urgent community response services) delivered at a patient's usual place of residence to deal with the most common presentations and maximise referrals (from NHS111, 999, primary care and hospital discharge) coordinated through a SPOA to support admission avoidance and early discharge.
- Continue development of our virtual wards so patients can continue to receive clinical oversight and nursing in their own homes. We will provide equality of offer of both step-up (admission avoidance) and step-down (early supported discharge) pathways across the system, and consistency in out of hours support and workforce models.
- Evaluate the impact of our virtual wards to understand the experience and outcomes for our population to inform service improvements towards a sustainable, financially viable model.
- Scope expansion of our virtual wards, beyond step-up and step-down frailty, ARI, and heart failure wards, to include other conditions and capabilities for all ages, and including mental health, driven by data in relation to population need and evidence of effectiveness and impact from our current services. This will be done in collaboration with partners across the system.
- We will develop a strategy for increasing and sustaining referrals from all access points: access to the stack, prevention of admission, turnaround at ED and early supported discharge. To maximise occupancy, we will develop a consistent and meaningful formula for virtual bed capacity so that the system is clear on the capability and acuity level of the 'virtual bed'. We will work to fully integrate virtual wards with other community services, primary care, hospital-based services and social care for seamless care and escalation purposes.

Priority 6: Focus on children and young people, mental health crisis response, and frailty and end of life care.

We will provide a focus on population health offering differentiated urgent and emergency care support with a focus on children and young people, mental health crisis response, frailty, and end of life care.

Why is this important?

Our needs analysis highlighted different cohorts in our population have different UEC needs, and as such a 'one size fits all' approach is not working. We identified three key population groups that require additional focus and a different approach to how we support their urgent and emergency care needs.

In HWE, emergency hospital admissions are highest in older people over 75 years, and young children (aged 0 to 4 years). ED attendance rates amongst these age groups in HWE are higher than national rates.

Children and young people

Over a quarter of all ED attendances in HWE are among children and young people. The rate of ED attendances in children and young people has been increasing over time whilst emergency admissions have been relatively steady (the highest amongst 0 to 4 years). Healthy children are often attending ED when their needs could be met elsewhere. Research suggests parental worry, need for reassurance and perceived advantages of paediatric ED are some of the key reasons for this. Our local UEC survey found over a quarter of respondents would make different choices about where to go for urgent care if it was their child who was ill, most frequently prioritising somewhere with short waits, and choosing ED over other services or somewhere they could see a doctor. Our needs analysis identified young children (less than 3 years) who were wheezy were at high risk of ED attendance.

Mental health crisis response

Patients can experience long waits in ED due to higher acuity and complexity of mental health needs, demand and capacity pressures with national mental health inpatient bed availability challenges, and S136 detentions[17]. EDs are often inappropriately designed to meet the needs of people in a mental health crisis. Staff in EDs are often lacking training with the skills in supporting the people who present, and the estate does not lend itself to enable reasonable adjustments to be made to ensure that patients can deescalate their mental health crisis safely.

Drug and alcohol presentations (coded as mental health needs) can place additional demand on ED. Clinical deep dives conducted in our acute trusts found that many patients are taken to ED because they have limited, or no access to safe-haven facilities for patients with drug or alcohol needs. Mental health services can provide a core component of the service offer required to meet the needs of these individuals in terms of supporting the patient/service user once their physical health needs have been met and on discharge. There is currently fragmentation of the system, and calls for better join up between mental health, drug and alcohol services, social services, and primary care.

Frailty and end of life

Currently older frail and end of life patients are experiencing the longest delays in ED and account for the highest volume of emergency admissions despite being particularly vulnerable to harm from inpatient stays and experiencing poorer outcomes because of these stays. Comprehensive Geriatric Assessment (CGA) is a key assessment process for the management of frailty in older people and when undertaken in secondary care can improve health outcomes (Ellis et al, 2017; Turner, 2014). Finally, uncertainty in end of life care

[17] Section 136 allows the police to take someone who appears to have a mental disorder AND not in a private swelling AND in need of immediate care or control, to a place of safety.

pathways often result in people at the end of life experiencing frequent emergency admissions in their last few months and dying in hospital.

What will we do differently?

We will ensure that our UEC system recovery and transformation maintains a focus on our population needs. We will ensure an all-age, physical, and mental health approach to delivery of all our strategic priorities but with a sharp focus on children and young people, those who require a mental health crisis response, and those living with frailty and near the end of life.

Children and young people

We will continue to develop our same-day, urgent care pathways to be more responsive to the needs of families with children and young people, and to overcome anticipated difficulties in accessing primary care. We will draw upon our whole system resource to empower and support greater self-care and self-management in families with young children. We will support children to receive hospital-level care in the comfort of their own homes to free up paediatric beds for those that need them most and reducing travel burden for families, driven by population need and effectiveness.

Mental health crisis response

We need to strengthen our mental health crisis response with a greater offer of alternatives to ED and better join up of our services including mental health, drug and alcohol, social care, and primary care. Mental health liaison teams are available in EDs, and a mental health urgent care centre has been launched on the Lister Hospital site. This, alongside a wider training and development programme for hospital staff, will ensure that people who present with a mental health crisis are supported effectively and efficiently as possible. We will ensure that we offer comprehensive safe haven provision and embed expertise across our UEC access points to ensure the right advice and care for those experiencing mental health crisis. Through integrated joint commissioning of UEC services for mental health, drug and alcohol, and social needs, we will ensure more appropriate alternative pathways for mental health crisis than ED are accessible.

Frailty and end of life

We will boost our capacity to respond rapidly to urgent needs such as falls, decompensation of frailty, reduced mobility or palliative support and wrap around the right care needed to support people to stay at home. If someone needs hospital-level care this will be provided, where possible, at home by our virtual ward/hospital at home and we will continue to develop new pathways to meet the needs of more patients. We will ensure that if people end up at ED their frailty is identified or acknowledged quickly at the front door and a comprehensive geriatric assessment made with swift onward referral to alternative services where clinically appropriate.

We will continue to improve end of life care by supporting clinicians to identify those in the last year of life to undertake a person-centred discussion about their preferences and priorities for their future care. Key information about the person's condition, needs, and preferences will be shared using consistent documentation understood by staff across the health and care system.

What can our population expect?

- Families of children and young children feel empowered to self-care and know when and how to seek the most appropriate care for any urgent and emergency health care needs.
- Clear routes to more responsive services in primary care and community settings so that families no longer perceive ED to be their best option.
- Children will benefit from receiving hospital-level care in their own homes.
- Appropriate and timely specialist support when they experience a mental health crisis, and that crisis cafes or sanctuaries are available in all communities to provide support during a mental health crisis.
- Out of hospital care is comprehensive, coordinated, and effective so acute level care is received at home, particularly for those who are frail or older.
- Older frail people are assessed quickly by a team of professionals on arrival at ED who can respond to their specific needs and prevent unwanted or unnecessary admission to hospital.
- We identify people approaching the end of life and support them to receive care and treatment they choose, in the settings they wish to be in, to improve quality of life and patient and family experience.

What will we deliver?

Children and young people

- Reduce demand, particularly seasonal demand, through robust plans to maximise the uptake, and reduce inequality in uptake of vaccinations, in particular childhood and flu immunisations amongst children and young people.
- Empower and enable families with young children to self-care, providing education on management of minor illness, anticipation of risks of childhood accidents, through digital technologies (e.g., Healthier Together website), existing 0-19 services, schools, and early years settings, and VCFSE partners. Raise awareness of when to seek urgent medical help using fun, inspiring campaigns to share through various channels, GPs, schools, and other family spaces. Understand from families and parents of children what will support them to feel more confident about self-care.
- Design communications and advice about the management of minor illness and navigation of NHS services with the parents, children, and families, and VCFSE sector and other partners. Support to build confidence in parents of young children in areas with high attendances rates and communities experiencing health inequalities, through links to social prescribers and VCFSE sector support.
- Expand support and paediatric expertise through NHS 111 clinical assessment service to support decision-making and management of minor illness.
- Design the UEC system to ensure we have appropriate capacity to manage patients with lower acuity health problems such as through UTCs or same day access hubs. The design will enable these services to flex in response to both planned and unforeseen changes in demand throughout the year, and better support young wheezy children. We will continue to improve access to paediatric pulse oximetry across our integrated urgent care system.

- Embed a common mechanism for identifying the deteriorating child that will run across the health landscape, the System-wide Paediatric Observations Tracking programme (SPOT).
- Ensure a consistent model for paediatric SDEC, based on population need and capacity matched to demand.
- Scope children and young people virtual wards to ensure step-down services to support HIU as identified in the population needs analysis (particularly wheezy young children via bronchiolitis pathway), enable early discharge and improved capacity to support children in Paediatric Intensive Care Unit (PICU) and on long-term ventilation.
- Ensure focus on whole system planning by monitoring CYP data and pressures not just in paediatric services, primary care, acute and mental health services, but also immunisation and school attendance.

Mental health crisis response

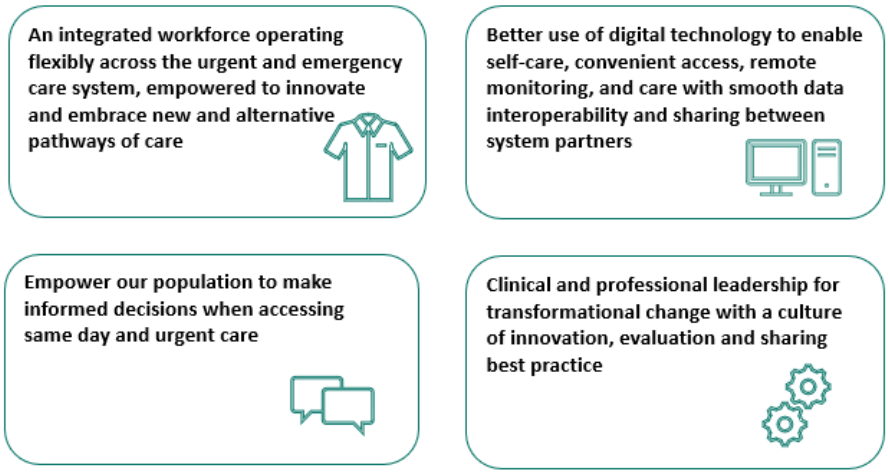
- Strengthen and transform our all-age mental health community services to manage existing long waiting lists and support prompt assessment and therapy to prevent deterioration or escalation and resulting ED attendance. This should include better integration on transitioning pathways from children and young people to adult services.
- Comprehensive coverage will be provided across the system for timely and reliable crisis advice for professionals, service users, and carers supported by direct access to urgent mental health support through multiple access routes (identifying locations for crisis cafes and sanctuaries in local communities, mental health expertise in NHS 111 CAS and the unscheduled care hub, and 24/7 all-age crisis support to meet emergency mental health needs in ED and acute wards).
- Our Essex Crisis Care Concordat and Hertfordshire Crisis Care Partnership, along with system partners, will review interventions to understand how best to support individuals experiencing mental health crisis, particularly out of hours, to avoid conveyance to ED (for example section 136 conveyancing pilots, street triage pathways, and mental health ambulance staffed by a mental health practitioner, paramedic, and police to give expert support).
- Ensure our ED services provide support to those experiencing mental health crisis with appropriately mental health-trained ED staff, through a wider training and development programme for hospital staff.
- Continue to develop supported discharge from ED for people with co-occurring mental health and substance misuse condition with collaboration between VCFSE sector, secondary mental health and alcohol and drug services.
- Support secondary prevention by provision of crisis care plans, crisis alternatives and targeted support when people are leaving acute mental or physical health services, including ongoing specialist support for drug and alcohol and mental health, placements for neurodiversity, and working across VCFSE sector, public health, and District Council's to develop complex needs pathways and support people via practical (emergency housing), social, and befriending support.

Frailty and end of life care

- Consistent documentation of ACPs to ensure that records are shared across the UEC system, and our workforce are confident in assessing end of life and supporting families' concerns, so patient's receive care and treatment in accordance with their wishes.
- Specially equipped vehicles to reach people who have fallen at home or in a care home within two hours to provide care and equipment will be deployed to non-injurious falls related ambulance calls to ease pressure on 999 services, this service will be monitored.
- Develop clinical pathways to support alternatives to conveyance and admission to hospital for older people who have fallen. This could include providing necessary care and treatment in the community for someone who has been lying on the floor for a prolonged period or supporting patients to remain in the community if they had a head injury and would not be a candidate for neurosurgery.
- Provide an integrated acute frailty service across the UEC pathway that supports staff across primary care, community care and 999 in identifying alternatives to conveyance. If a patient attends ED there is rapid identification of frailty at the front door, swift comprehensive assessment, and if required, a review by frailty experts to turn patients' diagnosis and treatment around promptly.
- Care homes will be able to access advanced clinical decision-making support out of hours, including palliative care, to support their residents to receive care in the right setting.
- Strengthen our out of hospital care to ensure those people at the end of their life who may experience acute illness or exacerbation of LTCs, are supported to achieve their preferred personalised goals of care by embedding end of life skills in virtual ward workforce and clear pathways to specialist palliative care support when needed.
- Evaluate and share learning from end of life discharge facilitator pilot in west Essex.
- Ongoing intermediate and long-term care demand and capacity planning using data to map our population's short- to long-term care needs to ensure both intermediate and long-term care services (understanding different level of care individuals receive when need or leave UEC) are fit for future ageing population and supports flow throughout the UEC pathway.

Key enablers

To enable the system to deliver the six core strategic priorities, we will:



Ensure an integrated workforce operates flexibly across the urgent and emergency care system, empowered to innovate, and embrace new and alternative pathways of care.

Our focus is on understanding and meeting the needs of our UEC workforce. The significant challenges facing the UEC system mean that often it is difficult retaining and recruiting staff. The transformation outlined will require our workforce to work in a very different way. We will ensure they have the right support and skills to flexibly deliver urgent and emergency care across the system and operate freely across organisations. We will work hard to support our workforce to be happy and healthy acknowledging the impact of the challenges faced by the system on our staff.

What we will deliver:

- Our focus is to gain a clearer understanding of what support the workforce in UEC need, to improve staff wellbeing and experience, and retain and sustain the workforce.
- System workforce modelling and planning to meet demand, including shared resource and integrated pooling of existing staff from across the system to enable staff (and volunteers) to operate freely across organisations as a skills-based workforce.
- Provide development opportunities for staff to gain new skills, including opportunities for apprenticeships, fellowships, rotational roles, or secondments in different organisations to support a shared understanding and trust of alternative pathways.
- Embed training across our UEC workforce to equip them with knowledge and skills to be flexible and provide tailored, individualised support to people with learning disabilities and autistic people, and to deliver trauma-informed practice and whole person approach when caring for underserved populations such as rough sleepers, and victims of domestic abuse.
- Continue to develop integrated and rotational roles, such as the new care support role within care settings that integrates key skills and development opportunities across health and social care, and support delivery of transformational services such as virtual wards.
- Development of our volunteer, peer support, and Expert by Experience career pathways to grow our workforce where there are recruitment challenges and skills shortages in the future.
- Improved collaboration and integration of the VCFSE workforce and volunteer base to support prevention, early management and to tackle wider determinants of health.
- Organisational development work to support a positive culture amongst organisations, and support our operational managers, and clinicians to embrace new and alternative pathways of care.

Make better use of digital technology to enable self-care, convenient access, remote monitoring, and care with smooth data interoperability and sharing between system partners.

The right digital capabilities are fundamental to achieving our core UEC strategic priorities and ensuring that those who are providing care across the UEC pathway can work effectively and efficiently together to ensure the best outcomes for patients. Improvements in the ability of digital solutions to talk to each other (interoperate) is crucial to 'joining up' our UEC system health and care providers, including VCFSE sector, so care for patients, is seamless and delivers the best outcomes.

What we will deliver:

- Efficient seamless digital patient streaming and shared access to patient records across the UEC pathway. This will include care plans (advance care plans, treatment escalation plans), GP records and letters, 'reasonable adjustment flags', and community pharmacy. Making available this context to decision-makers (particularly ambulance crew will ensure care is aligned to patient wishes, avoid inappropriate conveyances to hospital and duplication of care, and removes the need for patients to repeat medical information.
- We will work in partnership with digital technology companies to enhance the remote monitoring to support our virtual wards.
- Advancements in technology including artificial intelligence (AI) and machine learning will be incorporated within our PHM tools to identify cohorts at risk of deterioration earlier and our services to support decision-making tools, and navigation to the most appropriate service so patients are seen in the right place, first time.
- Digital solutions interoperate to make it easier for services such as ED, UTCs, NHS111, General Practice, and community pharmacy to book appointments directly in the most appropriate place. Build on pilots, such as St Albans where community pharmacy can book appointments for patients into the integrated urgent care hub. Coupled with 'reasonable adjustment flags' this could make it easier for autistic people to access the care they need, for example double-time appointment slots.
- Explore the use of multi-agency digital referral and signposting platforms, such as Frontline[18] to support visibility of, and referral to, local community support and wellbeing services.
- Empower residents to self-care and manage their health by making use of national tools such as NHS website and NHS App supplemented by local digital services.
- Expansion of online and virtual consultation will support interventions through more proactive care introducing specialists at the right time and specialist advice to aid clinical decision-making for urgent medical needs.
- Deploy technology assisted support to promote self-care and self-management.

[18] Thurrock Frontline. Accessed online at https://thurrockcvs.org/2023/12/20/have-you-heard-about-thurrock-frontline/

Empower our population to make informed decisions when accessing same day and urgent care.

We want to simplify the UEC system and effectively guide patients, carers, and clinicians in finding the right care, and encourage self-care and self-management. We will ensure information and support are readily available to enable people to make informed choices about their health and the most appropriate care. We want to build people's trust and confidence in the services available to them and in themselves to treat minor conditions.

What we will deliver:

- An updated annual communications plan that has key messages for public to support awareness of how and when to use services (including how to access care out of hours) and to support professional stakeholders across the system in using alternative pathways of care. This will include maximising the role of community pharmacy and increase support for self-directed care through community pharmacy consultation service, Pharmacy First, new medicine service (NMS), and other NHS pharmacy services. This will be linked across all ICS organisations to ensure consistent messaging.
- To support people to access the right urgent care easily and rapidly, we provide simple, clear access points, encourage people to 'call before walk-in' (taking learning from 'NHS111 First' campaign) and empower individuals and families to make just one decision 'is it life-threatening (999/ ED) or not (111)'?
- Disseminate information about, and build the confidence of patients and families in, alternative options to ED attendance through storytelling, with support from patient panels at the acute hospital and other forums.
- Implement system-wide communication strategies to educate all providers about each other's services and referral processes.
- Use intelligence to identify areas and populations for targeted communications to tackle inequalities in access and tailor bespoke communications to the different needs of our population.
- Develop an engagement plan to ensure we hear the voices of those underserved. In line with the HWE ICS VCFSE health creation strategy, we will strengthen the role of our communities through coproduction of plans, drawing on the communities' assets, and leveraging the resources, networks, and expertise of our VCFSE organisations. We will systematically engage with people with learning disabilities and autistic people and their carers to understand their needs and make our services more accessible across the UEC system, acknowledging that there is not one idea of 'autism friendly'.
- Share patient and staff stories widely to demonstrate the benefits from those with lived experience of the new alternative pathways of care.
- Use our social media channels in a responsive and dynamic way to react quickly to increased pressure or demand in different parts of our UEC system.
- Support real-time communication of waiting times in our busiest services and provide information to people on arrival at an urgent care service to explain next steps and reinforce messaging about accessing the right service.

Clinical and professional leadership for transformational change with a culture of innovation, quality improvement, and sharing best practice.

What does this mean?

We want to become an outstanding system delivering the best quality care. Our clinical and professional leadership will foster a positive culture with an understanding of clinical risk across providers, in the community and acute hospitals, quality improvement, and build a learning and improving culture that embraces innovation and embeds research. We will engage in cycles of quality improvement, developing an infrastructure, to evaluate and monitor our UEC transformation to care, and disseminate learning to ensure we achieve outcomes that are better for our population and reduce inequalities.

What we will deliver:

- Clinical and professional leadership across all parts of the system that is committed to fostering a positive culture, with an understanding of clinical risk across providers, in the community and acute hospitals. Acknowledging the greater system risk impact on personal risk of practitioners, senior leaders will foster a culture that ensures an open, honest, and trusted behaviour focus on people.
- A leadership that supports the workforce in exploring new models of delivering care and areas of innovation across the system.
- We will horizon scan for innovative new models of care, digital health and care technologies, and other examples of best practice
- We will build on health and care innovation being developed by near neighbours such as Cambridge University Hospitals and in London.
- Lead and foster a culture of continuous improvement in which staff are empowered to identify areas for improvement and make changes to improve quality of care.
- Establish a quality improvement methodology infrastructure and mechanisms to support implementation of successful pilots across the system, and dissemination of shared learning across the system We will continuously engage in cycle of quality improvement to improve care for patients, families and carers and ensure we measure key clinical and quality outcomes.
- Support localities to interrogate outcomes for their population, and question, why was this patient conveyed to hospital? Why were they rejected from virtual ward? Why were they admitted? Why were they not discharged promptly?

How we will deliver the strategy

The UEC strategy is aligned to the national UEC recovery plan and performance improvement requirements, and therefore, the implementation of the strategy will enable us to recover our UEC system, improve performance in key metrics and lead transformational and sustainable change.

Each year, drawing on the whole of the ICS resources, we will produce in partnership a prioritised ICS UEC delivery plan which will progressively implement the intent of this strategy, including meeting the needs of the annual operational planning process. In the initial year (2023/24) this Plan has focussed on the delivery of the UEC national recovery plan requirements and 23/24 operational planning priorities.

Figure 15. shows the key activities in the first year of delivery, 2023/24, allocated to each of the key workstreams. System UEC work is identified in the red boxes. This includes:

a) system-wide delivery of transformational activities, for example the NHS GP 111/CAS long term strategy and procurement, system coordination centre (SCC), or development of the unscheduled care hub/SPOA

b) system led UEC transformational work which is designed once at system and at the end point of the project is then delivered at SRG/LDB, for example SDEC.

We will ensure the UEC agenda focusses on supporting adult and children's mental health needs and our approach and delivery to all five key pillars is all-age, including children and young people through to frail older people.

Using resources effectively

To realise change, the annual delivery plans will need to be clear on how financial benefits realised will make a contribution to the financial sustainability of the ICS, how any new services and projects will be funded, and how any savings realised will be shared or reinvested for further gain. Each delivery plan will need to deliver on the annual operational plan requirements, taking balanced consideration to improving clinical outcomes, experience, performance, operational delivery, and financial sustainability. Due to current financial challenges, it is likely that initial years implementing this strategy will be focussed on initiatives that clearly deliver improved efficiency, productivity and outcomes, and where ongoing investment leads to prevention of cost expenditure elsewhere in the system or releases financial savings.

Links to other areas of work and strategies

Reflecting our whole-system approach, there are other relevant activities, programmes of work and Strategies across the ICS that will contribute to achieving our strategic priorities and the overall UEC Plan. These include system programmes such as Children and Young People (CYP), Mental Health, Learning Disabilities and Autism, Long Term Conditions, Frailty and End of Life, Primary Care, and Medicines Optimisation. For example, key interdependencies exist with primary care transformation for UEC recovery, particularly in support of modern general practice and same day access in prioritised areas (e.g., Harlow, Stevenage, and Hertsmere) and the integration with community urgent care and development of proactive care models led by INTs.

This strategy articulates our big design principles and UEC priorities, setting a vision of the UEC system we should be moving towards, one that our population can rely on to look after them promptly, safely, and effectively at all points of their journey, delivering a better

experience of care closer to home. The strategy is not intended to be prescriptive but allow flexibility and time for HCPs to deliver transformation locally using expertise of all partners and enable more effective integration of the UEC system for improved patient outcomes and efficiencies.

Figure 15. Key activities for delivery in 2023/24

Governance

The ICB UEC Board spans across the ICS with senior membership from all providers and partnerships including VCFSE sector. The ICB UEC Board has responsibility for overseeing the development, delivery, and maintenance of the UEC strategy. The focus of the UEC Board is to ensure outcomes are achieved from the work of the three place-based System Resilience Groups (SRGs)/Local Delivery Boards (LDB) (embedded within HCPs) and the five workstreams of the UEC plan above. Further scrutiny and oversight will be provided by Quality and Performance Assurance Committee, ICB Board, Health and Wellbeing Boards and NHSE Oversight & Scrutiny Committee.

The UEC Programme Board will oversee the delivery of this system strategy, monitoring progress of work, resolving issues, and managing interdependencies between activities by drawing together different partners responsible for delivery and providing a cross-system view of the projects. This should provide some central coordination of both the core UEC work and wider areas of change delivered across the ICS. This includes:

- CYP UEC recovery and transformation which has thus far been fragmented. This coordination will be enabled by visibility of the operational delivery and transformation occurring at place which encompasses children and young people as an all-age approach and deep dives into system wide CYP transformation programmes that are

monitored through the ICS CYP Board.

- The UEC mental health agenda for children and adults in the ICS is overseen by the multi-agency Mental Health and Learning Disability and Autism (MHLDA) Programme Board. Relevant UEC work from the Hertfordshire Crisis Care Partnership and Essex Crisis Care Concordat and other relevant West Essex MHLDA, Herts MHLDA, Herts MHLDA HCP Boards and Forums will be shared at the system UEC Programme Board to inform and support the work of the wider UEC agenda.
- Work completed under the ICS Frailty Board including a focus on priority areas such as falls, prescribing, care home support, comprehensive geriatric assessment and care coordination, and alternatives to admission.

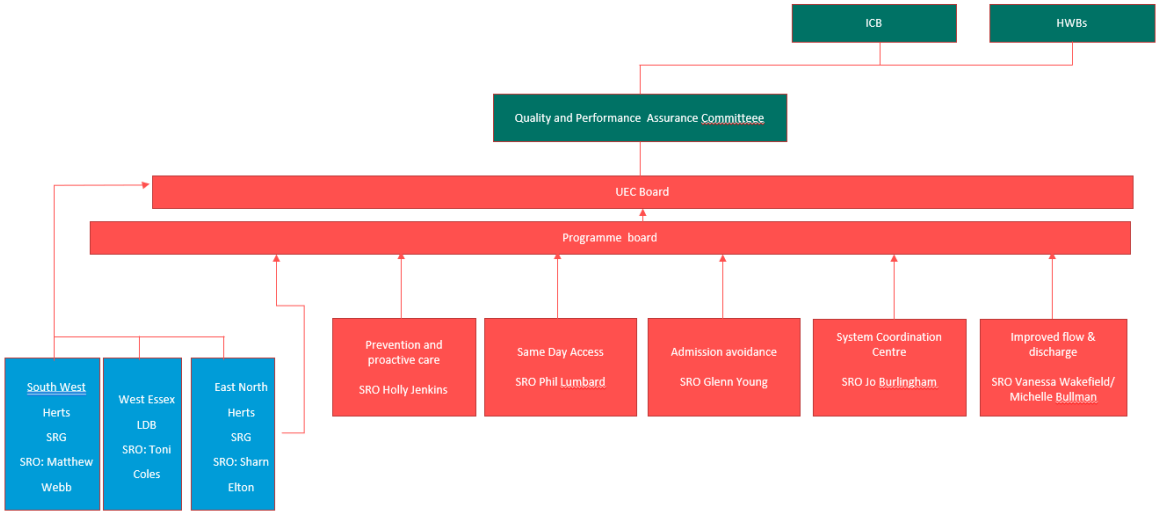
This governance structure enables the UEC Programme Board to have focus on our identified population groups - children and young people, those in mental health crisis, and frailty and end of life – alongside the core programme of work. Non-UEC led projects will report in line with their own programme governance (for example CYP Board, MHLDA Programme Board or Primary Care Board, the frailty and end of life UEC programme of work reports directly into UEC Programme Board and UEC Board). However, these non-UEC led activities will be shared at UEC Programme Board for assurance regarding progress in overall delivery of the key pillars of UEC work.

The SRGs/LDB are critical forums at place-level for UEC and are integrated into the broader work of HCPs. They provide local ownership, understanding, and delivery and monitoring of system plans and will report progress into the UEC Programme Board. SRGs/LDB are accountable to the UEC Board for place-level UEC delivery of transformation projects and coordination, operational resilience, and performance improvement. This includes dealing with daily operational issues and making tactical improvement.

SRGs/LDB will take a continuous improvement approach to implementing improvement projects on behalf of each HCP, evaluating change and impact on an ongoing basis. Support, capacity, and expertise from organisational wide teams will likely be needed to ensure delivery of our ambitions.

Measures of success (key metrics and outcomes) for progress against our strategic priorities will be tracked at UEC Programme Board. Trajectories for improvement which progress could be measured against will be created and any concerns flagged to UEC Board where outcomes are monitored.

Figure 16. UEC programme governance



Measuring impact

The success of this UEC strategy will be measured through population-health outcomes and impacts on our system performance, tracked at UEC Programme Board and any issues escalated to UEC Board.

Key operational performance metrics will enable us to track progress of our workstreams and demonstrate impact against the national improvement metrics.

To ensure that the urgent and emergency care that people receive is high quality, and safe, and that people receive the right care first time, we must collaborate across organisations and engage in a continuous cycle of quality improvement to promote equal access, positive experiences (for patients, families, and carers and our staff), and good clinical outcomes. We will audit patient journeys to identify opportunities for improvement in our pathways and look beyond individual service performance metrics to understand how responsive the UEC system is to improve access to the right care, in the right place, the first time. For example, we want to avoid a patient phoning 111, being redirected to 999, then being passed to our unscheduled care hub for triage by our community services and receiving an urgent 2-hour community response, but in fact the original call for help was many hours earlier.

We will ensure a suite of metrics that support monitoring of outcomes including impact on health inequalities, quality and safety, patient reported experience/outcome measures (PREM/PROM), and clinical outcomes. We know timely management is critical to improved clinical outcomes, so we will monitor the impact of more responsive UEC services on key clinical outcomes.

In addition to key UEC performance metrics, we will monitor key population health outcomes. Relevant tier 1 (strategic whole population) outcomes from the ICB Outcomes Framework include:

- Reduce the rate of ambulatory care sensitive emergency hospital admissions.
- Reduce the overall spend on emergency hospital admissions.

Tier 2 UEC programme specific population-based indicators are under development and relate to tier 1 whole population outcome indicators. Our programme of work should be directly impacting these tier 2 UEC programme-specific population-based indicators. There are other cross-cutting population-based indicators in the Outcomes Framework which relate to UEC. We will be sighted on these metrics, but other programme areas may have greater accountability in design and delivery of care that will directly impact those population-based indicators.

Incentives through contracting approaches will be aligned to future health needs of the population, supporting HCPs to target their resources to where need is greatest and greatest value can be achieved. The ICB are developing an Accountability Framework which will ensure evaluation of delivery of outcomes, including the selected UEC population health indicators from the ICB Outcomes Framework. This Accountability Framework will allow oversight and management of UEC outcomes and enable us to measure success of our strategy and the totality of work across the system.

A UEC strategy implementation group consisting of diverse membership will be empowered to review whether we are delivering work to meet our ambition. We commit to regular evaluation of our annual delivery plans.

Next steps

We will agree a prioritised ICS UEC delivery plan in quarter four of each year which will progressively implement the intent of this strategy the following year. We will develop key measures of success and outcomes for each workstream. The activities and projects supporting delivery of the workstreams will have agreed metrics and outcomes to track and monitor progress against.

Projects will be mapped to UEC strategic priorities and other local and national priorities. Consistent project plans for system level work will detail aims and objectives, key milestones and named leads.

We will hold ourselves to account on our strategic intent with continued quality oversight of the strategy delivery through the UEC strategy implementation group. This group will have membership from across the system, including patient and public involvement supported by the ICS Patient Engagement Forum. The group will meet quarterly to review progress the system is making in delivering its strategic intent. An annual report on strategy implementation will be used to assure the ICB Board that we are delivering our strategic intent and will achieve our vision.

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Appendices

Appendix a - HWE ICB Patient Engagement Forum – PEF Comments on the HWE Urgent and Emergency Care Strategy

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Appendix b - Your views on urgent and emergency health services in Hertfordshire and west Essex – a summary report

Survey[redacted]ngs_ Se
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Appendix c – Equality Impact Analysis

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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 (ICB) 7th March 2024

Review of Winter

Jo Burlingham, Deputy Director Operations, ICB

Working together
for a healthier future

Summary Components of our System Winter Plan 23/24

National Approach to Winter

- UEC Recovery Plan and 10 high-impact interventions
- System wide operational surge planning
- Enhanced system leadership and coordination
- Workforce Plans to deliver our plan over winter

System Coordination Centre

- Implementation of National Operational Pressures Level (OPEL) Escalation Framework
- Single ICS Surge and Escalation Plan
- Additional capacity monitoring
- Further enhancement to SHREWD (Action)
- Local Operation Cells linked to Unscheduled Care Hubs
- ICS Safety and Oversight Group
- BI support for demand and capacity profiling

Key UEC Transformation Priorities for Winter – monitored through UEC Programme Board

- Prevention and proactive care
- Same day access
- Admission avoidance
- Flow and discharge

Key organisational actions – plans in place for EEAST, primary care, acute and MH Trust, community providers, social care, VCSFE

Enablers

- UEC Strategy – understanding UEC demand and what we can do about it
- UEC Recovery and Improvement Plans
- NHSE Tier 2 Support Offer
- Linked Local Authority Winter Plans and VCSE support
- Systemwide Communications plan

A selection of key achievements and learning…

- System Coordination Centre
- EEAST Locality Oversight Cell
- Coordination of operational leadership – Winter Implementation Group
- Extremis actions to manage risk and safety
- Executive Director focus on areas for performance improvement – ambulance handover delays

HWE ICB System Coordination Centre

Principal function is to act as a central co-ordination service to support patient access to the safest and highest quality of care possible:

- Responsible for the co-ordination of an integrated system response using the Operating Pressure Escalation Level (OPEL) Framework alongside constituent ICS providers and ICB policies
- Supports proactive co-ordination of a system response to operational pressures and risks
- Utilises information and intelligence to plan for events that impact on UEC and wider system pathways

The SCC currently performs these functions through:

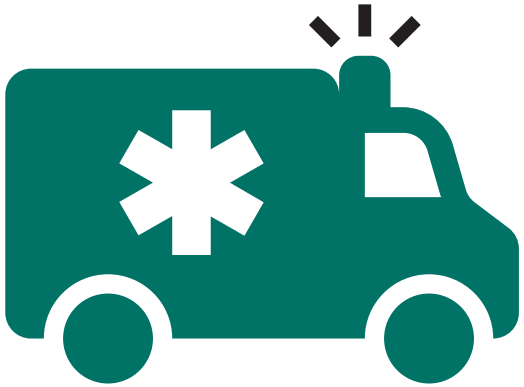
- Situational Awareness calls throughout the day with all system partners
- Live monitoring of Pressure and patient safety across the system through SHREWD
- Real time escalation from System partners to address any risks/concerns:
  - Risk to patient safety
  - Mutual aid requests
  - Mental Health escalations
  - Ambulance handover delays >60 minutes
  - Delayed repatriation requests
  - Requests for support
  - Requests for escalation calls
  - Underutilisation of alternative pathways
  - Declaration of OPEL 3 and 4
  - Declaration of incidents (business continuity, critical and major incidents)
- Working to coordinate formation of plans and in-day actions to reduce or eliminate the area of risk or concern
- Coordination of all reporting to the NHSE Regional team

24/25 ambition is to increase use of predictive data to pre-empt risk and proactively address areas of pressured operational delivery to avoid deterioration in performance

HWE EEAST Locality Oversight Cell (LOC)

What is the HWE LOC?

- The HWE LOC has been set up, in collaboration with our external partners at the;
- System Coordination Centre - SCC
- Integrated Care Board – ICB
- Unscheduled Community Care Hub - UCCH
- Local Emergency A&E departments.
- In line with the East of England Ambulance Service's (EEAST) and ICB's winter plan 2023/24.



What does the H&WE LOC do?

- Tactical/Silver level involvement with external system partners
- Tactical/Silver level representation of EEAST on SCC/ICB calls
- Risk sharing/mitigation on EEAST Arrival to Handover (A2H) delays to external system partners
- Risk sharing/mitigation on EEAST Handover to Clear (H2C) to HALOs and LOMs
- Operational and Tactical oversight of each H&WE locality within the sector, reporting risks, plans and/or actions to the management teams for maintained awareness,
- Implementation of Intelligent Conveyance (IC) across the sector, autonomously done by the LOC,
- Joint working and collaboration with OOA ICB LOCs for cross border IC implementation on exceptional days
- Creation and implementation of plans and mitigating actions to maintain EEASTs strategic intent and winter response plan

HWE ICS Winter Implementation Group

Fortnightly Senior Operational Forum for all system partners.

Key Workstreams to date:

- Initial NHSE assurance of Winter Plans and Numerical and Narrative submissions
- ICB Board and UEC Board Assurance of Winter Preparedness
- National OPEL Framework Implementation, automation onto SHREWD and its operational application and use across the ICS
- SCC Action Cards and Full Capacity Processes to ensure incremental actions at each stage of OPEL to support interventions across the ICS that ensure patient safety.
- Ongoing development of SCC Model – resourcing, day-to-day processes, escalation procedures, lead roles and responsibilities, including extension of opening hours – dependent on requirements from NHSE for next winter
- Ongoing clinical review of system risks at the ICB led SCC Safety Oversight Group
- Implementation of new policies and procedures from NHSE – Ambulance Handover, Divert, EPRR Policies
- Implementation of Locality Operations Cell and associated processes to support ambulance demand and improve operational efficiency
- Implementation of learning from Industrial Action and SCC coordination over Xmas
- Ongoing development of SHREWD including Action Alerts, Consistent Mental Health Parameters and implementation of a single HWE ICS surge and escalation plan and a local capacity dashboard
- Monitoring of SCC activity and impact – particularly in relation to system risk
- Focus on key operational issues impacting system performance as they arise, e.g. Implementation of focused actions to prevent excessive ambulance handover delays across the system

Enhanced Actions agreed in addition to broader tactical/ operational actions to support the System at times of Pressure	
Clinical Principles Agreed	• Enhanced clinical oversight to support earlier decision making for all patients • Lowering the clinical threshold for admission to alternative pathways • Enhanced clinical review of patients either on the Stack or in an ambulance outside acute hospitals with the intention to divert away to alternative pathways • Shared ownership of system risk – Medical and Nursing leaders to have the conversations about risk thresholds with teams and to share leadership practice on this. This will feed into the SCC Safety oversight discussions
Unscheduled Care Hub Actions	• Line-by-line review of each patient on the ambulance stack by a senior clinical team consisting of community, primary care, Acute and EEAST clinician's • Additional community trust GP's sourced in day and agreed a broader set of clinicians would need to be trained for future use • EEAST sourced Advanced Paramedics (AP) to support CB4C and agreed to proposals for training APs needed for a future more sustainable model (as part of a broader MDT in the hub) • EEAST to review if GP Heralded calls triaged as C345s can be automatically transferred to Stack for HUB review • C2 reviews to be considered as part of future model supported by ED/Acute Consultants as part of the hub MDT - governance to be agreed
Ambulance Queue Reviews	• Process for review of ambulance queues outside of acute trusts in collaboration with HALO, Hub and senior clinicians to be scoped and agreed with EEAST and Acutes • Triggers for enactment to be agreed with SCC as part of OPEL
GP Heralded calls 999 Calls/CCC	• Review scope for EEAST to treat differently when in extremis, e.g. enforcing GP F2F review and referral. • GPs to use the three Care Coordination Centres in the place areas proactively.
HUC/ AIHVS resource	• Consider redeployment of Acute In Hours Visiting Service resource to support UCR response • Source additional HUC GPs to go into all acute sites (including UTCs) to support GP referrals and self-presentations
MH Escalation	• In day escalation processes to be supported by Joint Commissioning Team • Escalation to regional team for mutual aid and to understand if HWE can access private MH beds cross border in the London area
Primary Care Actions	• Comms to reflect system pressure and the requirement to act differently e.g. HCP referrals and 'Dear Doctor' letters • Place based communications on all available pathways/ mini directory of services for HCPs needs to be further developed • Clinically led webinar for Primary Care Clinicians to support primary care messaging • PC to support the development of the GP heralded pathway via the Hub.

Executive Director system focus on performance – reducing ambulance handover delays

- Short term executive level focus group established weekly from 27th December 2023 to immediately address excessive ambulance handover delays in HWE ICS. Agreed the following standard:
  - Zero tolerance over 45 mins – patient brought into hospital and ambulance released
  - Never over 5 ambulances outside – on arrival of 6th ambulance, most appropriate patient brought into hospital and ambulance released
  - Place based escalations and incremental actions embedded to support delays beyond 1 hr
  - Aspiration of 3 hr ambulance handover delays to never happen in HWE
- Group agreed actions in support of achievement of agreed standard
- All partners agreed the forum was impactful and we have seen a sustained improvement in ambulance handover performance
- All system partners agreed to turn focus to recovering the 4-hour standard to 76% for March

Winter 2023/24 In Summary (1)

- Continued to build our system ways of working
- Clear processes for: day-to-day management, surge and escalation management, shared management of risk, performance improvement, and a focus on priority transformation
- Advanced in our system coordination processes and will continue to build this capability
- Learning from critical incidents has supported system commitment to:
  - Support optimal clinical decision making
  - Make use of alternative pathways
  - Coordinating our system and managing risk between partners
  - Using all available capacity appropriately with transparent decision making

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care Board (ICB) 7th March 2024

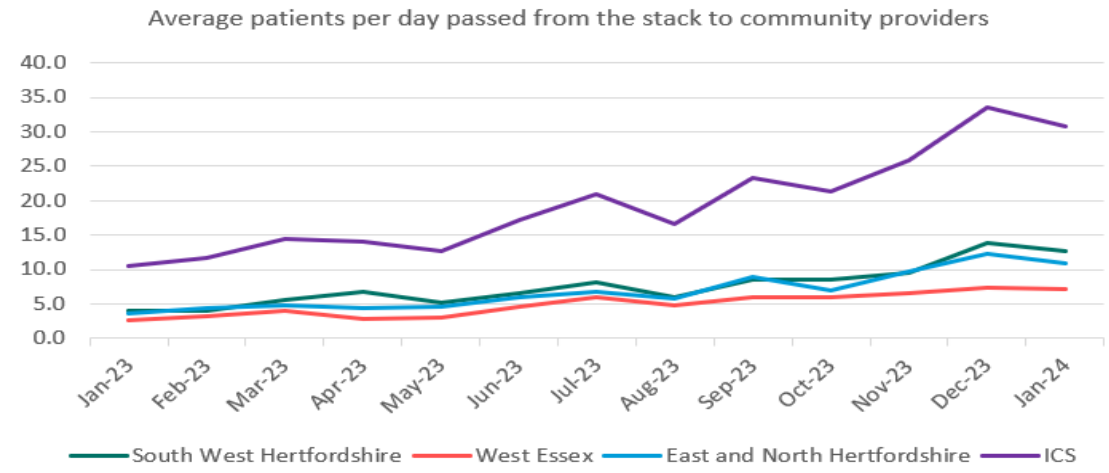
Innovation in Demand Management

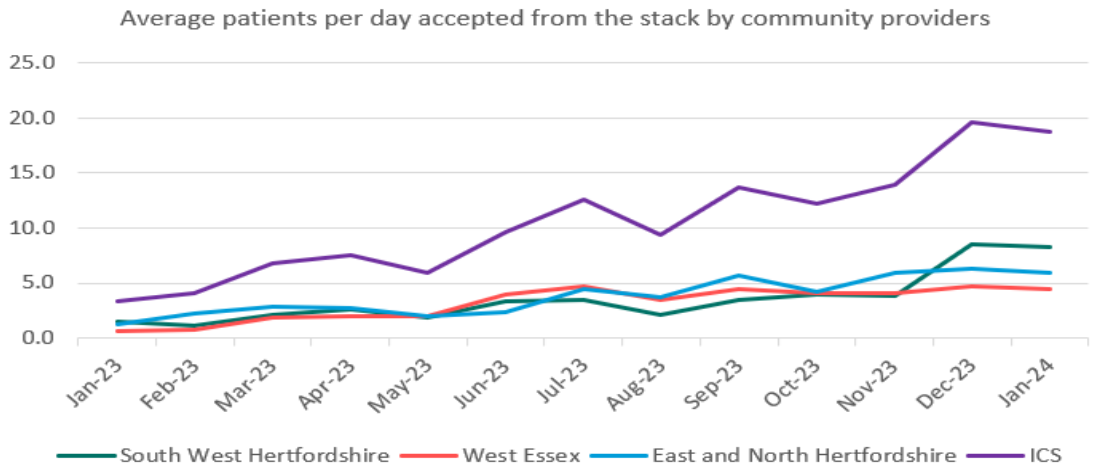
Glenn Young, Deputy Director of UEC, EEAST and ICB

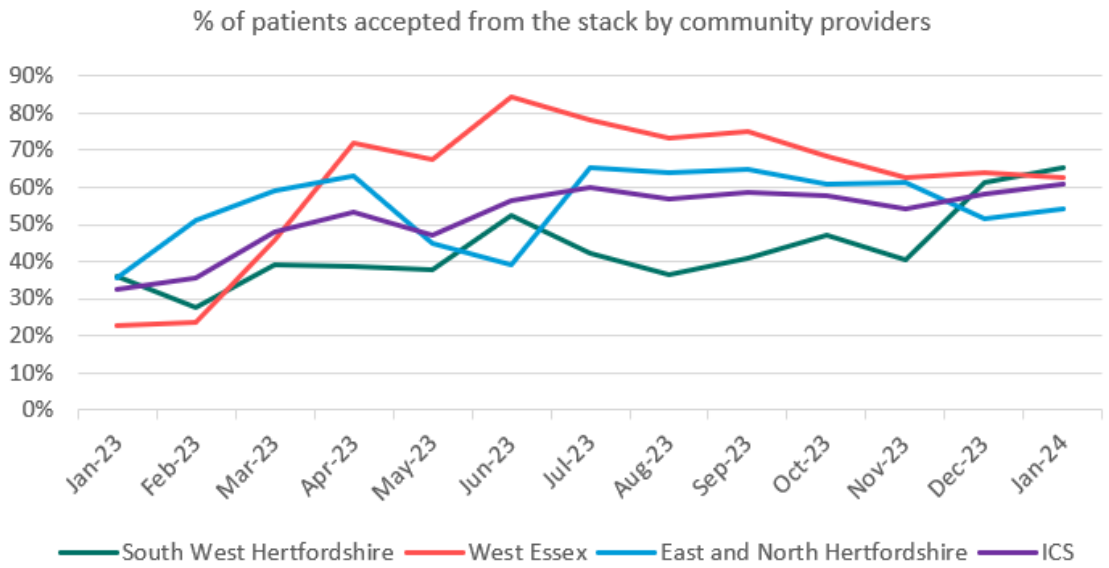
Working together
for a healthier future

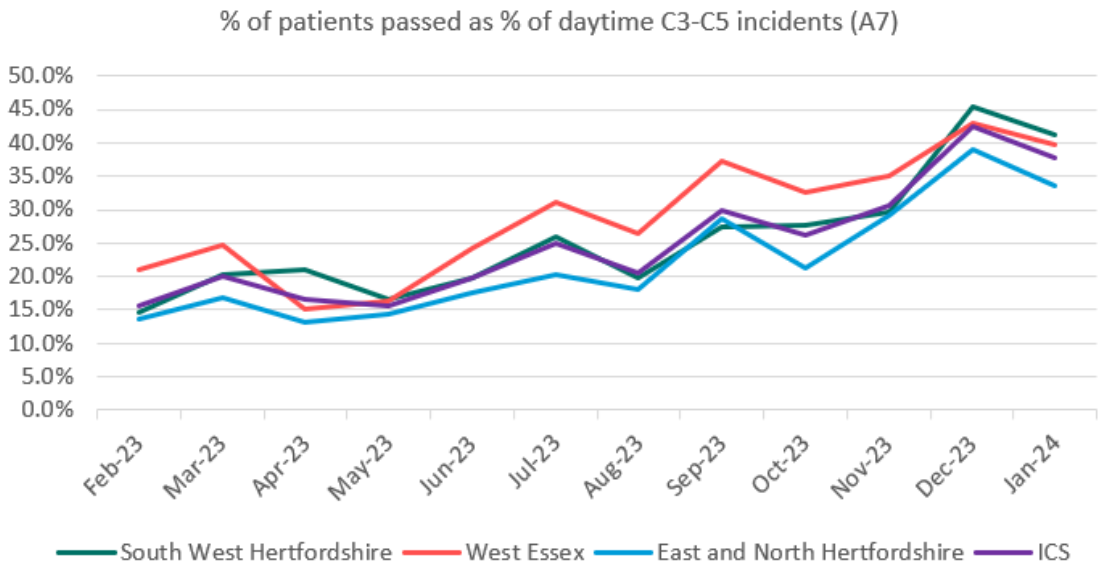
Access to the Stack (A2S) Direct Impact Metrics

Direct impact metrics



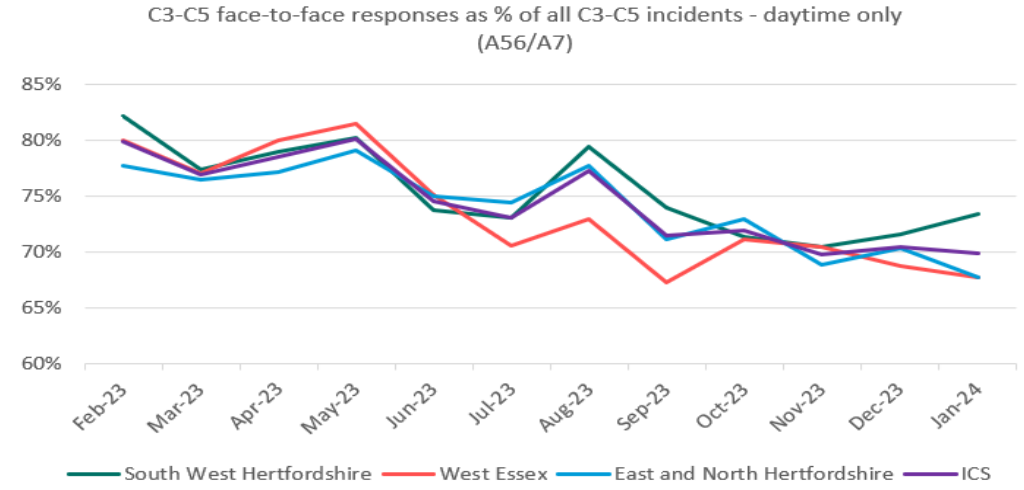


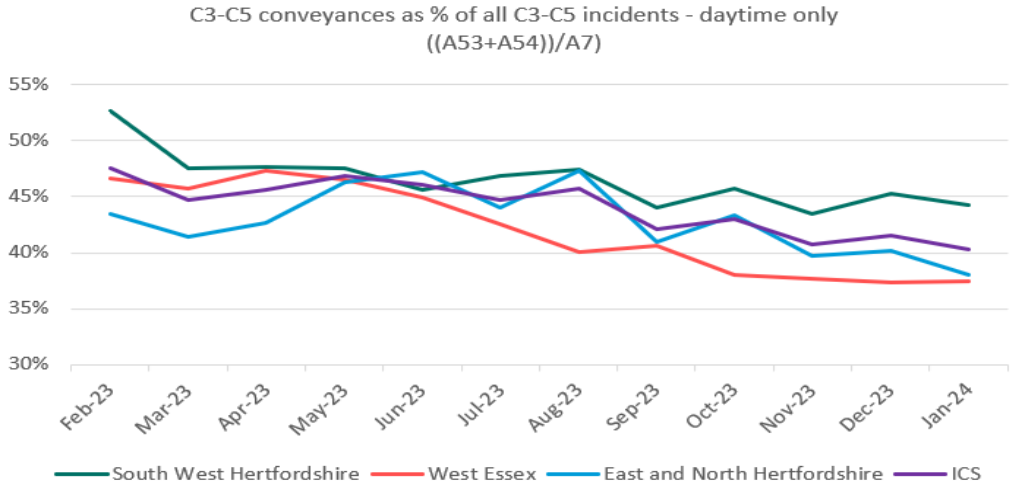


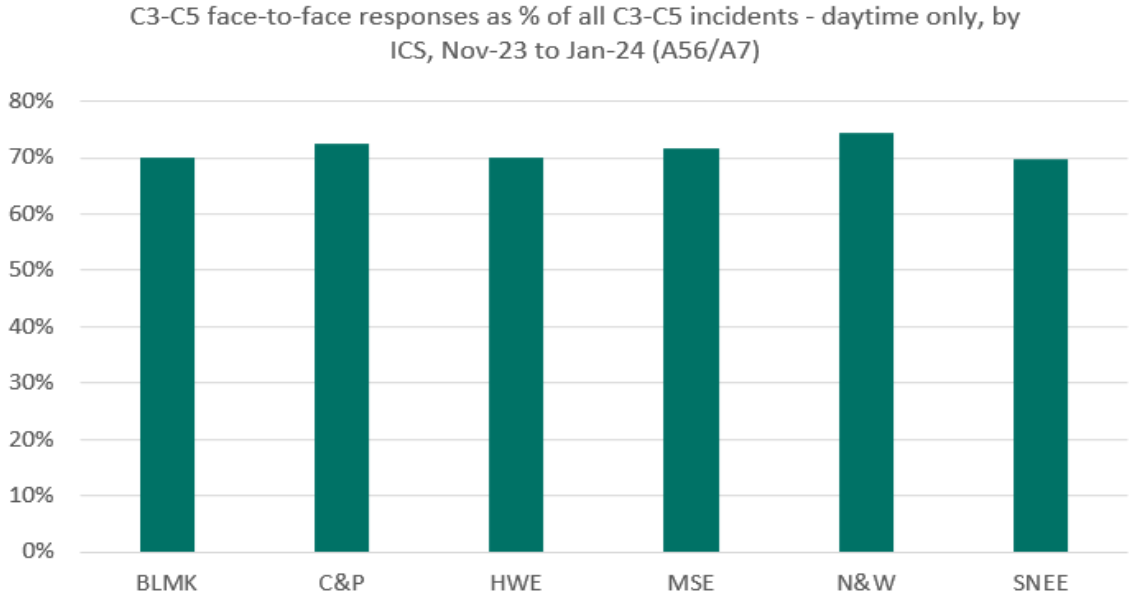


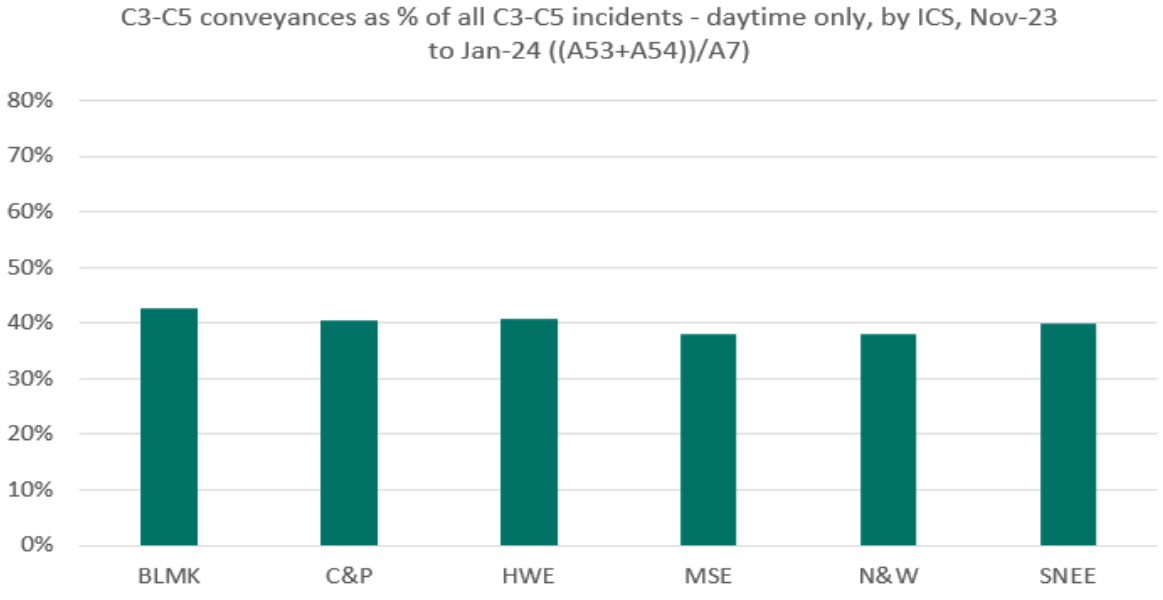
A2S Indirect Impact Metrics. (08:00-19:00)

Indirect impact metrics









Enabling the UCCH By Core Skill Sets

CAS clinician

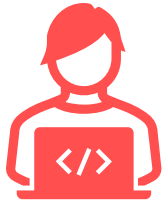
Role: Triages and Identifies suitable patients on 999 CAD stack and passes them over to Community provider via access to stack

Advanced Paramedic

Role: Contacts crews on scene with patients to provide clinical advice, signposting and navigation in collaboration with GP-Trusted assessor

GP- Trusted assessor

Role: Co-located with AP, reviews patients with crews on scene and accepts and refers into community and SDEC pathways on behalf of system



UCCH data admin

Role: enable efficiency of UCCH clinicians through administrative and data collection tasks

Hertfordshire and West Essex Integrated Care System

Advanced Paramedic (AP) Direct Impact in the Unscheduled Care Coordination Hub (UCCH)

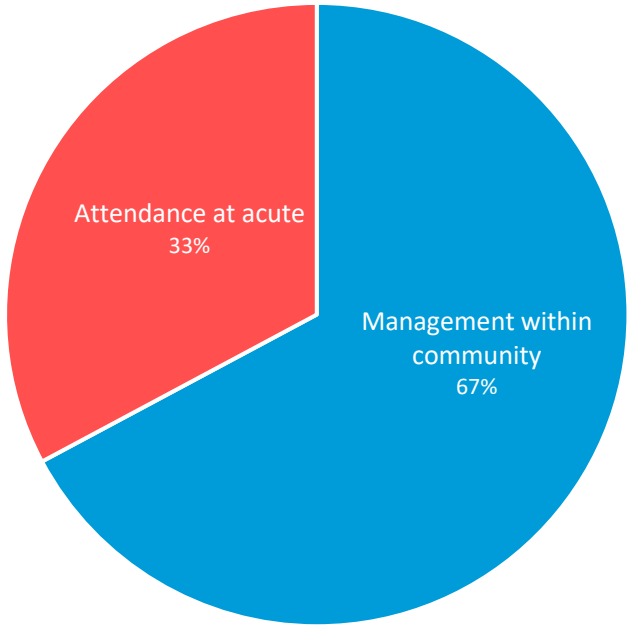
Advanced Paramedics (APs) within the UCCH maximise access to call before convey by contacting crews on scene with patients and providing Clinical advice and navigation

When the AP is in the UCCH, they can deal with between 15-20 patients on average per shift

If staffed 7 days per week, this could support >300 patients to be managed within the community per month across HWE

Commitment from EEAST to provide an AP – working through implementation

Patient outcome disposition through AP call before convey



Hertfordshire and West Essex Integrated Care System

Deep Dives = A2S continuous improvement

1 Deep dives

Forums to analyse data from a week in focus using quality improvement methodology. Case studies used to review patterns and themes at individual, process and system level.

Key themes identified as shared learning opportunities :

- Operational awareness and engagement with current A2S processes
- Constraints of criteria based vs patient centred acceptance
- Capacity limitations within current systems

2 Front door audit

2-part audits to measure missed opportunity for community pathway use.

Part 1- day long audits at emergency department to collect data on conveyed patients including use of call before convey and attempted community referral

Part 2 – Follow up at 48 hours to follow patient journey and identify patient groups that could have maintained care within community or accessed SDEC pathways if in place

3 Review of systems and processes

Use QI methodology to identify areas of improvement
Review performance measures
Share learning and scale implementation of change

Hertfordshire and West Essex Integrated Care System

Quick Wins

The Deep Dives have increased acceptance rate, for example in December the ICS was 59% and in February its 79%. We are now currently sharing our approach with other ICBs via the EEAST Business Partnership Team.

Acceptance Rates

The ICB has now got access to more EEAST information on Power Bi to support with analysis of A2S and other performance metrics.

Power Bi

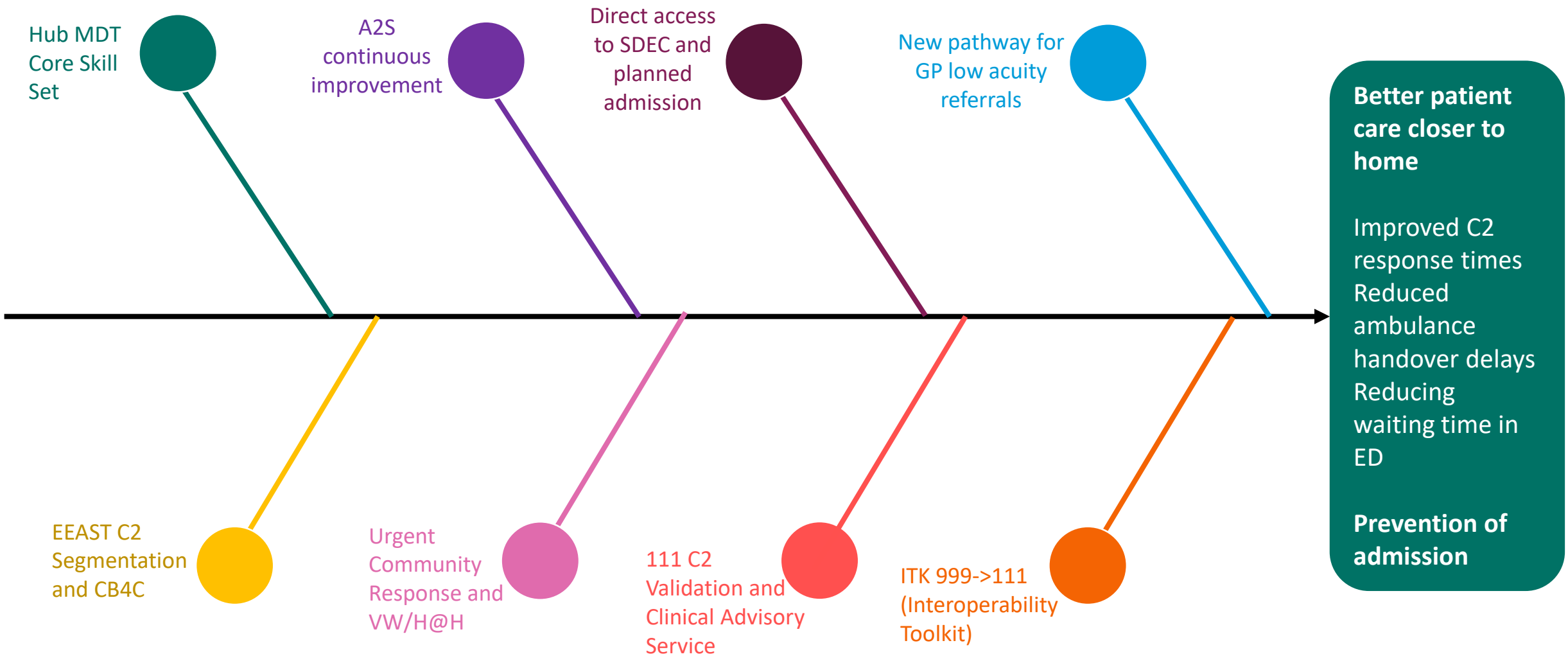
Hub Manager is the interface that supports bringing more consistency in approach across the ICB and can highlight in day challenges working collaboratively with all providers. This role needs to be permanent fixture of the Hub going forward.

Hub Manager

Working on an Action Card for times of extremis for Community Providers to support Ambulance Delays with reviewing patients outside EDs.

Action Card

Potential for a new demand management model emerging…



Advance Paramedic: Dave Martindale Feedback working in the UCCH

Providing clinical support and advice to crews who are at scene of a 999 call. Plus being able to use my urgent care experience to clinically navigate patients to appropriate pathways.

Being able to work flexibly and dynamically with other clinicians in the Hub to support patient care, especially at time of pressure.

Working along side GPs in the Hub, which allows me to access additional clinical support when needed and being able to discuss plans for individual patients.

Over the past 9 months building those relationships has helped with shared learning and best practice. I am able to use my position in the UCCH to support shared learning with new trainee Advanced Clinical Practitioners on what the Hub can offer and to support the implementation of the model across EEAST

Thank you and questions?

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

ICB Board Questions from the Patient Engagement Forum

The PEF has agreed both a close working relationship with the ICB communications team and a comprehensive approach to networking to both disseminate content and drive engagement to hear the patient voice. The PEF appreciates the support that it is receiving from the ICB in living up to the Constitution and putting patients at the centre.

Question 1:

What steps is the ICB taking to promote patient choice to ensure the success of the elective hub at St. Albans City Hospital?

A programme of work is underway to ensure strong patient engagement and communication to support patient choice in relation to the Elective Care Hub which will open next winter in St Albans. System partners are working with Healthwatch, patient forums and engaging with patients on current waiting lists, to implement a communication and engagement plan. Patients will be well supported and informed about the opportunity to receive surgery at the Elective Care Hub.

This will commence from the start of their pathway in the outpatient setting at each acute trust and follow all the way through to their surgery. The system intends to create a patient portal with virtual information about the hub, provide clear guidelines and education for staff to support dialog with patients and provide solutions to potential barriers for patients e.g travel.

Patients will continue to have a choice for the location of their surgery, with no termination of services at the current acute trust providers. Those patients who do not wish to access the new facility or do not meet the clinical criteria will remain at their local trust for surgery.

Question 2:

What steps is the ICB taking to secure redevelopment at PAH and WGH and what do you believe are the prospects of success?

The redevelopment of Watford General Hospital on its existing site and the development of a new Princess Alexandra Hospital on an alternative site are both part of the national NHS New Hospital Programme. The ICB supports both Trusts in their detailed work with the national team to meet

the requirements and timelines of the complex national programme. Currently we are working with both organisations on capacity modelling and pathway transformation to support the next stage of the national submission process.

It is worth noting that work on the Watford development programme is on track with early enabling work already underway on site, which will continue through 2024 & 2025 to prepare the site for construction which is due to start in 2026 subject to the ongoing national approval process.

Plans for the new Princess Alexandra Hospital, are on track and the Trust anticipates building to begin in 2027 with enabling work starting in 2026. The Trust is working closely with the national New Hospital Programme team and contributing to Hospital 2.0 a centralised approach for all new hospitals. When the Hospital 2.0 guidance is complete the Trust will resume engagement with patients and communities. Negotiations with landowners have been reinvigorated, and work on planning permission has also begun.

Both providers provide regular stakeholder briefings and would welcome engagement from the ICB patient engagement forum at these sessions and on the relevant mailing lists.