NHS HWE ICB Board Meeting [Public Session]

Friday 27 January 2023

09:30 - 12:30

Council Chamber, County Hall, Pegs Lane

Hertford , SG13 8DQ

Hertfordshire and West Essex Integrated Care Board

Meeting Book - NHS HWE ICB Board Meeting [Public Session] Friday 27 January 2023

09:30	1. Welcome, apologies and housekeeping		Chair
	2. Declarations of Interest		Chair
09:35	3. Minutes of last meeting held on Friday 18 November 2022	Approval	Chair
	4. Action Tracker	Approval	Chair
09:40	5. Questions from the public	Discuss / Information	Chair
	LIVED EXPERIENCE		
09:50	6. Patient and carer experience	Assurance/Information	Elliot Howard-Jones
	BOARD DEEP DIVE		
10:15	7. Board Deep Dive - Community Services	Assurance/Information	Elliot Howard-Jones
	CHAIR, CHIEF EXECUTIVE, QUALITY AND PERFORMANCE REPORTS		
10:45	8. Chair's update report	Information	Chair
10:50	9. Chief Executive Officer's Report	Information	Director of Strategy
10:55 - 11:05	COMFORT BREAK		
11:05	10. Integrated reports for finance, performance, quality and workforce	Discuss / Information	Chief of Staff
11:25	11. Quality Escalation Report	Assurance	Director of Nursing
	11.1 HWE Quality Dashboard	Approval	Director of Nursing
11:30	12. HWE Performance Report	Assurance	Director of Performance and Delivery
	FINANCE AND STRATEGY		
11:35	13. Finance Report Month 8 2022/23	Assurance	Chief Finance Officer
11:45	14. HWE ICS Planning Report	Information	Director of Operations
11:55	15. ICP Integrated Care Strategy	Decision	Director of Strategy
12:10	16. Hertfordshire & West Essex Better Care Fund Adult Social Care Discharge Fund Allocations 2022/23	Decision	Director of Operations

	GOVERNANCE AND COMPLIANCE		
12:20	**17. Governance Report**	Approval	Associate Director of Integrated Governance and Organisational Alignment
	18. Committee Summary Reports	Assurance	Committee Chairs
	CLOSING ITEMS		
12:25	**19. What would service users, patients, carers and staff take away from our discussions today?**		Chair
12:30	**20. Close of meeting**		Chair
	Date of Next Meeting: Friday 24 March 2023		

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

The Nolan Principles

In May 1995, the Committee on Standards in Public Life, under the Chairmanship of Lord Nolan, established the Seven Principles of Public Life, also known as the "Nolan principles". These principles are the basis of the ethical standards expected of all public office holders.

The Hertfordshire and west Essex Integrated Care Board recognises that in all its work it must seek to meet the highest expectations for public accountability, standards of conduct and transparency. It will therefore ensure that the Nolan principles, set out below, are taken fully into account in its decision making and its policies in relation to standards of behaviour.

1. Selflessness. Holders of public office should act solely in terms of the public interest.

2. Integrity. Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity. Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability. Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness. Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty. Holders of public office should be truthful.

7. Leadership. Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

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 18 November 2022**			
Time:	**11.00am - 2.25pm**			
Venue:	**The Forum, Hemel Hempstead 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
Jane Kinniburgh (JK)	Director of Nursing	Herts and West Essex ICB
Lance McCarthy (LM)	Partner Member (NHS Acute Trust)	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
Thelma Stober (TS)	Non-Executive Member	Herts and West Essex ICB
Karen Taylor (KT)	Partner Member (NHS Mental Health Trust)	Herts and West Essex ICB
Lucy Wightman (LW)	Partner Member (Local Authority ECC)	Herts and West Essex ICB
Members in attendance via Microsoft Teams:		
Nicolas Small (NS)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
In attendance:		
Chris Badger (CB)	Director of Adult Social Care	Hertfordshire County Council
Elizabeth Disney (ED)	Director of Operations	Herts and West Essex ICB

Iram Khan (IK)	Corporate Governance Manager	Herts and West Essex ICB
Adam Lavington (AL)	Director of Digital Transformation	Herts and West Essex ICB
Tania Marcus (TM)	Chief People Officer	Herts and West Essex ICB
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)	Associate Director of Integrated Governance and Organisational Alignment	Herts and West Essex ICB
Phil Turnock (PT)	Managing Director of HBL ICT Shared Services	Herts and West Essex ICB
Michael Watson (MW)	Chief of Staff	Herts and West Essex ICB
Matt Webb (MW)	Place Director, S&W Herts	Herts and West Essex ICB
Sharn Elton (SE)	Place Director E&N Herts	Herts and West Essex ICB
Apologies:		
Rachel Joyce	Medical Director	Herts and West Essex ICB
Owen Mapley	Partner Member (Local Authority, HCC)	Herts and West Essex ICB
Joanna Marovitch	VCFSE Representative	Herts and West Essex ICB

ICB/40/22	Welcome, apologies and housekeeping
40.1	The Chair welcomed all to the meeting.
40.2	Apologies for absence had been received from: • Rachel Joyce • Joanna Marovitch • Owen Mapley
ICB/41/22	**Declarations of interest**
41.1	The Chair invited members to update any declarations relating to matters on the agenda: • None declared. All members declarations are accurate and up to date with the register available on the website: Declaration of interests – Hertfordshire and West Essex NHS ICB
ICB/42/22	**Minutes of the previous meeting**
42.1	The minutes of the previous meeting held on 23 September 2022 were approved as an accurate record.
ICB/43/22	**Action Tracker**
43.1	The action tracker was reviewed and the current status of all actions noted: • ICB/12/22: Patient and lived experience stories: ongoing. • ICB/16/22: Format/content of future quality/performance reports: the development of a dashboard was underway and had been discussed at the Quality Committee meeting held in October. The first iteration would be shared at the January Board meeting. • ICB/17.5/22: Benchmarking in performance reports: the national benchmarking process had now been restarted and data would be included in future reports. • ICB/31.5/22: Meaningful mental health measures to be included in the quality report: JK was working closely with colleagues at HPFT and this data would be included in the January report. • ICB/32.4/22: Board members to share feedback on quality/performance reports: ongoing. • ICB/37.4/22: Long term strategy for UEC: see deep dive presentation at agenda item ICB/46/22.
43.2	**The Board noted the action tracker**
ICB/44/22	**Questions from the public**
44.1	One question had been submitted: "What are the plans to allow further CGMs to be added to prescription that are of a similar price of Libre? Are primary care going to be able to prescribe as currently we have to go via community team / secondary care to get changes etc? If a patient can prove that using a more expensive CGM e.g. Dexcom G6 is improving outcomes and their health, how can they be prescribed / request funding?"
44.2	**Answer:** Hertfordshire and West Essex Integrated Care Board currently fund Continuous Glucose Monitoring in people with diabetes, in line with regional criteria and NICE guidance published in 2019. Considering the revised NICE guidance published in June 2022, the ICB are in the process of reviewing the existing local policy to identify priority groups who will be most likely to benefit from this technology. It is expected that this will be over the next 3 months. The process for reviewing and developing policies includes patient and public engagement, using existing groups and networks. Approved policies will be published to the ICB website - https://hertsandwestessex.icb.nhs.uk/

	Funding more expensive options that are not routinely commissioned, funding can be requested via the Individual Funding Route (IFR) route.
ICB/45/22	**Patient/carer Lived Experience**
45.1	Unfortunately, the patient due to contribute his experience at this meeting, was unwell and could not attend in person as had been planned. For future meetings a backup story (on video) would be prepared. The board would review the impact and how to make the most of the lived experiences agenda item in 6 months' time.
ICB/45.2/22	***Action: The Board to review the lived-experience section in May 2023 – M Watson***
ICB/46/22	**Board deep dive: Urgent and Emergency Care (UEC)**
46.1	Elizabeth Disney (ED) presented the UEC deep dive (see pages 14-24 of the document pack) drawing the board's attention to: • The priority metrics for the winter period. • Transformation and improvement initiatives planned or already underway. In the pilot phase of the "handover @ home" work, data showed that around 70% of cases could be safely managed by community services without the need for transfer to hospital. • The population health management approach to UEC had already begun and ED shared slides showing those patients with more than 4 UEC admissions in the month of July. Further analysis was needed to understand why demand was rising and why people were accessing care in this way. • HWE data was not out of step with the national picture, and every part of the country was facing significant challenges. • A trajectory had been set to ensure UEC performance returned to 2021 levels ("bronze" level). • Collaborative working with the national team to share best practice from other areas re discharge and flow was in place.

46.2	Questions and comments were invited:
	• The Board welcomed this level of analysis and noted the default position of patients attending UEC or calling their GP. Education and comms had a part to play in supporting people to consider alternatives.
	• The scale and sustainability of the Handover@home trial were discussed. Relationships between EEAST and the community hubs were critical.
	• The main risks to achieving the planned trajectory were considered:
	  ○ Weight of culture/existing practice/history vs new working methods and models.
	  ○ Capacity to manage this ambition alongside ongoing service improvements and daily pressures.
	  ○ Population acceptance of alternative pathways.
	• Real time monitoring of service would track progress against the ambition of achieving the bronze standard. Service Delivery Boards would be monitoring key actions and metrics and sharing these with the UEC Board.
	• Changing the clinical culture would take some time; eg the virtual ward deep dive noted that it was working at 50% capacity at the moment. In response to this a piece of work was underway with clinicians to drive greater usage of the virtual ward. If this is successful, it will be replicated to other areas.
	• Equality of access and engagement with the population in a proactive way is needed to support change and improvement.
	• The Primary Care OPEL Framework had recently been launched (c70% sign up currently), this would capture the extent of pressures in primary care on a daily basis across the ICS.
	• Maximizing the potential of looking after people at home was the shared ambition of the board.

	• The risk of initiative overload was raised, eg short term solutions for discharge rather than a long-term system wide strategy. • Learning should be made from existing strategies in partner organisations, eg direct calls to HPFT Single Point of Access from ambulance service to divert conveyance and the crisis café in Stevenage operated by the voluntary sector.
46.3	**The Board noted the deep dive presentation on UEC**
ICB/47/22	**Chair's update**
47.1	The Chair referred to his update (see pages 25-29 of the document pack) drawing the board's attention to: • The mission and high-level priorities for the ICB (3-5yr focus) and the means by which the ICB would deliver them. • That a further report on the delivery plans for the ICB will be received at the Jan board.
47.2	Comments and questions were invited: • The delivery specifics within each six-month period were key. • There was agreement with the headline ambitions. • It was clarified that the reference to our "people" related to the systems workforce (not population).
47.3	**The Board noted the Chair's update and approved the mission and high level priorities**
ICB/48/22	**Chief Executive Officer's report**
48.1	Jane Halpin (JH) referred to her report (see pages 30-41 of the document pack) drawing the board's attention to: • The driver for future success; training support for PCNs. • The innovation in primary care (formal and informal). • The updates from each of the three place partnerships and mental health services. • The success of the virtual chronic kidney disease model pilot; way of identifying patients earlier to prevent later deterioration. • Southwest Herts partnership success in reaching the final stage of the recent HSJ awards. • Collaborative work with district councils eg levelling up in Harlow. • The improved service for young people with eating disorders – the waiting list had been eradicated against a backdrop of reduced beds available and rising demand.
48.2	Questions and comments were invited: • The pressures on the voluntary sector were acknowledged and the board were pleased that there was a better line of sight of this.
48.3	**The Board noted the CEO's report.**
ICB/49/22	**Nursing and Quality report**
49.1	Jane Kinniburgh (JK) presented the quality report which related to quarter two across the system (see pages 42-77 of the document pack) drawing the Board's attention to: • The Quality Committee had met in early November and reviewed in more detail the data shared in the presentation. • LeDeR: whilst there had been positive progress in some areas, inequality remained. The appendix summarised the key themes and learnings. Next steps would include a joint meeting between lead GP/primary care and quality team colleagues to help primary care better understand the issues and barriers. A named, LD champion would be identified for each practice. • Maternity: Update on key outcomes/findings from recent CQC inspections. Highlighted relevant learning from the Kirkup report from East Kent which focused on culture, safety and performance issues and highlighted flawed team work.

	• Good progress at PAH which now has a new leadership structure in place. PAH would be involved in a new national programme starting in January bringing together the medical and nursing work force. If successful, this would be rolled out to other Trusts. • Improvements at WHHT meant that it was not required to move into an improvement programme. The benefits of the new director of midwifery had been noted. • The CQC inspection at ENH had identified areas for improvement and the team were awaiting the publication of the final report. • A useful LMNS meeting had been held to benchmark workforce reporting and create a template to be used across the system as well alignment of job descriptions and training. Tania Marcus was supporting.

49.2	Questions and comments were invited:
	• Performance and quality were inextricably linked to capacity/work force and ways of working.
	• The right balance between the drivers of quality and assurance were needed.
	• Items rag rated amber in the LMNS report were raised: what update was available?
	  ○ Neo-natal: discussions were ongoing with NHSE regional team as to the need for West Herts to continue to liaise with the North London network in light with established clinical links and patient flows (rather than Cambridge/Norfolk). This had not yet been resolved.
	  ○ Achieving two ward rounds per day: this was a high-level headline and was linked to the obstetrics workforce, JK expected that there was currently variable practice across HWE but will check.
	• A pilot had been applied for the mental health equality improvement programme and Department of Health ministers had visited HPFT to view best practice.
	• HPFT Forest House update: A further inspection had seen this provision move from inadequate to RI.
	• There was a discussion about how the quality report could be further developed to make it as easy as possible to focus on priority areas, given the wealth of data in the report. JK would continue to refine the report to ensure it was meaningful for board members and the Quality Committee chair noted that a review meeting was held after each committee/board meeting to consider feedback. It would be useful to differentiate between risks and issues.
	• It was noted that although the Kirkup review was in respect of maternity and neonatal services there was wider learning to be taken. Given the ICB is accountable for system quality what routes could be used to gain assurance that the issues identified by Kirkup were recognised. This could be triangulated by visits to settings, from lived experiences and from staff and patient voices.
	• Did safeguarding have a high enough profile? It was noted that Adult and Children's safeguarding reports were reviewed by the quality committee.

49.3	**The Board noted the Quality Report**
49.4	***Action: Discussion for future board meeting: what assurance is there that there is substance below the reports/data – J Kinniburgh***
The meeting paused for a 25-minute lunch break. Catherine Dugmore and Karen Taylor left at this point.	
ICB/50/22	**Performance report**
50.1	Frances Shattock (FS) presented the Performance Report (see pages 78-121 of the document pack) drawing the Board's attention to: • Community service data would be reported at the next meeting. • Mental health data sets had been included and the performance team were working collaboratively with HPFT colleagues. • Regarding elective recovery; ENHT had de-escalated from Tier 1 and there was a good reduction in the cancer back log.

	• The progress already highlighted re improvements in the eating disorder service were not yet seen in the data because of the timing lag.
	• Items to escalate:
	  ○ UEC: no improvement yet demonstrated in the data.
	  ○ The progress of the winter plan will be monitored by the UEC Board who will report to the Quality Committee.
	  ○ Mental health: increased demand and activity. Performance improvement trajectories were in place.

50.2	Questions and comments were invited: • The interdependencies between finance/ workforce/ performance and quality were noted and the challenges in reporting this to the board. • FS noted that this matter was being discussed by performance directors at a facilitated session with the regional team. It was a challenge facing all ICBs. • An integrated reporting mechanism might require an integrated committee and a further review of the current committee structure. Did the current committee structure facilitate these discussions in the way the board wanted/envisaged? • There was a marked disparity between HWE and the national picture for beds per % of the population for mental health patients. This was expected as a strategic decision had been made to build up community services for mental health patients. • 70% of MH patients in Hertfordshire received community service, 30% required acute beds. Given the rising demand for this service, it was likely that more beds would be needed and plans had been put in place to address this (this was currently awaiting DfH/Treasury approval as it was above local threshold).
50.3	**The Board noted the Performance Report.**
ICB/51/22	**Capital and Revenue Winter Funding Allocation 2022/23**
51.1	Elizabeth Disney (ED) presented the Capital and Revenue Winter Funding Allocation for 2022/23 (see pages 122-132 of the document pack) drawing the board's attention to: • The outline process of allocating the winter fund. • The need to convert all increases in efficiency into the "currency" of acute beds.
51.1	Questions and comments were invited: • The voluntary sector needs to be considered as an equal partner as part of the winter resilience programme. • Their work has been match-funded to create sustainability. • Tranche One of the winter fund had been announced on 17 November, the finance team were working through the detail of this.
51.3	**The Board noted the Capital and Revenue Winter funding allocation 2022/23**
ICB/52/22	**Finance Report: Month 6**

52.1	Alan Pond (AP) presented the ICB finance report for month 6 (see pages 133-143 of the document pack) drawing the board's attention to:
	• Year to date projections: breakeven.
	• Pressure points within the ICB budgets: CHC costs and prescribing (no change from previous report).
	• Aggravating factors:
	  ○ Inflationary pressures on care home costs.
	  ○ Increased demand and supply side pressures for some medicines resulting in higher prices.
	  ○ Projections for volume growth in prescribing had been underestimated.
	• Financial pressures in acute providers are currently worse than had been predicted and, if they progress, might put system financial balance at risk, so plans are being developed to deliver a system balanced position.

52.2	Questions and comments were invited:

	• CHC remained an area of risk. The CHC budget was proportionately bigger in south and west Herts than other areas however SW Herts were overspending by more than other local areas. How will the team address (eradicate) these local market variations? • The service delivery model is different in each place. Some categories of patients are serviced by only one provider (monopoly situation). Initial investigations had shown that there was less home care available in SW Herts and more complex patients in SW Herts than elsewhere. • MH CHC was included in the HPFT contract; was this the same in each area? • A deep dive into CHC was required, this would look at conversion rates, average cost of packages, rigour of oversight of teams etc and apply some public health management approaches.
52.3	**The Board noted the ICB and ICS finance reports for month 4 2022/23**
52.4	***Action: Deep dive into CHC costs and the cause of disparity between SW Herts and the rest of HWE – A Pond.***
CB/53/22	**HWE ICS People strategy**

53.1	Tania Marcus (TM) presented the HWE ICS People Strategy 2023-25 (see pages 172-209 of the document pack) drawing the board attention to:
	• A summary of well-known challenges:
	  ○ Work force pressures
	  ○ Cost of living crisis
	  ○ Recruitment and retention
	  ○ Strikes
	  ○ Burn out
	• The four core priorities were listed on slide 189 and covered:
	  ○ Diversity and inclusion
	  ○ Workforce supply
	  ○ Retention and attraction
	  ○ Integrated approach to workforce planning
	• Working partnerships with research institutions, eg University of Hertfordshire.
	• Recognition that the workforce was not just the responsible of the HR team.
	• Need to develop a funded workforce transformation team to implement the strategy.
	• Approval of the clinical care workforce transformation pathways.

53.2	Questions and comments were invited: • The Board welcomed the strategy and were happy to adopt it • The need for an adaptive workforce was well established. Preliminary discussions were being held between NS/RJ/AS to come up with ways of working across the sector. Training was key. • Recent innovation in the PC workforce has shown the benefits of enhancing skills and doing things in a different way • Recruitment needed to be sustainable and local; making use of links with schools/ colleges, community groups and job centres. Goal: residents to live/learn/work in the locality. • Plans were needed to make a career in the public sector more appealing in the local community. The success of international recruitment by HWE should be replicated locally. Need for a shared culture. • TM noted that the team were working with the refugee community/Step-up to work and a recruitment bus would soon be out and about in Herts and west Essex. A variety of different initiatives were being planned eg training to bring nursing associates into care homes. • The request for funding for a central team was raised again and would require further consideration; there were workforce colleagues across all providers who might have capacity to support a system wide initiative. This would also ensure a coordinated approach. JH would hold conversations with system CEOs.

	• There was only one reference to levelling up in the strategy and perhaps this should be expanded. • More time should be spent "walking in the shoes" of the workforce. This would better help the Board understand the pressures being faced in different teams. Understanding why there was such high mobility within partner organisations would also be useful. • Front line staff should not be forgotten they also needed career progression. • TM noted that a system wide group of HR colleagues were in place to take programmes forward, they just needed more time and capacity to do this. • Workforce pressures had been an issue for a long time, other initiatives for example, to widen GP portfolios to promote retention had not worked. • AP reassured board members that the non-recurrent funding method for central HR was historical; whilst technically non-recurrent funding it had generally been continually renewed.
53.3	**The Board approved the HWE People Strategy for 2023-25.**
53.4	***Action: JH and CEOs to finalise a resource commitment for the workforce transformation team.***
ICB/54/22	**HWE ICS Digital Strategy**
54.1	Adam Lavington (AL) presented the HWE ICS Digital Strategy (see pages 144-171 of the document pack) drawing the board attention to the main drivers behind the strategy: • Digital Collaboration – System Wide Collaboration • Digital Platforms – Essential Strategic Digital Platforms • Digital Direct Care – Proven Digital Care Enablers • Digital Innovation – Local Digital Care Innovation • Digital Skills – Digital Inclusion and Workforce Capability
54.2	Questions and comments were invited: • The Board welcomed the strategy and were happy to adopt it • The Board emphasised the need for digital inclusion. Certain social-economic cohorts have been left behind despite the efforts for digital inclusion in the past. • Was there scope to work with the voluntary sector to support digital inclusion for example? • The guiding principle was "digital first but not digital only". • There was a large piece of work being undertaken by digital and Primary Care and this would be reported to the next meeting. AS expected there to be some good case studies and examples to report. • Each strand of the strategy was being led by a different CIO, to ensure greater collaboration across the system. • Board members hoped that the drivers would remain the impact on citizens and the impact on clinicians. Changes need to make clinicians' work more efficient. • New initiatives should be mindful of data sharing/GDPR legislation and governance. • Technological advances should be able to help people remain independent and at home for longer. • Shared care records work was progressing well.
54.3	**The Board approved the HWE ICS Digital Strategy**
ICB/55/22	**Governance report**
55.1	Simone Surgenor (SS) presented the Governance report (see pages 210 – 222) of the document pack) drawing the board attention to the items requiring approval: • Constitutional change: voluntary sector representative to become a full board member. (See draft wording shared in report). • Submission to NHSE for increase in board size (see draft wording shared in report).

	• ICB Governance handbook changes: see item 2.2.2 in the governance report relating to the names changes for some committees and changes to the terms of reference of sub-committees, updated standing financial instructions and clarification of the use of the seal. The board approved the changes proposed.
55.2	Matters to be brought to the next board meeting would cover: • Quoracy • Revised wording for population health outcomes
55.3	Other governance documents to note: ▪ Procurement policy ▪ Delegated responsibility ▪ Board and committee meeting dates. ▪ Risk report (a summary of all ICB relevant risks with a score of 16+). ▪ Delegation for specialist commissioning.
55.4	**The Board approved proposed changes to the constitution and the ICB governance handbook and noted the other documents.**
55.5	***Action: Item for development session: Risk appetite – M Watson***
ICB/56/22	**Committee summary reports**
56.1	Summary reports had been prepared by committee chairs and the corporate governance team (see pages 223-232 of the document pack) and were intended to be a more transparent and digestible way to share discussion and actions from committees.
56.2	Questions and comments were invited: • The Quality report referred to the impact of higher numbers of asylum seekers being housed in hotels. This was a live issue and may require further Board review.
56.3	**The Board noted the committee summary reports**
ICB/57/22	**What would service users, patients, carers and staff take away from our discussion today?**
57.1	The following was noted: • Focus of board discussions on workforce issues. • The need for patient experience to triangulate reports. • Increased pace of work. • The potential risk of industrial action to be closely monitored.
ICB/58/22	**Any other business**
58.1	None raised.
Date of next meeting: Friday 27 January 2022	
The meeting closed at 2.25pm	

Herts and West Essex Integrated Care Board Board Meeting Action Tracker Last updated on 17 January 2023								
Private / Public	**Action Tracker Ref No**	**Date of Meeting**	**Subject**	**Action**	**Responsible Lead**	**Deadline Date**	**Comments and Updates**	**Status**
PUBLIC	ICB/12.4/22	27/07/2022	Patient and lived experience stories	**Ensuring patient and lived experience stories are built into the ICB Governance Framework and ensuring that learning from best practice and across the system is incorporated.**	M Watson	**Ongoing**		**Open**
PUBLIC	ICB/45.2/22	18/11/2022	Patient/carer story	**Board to review the impact of lived-experience section in May 2023**	M Watson	**26/05/2023**		**Open**
PUBLIC	ICB/37.4/22	23/09/2022	UEC Assurance Framework	**Draft long term UEC strategy to be shared at next meeting**	E Disney	~~**18/11/2022**~~ ~~**27/01/2023**~~ **24/03/2023**	**07/11/22 -** E Disney updated - A workshop is scheduled for 29 November which will draft a framework and high level priorities for the Strategy **Jan 2023** - Postponed to 24 March 2023	**Open**
PUBLIC	ICB/16.5/22 ICB16.6/22	27/07/2022	Quality Report	**Development session to be arranged to agree the format of future quality (and performance) reports to the Board** **The Board requested that the quality data dashboard is further developed.**	M Watson / J Kinniburgh	~~**21/10/2022**~~ **27/01/2023**	**13/09/2022 -** Development session scheduled for 21 October to discuss Board reports Development session has taken place and reports continue to be refined with addition of triangulated summary First Draft of Quality Dashboard has been developed and is included for comment and review at January Board	**Closed**
PUBLIC	ICB32.4/22 ICB31.5/22	18/11/2022	Quality and Performance Reports	**Quality and Performance Reports:** **- Agree meaningful MH measures for future Quality reports** **- To ensure reports have sufficient assurance around substance below the reports/data**	J Kinniburgh / F Shattock	**21/10/2022**	08/11/22 E-mail and follow up discussion has taken place with HPFT DoN to work collaboratively to agree future Quality reporting for MH. To include for January Board.	**Closed**
PUBLIC	ICB/52.4/22	18/11/2022	Finance Report	**Deep dive into CHC costs and the cause of disparity between SW Herts and the rest of HWE.**	A Pond	**27/01/2023**	Included within January Finance Report.	**Closed**
PUBLIC	ICB/17.4/22	27/07/2022	Performance Report	**Future report(s) to provide an overview of outcomes following other long-term conditions, and also to seek to provide an overview of drivers underlying key performance issues.**	F Shattock/ R Joyce	**Ongoing**	**14/09/2022 -** S Williamson updated: **Overview of outcomes**. The Population health management and medical directorate are developing a series of information packs assessing health and care needs for the population. Health needs and outcomes from stroke will form part of the cardiovascular information pack. Once completed, this will be shared with the relevant teams as well as the ICB Board for information.	**Closed**
PUBLIC	ICB/17.5/22	27/07/2022	Performance Report	**Future reports to include appropriate benchmarking.**	F Shattock	~~**23/09/2022**~~ ~~**18/11/2022**~~ **27/01/2023**	**13/09/22 -** On-going work to establish where we source the data for regional/national benchmarks **07/11/2022** - F Shattock updated - the national report used for benchmark data has not been stood back up yet. Some benchmarking has come in, but isn't complete yet. A further update will be provided at the next meeting.	**Closed**
PUBLIC	ICB/53.4/22	18/11/2022	HWE ICS People strategy	**JH and CEOs to work out a resource commitment for the workforce transformation team.**	J Halpin / T Marcus	**27/01/2023**	**16/12/22 -** A discussion re prioritisation of posts has taken place and a business case will go to the ICB Executive team meeting in the new year for further discussion	**Closed**

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**27/01/2023**	
Report Title:	**Chair's Update Report**				**Agenda Item:**	**08**	
Report Author(s):	Michael Watson, Chief of Staff						
Report Signed off by:	Paul Burstow, ICB Chair						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☒	**Information** ☒
Report History:	Not applicable						
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 are asked to note the contents of this report.						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☒
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☒
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☒

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Chairs Report to the Integrated Care Board- January 27th 2023

I would like to begin my report by thanking all staff across the NHS, local government and the voluntary sector for their dedication, hard work and professionalism in the face of historic pressure on our health and care system in recent weeks, and in particular over the festive period. The level of demand and its impact on the system will be detailed elsewhere on the board's agenda, alongside the action being taken to improve the situation in the future. However, I am sure the whole board will wish to join me taking this opportunity to recognise and thank all staff for going above even their usual level of dedication in recent weeks.

I would also like to use this opportunity to share with the board a sentiment that I have heard expressed by colleagues from across the system over the last few weeks- that there has been a genuine sense in recent months of a system approach to overcoming the current challenges we face, in particular in relation to urgent and emergency Care, and that although we must acknowledge that our performance is not at the levels we would want it to be (along with every other system in the NHS), system working has made a real difference.

Hewitt Review

Colleagues will be aware that the Rt Hon Patricia Hewitt, who herself is the Chair of an Integrated Care Board in the East of England, has been asked by the Government to lead a review of the oversight and governance of ICBs.

Hertfordshire and West Essex ICS submitted a system response to the reviews initial call for evidence, which has been circulated to members of the Board separately. Thank you to all organisations across the system that contributed to the response. The response was guided by a number of key principles, and the belief that oversight and governance should have:

1) A focus on outcomes
2) A presumption of competency
3) Autonomy in discharging statutory purpose, for example duties and powers
4) A responsibility for ICBs to 'course correct' as needed
5) Mutual transparency and candour
6) Proportionate oversight

There are a number of changes we would like to see which support those principles in practice:

- A reduction in centrally mandated priorities and performance measures- and we welcome the steps made towards this in the recently issued planning guidance
- For that smaller number of priorities to remain consistent over a longer period of time than has been the case in the past- to support planning and delivery

- A more proportionate and flexible approach taken to the allocation and use of capital funding
- Greater flexibility in how budgets are spent, with fewer specific pots of money that require bids
- ICBs being allowed to act as a 'single point of contact' for the ICS with national teams in the areas that they have responsibility for
- A national and regional focus on sharing best practice, high quality tools and material and ensuring access to the data needed to drive improvement.

I have been asked to chair a workstream of the review, looking at Regulation, Autonomy and Oversight. The workstreams have been asked by Patricia to develop their proposals with the following principles in mind, but also to consider whether the principles themselves capture the change we are trying to make:

Collaboration: within each system as well as between systems and national bodies. Rather than thinking about the centre, regions, systems, and places as a hierarchy, we should view each other as real partners with complementary and interdependent roles and work accordingly. This means recognising the importance of collaboration between partners from the NHS, local government, social care providers and the VCSE in neighbourhoods, places and systems. Because different local partners have different accountability and funding arrangements, only ICSs can create mutual accountability between all partners around jointly agreed outcomes and targets (for both the long-term health of the population and for immediate issues such as discharge and tackling the backlog). On the other hand, it is also essential to recognise that, while the role of the centre should change, some things can only be done effectively and efficiently by them. NHS England's new operating framework and its emphasis on aligned support and collaboration managed by or with the ICS rather than direct to provider organisations is therefore very helpful and should be followed by more joining up between DHSC, DLUHC, NHSE and other national bodies to mirror the integration within ICSs.

A limited number of shared priorities: the public's immediate priorities – access to primary care, urgent and emergency care, elective care, and mental health services - are priorities for all of us, Ministers, NHSE and ICBs. The level of interest in these matters rightly makes them a central part of accountability for all ICBs – and their partners in the wider ICS. Evidence-based guidance and best practice examples are, of course, invaluable to local leaders; but it is essential that those local leaders have flexibility about how they apply those lessons to their particular local circumstances.

Give local leaders space and time to lead: Effective change in any system - particularly one as complex as health and care - needs consistent policy, finances, support, and regulation over several years. Adding new targets and initiatives, providing small funding

pots (often with complex rules and reporting requirements), or non-recurrent funding makes it impossible to plan or even recruit, wastes money and time, and weakens impact and accountability. Multi-year funding horizons, with proportionate reporting requirements, are essential.

Systems need the right support: ICSs require bespoke support geared to the whole system and the partners within it, rather than to individual providers or sectors. But support also needs to be proportionate: less intervention for mature systems delivering results within budget; more intervention and support for systems facing greater challenges.

Balancing freedom with accountability: It is right that with greater freedom comes robust accountability, including for financial spending and ensuring value for money. That accountability includes the local accountability that is hard-wired into ICSs - through ICPs, HealthWatch, Foundation Trust governors and many other forms of patient and public involvement. Peer review, widely used in local government, may also have a role. This local accountability is complemented by NHSE's role to support and provide oversight for ICBs in line with the statutory framework including NHSE's support for NHS organisations within the ICS with greater challenges. The role of CQC as the independent inspector has itself been strengthened by the 2022 Act. The CQC's remit now includes inspecting ICSs as a system, regulating local authorities in relation to their adult social care functions, as well as their existing functions in relation to social care, NHS and other healthcare providers. CQC is transforming its own working methods to meet these new responsibilities. It will also be essential to consider the vital, but different, role of supporting ICSs, ICBs and providers with great challenges to improve, particularly where there are major failings in care. This will need to be done hand in hand with NHSE's role in overseeing systems.

Enabling timely, relevant and transparent data: we recognize that timely, relevant and transparent data is essential for integration, improvement, innovation and accountability. As high performing ICSs are already showing, high quality, integrated data collection and interoperable digital systems can initiate real change. Good data, used well, can generate actionable insights into outcomes and the drivers of inequalities, as well as productivity, quality and safety. ICSs should focus on enabling data sharing and digital innovation that supports real-time service improvement, Of course, effective data can also enable greater accountability, a learning culture and research, although simply doing this through uncoordinated data requests can create unnecessary administrative burdens rather than improvements. NHS England, working in collaboration with DHSC and local government (including through DLUHC, the LGA and CCN) have a key role to play. By defining

standards on data taxonomy and services' interoperability, and coordinating data request to the system, they can create the conditions for wider transformation.

I look forward to contributing to the successful outcome of the review and would welcome any thoughts from colleagues on the above.

ICP Strategy update

I am pleased to report that the ICP strategy, which the board will consider as part of todays agenda, has now reached the approval stage. Again- it is the product of real collaboration between partners across our system.

As with all strategies, we will not achieve the ambitious objectives it sets without a real focus on implementation- and the ICP will be developing its delivery plan over the coming weeks. It is also important that this plan aligns with the operational plan being developed by the NHS, which we will be discussing today. I am pleased that the priorities of the ICP strategy are aligned with the strategic objectives we set for the ICB in the strategic framework we agreed at our last meeting.

Voluntary Sector Representation on the Board

I am delighted to be able to confirm that the proposed change to our constitution to change the status of our VCSFE representative to become a full member of the board has been agreed by NHS England. We are one of the first Integrated Care Boards to make this change and its underpinned by two key principles- that we strive to be a truly unitary board, and that the Voluntary Sector has a crucial role to play, as an equal partner, in making our ICS a success.

Kings Fund

Thank you to all colleagues that attended the successful Kings Fund facilitated workshop in November, which considered our approach to population health. The workshop identified several areas that require further consideration and discussion. As a result, we will be setting up further workshops over the months ahead, with the ongoing support of the Kings Fund.

The next few months

In recent weeks I have attended the Hertfordshire Growth Board and visited Watford General to learn about the investment they have made in robotic surgery and discuss virtual wards. I have also had the pleasure of attending the board of the East and North Herts Trust, and Hertfordshire Partnership Foundation Trust. The opportunity to meet the members of those boards and to hear their plans has been invaluable, and I look forward to attending the boards of other system partners in the weeks ahead.

I also look forward to seeing you all at our Board development day on the 24th of Feb.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**27/01/2023**	
Report Title:	**Chief Executive Officer's Report**				**Agenda Item:**	**09**	
Report Author(s):	With contributions from the ICB Executive Team						
Report Signed off by:	Jane Halpin, Chief Executive Officer						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☒	**Information** ☒
Report History:	Not applicable						
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 are asked to note the contents of this report.						
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	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
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Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☒
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☒
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Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Chief Executive Officer's Report

In my November report to the board, I highlighted the likely challenges we would face as a system as we entered winter, and over the festive period. Unfortunately, we have faced an even more challenging operating context than I anticipated then- with the prevalence of Strep A and other illnesses driving increases in demand that have stretched our already extremely busy services.

Despite this, as I meet colleagues from organisations across the system, I am struck by two things. The first is the continuation of the absolute dedication to patient care that we have come to expect from staff across our health and care system. That dedication has been even more apparent in recent weeks. It's always vital that we support our workforce and never more so than now and it is for this reason that we are seeking to share our award-winning staff support programmes 'Here for You and the Enhanced Health and Wellbeing Services' across the whole system.

The second is a universal recognition that the challenges we face impact the whole system and therefore require a system response. The increase in demand, workforce shortages, the need to maintain high levels of discharge for those that can leave hospital and other capacity and planning challenges are being experienced by us all- and we will need to work together to overcome them. In this month's report, as always, there are fantastic examples of system working that are delivering results- that will make a difference now, and also help us to move to a stronger position for the future.

Critical to creating that longer term change and ensuring that we achieve our strategic vision of 'Better, Healthier and Longer' lives for all in Hertfordshire and West Essex is the development of our infrastructure for Population Health Management (PHM). As detailed elsewhere in this report that infrastructure includes the new data platform that has been commissioned, and which is now moving to implementation. Alongside our ICS segmentation model this will transform our ability to understand and meet the complex needs of our population.

I would also like to draw the boards attention to the collaboration of system partners to set up and deliver a targeted lung health check-up pilot in Harlow. The pilot, which took just two months to mobilise, has been a positive lifesaving process and the ICB is keen to pilot more widely.

Finally, I would like to take this opportunity to highlight the change in name for the Hertfordshire MHDLA Collaborative, which in future will be the Hertfordshire Mental Health, Learning Disabilities and Autism health and Care Partnership (HCP). This change, which has the support of the whole system, more clearly defines the vital role this HCP has to play within the Integrated Care System. I look forward to continuing to work with the HCP as it seeks to deliver its ambitious agenda.

Jane Halpin
CEO

Appendix A: Key Updates

1. Primary Care Update

1.1 Primary Care Access

Primary Care continues to see more patients with 28,000 more appointments across all modes in November 22 compared to November 21 (145,000 more when compared to November 2020). To note this does not include all the primary care activity delivered at scale through primary care network hub which is currently being looked at locally as to how we add all that activity in. Whilst the delivery models if general practice vary with the implementation of triage/remote monitoring/use of digital tools such as ACCURX to support with batch messaging, video consultation and enhancing patient care through remote questionnaire for patients with long term conditions, the proportion of face to face is on an increase and average to 70% for November. In addition, HWE commissioned additional primary care capacity via primary care networks (PCNs) from December 22 to March 23.

1.2 OPEL reporting

The Primary Care teams at place undertake daily review of OPEL reporting by practices and follow up by place teams with individual practices reporting OPEL 3 and 4. Since the launch, in October, it has provided an opportunity to highlight the pressures in primary care to system partners and also how we have revised the actions to be taken by practice and ICB on practical actions that would support the practice. These are being reviewed with clinical leads to be disseminated in the next week.

1.3 Asylum/Refugee

In addition, across HWE we have had numerous ‘spot booking’ asylum seeker hotels stood up at short notice which have required GP registration and outreach from primary care and with support from community partners especially around vaccination of this vulnerable population. Significant short pressure on already stretched services especially where a number of sites have had outbreaks. All partners have worked in collaboration to support this an ongoing basis whilst looking at how we commission this from April to make this sustainable service. To date we have over 2000 new registrations which continues to grow.

1.4 Response to Strep A and Acute Respiratory Hubs

In light of high circulation of respiratory illnesses in particular Strep A in children, primary with support from community partners stepped up to implement three respiratory hubs one in each place to initially support pressures of children activity from NHS 111 and A&E. Since then, it was agreed to open the capacity to adults to support system pressure. Further work underway across each place to evolve this further including how this support pressure in primary care reporting OPEL 3 and 4 and the learning from these hubs over the last three years how this informs future strategy on same day access and urgent/emergency care strategy.

1.5 Further support to practices via local enhanced commissioning framework CF

The ICB has undertaken a risk-based approach to review of the Enhanced Commissioning Framework, recognising that this is a substantial additional workload for practices to deliver enhanced care. The aim was to prioritise key areas balancing operational pressures (both within primary care and across the wider health system) with the health needs of the population, particularly those with long standing physical and mental health conditions. This has led to removing reporting across a range of indicators in the ECF, totaling 265 ECF points. The funding associated to these points will be protected to practices. For the remaining indicators, further measures were taken to

reduce the burden on practices and create more financial security, recognising that many practices rely on the income that the ECF provides.

1.6 Delegated Commissioning of Dental, Optometry and Community Pharmacy

Progress underway with each ICB being delegated for the above contracts from NHSE. Since the last meeting; NHSE E contracting staff consultation underway from 23rd January 2023 with a view that staff will TUPE to ICBs for April.
Since the last meeting, it has now been confirmed that the complaints function for primary care contracts will now be transferring to ICBs in totality. NHSE currently aligning staff to each ICB in preparation for this and anticipating for a July 2023 transfer of staff to ICBs, with the staff consultation predicted to be in May 2023.
The National team confirmed on 9th January that the Contact Centre (front door) will also transfer in July and that financial resource will be received by ICBs. A Complaints T&F Group has been established, first session held 9th January. A Complaints Safe Delegation Checklist will be shared with ICBs in coming weeks and the NHSE Nursing and Leadership Team will set up calls with ICBs to walk through.

A deep dive is also planned on Pharmacy finances, noting some instability in pharmacies in some areas closing as unviable.
The Dental Public Health Commissioner is aligned to each ICB who is working on a scope for review and report of dental data at ICB level to inform local priorities and our transformation plans for dental. The ICB has also made contact with the Local Dental Network, to attend future fora and to plan how Dental transformation and clinical input is incorporated through the Primary Care Board.

1.7 Patient Access to Health Information

Since middle of December NHSD have been enabling a small number of practices so that practices can view their prospective GP Record via the NHS App and other compatible apps. Currently across HWE we have 5 practices live with this functionality and a further 15 likely to go live in early February. There continues to be a dialogue between NHSD and the various GP bodies (e.g. BMA, RCGP) around the wider rollout and how this is managed. The ICB is supporting practices from an information governance perspective and with ensuring they have considered all relevant actions needed to protect patients where there are specific safety concerns.

2. Performance, Operations and Commissioning

2.1 Cancer:

- In September 2022 the East of England Cancer Alliance offered HWE ICB a small allocation of funding to set up and deliver a Targeted Lung Health Check Pilot at 2 GP practices in Harlow, one of our most deprived areas. The pilot was modelled to identify approximately 200 patients from this patient cohort who would be assessed and triaged to determine their level of Lung Cancer risk
- The results of the pilot are now available and show that of 925 patients in the cohort, 172 were identified as high risk and of these, 163 took up the opportunity to have a CT scan. From these 163, the pilot has identified a small number of patients who are undergoing further cancer diagnostics, some patients for whom ongoing cancer surveillance will be put in place, and some other patients referred to the respiratory team for ongoing treatment for other lung/respiratory conditions

- The Pilot took just two months to mobilise (currently thought to be the fastest thus far) and was a successful collaboration of external and internal partners.
- It is felt that this small pilot has been a positive lifesaving process and the ICB is keen to receive further funding from the Cancer Alliance to continue with wider pilots within key areas.

2.2 UEC and Operations:

- Joint agreement on the use of the ICB and County Council allocations of the Adult Social Care Discharge Fund was reached in December in time to implement the range of additional capacity options and workforce support packages prior to Christmas
- A workshop on UEC strategy defined a set of priorities that will be considered by the UEC Board at the February meeting
- Our System Control Centre continues to be implemented with the next phase of development underway
- Ongoing preparations for system resilience in response to planned industrial action

2.3 HCPs:

- Workshops in December agreed the purpose for our HCPs, a timeline for their development, and support for the formation of a HWE HCP Development Network to oversee the next steps of this work including development of linked delivery plans for 23/24. Further workshops with the System Leaders Group and ICB Executive are being planned.

3. Place-based Updates

3.1 East and North Herts

Key successes since the last meeting

January's Partnership Board meeting focused on the partnership's strategic refresh, the Hospital at Home business case, and an update regarding winter initiatives to address system pressures. We have extended the membership of our Partnership Board to include representation from the VCFSE and are delighted to have the Chief Executives of Hertfordshire Age UK and Stevenage Citizens Advice Bureau as formal members of the board. A lived experience advisory panel has also been set up to support the work of the partnership.

Our out of hospital strategy has been rebranded as 'care closer to home' and is focusing on High Intensity Users. The work will be informed by our population health analyses and we are hoping to launch a pilot in the New Year to test the concepts. The Hospital at Home business case has been approved and presented to the Commissioning Committee earlier in January. The business case is requesting funding for the permanent establishment of a Hospital at Home model of up to 204 'beds' from December 2023. The case for change suggests that a significant amount of hospital activity could be provided under this model which would deliver significant benefits and there is a growing body of evidence that supports 'virtual ward' models. The preferred option is to expand capacity with intermittent remote monitoring. A joint approach between partners, particularly ENHT, HCT, and Primary Care, will be crucial to maximise potential benefits.

The virtual Chronic Kidney Disease (vCKD) project has been very successful in reducing waiting times for all patients and prioritising those for face-to-face appointments. Following a presentation to

our joint Clinical Professional and Transformation Group we are focusing on how we use the strong clinical leadership in this area as a platform for future work across priority areas. The clinical lead is very keen to support the role out of this model to other specialties.

The clinical model and the case for change for the integrated heart failure business case has been approved. Linked to this work, the Managing Heart Failure at Home (MHF@H) pilot, funded by NHSE, is due to go live in mid-January. The project aims to test the implementation of remote monitoring, personalised care, and self-management in over 50 people living with heart failure. Our Quality Group now forms part of the HCP governance and is focusing on quality improvement in our strategic transformation priorities, supporting integrated pathway development, and a joint approach to incidents. The group is chaired by the Director of Nursing for the Community Trust.

Upcoming opportunities, key events, and challenges

With funding from the Leadership Academy, we are working with a third party to develop and deliver the development programme for the HCP. The programme is designed to be far reaching across the partnership and inclusive of clinical, operational, senior managers, system leaders, executive, directors, chairs, and non-executive members.

The ENH HCP was formally established by Memorandum of Understanding (MoU) in August 2021. The Partnership Board has ten members which include the care, health, and VCFSE sectors. Since August 2021, partnership development activity has focused on: (1) driving strategic transformation; (2) facilitating a shift towards population health management and (3) culture change. A strategic refresh is appropriate given recent collective experience, new legislation, and NHSE guidance. We also recognise the opportunities for alignment with the ICP strategy, joint five-year plans and organisational strategies. As part of the refresh of our partnership strategy, target operating model and plans, we intend to increase our focus on improving health inequality outcomes and strengthen the work across our localities and Primary Care Networks. In support of this we are participating in an inclusion research project which is being undertaken across the ICB.

3.2 South and West Herts

Key successes since the last meeting

- Mobilisation of the integrated urgent care hub (IUCH) at St Albans City Hospital, which opened on 31 October, is continuing to progress well. In addition to NHS 111 referrals, the IUCH began accepting referrals from primary care in late November. The service offers same-day care from 9am to 6pm 7 days a week for booked patients with minor illnesses/injury. In the first month, there were 618 booked appointments from patients with minor illness. The hub will be able to work at full capacity when its radiology pathway is finalised, which is expected in a few weeks. Since 19 December, a GP has been onsite as a temporary interim measure to help meet increased demand arising from winter illnesses. All substantive staff for the hub will be in post by the end of February.
- Two respiratory hubs opened in Hertfordshire and west Essex on 21 December in response to increased numbers of children presenting at acute hospitals with Strep A or other respiratory conditions. One of these hubs is based at Potters Bar Community Hospital in Hertsmere. Run by Hertfordshire Community Trust, it takes referrals from patients of all ages from NHS 111 and WHTHT's emergency department. Since 5 January, all GP practices in Hertsmere, or any Hertfordshire and west Essex GP practice that is reporting overall OPEL (operational pressures escalation levels) 3 or 4, can also refer into the hub. Two further sites will soon open – one in

Hemel Hempstead and the other in St Albans, provided by Dacorum Healthcare Providers Ltd.

- The early intervention vehicle (EIV) in south and west Hertfordshire was enhanced in December to now deliver services 12 hours a day (previously 10), 7 days a week. The service, provided by Central London Community Hospitals Trust and Hertfordshire County Council, responds to referrals from East of England Ambulance Service (EEAST). The EIV team provides assessment, treatment and equipment required to keep patients safe at home. This helps to relieve pressure on EEAST and to provide the most appropriate care for patients. Since November, the team can also pull referrals directly from the list of calls made to EEAST.
- In November 2022 the South and West Hertfordshire Health and Care Partnership (SWHHCP) launched a 12-month advanced care planning pilot. This pilot project uses a dedicated workforce to increase the number and improve the quality of advance care plans (ACPs) in place for residents in care and nursing homes. On 3 January 2023, 99 ACPs had been put in place since the pilot's launch. After nine months, a review will take place to understand the impact and help develop future options.

Upcoming opportunities, key events and challenges

- Following approval at commissioning committee in January, SWHHCP will be expanding the virtual hospital to include frailty and acute respiratory infections (ARI) pathways. These will add to the heart failure and chronic obstructive pulmonary disease pathways already in place. The frailty and ARI pathways are expected to go live at the end of January/early February after final approval is received from the commissioning committee. A diabetes pathway for the virtual hospital, which was referenced in the last board report, is being worked on alongside other pathways under development. We are expecting this to launch in autumn of this year.
- The enhanced primary care attention deficit hyperactive disorder (ADHD) service that was approved by the ICB in September 2022, has now recruited the staff who will provide it. The team includes a GP, ADHD prescribers (nurse/pharmacists) and administrators. The clinical model is designed to increase capacity to tackle the immediate identified demand and the needs of those on the waiting list for ADHD services in south and west Hertfordshire. Following a period of training and shadowing in January, the service will start seeing patients at the end of January/early February. Progress will be reported to the commissioning board in 3-6 months' time.
- The ICB is working with West Hertfordshire Teaching Hospitals Trust (WHTHT) to develop a community breast pain clinic to be mobilised in two locations in spring 2023. The clinics will be managed by the WHTHT breast team. The model follows the nationally recognised 'Derby Model' where the clinics are based in a primary care setting, allowing patients with only breast pain to access alternative and more appropriate care. The clinics will provide a full clinical assessment, a family history risk assessment and breast pain management advice.
- Redevelopment activity with WHTHT is focussing on reconfiguration of the Watford General Hospital site to make space for the new planned hospital. Work is ongoing for a new pathology facility to move it from its existing location near the multi-storey car park to the Willow Lane entrance. This will free- up vital space as part of the redevelopment plans and the new building will provide a better environment for staff and visitors. Plans are also underway to convert some office accommodation in the Shrodells building into a space, providing 44 additional beds.

3.3 West Essex

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Development of the Health Care Partnership

In response to HCP development workshop held by the ICB in December the WEHCP partnership is reviewing its current strategic priorities in readiness for the 2324 planning round. The review is considering where the HCP has the greatest combined opportunity to improve health outcomes of the population in west Essex, a focus on west Essex population needs analysis that identifies west Essex an outlier compared to the rest of the ICS, builds on current work programmes and opportunities to make more effective use of combined resources. The outcomes of this review will certainly identify some key delivery priorities focussed on Harlow. This process will also help inform the development of key enablers that need to be in place to support the development of the HCPs will feed into the ICB Operational planning process and the Joint Forward Plan.

Addressing health inequalities

- The three west Essex district councils have refreshed and published their health and wellbeing strategies, all of which align with the Essex County Council strategy. The West Essex Health & Care Partnership (WEHCP) health inequalities and prevention committee is hosting a meeting between the districts in February to consider how the delivery plans for the strategies might be implemented and, where appropriate, joined up.
- The WEHCP health inequalities and prevention committee is also undertaking an extensive survey of the services being provided at community hubs across west Essex. This includes help and advice around the cost of living, employment and voluntary sector support. The purpose is to establish what is being offered, and where, and to get a better understanding of demand and effectiveness so that proper, and more sustainable, resourcing can be put in place. The survey is also covering the services provided by Frontline and the Essex Wellbeing Service and has already identified opportunities for the many different providers, including health providers, to work closer together. The survey is due to be completed at the end of January and will be shared with interested parties in due course.
- A similar mapping exercise in Harlow has identified over 140 projects, schemes and mechanisms that relate in some way to the Levelling Up agenda. It's the result of two workshops held late last year to improve connectivity between the many different organisations involved and to help develop a Levelling Up programme for the town. This will be led by a task and finish group that includes representatives from WEHCP, Harlow District Council, Essex County Council, Harlow College and Essex Police. The programme is set to initially focus on skills, education and health and wellbeing.
- The Harlow pilot population health management programme mentioned in the update last November has launched successfully. This involves some 300 patients, of working age, living in some of the most deprived parts of the town who are on multiple waiting lists and frequent users of primary care or attenders at PAH A&E, with no admission. They are being contacted by social prescribers to identify any themes and gaps in services that could more appropriately support either them or their households. The pilot is being managed by west Essex ICB staff, with support from EPUT and the Essex Wellbeing Service. More information on this will be shared over the coming weeks.

Delivery objectives

Key updates since the November board report include:

Short term:

- Successful implementation in December of the Virtual Hospital in West Essex to create 66 virtual hospital beds for Acute Respiration Infections and Frailty supporting admission avoidance and discharge. This is a consultant led MDT service coordinated through the Care Coordination Centre (CCC) integrated with the PAHT Patient@Home service. System partners are working closely to ensure it maximises the use of this capacity.
- Partners continue to implement the winter capacity schemes as part of the ICB winter plans. Since the November report the D2A wrap around support for D2A nursing home beds is being moblised along with additional bridging capacity. The voluntary sector UCAN "Ticket Home" project is now live with social prescribing in PAHT to support discharge with positive service user feedback.

Longer term:

- Pilots for an Integrated Neighborhood Team (INTs) approach to Anticipatory Care are being developed with our six INTs. This is a MDT case management approach for a cohort of high intensity users to support in the community to avoid admissions (10%). Proposed start of pilots from January 2023 as test and learn to inform new models from April 23.
- The Intermediate Care programme is starting in January with the forensic review of the outcomes of population cohorts accessing intermediate care services in west Essex. This will inform the future model and commissioning framework for intermediate care. To report in March.
- WECHP is now working closely with Northeast London HCPs and Barts Health NHS Trust as part of the Integrated Delivery Framework (IDF) to support people in the community for populations served by Whipps Cross. This includes the population served by LBC PCN. WEHCP out of hospital model of care is closely aligned with the IDF.

4. Herts Mental Health, Learning Disabilities and Autism Health and Care Partnership

On 01 December 2022, the Hertfordshire MHLDA Collaborative changed its branding and title. It is now the Hertfordshire Mental Health, Learning Disabilities and Autism Health & Care Partnership (HCP). This change recognises that our partnership's ambitions, membership, and ways of working are beyond those of a formal 'provider collaborative' and more aligned to those of a 'place-based' partnership.

This rebranding will support the wider system, staff and partners to better understand the role of the Partnership within the HWE ICS and will help ensure that all system developments apply equally to this Partnership alongside the other existing Health and Care Partnerships.

Since the last update to the ICB Board, there has been further progress against our key transformation priorities.

We are in the process of scoping the reach and remit of the Neurodevelopmental work for Children and Young People and ran a successful multi-agency workshop in December to fully understand the range of services and interventions already in place across the NHS, social care and education. We are working closely with colleagues across the ICB and HCC to ensure that this work is connected to and cognisant of other strategic developments around Children's health services in the ICS.

We are mobilising system support around the delivery of the newly approved Dementia Strategy. A partnership and launch event, run on behalf of the ICP and the MHLDA HCP is scheduled for late February to help galvanise organisations and partners across and beyond health and social care to help deliver improvements in local outcomes. We have been in touch with colleagues in the Greater Manchester ICB and hope to be able to draw upon the experience and expertise of their Dementia United approach.

In response to increasing pressure we are seeing across the system, the Substance Misuse and Mental Health Task and Finish Group concluded the first step of its work and developed a shared picture of existing resource and initiatives underway. The Group has proposed a programme of activity required to address potential gaps in provision and where further support or investment may be required. We are now considering how this programme can be best resourced and progressed.

On 29 November 2022, the MHLDA HCP held its first Development session. Partners identified that the HCP now allowed for a greater sense of involvement, more diverse agendas and is increasingly the means through which to lead and deliver system-wide activity. Looking ahead, HCP Board members emphasised the importance of developing the HCP's communications, strengthening its work and connections with the other HCPs and developing clearer oversight over progress against its priorities, plans and programmes.

The MHLDA HCP Development team hosted a joint session with East and North Herts HCP's transformation team on 31 October 2022 and a joint meeting with South and West Herts HCPs transformation team on 05 December 2022. This has helped to further develop the network and relationship between the teams and to establish a clearer understanding as to how the transformational activity of each of the HCPs can complement one another.

Following agreement from system leaders, the MHLDA HCP has submitted an Expression of Interest to be part of the NHSE Collaborative Innovators scheme. Seven collaboratives/partnerships will be selected from across the country and will receive additional NHSE input and support to help them address local issues. In light of recent HCP Board discussions and feedback from the HCP's Development session, we have asked for NHSE support in the following areas:

- Support to develop a model of quality management and improvement so that we can collectively identify areas for improvement and mobilise multi-agency responses. This has been identified as a specific area for improvement, noting the recent quality issues in Mental Health and Learning Disabilities services highlighted by the Panorama and Dispatches investigations.
- Support around the development of system intelligence across our partnership, so that we are better equipped to evaluate system-wide activity and outcomes and, in turn, to make the best use of system resource.

5. Population Health Management (PHM)

The PHM programme is continuing to progress the planned programme of work as well as respond to emerging requests for support. Recent work progressed by the PHM team includes:

5.1 PHM Infrastructure development

- The new data platform has been commissioned and is moving to implementation. The PHM team is working with the supplier (Oracle Health) to deliver the PHM capabilities, utilising local and national data sources

- As part of the new platform, the ICS segmentation model will be incorporated, meaning that the local population will be segmented in near real time. This will support strategic planning as well as transformation programmes to identify priority groups and target services to people in segments that are most likely to benefit.
- In addition, the PHM team have developed a draft outcomes framework and are supporting the frailty and end of life transformation programme to develop an outcomes framework. This will complement the overarching whole system outcomes framework. It is planned for this process to be replicated for other transformation programmes as capacity allows. The outcomes framework will be incorporated into the new data platform, allowing the ICB to assess and monitor the health of the local population as a whole as well as sub-groups (segments, geographic areas, demographic groups, etc).
- The PHM team is also support transformation programmes with a range of analytics projects, ranging from needs analysis, modelling and service evaluation at all levels of the system, from ICS, through Place level down to PCN. This includes:
    - Supporting the UEC transformation programme and strategy development with a UEC needs analysis
    - Producing PCN information packs.
    - Undertaking service evaluations across the ICS, including a review of the community frailty service in ENH.
- The PHM team are also developing the governance structure that will sit beneath the Population Outcomes & Improvement Committee as well as how PHM will work alongside the research groups within the ICS. Vacant posts within the team are being recruited to and there is closer working with the PHM analysts in the BI team, with regular meetings taking place. The ICB team is also working closely with wider Public Health teams on relevant projects.

5.2 Analytical outputs and PHM projects

- Recent outputs include:
    - Urgent and emergency care needs analysis, including the use of machine learning to identify high risk individuals. Use of the analysis is supporting the development of the UEC strategy as well as identification of priority cohorts for a case management service in ENH.
    - HWE needs analysis, diabetes needs analysis, falls needs analysis
    - Needs profile for people with multi-morbidity in SWH to support development of a case management service.
- Current work includes:
    - PCN information packs
    - ENH community frailty service evaluation
    - Application of outputs of machine learning from UEC analysis to create GP IT system searches and identify high risk individuals.
- Recent analysis is being used to support the prioritisation of work plans. As part of a review of existing projects and programmes of work, the medical directorate is working with the commissioning teams to identify the current transformation portfolio and assess whether the ICB is working on areas which will deliver the greatest impact based on need, demand and national requirements. Also, our ICS research leads are map existing research projects against the emerging clinical priority areas to understand gaps and opportunities.

5.3 Successes

- Analytical outputs have informed a number of work programmes, ensuring that plans are based on the health needs of the population and targeted to groups with the greatest capacity to benefit. For example, the analysis for the UEC programme has identified specific segments and cohorts that would benefit from targeted intervention.

- The locally developed segmentation model and outcomes framework has been very well received both within the ICS as well as by partner organisations. The ICB is putting forward a submission to the HSJ digital awards.

5.4 Issues and challenges

There is a delay to the implementation of the new data platform resulting from issues with information governance and contract finalisation. IG are now resolved and final agreement on contractual issues is progressing through relevant teams. This issue will be partially mitigated by deployment of capability as it is developed Capacity. The PHM team is managing a large volume of requests for information and support, along with delivering the planned programme of work. This will be partly managed through the development of new processes and reviewing and prioritising workload as well as recruitment to vacant posts. However, it is anticipated that the workload will remain high in PHM

5.6 Long Term Conditions

- Reviewing the work programmes for each disease area across the LTC portfolio as part of the ICB prioritisation work. Linked to this, each disease area will be developing a programme outline and strategic plan, with clear links to national requirements and targets.
- Asthma diagnostic hubs. We have had good uptake from PCNs via expressions of interest and are into procuring the devices
- Continuing to implement diabetes transformation plans, linked to national priorities. Current pressures in primary care are likely to impact on restoration of 8 care processes and 3 treatment targets.
- Successes
  - Successful in a bid for £100k from NHSE to fund a project to increase AF detection and management in hard to reach/underserved populations in Stevenage. About to start implementation. Plans have been affected by NICE removing approval for the planned technology (due to IG issues identified with the provider).
  - Successful in 2 bids for funding to develop plans and implement the national integrated community stroke service specification. Both projects are now progressing with a view to having an implementation plan by April and a pilot for vocational rehab within the ICB.
  - Awaiting feedback on a bid to scope the use of community lipid clinics. There is a large demand for management of hypercholesterolaemia, due to introduction of IIF metric and LTP ambition to increase the diagnosis of familial hypercholesterolaemia. Emerging evidence of impact of community lipid clinics in other parts of EOE. Bid submitted to BHF to scope the implementation of similar models, building in positives from SNEE and BLMK.

5.7 Issues and risks

- Pressures in primary care have resulted in removal reporting for a range of indicators in the ECF. This includes care across a number of long-term conditions, including diabetes, heart failure, COPD, CKD, AF and cholesterol management.
- Progress on transformation in long term conditions and development of strategic plans is limited by the limited resource at ICS level. Current programme/transformation/commissioning resource is in Place teams and working through how the teams can support each other to avoid duplication of work, inconsistency in service development and/or lack of coordination and management within the ICS and with the region.

5.8 Examples of recent UEC clinical work to support service pressures:

The medical directorate team are supporting the UEC needs analysis (captured under the PHM update) to support the development of a UEC strategy, as well as targeted support to identified

urgent care transformation projects, eg the development of falls pathways and redesign, a high intensity users project, well as specific support to the programme leads on SDEC (same day emergency care), handover at home/ ambulance conveyance reduction, respiratory hub pathway development, mental health users in A&E.
Recent work for children and young people's UEC has included responding to the high number of strep A and scarlet fever cases and demand in primary care, 111 and A&E. Communications for patients and public have been developed and shared, including on the HWE Healthier Together website. A clinical pathway for primary care hubs.

In light of significant system pressures, the medical team rapidly developed a protocol for paramedics to use to avoid conveyance when in the patient's home/ care home, and when and how to seek senior community clinical advice with the intention of avoiding conveyance and progressing to safe clinical care in the community. This was signed off by all medical directors and directors of nursing. The UEC clinical leads are now working on a criteria to admit protocol and process to maximise alternatives to admission when the patient is in A&E or other acute trust departments.

6. Pharmacy and Medicines Optimisation Team (PMOT)

The three-place based pharmacy and medicines optimisation teams have been through a re-structure to form one ICB wide team. The team have continued their excellent work supporting prescribers and health and care providers across the system. Key priorities for the team which will continue into next year include:

1. Reducing polypharmacy which is one of the national safety targets for 2020-2023. The latest data shows the ICB and each place remains below the national average of 3.53 unique medicines per patient. The PMOT will build on work to date to tackle weaknesses in the prescribing system and culture and develop key areas that support implementation of the recently published National Overprescribing Review. A key area of focus for the ICB this year has improving the safe prescribing of opioids across the patch.
2. Reducing antibiotic resistance remains a key national priority. Targets are set out in the 2022/23 NHS System Oversight Framework (SOF). Reporting of place and ICB performance for the antibiotic prescribing indicators are published monthly. The target for overall total primary care antibiotic prescribing has been made more stringent in 2022/23 to align it with the UK Antimicrobial Resistance National Action Plan which aims for a 25% reduction in community antibiotic prescribing by 2024. The ceiling target for total antibiotic prescribing (number of antibiotic items prescribed in primary care, per STAR-PU per annum) is not currently achieved by each of the places. The ICB and all three places have made reductions in broad spectrum antibiotic prescribing such that each place and the ICB now meet the NHSE ceiling target for this metric. PMOT are proactively working with practices that benchmark as outliers to support appropriate antimicrobial prescribing across the ICB. Supporting prescribers across the system to use the most cost effective medicines. We expect totals for antibiotic use to rise in Q3 and Q4 following a national call to treat more Streptococcus A patients, in line with NHSE advice. This will affect all ICBs. An ICS wide antimicrobial group has been established, which aims to share good practice. It meets quarterly.
3. There is significant saving for the system by prescribing the most cost effective DOAC across the system and this is being prioritised.
4. Continuing with our established Area Prescribing Committee so that formulary decisions are made across the ICS and are integrated for the whole patch. Where we have different historical decisions from the past we are noting these for review at a future date. Integrating three formularies into one is a large piece of work which cannot be done immediately, as it

requires ICS buy in from all providers where historical decisions were made which were different.

5. Supporting the appropriate use of oral nutritional supplements (ONS) through highlighting, consistently communicating and supporting the implementation of the recently approved ICS wide guidance on appropriate prescription of ONS and use of a food-based approach instead.
6. Supporting the appropriate prescribing of baby milks through producing consistent guidance across the ICS and then supporting its implementation across the ICS in 2024/5.
7. Rolling out the use of Eclipse Live across E&N Herts place. Its use in SWH and in WE help us to identify patients with red and amber alerts where patients have abnormal lab results which may be caused by medication. This is believed to reduce admissions, through picking up these combined datasets for patients earlier.
8. Continuing with the functioning ICS wide medicines optimisation group which involves all partner organisations chief pharmacists. Each member of the group leads on one or two areas, which may mean coordinating work or formation of task and finish subgroups. The key priorities the group are working on together are workforce (which is challenging across all sectors of pharmacy), safety, financial efficiencies and sustainability.

Areas driving prescribing budget pressures include supply difficulties leading to nationally negotiated price concessions and implementation of NICE technical appraisals (TAs) and guidance. It should be noted that the ICB spends less than the national average on primary care prescribing. A population health management approach is recommended going forward to determine the value of the medicines being prescribed across the system.

7. VCFSE Alliance

The VCFSE Health Creation Strategy was ratified by the ICP and will build on the learning from Covid, ensure that the VCFSE remains a strategic partner in delivering plans to tackle the wider determinants of health and complement the Integrated Care Strategy. It promotes the role of the VCFSE in creating health across the system ensuring our role is visible, particularly in prevention and improving prevention, equity of access, reducing health inequalities, and addressing the wider determinants of health. Recruitment for the Alliance Secretariat is taking place, with interviews at the end of January.

8. Our People

The RCN strike in December affected two organisations within the system (Hertfordshire Community Trust, Herts and West Essex ICB). We were not affected by ballots from other unions. The HRD network continue to meet and link to each other to ensure there is appropriate support across the system.

We are utilising our Reservist model to provide support for Herts urgent care and other organisations who are struggling in relation to surge activities.

Business cases for both our award-winning psychological support service Here for You and the Enhanced Health and Wellbeing services offered to staff across our system have been developed and are being shared across the system to create a sustainable future for the service. Mental health is the most significant contributor to our staff's reasons for sickness absence and currently accounts

for almost a third of sickness/absence across the system.

The People Board met in December and hosted a workshop review workforce issues relating to Urgent and Emergency Care and discharge support. Six workstream areas are being reviewed, including career development pathways, promotion of opportunities within urgent and emergency care and staff mobility across the system. This is the first workshop style meeting the Board has held but hopes to continue working in this way to support transformational delivery of key system priorities on an ongoing basis.

The system has secured funding to provide support for NHS staff in relation to cost of living through the purchase of Blue Light Cards across the system. Additionally, we have secured ongoing investment for Allied Health Professional staff across the system, and reviewing what systems need to be put in place to best support this investment and ensure the best possible outcomes. Out integrated planning network have also come together and are currently engaging across the system to prepare our system response to the 23/24 Operational Planning response required over the next two months.

The ICB have procured an appraisal platform to support appraisals, wellbeing conversation, 360-degree appraisals and monitoring of objectives. The ICB has also approved a proposal to join the HWE bank collaborative which will enable us to use NHSP to support our provision of temporary staffing for the ICB. It gives the ICB a method for engaging bank workers, rather than agency workers and where agency workers are required, this proposal will ensure that the agency worker engaged is from an agency with a history of good supply, at an appropriate price and from an agency listed on approved frameworks.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**27/01/2023**	
Report Title:	**Summary report: Performance, Quality, Finance and workforce summary report**				**Agenda Item:**	**10**	
Report Author(s):	Michael Watson, Chief of Staff						
Report Signed off by:	Alan Pond (Chief Financial Officer), Tania Marcus, (Chief People Officer), Frances Shattock (Director of Performance), Jane Kinniburgh (Director of Nursing and Quality						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☒	**Information** ☐
Report History:	N/A						
Executive Summary:	This report represents the first iteration of combined reporting across performance, quality, finance and workforce, and focus on the shared factors that are critical to improvement across all four.						
Recommendations:	The board is asked to note the contents of this report.						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			
	N/A						

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	YN/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☒
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☒

Executive Summary

The board has previously agreed that it would like to see a move towards integrated reporting across Quality, Performance, Finance and Workforce. This is the first report that seeks to meet that requirement and has been produced in collaboration by several members of the Integrated Care Boards Executive team.

The Board is asked to note that this paper is a summary of the Quality, Finance and Performance reports presented elsewhere on the agenda, and should be read alongside them.

Approach Taken

Following a review of board and other reports, and discussions with relevant directors, the five areas critical to improvement across finance, quality, workforce and performance have been identified and agreed. They are:

- Diagnostic capacity
- Workforce- recruitment, retention, sickness and absence
- Demand for services

- Barriers to discharge
- Funding and other constraints (for example estate)

This report considers in more detail the impact of these five areas and summarises the current approach of the system in relation to each.

It is proposed that in future the Board receives a report which provides a summary update of developments across the five areas identified.

Summary of Current Position

Finance:

The system has a Forecast Out Turn (FOT) of break even. Trusts have a deficit of £23.8m YTD, which is variance of £16.2m against plan. As the finance report sets out, the key drives for this variance are:

- Pay, including ED pressures, medical staffing and agency costs (Both trusts)
- The cost of Urgent Treatment Centre (PAH)
- Increased back log maintenance (PAH)
- Tier 1 Cancer and Diagnostic plan (ENHT)
- Elective recovery income not covering the cost of elective recovery activity (PAH)
- Reduced covid income not covering the cost of elective recovery activity (PAH)

Performance:

The table below summarises the current performance across the Hertfordshire and West Essex Integrated Care system;

Area	Performance summary	Critical drivers of performance
UEC	Performance remains challenged after a period of high demand – with declining performance across all key indicators	• Continued high demand for UEC services • Increased Covid/Flu admissions and acuity of patients • Workforce availability and impact of Covid/Flu on the UEC workforce • Discharge challenges leading to capacity issues • MH assessment delays and bed shortages • Acute capital build in some areas impacting on the management of current and future demand until completion in December
Cancer	Continued high levels of 2 week wait referrals. Improvement in 62 days backlogs although	• Workforce shortages • Demand outstripping capacity • In some cases 62 day issues due to slow diagnostic pathways and lack of outpatient capacity

	trajectory below recovery plan.	
Planned Care	Continued delivery of 104ww recovery- no breaches. Current system focus on waits over 78 weeks- ahead of trajectory, although pressure remains in some specialties	• Whilst there has been a reduction of longest waiting patients, not enough activity is being delivered to deliver a reduction in the overall waiting list, which continues to grow • High referral volumes in early 21/22 now reaching their 52 week wait • Diagnostic waiting times especially in key modalities • Staffing remains a challenge, particularly around anaesthetics
Community	Waiting lists continue to be at historically high levels. % of children waiting below 18 weeks has continued to significantly decline.	• Workforce shortages, and staff absence impacting on services • Increase in demand
Mental Health	Out of Area bed placements increasing in October. Dementia diagnosis remains challenged although improved in most recent data	• Demand at historically high levels for a sustained period • Recruitment and retention • Staff sickness • Lack of diagnostic capacity (access to specialist brain imaging/scanning in West Essex
Primary Care and Continuing Healthcare	Total number of GP appointments remain higher than pre-pandemic levels and increasing. Southwest Herts CHC assessments remain a challenge but improving in October (see Quality Report).	• Significant pressure from Respiratory illness • Rapid increase in 'spot booking' hotels set up without notice by Home Office to house asylum seekers with significant health need including scabies and diphtheria outbreaks

Quality:

The report from the Director of Nursing and Quality details the impact that the five areas of focus in this paper are having on quality across Hertfordshire and West Essex. In particular the report references

- The challenge of workforce shortages across key service such as maternity, CAMHs and UEC, and the risk this represents to patient outcomes
- Ongoing issues around discharge and ensuring quality is maintained
- The growth in demand, for example in relation to the care of Young People but in other areas as well

- The impact of elective waiting list on patients, as detailed

Workforce:

The People Board report highlights key areas of workforce issues across the system – however more detailed analysis is to be undertaken to identify key areas of focus and prioritisation. Data quality and integrity is not equitable across the system, and while we know of significant pressures to social and primary care staffing, we are not as able to gain as detailed an understanding of the workforce pressures currently:

- Staff sickness/absence remains high at over 5%, with mental health the largest reasoning, accounting for over a 1/3 of absences within NHS providers
- Retention and turnover is a significant concern – particularly within first year of service where HWE is identified as an outlier for the region within certain professions such as Nursing.
- Staff survey responses are due to be published shortly and we will seek to undertake system and trend analysis of those areas of staff experience.

Section Three: Summary of work taking place across key areas

Diagnostic capacity:

The system wide diagnosis strategy was submitted to NHS England in November. This included recovery trajectories for all challenged modalities (which can be found in the performance report). All modalities are expected to be DMO1 compliant by March 23 with exception of following challenged areas with longer recovery trajectories: Audiology, Non-Obstetric Ultra Sound, MRI (ENHT), ECHO (WHHT) and DEXA (WHTH and ENHT).

Mobilisation of Community Diagnostic Centres has now commenced- with PAH and WHHT due to be in operation in late 23/24.ENHT are due to submit a further business case for additional MRI in 23/24.

The Community Diagnostic Centre at QE2 is starting to deliver an impact on waiting times, but the service remains challenged due to staffing

West Herts Hospital Trust are flexing their operational hours for each modality as and when required and Princess Alexandra Hospital is using an MRI mobile unit on an ad-hoc basis to try and manage waiting times

Diagnostic activity is severely impacted by vacancies across the system. The ICS Health and Care Academy has sought to proactively promote roles within this area through digital promotion and release of new video resources. As part of our expansion within ethical international recruitment, the system is working with associated stakeholders to recruit radiographers from appropriate markets internationally to support this area going forwards. West Hertfordshire Hospital Trust have begun to introduce a new scheme providing resources of support for diagnostic staff, and the system has applied for a funded post to improve the clinical education and training environment for diagnostics staff across the system.

Workforce- recruitment, retention, sickness and absence:

There is extensive work underway in relation to staff retention, specifically the system's retention pathfinder programme, which is focussing on four key workstreams to improve staff turnover across the system, including flexible working, career pathway development, onboarding and cost of living. The People Board will be undertaking a deep dive into retention at the end of February and seek to support identification of any additional initiatives that are required across the system. All NHS provider staff have been offered the opportunity to get a blue light card to support access to discounted products and services. Here for You and associated health and wellbeing services are still available and staff are currently working hard to identify ways and means of enabling them to become sustainable offerings. Projects relating to HCSW and international recruitment (including allied health professional staff as noted above) have proved successful in their delivery and are being reviewed and expanded to other areas of working. A steering is group looking at new ways to recruit and retain staff in CAMHS (from quality report)

Demand for services:

UEC:

Implementation of the HARIS/Unscheduled Care Co-ordination (which includes call before convey and access to the Stack) to provide health care professionals working within our system access to appropriate clinical support to make the best use of services across the system and to reduce delays to improve performance. This program has commenced with support to EEAST Ambulance service (East of England Ambulance service); the HARIS proof of concept week was successful in reducing ambulance conveyance and demonstrated a related improvement in 30 & 60 minute handover times. Challenges continue with establishing a sustainable model and work continues with colleagues and region to further develop the approach.

Due to the ongoing high demand and pressure on the system there is an ongoing triangulation of patient safety and experience information to identify specific themes for concern and to take the needed action. Safe staffing levels focus remains in place.

Hertfordshire and West Essex is participating in the integrated Urgent and Emergency Care (iUEC programme) supported by the National Improvement team. The ICB is one of two systems that are participating in the pilot programme. The aim of the programme is to support development of a UEC strategy, support UEC recovery and reduce overcrowding in the EDs through diagnostics based on population health needs and service redesign.

People Board undertook a dedicated workshop to review support and development options for workforce within urgent and emergency care and supporting broader discharge across the system. The Board identified six key areas of development for progression including promotion of urgent and emergency care as an area for career development and identifying new ways of working across the system including improved collaborative work within the community. Progress is also developing relating to supporting improvements in the culture of utilising full capacity of the virtual wards across the system.

Planned Care:

To aid elective recovery and reduce the current waiting lists, the system is focused on:

- **Insourcing and outsourcing** to use IS capacity where appropriate which is managed through BAU processes
- **Increasing physical capacity**, which is through the development of the elective hub based at SACH and community diagnostics centres projects, as noted above.
- **Improving Productivity**, through the implementation of the recommendations of the GIRFT programme through a system wide, clinically led programme of work which includes theatre efficiency, day case rates and length of stay
- **Transforming our Pathways**, which will enable us to use capacity more efficiently through PIFU, virtual hospital and the HVLC programme

These themes are brought together and managed as a planned care programme.

Barriers to discharge:

Joint agreement on the use of the ICB and County Council allocations of the Adult Social Care Discharge Fund was reached in December in time to implement the range of additional capacity options and workforce support packages prior to Christmas. A paper detailing setting out the detail of the approach to be taken in Hertfordshire and West Essex can be found elsewhere on the Board agenda <input ref>

As detailed in the Quality report work is taking place across ENHT and WHTH regarding discharge summaries.

Funding and other constraints (for example estate):

The New Hospital Programme has not yet made any announcement with regards to the proposals for WHHT and PAH.

The ICB is completing its own piece of analytical work to identify reserves that may be available to support the system position. This will help support a reduction in the deficit.

Trust capital plans are currently being re-profiled due to slippage (at the request of NHSE). NHSE have made a further 269K available to support going forward to winter, bringing the total system allocation to 64,893k. Plans to spend are currently being developed.

The ICB has a capital allocation for investment in Primary Care (PC) and GPIT. The allocation for 22/23 will be spent in total.

Next steps

This paper sets out the five areas critical to improvement across finance, quality, workforce and performance, as identified by the relevant members of the ICB Executive Team. They are:

- Diagnostic capacity
- Workforce- recruitment, retention, sickness and absence

- Demand for services
- Barriers to discharge
- Funding and other constraints (for example estate)

The report authors would be grateful for the boards view on whether the areas identified are the correct ones.

Future boards will receive a revised version of this report which will track progress across those five areas identified, beginning at the March meeting.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**27/01/2023**	
Report Title:	**Quality Escalation Report**				**Agenda Item:**	**11**	
Report Author(s):	David Wallace Deputy Director of Nursing, ICB Hayley Mounsey, Assistant Director Nursing and Quality, ICB Chris Harvey, Assistant Director Nursing and Quality, ICB Shazia Butt, Associate Director of Quality Assurance & Performance Improvement, ICB Mary Emson, Assistant Director of Nursing, ICB (With contributions from wider Nursing and Quality Team)						
Report Signed off by:	Jane Kinniburgh, Director of Nursing and Quality						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☒	**Information** ☐
Report History:	The report sets key areas of focus for quality and safety in relation to key ICS services and providers. The report provides high level summary with associated actions to mitigate and next steps. Where possible, the report aligns across the ICS footprint for example to highlight status of serious incidents and infection prevention and control.						
Executive Summary:	This paper gives the current Quality position across West Essex, Herts Valley and East and North Hertfordshire, the Quality Committee meeting agenda is summarised as follows: • Quality Summary Key Reports • Extraordinary Items verbal update						
Recommendations:	The Board is asked to note the report for discussion and recommend areas for further development ensuring this is aligned to the Quality Committee Terms of Reference.						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			
	N/A						

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☒
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☒

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

January 2023

Hertfordshire and West Essex Integrated Care System

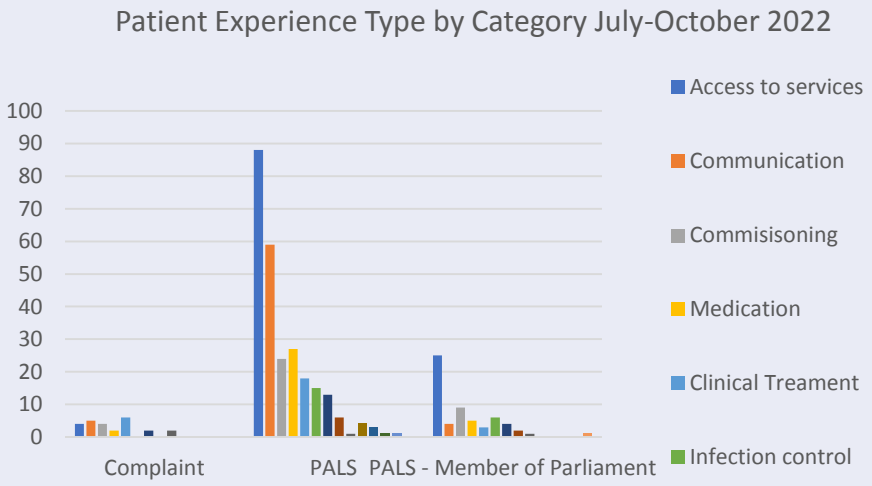
NHS Hertfordshire and West Essex Integrated Care Board

Report Contents

Patient Safety and Experience Q2

Summary Description – Patient Experience

Locality	Complaints	PALS	MP	Comments/ Compliments	Whistle-blowing	FOI	Totals
East and North Herts (ENH)	4	26	9	0	0	0	39
South West Herts (SWH)	5	55	14	0	0	0	74
West Essex (WE)	1	55	5	1	1	0	63
Other	0	5	0	0	0	1	6
Totals	10	141	28	1	1	1	182
Key Themes	Information requests, appointment availability, referral delays, prescribing.						



Quality review System/GP queries

Locality	Reported in October and November	Identified as Incidents	Total Practices
ENH	99	0	29
SWH	1	0	1
WE	47	0	18
Totals	147	0	48
Key Themes	Referrals, inappropriate requests for primary care action, missing information, 2 week wait (ww) referrals, incorrect/absent discharge summary.		

Next steps and ongoing monitoring

Patient Experience

- 146 queries- 80%, have been closed.
- 67 information provided to the enquirer in relation to their concern
- 1 partially upheld
- 25 resolved
- 28 for information only
- 14 closed as no consent or further contact
- The remaining 20% remain under investigation

GP Queries

- GP queries: 44 relate to Princess Alexandra Hospital and 35 to East and North Herts Trust
- 4 queries have been raised by acute providers in relation to primary care
- The Team are working with PAH to address outstanding queries. The top three issues to be addressed in all acute Trusts are

- lack of or incorrect discharge summary
- asking primary care to carry out (in 2WW)
-asking primary care to check results of tests done in hospital.

Patient Experience PALS/ PALS Member of Parliament/ Complaints: July – October 2022

Top 10 by Organisation	Totals
Herts and West Essex ICB	132
General Practitioner	78
The Princess Alexandra Hospital NHS Trust	39
East and North Herts Trust	14
Hertfordshire Eye Hospital	9
Other Organisation	8
Essex Partnership University Foundation Trust	7
Herts Partnership Foundation Trust	7
Herts Urgent Care	7
Hertfordshire Community NHS Trust	5
Connect Health	5
NHS England	5
Grand Total	**316**

Top 10 Specialities	Totals
General Practice	74
Commissioning	34
Continuing Healthcare	30
Administration	22
Covid vaccination programme	22
Medicines Management	20
Ophthalmology	15
Mental Health	14
Primary Care	10
Trauma and Orthopaedics	9
Grand Total	**250**

Top 5 Categories	Totals
Access to services	118
Clinical Treament	27
Commisisoning	37
Communication	68
Medication	34
Grand Total	**284**

Access to services	Sub-Category
Appointment unavailable	29
Delayed referral	16
Information required	13
Face to face appointment	9
Delayed follow up outpatient appointment	6
Patient choice not offered	6
Delayed 1st O/P appt	5
Transport (non-urgent)	4
Cancelled Surgical procedure	4
Telephone Access	4
Delayed pathology services (inc phlebotomy)	3
Wait for treatment over 18 weeks	3
2 week wait issue (suspected cancer)	2
Delayed imaging	2
Delayed therapies	2
Finding GP	2
Removed from GP register	2
Telephone triage	1
Transport (urgent)	1

The data in this table reflects the top 10 organisations

Herts and West Essex ICB, has the highest number of queries due to concerns relating to; primary care, CHC and commissioning of services.
Primary care/GP concerns relate mainly to access to services and communication.
The team have only received 3 PALS/ Complaints in the past 3 months- relating to West Herts Teaching Hospital NHS Trust so they are not in the top 10 organisations.

The top 10 specialities have been reviewed and recoded as there were a large number identified as "Other/Not stated" whilst it may not be apparent a the initial point of registering a query this field has to be revisited once further information has been established – this is a training issue and has been discussed within the team .

Current Performance
The team are managing queries well:
40.5% of queries are managed and closed within 5 days
49.5% within 10 days
There are currently 26% over 25 days, the majority of these are formal complaints and/or complex queries involving multiple organisations.

Patient Safety and Experience Q2

Serious Incidents

Locality	Reported Oct and Nov	Never Events	Themes	Locality	Reported Oct and Nov	Never Events
ENH	20	3	System wide ambulance delays	ENH	20	3
SWH	17	1		SWH	17	1
WE	5	0		WE	5	0
Other	6	0	Self -harm	Other	6	0
Totals	48	4		Totals	48	4
Locality	Reported Oct and Nov	Never Events	Themes	Locality	Reported Oct and Nov	Never Events

WHTHT - Serious Incident (SI) Themes

9 SIs through October and November2022. Diagnostics and Maternity are the key areas in terms of themes, with 3 and 4 SIs respectively.

The diagnostic SIs include two cases of wrong X-ray interpretation and one case of missed review of previous computerised tomography (CT) reports. The maternity SIs include an Intra Uterine Death (IUD) following reduced foetal monitoring and a case of neonatal hypoxic ischaemic encephalopathy (HIE grade 2), both of which have been referred to Healthcare Safety Investigation Branch (HSIB).

East of England Ambulance Services Trust (EEAST)

- Significant delays in arrival to handover times at all acute hospitals continue to worsen, a major factor in increasing delays in ambulance response times. Serious Incidents are increasing with most related to delays. Emerging themes also appear to be linked to respiratory and category related issues with some assessed initially as category 2 but then move into category 1 after a few hours. Delays also feature in complaints.

E&NHT - Never Events (NE's)

4 NEs have been declared in Oct/Nov; 2 by East and North Herts NHS Trust, 1 by a private provider and 1 by West Herts trust – all investigations are on-going. The incidents are:

- Use of NG tube not in the stomach
- Excision of the incorrect lesion x2 (some months apart)
- Incorrect lens inserted.

HUC 111 - 1 SI was declared in December 2022. Investigation underway due to cause of Child Death Group A Streptococcal Sepsis. Immediate actions include ensuring staff compliance with sepsis training and learning from incident engagement event for clinicians. Immediate analysis identified missed opportunities regarding escalations for children to be seen by the paediatric team as well as related to early warning signs and low threshold considerations.

Next steps and ongoing monitoring

WHHT – Previous 2 Never Events in relation to wrong site surgery and retained swab

Follow-up Quality Assurance Visit (QAV) in November to gain assurances on the progress made against the June 2022 visit recommendations. Training on human factors successfully rolled out which is further embedded through the new team links into the 'here for you network' providing reflective time to increase situational awareness and human factor impacts. The Trust continue with plans to digitalise and achieve full compliance for the World Health Organisation checklist and observational audits which are aligned to the Electronic Patient Record (EPR) development updates

- **WHHT** sent patient safety alerts following SIs to share early learnings including use of Sepsis Bundles and importance of Local Safety Standard for Invasive Procedures
- SI investigations are ongoing and will be reviewed at the SI panel when the root cause analysis has been shared.
- Ongoing assurances around SI themes is maintained through monthly Quality and Performance Assurance Meetings. Maternity aspects have additional oversight through bi-monthly maternity meetings.

- **EEAST** attend the daily system calls and are working with partners to improve flows and review of escalation procedures. The Hospital Ambulance Liaison Officer role continues in 2022/23 to help manage ambulance handovers.
- SI's are reviewed by the Integrated Care Board (ICB).

- **HUC** – initial learning shared with staff- to have a low threshold for referral in a child who presents on multiple occasions with the same episode of illness and the relevance of tachycardia in a child during a period of illness when their temperature seems to be responding to medication. Clinicians are asked to consider early warning scores.

Serious Incidents (SIs) -Some of the ICS main providers have overdue SIs and Locality teams continue to work with providers to address the backlog; progress continues to be made. **Below table highlights reductions in SI backlogs for key providers** ;

Overdue SIs July 2022		Overdue SIs November 2022
ENH	95	37
PAH	18	14
WHTH	38	15
Herts Partnership Foundation Trust	95	33

Patient Safety - Key Themes and Actions Arising

Provider/s	Summary Description	Mitigating Actions and Timelines	Next Steps
Urgent and Emergency Care (UEC) for key acute services across Herts and West Essex (HWE)	• Continued high demand for UEC across key acute providers alongside workforce pressures due to sickness absence and vacancy factors. Business Continuity impacts continue to be felt due to these pressures resulting in flow being impeded and impacting patient experience and safety. Patients are required to be treated according to clinical prioritisation.	• Clinical prioritisation and harm reviews remain in place • Each acute provider has its own internal Urgent Care improvement plan including a critical focus on mental health support • Ongoing triangulation of patient safety and experience information to identify specific themes for concern and take needed actions • Safe staffing levels focus in place – and all patients are assessed by senior decision makers on arrival and treatment commenced if handovers are delayed.	Escalations and assurances provided via Joint Quality and Performance Assurance Meetings related to clinical harm and patient experience. Daily escalation calls in place between ICB and trusts to understand pressures and take needed actions including system wide.
Princess Alexandra Hospital Trust (PAHT)	**PAHT Review Lists** • Large numbers of out-patients waiting on Review lists. Specific concerns relate to those lists for patients who were recorded as needing a review appointment within 1 months but have been waiting 12 months or more. • Reasons for delays are varied including the following: ▪ Patients requiring Long term follow-up ▪ Patients seen (Data Quality issues) ▪ Patients on a live Referral To Treatment (RTT) pathway ▪ Patients waiting for a diagnostic test ▪ Patients who should be on the review list	• Trajectory to reduce backlog, and data cleanse the review lists, and sharing of associated internal risk assessments. • Quality and Contracts teams attending Trusts system access Board to review status of all waiting and review lists, status of harm reviews and actions associated. • Discussion and monitoring via the monthly ICB Quality and Performance meeting with the Trust • . An options appraisal paper is in progress. NHSE leads have been updated and progress/updates will be monitored at the ICB Trust Quality Review Meetings.	PAH are carrying c10% more outpatients - face to face and non-face to face than in 2019) which is having a real impact. A “within 6 weeks” list. Trust has now added patients that need to be seen in less than 6 weeks to the Review List
East and North Herts Trust (ENHT)	**ENHT - Ophthalmology** • Issues related to diabetic eye screening, cluster of Ophthalmology incidents, and overdue follow-ups. There are currently 21,000 patients needing follow-up appointment and 12,000 overdue	• Ophthalmology Recovery Group(ORG) meeting following cluster of incidents. ORG are looking at the pathway/gaps to assess how to support quality of care and manage risks. ORG to develop a communication plan/letter to contact follow-up patients. • Risk register includes risk related to patients on Hydroxychloroquine (HCQ) due to no screening service. Royal College of Ophthalmology recommends screening for all HCQ patients annually who have taken the medication for 5 years or more.	•Diabetic Eye Screening- discussions underway to reduce current surveillance eye screening backlog, due to concerns raised from NHSE about patients needing to be re-referred into NHSE commissioned Diabetic Eye Screening programme.

Summary description	Next Steps and ongoing monitoring
Falls	
West Herts Teachings Hospital Trust (WHTHT) - Total falls with harm In September 2022 was 11 . This has risen in October 2022 to 19. Overall a downward trend since April 2022.	• Focus on reducing falls through harm free care stewardship programme. Weekly monitoring of data allows for early signs of concern to be identified and rapid intervention from the fall's prevention team. • Oversight of harm free care data continues to be discussed at monthly Joint Quality and Performance Assurance Meeting
East and North Herts Trust (ENHT) - Rate of patient falls per 1,000 for overnight stays was 4.3 (November 2022). There were no falls with serious harm incident recorded for the month of November 2022.	• Inpatient falls data continues to show common cause variation. • Trust falls training will be amended early next year to reflect falls documentation digitisation. Training to medical staff were provided in November. Positive feedback on completed QI projects was received, which reflects good outcome.
Princess Alexandra Hospital NHS Trust (PAHT) –Rate of inpatient falls per 1,000 for overnight stays was 7.67 (October 2022)	• Inpatient falls data shows common cause variation and hist and miss target subject to random variation. • Strategic falls action plan is in place. The Enhanced Care programme is being embedded across the Trust 3. Falls awareness training is mandatory for all staff and current compliance is 86%4. The STOPIT initiative is being rolled out across the Trust ((initiative to de-prescribe culprit medications)
Hospital Acquired Pressure Ulcers (HAPU) **WHTHT –** Total of HAPU (category 2 and above **)** continues to show an overall downward trend since April 2022 reducing to 11 in September 2022 although and increase to 19 in October 2022.	• Real-time basis monitoring to assist providing targeted HAPU support. • Ward based training to support correct categorisation and timely intervention and continued use of Pando app to capture skin condition on admission. Expansion of the Tissue Viability Nurse team which has enabled the review of all category 2 HAPUs.
ENHT -Total of 13 Pressure Ulcers (category 2 and above) reported in November 2022 compared to 32 reported in October 2022. Themes for November include equipment provisions, device care or currently awaiting Root Cause Analysis.	• Completion of digital waterlow assessment within 6 hours of admission is improvement priority. Lack of skin inspection and repositioning are main themes of learning reviews. Tissue Viability Nurse (TVN) to work on improving skin inspection and repositioning regimes following digitisation. • TVN-related assessments and care plans now live in Nerve Centre and across all adult inpatient areas. TVN auditing staff knowledge of pressure ulcer prevention, focusing on wards with highest number and then expanding to other areas.
PAHT – Data shows a rate of 5.01 HAPU per 1000 bed days There were a total of 66 pressure ulcers in October, 15 more than September. Of those 66 PUs, there were a total of 48 patients injured, meaning 10 patients sustained more than one pressure ulcer during admission, the higher being one patient with 6 pressure ulcers (COVID pneumonitis patient due to prolonged hours of proning).	• Common cause variation while hit & missing the target • Tissue Viability Nurses have now introduced tissue viability link practitioners across the Trust. Trust has trained 42 staff. Link practitioners are starting to develop projects in their area around pressure ulcer prevention. All pressure ulcer prevention resources are available via Intranet, YouTube, ward folders & X drive.

Other Areas for Noting - Quality Assurance Update

Summary description	Next Steps and ongoing monitoring
Venous Thromboembolism (VTE) **West Herts Teachings Hospital Trust (WHTHT)** - VTE performance just below target in Sept 2022 at 94.4% although improved to achieve compliance in October 2022 at 96.5%.	• Ongoing focussed awareness and training sessions for staff, mandatory training for doctors and nurses • Introduction of VTE prevention specialist nurse role. • Harm Free Care stewardship programme in place.
East and North Herts Trust (ENHT) – For November 2022 VTE initial assessment was 62.3% and for stage 2, 3 and/or 4 was 43.2% against a target of 85%.	• ePMA rolled out across all adult in-patient medical and surgical wards during March 2022. From April 2022 data demonstrates full impact of the roll out on VTE risk assessments and prescribing. • New Nerve Centre VTE risk assessment to be trialled then rolled out start of 2023. • Consultant for VTE in Planned Care. • Continue regular clinical engagement to share VTE data, improvement work and learning from HATs. • Continue to monitor training figures for VTE standards and report the results at Thrombosis Action Group. Continue to improve patient engagement and review VTE patient information during admission and on discharge
Princess Alexandra Hospital Trust (PAHT) –Princess Alexandra Hospital Trust (PAHT) –1 validated hospital acquired VTE has been reported April – September 2022 (minor harm), compared with 2 reported for the same time period in 2021 (1 no harm, 1 minor harm). The no harm was attributed to a patient who had acquired a VTE within 90 days of discharge,	• Ongoing awareness and training for staff. Validation process to scrutinise all potential reported VTE's. • VTE is one of the Trust key priorities within its Safety Strategy published in 2022. -= Provide excellent care and Prevention in order to reduce harm

Patient Safety - Key Themes and Actions Arising

Provider	Discharge Summaries	Mitigating actions and timelines	Next steps
E&NHT	• During October 2022 an update was provided to the ICB highlighting that there were 2,800 discharge summaries outstanding, predominantly in the emergency assessment services across the Trust (Surgical Assessment Unit, Clinical Decision Unit and Children's Assessment Unit). • The Trust have 2,695 outstanding discharge summaries (as of 16th November). The majority of outstanding summaries are in Children's Assessment Unit (CAU) (1,642 on 16th November).	• Daily report available to clinicians to review the outstanding summaries and to action. • Creation of common encounter templates within Lorenzo patient administration system.. • The operational team are creating template discharge summaries to ensure vital information is covered. • The teams are also leading discussions with data quality to ensure misallocations are minimised • Clinical and Medical Directors are leading communication and training for doctors • Service co-ordinator has been assigned to look at the process. Focus is organising current backlog, signposting doctors to the right encounters, supporting ward clerks and investigating missing summaries or notes. • Expansion of discharge summary completion to specialist teams, such as nursing, and training to accompany this roll out.	Escalated to Trust Executive Committee. Progress monitored at ICB Trust Quality Meeting Assurance requested regarding any potential identified harm as well as escalations. The Trust has been asked to provide a trajectory, including an estimated date of completion for all outstanding summaries to be issued.
WHTHT	• In Nov 2022 Integrated Care Board (ICB)were informed by Primary Care of missing discharge summaries from WHTHT which have caused significant issues in primary care I.e.. made it very difficult to manage individuals ongoing care and in particular cases included end life care, and that compromises clinicians from having needed conversations with the patient and their families	Review of Datix and complaints undertaken using details provided for individual patient cases. From initial investigation there seem to be 3 potential points of failure: **Human Factors -** letters not being produced or actioned by clinical/ward teams. **Infrastructure (internal) -**letters not progressing from the IT software ,or not progressing past the "syntek" system. Health information exchange should work as a failsafe, whereby , letters will automatically be shared with General Practitioners (GPs) even if the 2 previous systems failed. **Infrastructure (external) -**The receiver (the GP surgeries) may have a system issue on letter receipt from WHTH . Further meeting with ICB held on 01/12/2022 with further actions agreed. ICB Patient experience team confirmed no other concerns raised via ICB complaints and Quality Review System (QRS) database.	Task and finish group set up. Key actions include establish length of historic review of patients discharged previously wit hout discharge letters), harm review and DOC agreements to be defined subsequently. Bespoke/targeted education resources for staff producing discharge summaries . WHTH/ICB review Jan 23 to review progress, identify further actions needed.

Summary description Essex Partnership University Trust (EPUT)

Essex Partnership University Foundation Trust

The CQC undertook unannounced targeted inspections on 6th –7th October and further announced inspections of core services across Essex on 22-24 November 2022.

The inspection identified concerns against several high-level themes as set out below:

- Incident Reporting
- Staff sleeping on duty
- Sexual safety concerns
- Racial abuse of staff
- Lack of boundaries
- Restrictive Practices
- Management of Patients in crisis
- Medication management

The Trust was issued with a Section 31 Possible Urgent Enforcement Action letter (25/11/2022), but have provided the CQC with sufficient immediate assurance to address those areas of concern (this information has been shared with the Essex ICB's)

Despite the redaction of the Section 31 it was agreed by system partners that a rapid Quality review meeting was required because of the level of concern and the themes that had been identified.

It was agreed that the Purpose of meeting was:

- To assure that the Trust develops an action plans addressing the issues identified by CQC and Despatches Programme, needs and expectations of all key stakeholders
- Maintain public confidence in the services that EPUT delivers, acknowledging that Partners have a duty to support EPUT to achieve this.
- To work collaboratively and proactively to achieve transparency, reliability and mutual confidence in service provision.
- Communicate the changes that EPUT and the System are committed to making.

Next steps and ongoing monitoring

A Rapid Quality Review meeting was held on 14th December with Executive Representation to review findings, gather perspectives of the partners and agree key actions. Those in attendance at the meeting included:

EPUT
Hertfordshire & West Essex ICB
Mid & South Essex ICB
Suffolk & North East Essex ICB
NHS England
Nursing & Midwifery Council
General Medical council
Southend, Essex and Thurrock Local authorities
Healthwatch Essex

The outcome of the meeting was the following agreed actions:

- Commencement of Weekly Safety Huddles with the 3 ICB Chief Nurses and EPUT Chief Nurse – 29th December 2022.
- Establishment of a 3 ICB Essex wide Quality and Oversight Group.
- Consideration of outcomes from the Well Led inspection taking place 17th-19th January 2023.
- The 3 ICB Chief Nurses, EPUT and NHSE to develop the action plan and Local Authority partners closely involved.
- Healthwatch support regarding service user experience and engagement.
- Prepare a joint comms statement.
- The CQC will be returning to complete a Well-Led inspection from 17-19 January 2023, and a whole system Safety Summit will be called once the final CQC report and findings have been shared. (not expected until end of Q4 2022/23)

Care Quality Commission (CQC) Summary Inspections Update

Summary description	Next steps and ongoing monitoring
West Hertfordshire Hospitals NHS Trust (WHTHT) - Maternity All CQC action plan 'must do' actions were completed in November 2022 with only one exception relating to nitrous oxide monitoring.	• The nitrous oxide testing phase demonstrates newly installed scavenger units maintain levels within safe limits. As part of ongoing monitoring compliance and assurance body monitors will be used for ongoing audits of safe limits. • If further action in response to nitrous oxide levels is identified, then the improvement plans and funding have been approved in advance. • WHTHT continue to risk assess and give choice to pregnant staff who can be redeployed if they choose.
Royal Free London Hospitals NHS Trust (RFL) - Maternity Following the August 2021 maternity Care Quality Commission (CQC) report an improvement plan was developed. This report rated RFLs maternity services as 'Requires Improvement'. All CQC actions for Barnet Hospital (BH) remain on track for completion within the target timelines. Actions completed in October 2022 include safe and secure handling of medicines, induction of agency staff, information for patients on discharge.	• RFL has developed a 5-year Maternity Strategy 2022-2027 following the CQC maternity action plan. Aimed at transformation of the maternity service, the strategy sets out six priorities including user involvement, equality of care and empowerment of workforce. • Quarterly oversight maternity focused assurance group in place - which incorporates CQC action plan oversight . Led by North Central London Integrated Care Board (NCL ICB) alongside Hertfordshire and West Essex Integrated Care Board (HWE ICB) input.
Princess Alexandra Hospital NHS Trust The Trust continues to provide monthly audit data to the CQC regarding the suite of audits within the Emergency Department required under the terms of the Section 31 Warning notice issued earlier in 2022. Trust has received external supportive visits from ICB Quality Team and a separate visit from regional external colleagues (at request of the Trust) to triangulate observational data with Audit findings. **CQC Inspection reports pending** • Hertfordshire Partnership University NHS Foundation Trust (HPFT)- Forest House • Cheshunt Minor Injury Unit (MIU) • East and North Hertfordshire Trust Maternity	• The Trust has written to the CQC to request review of the section 31 notice, this will trigger a review of data and visit to the department prior to any decision as to whether the S31 will be removed. Date for this is not yet known.

Assurance Report - Safeguarding Adults Update Q2

Summary description	Next steps and ongoing monitoring
West Essex - Safeguarding Adults Reviews (SARs), Domestic Homicide Reviews (DHRs) and any other Reviews . **Essex Safeguarding Adults Board (ESAB) published 6 SARs on 21st November 2022.** 5 common themes identified : • Challenges when working with individuals with Complex Needs • Improving Making Safeguarding Personal and hearing the voice of the adult at risk. • The importance of a shared approach to setting high standards in safeguarding practice and oversight from ESAB. • ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems. • Improving interagency communications between Health and Social Care.	Although none of the 6 published reports relate directly to West Essex resident it is anticipated that learning in relation to the themes identified will be Essex wide. The development and delivery of action plans that enable learning from these reviews will be monitored by ESAB and its multi-agency partners. The safeguarding Adult team will work with ESAB and the wider Essex health partn to support Providers response to the themes.
Hertfordshire - Safeguarding Adults Reviews (SARs), Domestic Homicide Reviews (DHRs) and any other Reviews. • There are 2 SARs in progress, 2 SAR reports awaiting agreement and 2 SARs that will commence in the new year. There are 6 DHRs in progress and 3 waiting to commence. • The launch of the Hertfordshire Domestic Abuse and Sexual Violence policy toolkit for GP practices to adapt and adopt is being planned for the new year.	• A SAR action plan that is underway identifies the need for closer partnership working with the Community Safety Partnership and when working with complex cases. A feasibility study will take place regarding the introduction the SafetyNet IT system across partners to facilitate information sharing. • Two primary care Domestic Abuse webinars were delivered by a subject matter expert in Oct and Nov with a focus on intrafamilial abuse in response share learning from Hertfordshire DHRs.
HWE ICB **Mental Capacity (Amendment) Act (2019)** • The timeline for the publishing of the Government response to the consultation remains 'winter 2022/23', it is anticipated that an indication of implementation date for Liberty Protection Safeguards (LPS) will be given at this time, it is envisaged that the date of implementation may be in 2024. • The HWEICB Executive LPS workshop was hosted by Chelle Farnan, Liberty Protection Safeguards Clinical Lead for the East of England. On 23rd December. Attendees were brought up to date with our progress towards LPS and the implications and challenges for the ICB. Recordings of Chelle's presentations and additional resources are available on the N&Q SharePoint.	• Work to ensure a strong foundation in the knowledge and use of the Mental Capacity Act (MCA) continues within the ICB and providers, with a particular focus on 16- and 17-year-olds. • The ICB LPS Operational Group will reconvene in the new year and ensure th Executive Team are kept informed. • The Safeguarding Team and relevant ICB colleagues are active members of t Hertfordshire and Essex local authority Liberty Protection Safeguards (LPS) Programme and Implementation Boards and the NHSE &I LPS Implementati Steering Group.

Assurance Report - Safeguarding Children Update Q2 Hertfordshire

Summary description	Next steps and ongoing monitoring
Hertfordshire Safeguarding Practice Review: A joint Safeguarding Adult Board and Safeguarding Children Partnership Review is under way. The case involves the death of an 18 year old. HPFT completed a serious incident report that will feed into the review.	Add HPFT learning from SI.
Hertfordshire is currently undertaking the mock Joint Targeted Area Inspection (JTAI) in anticipation of an inspection. The new scope will focus on how children are assessed at the front door. The re-organisation of the Front door (gateway) is being progressed in response to national reviews and the inspection framework.	The evaluation process is underway led by the Hertfordshire Safeguarding Children Partnership (HSCP) to inform preparedness for the full inspection. The ICB safeguarding team will continue to coordinate for commissioned services.
Children Looked After SEND & children with complex needs in residential care audit identified the need to strengthen the application of the principles of the mental capacity Act for 16–17-year-olds.	Work to ensure a strong foundation in the knowledge and use of the Mental Capacity Act (MCA) continues within the ICB and providers, with a particular focus on 16- and 17-year-olds.
Initial Health Assessments: there has been a significant increase in the number of children looked after since Q1: this is part due to the number of separated migrant children. Significant delays in completing statutory Review Health Assessments Due to the number of Looked After Children placed outside Hertfordshire County. The compliance rate for Statutory Initial Health Assessment is below 85% within the statutory timeframe. Delays are linked to late request from Social Care and the sharp influx of displaced Migrant Children	Work in partnership to monitor service provision for Separated Migrant Children across Hertfordshire. The commissioning strategy is to reduce the number of children placed outside County. The Designated nurses continue to work with local teams to promote reciprocal arrangements for children placed Out-of County. This is not always effective due to variation in local resources and priority
Fathers and Partners : partnership fundings has been agreed to implement Infant Crying and How to Cope (ICON) across Herefordshire to support parents of crying babies with advice.	To promote the Partnership implementation plan for Fathers and Partners with frontline services.
Impact of safeguarding training and lesson learnt from statutory Reviews: the safeguarding adult board and the safeguarding children partnership in collaboration with Hertfordshire University is undertaking evaluative research into the impact of training.	The ICB safeguarding team will support as the lead reference group for this work.
ENHT safeguarding capacity: high levels of long-term sickness within senior members of the safeguarding team.	Mitigation plans are in place to address identified risk.
The National Safeguarding Panel: published guidance for all local Panels to review current policies for bruising un <1yr. This has been completed in Herefordshire .	Ongoing training and auditing ensure compliance to procedures.

Assurance Report - Safeguarding Children Update Q2 West Essex

Summary description	Next steps and ongoing monitoring
West Essex Child Safeguarding Practice Review, Child S review is due to be published following criminal proceedings. It relates to the death 11-week-old in 2020. Summary of learning – assessing fathers/male carers, ensuring cultural competence, understanding impact of twins on parenting capacity, escalation of concerns and recognition of those concerns within the child protection process**.**	• All learning has been shared and actions are in progress. A multi-agency conference took place in December 2022 to explore how 'hidden' adults within the family can impact on safeguarding.
System challenges in meeting the needs of children and young people presenting with accumulative trauma. Challenges remain across the system to meet the specific needs of this cohort, services working together to make best use of current resource.	Escalation of individual cases Raise themes and challenges within the system at regional and national levels. An Essex multi-agency case audit has been requested to consider children with cumulative complexity and adversity who present a significant risk within the system.
Initial Health Assessments (IHA) Due to on-going paediatrician capacity and the significant rise in number of Separated Migrant Children placed in West Essex, IHAs are not completed within the statutory timeframes**.**	To undertake a scoping for a dedicated provision for Separated Migrant Children across Hertfordshire and Essex; pending roll out of a digital platform to track the timeframe for IHAs across Southend, Essex and Thurrock. Oversight of the challenges for timely IHA has been escalated at both regional and national levels.
Solihull Joint Targeted Area Inspection (JTAI) How assurance is sought with regards to the Essex Children and Families Hub front door and whether a different model including health representatives could be contemplated.	Further discussion is planned at the ESCB Board to consider different models of practice.
Performance Audit and Quality Assurance (PAQA) Sub-committee of the ESCB The structure and function of PAQA is being reviewed to gain assurance & evidence across the system that children and young people are being safeguarded in Essex.	A proposal is being presented to the ESCB Executive Committee to outline how health will actively participate in this process.
Impact of the cost-of-living crisis on vulnerable families is becoming more apparent.	The Essex-wide response has been coordinated within the Stay Safe forum and shared widely.

Assurance report : CAMHS

Summary description	Next steps and ongoing monitoring
Hertfordshire CAMHS Update. **Herts: Crisis presentations**: **C-CATT update** • C-CATT saw 156 referrals, many-at Watford General hospital with ongoing cases also needing review on the wards. C-CATT have continued to be flexible and aim to meet needs – additions of the twilight shifts have helped. • Parent group starting in new year in intervention **Liaison with acutes:** • Watford General Hospital have held a high level of cases, including longer stay with complexities. We have seen many positive shifts to tier 4 beds; however, some continue to await provision fitting their needs. • Lister – Relationship building ongoing re: staffing relationship and MH promotion for care – weekly drop in on site available for acute staffing, support from senior leads and exec in place. • Continues to be high levels of referrals, high complexities of cases – resulting in longer stay in care of acute hospital. **Eating Disorder** • CYP ED support continues to remain stable. • New Early help ED service has enabled improved demand and capacity.	• HPFT actions plans, supported by commissioners have successful reduced the community eating disorder waiting lists and improvements across C-CATT. This now needs careful monitoring to ensure recovery continues • Increasing capacity: C-CATT Saturday clinics are ongoing continue to offer 7 day follow ups at over 95% within 7 days This are very well received by both families and staff and are supporting recovery and stabilisation • The developing MH Paediatric liaison model is currently at recruitment stage, and continues to present recruitment challenges. In the interim C-CATT have been providing support to wards. • Crisis service(s) evaluation and closer working with HCT and HCC, joint assessment(s) and pathways – Monthly reviews – request in place for cases in terms of uptake, delay/good practice examples, yp outcomes in place above establishment to help raise concerns in process due to new pathways to help smooth any blips in practice across and within services. • Parent group starting in new year in intervention (delayed due to ensuring clear schedule in place and winter pressures support prioritised to children in crisis/follow ups). • Workforce continues to challenge across the who of the CAMHS system. The ongoing workforce steering group is working to look at new ways to recruit and ret
Essex CAMHS Update **Waiting lists** • There are a significant number of CYP waiting across the system. 75.69% of those waiting fall within 0-17 weeks and 34.31% have been waiting for 18+ weeks. • The numbers of 18+ week waiters are greater within the Mid and West hub where teams are experiencing significant staffing pressures. **Crisis Essex** • The Crisis service experienced 1 true breach in October 2022. This was due to capacity; multiple referrals were received at the same time from Mid and West Essex. . • North- East London Foundation Trust (NELFT) . Continues to meet assurance targets including being 1 of only 3 nationally to meet the eating disorder targets. There has been an Increase in the crisis team and eating disorder team and preventative smaller contracts are in place for complementary support. **Eating Disorder Service** • The eating disorders home treatment team are experiencing pressure due to requests for support of young people presenting with disordered eating and who do not meet criteria for intervention from the eating disorders team.	• Managers within the service are reviewing and monitoring progress weekly • North- East London Foundation Trust continue to work with in partnership with Health Care Resource Group (HCRG) who are managing the getting help (previously tier 2) referrals • Work is ongoing to define clear pathways for the management of these young people. • The eating disorder service are supporting wider organization's by offering consultations when required. • Monitoring of performance and quality is undertaken through monthly contract meetings.

Escalation report: Subject CAMHS Workforce

Subject	Key issue summary/Risk	Mitigating actions and timelines	Next steps and timelines

Workforce Herts	• Workforce retention and recruitment remains critical across our system and our greatest barrier to success.
	• Staff wellbeing is reported low, with staff shortages exacerbating an already stretched system
	• Demand in significant excess of supply
	,
		• Established a health and care Workforce Steering Group – operational/HR/Clinical
		• Address the situation as a system, to understand size and complexity
		• Working collaboratively to consider ways that will improve staff wellbeing, address staff shortages and recruitment challenges and enable improved staff retention
		• 'Working' action plan developing as steering group mature
		• Task and finish groups
		• Developing set of considered and 'future proofed' set of recommendations that will support improved workforce planning moving forward.
			• A health and care training academy
			  • Dedicated training and supervision resource to 'grow our own'. Conversations have began with University of Hertfordshire who may be able to support
			  • University of Hertfordshire has clinical training programme – 53 Clinical Associate Psychology students from Sept (rolling programme)
			• Rotational staffing
			• Small time limited task and finish group – need to work through barriers
			• Trainee contracts
			• Flexible working arrangements – extended hours?
			• Wellbeing support for staff, peer advocate.

Workforce Essex	• This remains the biggest risk to the system • There has been an increase in the vacancy rate across the service which is impacting on waiting times.	Agency and Bank staff are being recruited where possible to support the service. • NELFT have recently been successful in recruiting a new team manager and a clinical lead to the team. Wider posts are out to recruitment. • Staff are well supported by management who monitor staff wellbeing.	• Recruitment drives continue with the service proactively considering and implementing ways to attract new staff. • Use of agency staff continues to support the service.

Maternity Programme - Highlight Report

LMNS: Herts and West Essex | **Submission date: 1 December 2022**

Maternity Deliverables Overall RAG

Milestones	Due date	Current assessment
Capability and Capacity Framework: LMNS progressing action plans against domains and ensuring direct reporting line to ICB	30 March 23	
Workforce:		
Each provider is submitting their workforce plan every six months to board.	30 Apr 23	
Maternity units workforce data submissions are correct on PWR. ESR data cleansing.	31 Jan 23	
Ensuring that each provider completes an assessment of their obstetric staffing using the RCOG workforce tool.	31 Dec 22	
Developing plans, approved by the LMNS to implement a training programme to upskill MSWs in line with HEE's Competency, Education and Career Development Framework. ESR coded correctly as MSW's.	31 Dec 22	
Training programme in place to progress band 2 to band 3's. Band 3's make up a minimum 10:90 (MSW to Midwife) ration in-line with Birth Rate Plus recommendations.	28 Feb 23	
Implement the Core Competency Framework, ensuring all maternity staff receive MDT training in line with the Framework. Assure funding allocated to each provider from 21/22 for MDT training is being used for that purpose.	28 Feb 23	
Transformation:		
LMNS progressing actions set out in equity strategy with working group in place including MVPs and other stakeholders.	30 Dec 22	
LMNS progressing MCoC implementation (where safe staffing levels allow) with support from Regional Implementation Leads	30 Dec 22	
MMN: All LMNS actively engaged with CUH and NNUH which will strengthen clinical referral pathways and ensure women and birthing person receives the right care at the right time	30 Dec 22	
LMNS' supporting Digital Midwives in progressing the key actions set out in the digital strategy	30 Dec 22	
Safety:		
Following the 'Ockenden Assurance Visits' feedback, the LMNS monitors and has oversight of the maternity service action plan with trajectory's to achieve full compliance, with the Ockenden &IEA's.	28 Feb 23	
The LMNS supports the implementation of SBLCBv2 in order to achieve CNST MIS safety action 6 and Ockenden	31 Jan 23	
LMNS progressing implementation of NHS Smoke free pregnancy pathways and delivery plans to ensure availability of 46% of maternal smokers by March 2023	30 Mar 23	
Have oversight of the initial benchmarking against East Kent prior to the national launch of the single delivery plan	28 Feb 23	

Milestone key	
Complete	The Milestone has been completed within specified timeframe – No support is required
On Track	The Milestone is currently on track to completed within specified timeframe – No support is required
At Risk	The Milestone is currently at risk of not being completed within specified timeframe – Some support is required
Will not be met	The Milestone will currently not be completed within specified timeframe – Support is required

Maternity

Key activities this reporting period (high level bullet points)	Key activities next reporting period
1. Equity: Development of a reporting system and co ordination of workstream meetings to roll out implementation of the plan	1. Meeting arranged to receive Regional feedback on plan. Arrange listening events within the community.
2. Neonatal: Pulse Oximetry meeting across the System to support shared resources. Parents survey is now live. On-going reviews of RPB cases. Data and repatriation workstream reviews to be shared. Roll out of normothermia care bundle.	2. On going repatriation QIP and normothermia care bundle. First review of parents survey. Q4 CY assurance dashboard prep.
3. Visits to Community teams with resources and information ongoing. New Pelvic Health Physio is now in place at ENHT and both WHTHT and ENHT have successfully recruited to the Band 3 role. Band 3 and Band 8 role out to advert at PAHT.	3. Finalise recruitment into all roles. Developed Pathway/guideline to go to LMNSPB Jan 23 for ratification
4. The LMNS and all 3 organisations compliant with CNST SA2 with maternity digital strategies signed off through LMNS and Trust boards. CNST Scorecard for July released. HWE have met all criteria for MSDS for the first time since October 2021. EoE Digital Midwives Expert Reference Group met for their 2nd away day and compiled a list of key actions, that will inform the LMNS digital leads programme of work across the region.	4. SMART action plan to be developed and HWE LMNS digital maternity reporting criteria to be set.
5. Postnatal Improvement: Plan has been reviewed in light of East Kent report and adjustments made to reflect current situation. LMNS Infant Strategy has been developed with all key stakeholders. Refreshed approach to MW/HV joint working as lack of engagement due to staffing pressures continues.	5. LMNS developed Infant feeding strategy to be agreed through LMNSPB. Ensure postnatal plan reflects PNMH ambitions
6.Health Scrutiny: Reviewed and accepted the recommendations from the reducing inequalities health scrutiny report. The health scrutiny focusing on the Ockenden report took place on the 12th October with a follow up in 12 months	6. Continuation of work on recommendations in collaboration with ICB and wider partners.

Challenges, learning & good news

Challenges: Workforce across all areas remains challenging, workshop planned for New Year with support from ICB workforce leads. Appropriate estates for community teams continues to be a priority and a challenge with restricted community venues available.

Learning: The Human Rights and Consent training being provided by Birth rights has completed with good engagement

Good News: Two new co-chairs appointed for Lister MVP. All neonatal units celebrated *World Prematurity Day* in Nov.

Children Young People Q2 Update

Summary description	Next steps and ongoing monitoring
Autism Spectrum Disorder (ASD) Diagnosis Waits Demand continues to be significantly high, impacting further on waiting times (Oct22 – 52 new referrals, 1436 on waiting list, average waits 105wks). An action plan is being delivered, including outsourcing additional capacity, recruiting additional capacity in house, and the addition of medical information from the GP in the referral process.	• Monitoring impact of action plan. • Additional Community Paediatricians to onboard in January, and April. • Deep dive review of wider community paediatric pressures to be presented to the ICB.
Strep A Significant increases in demand within primary care, 111 and Accident and Emergency (A&E). Many parents seeking assurance. National communications for professionals and public remain ongoing. Primary care hubs in all three places are being mobilised with initial activity diverted from 111 and A+E. Clinical pathway has been developed for the primary care hubs and shared with relevant stakeholders. Patient information has been updated on the healthier together website.	Further scoping of the number of additional Herts children discharged to West Essex CCN pathway with the intention of providing a catchment service to the Trust.
ADHD diagnostic pathway South and West Herts have started mobilising and anticipated to go live in quarter one in 2023. Enhanced primary care team recruitment is going well, expected to be able to pass on cases from January.	• Recruitment underway.
Community Paediatrics Increased demand in Herts, ENHT demand for community paediatrics is above capacity, leading to long waiting times. Additional investment & transformation will be required to deliver service and stop ongoing increase in waiting times.	• Business case underway by ENHT and ongoing monitoring.
PAHT Discharge Pathway An improved and streamlined pathway of referral from PAHT paediatrics to Children's Community Nursing (CCN) went live on 14Nov for West Essex CYP. Some teething problems being addressed, however referrals to CCN have significantly increased in support of children being discharged home.	• Ongoing monitoring, communications with professionals, partners and public. • System working around establishing potential hub.

Care Homes

Subject	Key issue summary	Next Steps and ongoing monitoring
West Essex	3 care homes currently suspended to admissions by Essex County Council (ECC) Particular concern re Alder House. Significant support over 6 months but risks remain. CQC re-visited but warning notices to remain in place. Covid outbreaks in care homes currently low but further peak is predicted. Some influenza cases seen-again escalation is expected. Recruitment difficulties in care homes meaning high use of agency staff which is a factor in quality/safeguarding concerns. Overseas recruitment has increased but inadequate support/training leading to additional challenges.	Escalation to Leonard Cheshire senior team due to the systemic nature of the concerns. Organisational change needed to support home managers. Ongoing monitoring/support co-ordinated by ECC. Contact Tracing continue to monitor covid outbreaks. IPC advice and support offered to individual homes as required. System partners continue to work with individual homes to improve standards. ECC working on a winter funding package for providers and additional support around overseas recruitment .
Hertfordshire	95 avoidable admissions (Total 399) Main themes were falls, UTIs, constipation and catheter issues. The Hertfordshire Admission Avoidance Response Car (HAARC) and other admission avoidance services were well utilised. 5 services currently in Quality Assurance Monitoring/Serious Improvement Process stages 1 and 2 homes in Multidisciplinary Management Meetings (MDMM) Themes and trends identified: • Management /leadership oversight • Documentation • Care planning • Governance • Staff culture Larger outbreaks in care homes continue to be discussed through the outbreak cell. 2 X Band 6 Care Home Improvement Team (CHIT) posts remain vacant. 2 CHIT band 6 nurses continue to support homes and prioritise training, with support from the whole team. Non contracted activity (NCA) -3 delays in October and 4 in November. Themes identified: • Complex difficult to place patients-non neuro high-cost placement • Complex prisoner status no clear discharge pathway • Complex mental health needs –Enhanced monitoring 18 hours a day • Disputed negative Decision Support Tool triggering a Decision-making panel.	Training, support and analysis is undertaken with the care homes by the CHIT nurses, with referral to Herts Care Providers Association (HCPA) for further in-depth accredited training; particularly for falls. The Primary Care Link Nurse works with Primary care networks to identify areas of support needed to reduce avoidable admissions. For homes in the safety improvement process, the CHIT team support with advice, training and increased visits. Strategic management meetings led by Herts County Council (HCC)occur bi- monthly to ensure assurance, improvement and sustainability. CHIT team continue to provide IPC training and support to all homes to promote the welfare of staff and residents. Delays escalated to ICB commissioners as identified and discussed at fortnightly NCA meetings with the NCA nurse and commissioners. Extension requests for each delay are submitted to the executive team for scrutiny, review and funding extension authorisation.

Assurance Report – Primary Care Update

Summary description	Next steps and ongoing monitoring
Care Quality Commission (CQC) Ratings for General Practitioner (GP) Practices in Hertfordshire and West Essex – Minimal change to overall CQC status – the dashboard will be reported 6 monthly to report trends. • **Grovehill Medical Centre (Hemel Hempstead)** was recently inspected by the CQC.	• The outcome of this inspection is awaited .
Practice rated Inadequate- Lister Medical Centre, Harlow, West Essex CQC report published June 2022 – practice rated as inadequate overall and in 4 domains (Safe, Effective, Responsive & Well-led), placed in special measures and 3 warning notices received. The practice will be re-inspected by the CQC in January 2023.	• Integrated Care Board (ICB) contract/ quality visits carried out by ICB on 3rd October 22 and revisited on 28th November 2022 when significant progress was seen . • ICB Summit meetings followed each visit where next steps were agreed- continue to monitor/ support & hold formal review meetings fortnightly. Monitoring arrangements will be reviewed following the CQC re-inspection in January 2023.
Practices rated Requires Improvement - East and North Herts • **Garden City Practice's** report has recently been published, with the practice being rated as 'Requires Improvement' overall and in 3 domains – safe, effective and well-led. A breach notice was issued, and the practice is required to develop an action plan in relation to this. • **Buntingford Medical Centre** was rated by CQC as 'Requires Improvement' overall and in the 3 domains that were reviewed – safe, effective and well-led. Breach notices were issued. The practice has completed their actions and is awaiting reinspection during 2023. • **Stockwell Lodge Medical Centre** is awaiting reinspection.	• Quality and Contracts Teams to monitor progress against action plans and provide support as required. • The Practice has completed their actions, and is awaiting reinspection by the CQC during 2023 • All actions are complete and the ICB Continues to monitor and support.
Whistleblowing concerns raised to the ICB and currently being managed: • **Hatfield Road Surgery (South and West Herts)**– Limited assurance to the Primary Care team. Further actions, monitoring and support taking place	• HWE ICB guidance approved on actions to take when the ICB receives concerns from General Practice employees/contractors to ensure consistency in process • Contract/quality visits to ensure practices have in place a process to enable staff to raise concerns

Assurance Report – Infection Prevention and Control (IPC) Update

Summary description

Healthcare Associated Infection (HCAI) - Data to end of Oct only. November data not yet available from UK Health Security Agency (UKHSA.)

C. difficile (CDI): CDI rates continue to increase, by the end of October, the overall number of cases was above the ceiling within the Integrated Care Board (ICB). However, the rates of infection were below that for East of England (EoE).

East and North Herts Hospital Trust (ENHT) has the 3rd highest rate of infection across acute trusts in the region.

MRSA Blood stream infection (BSI): No new cases since last report. Learning identified through joint case reviews has included device management (urinary catheter / IV access), and MRSA screening etc. This reflects the national picture.

MSSA Blood Stream Infection (BSI): Although the number of cases is higher this year within the ICB, ENHHT and West Herts Teaching Hospital Trust (WHTHT), the rates of infection are lower than EoE for the ICB but higher for the two Trusts above. Princess Alexandra Trust (PAHT) has reported a reduced number of cases, and has one of the lowest rates of infection within the region

E coli Blood Stream infection (BSI): Although the objectives for the ICB and the Trusts have been exceeded, the infection rate is below that of EoE. Only PAHT and WHTHT were above regional rate.

Klebsiella Sp Blood Stream Infection (BSI): The mixed picture continues and there has been an increase in cases compared to 21/22. and are above their ceilings. All are near or slightly below regional rate.

Pseudomonas aeruginosa Blood Stream Infection (BSI): At the end of October, the ICB and the acute trusts have reported a lower number of cases than last year and are all below their ceilings. All had a rate of infection below the regional rate

Incidents and Outbreaks - COVID 19

The number of reported outbreaks and clusters has decreased for the period from October – 8th Dec 2022. In total, 44 new outbreaks relating to Covid 19 were reported and investigated which is a decrease of 20 from the previous quarter (July – Sept 2022).

Norovirus: 1 Norovirus outbreak and 2 clusters were reported at WHTHT.

All IPC preventative measures were implemented.

Period of Increase in incidence – Gram negative organisms: WHTHT reported an increase in Gram negative organisms in ITU which identified likely transmission as the genetic typing had highlighted the same profile. An action plan was developed, and the progress monitored.

Methicillin-Resistant Staphylococcus Aureus (MRSA): 2 separate outbreaks of MRSA colonisations have been reported in the Neonatal Intensive Care Unit (NICU) at ENHHT. The first outbreak involved 6 babies who had the same profile. An action plan was developed and implemented. All babies were well and were all discharged home. Following a 5-week gap, a second MRSA colonisation outbreak on the unit was reported. This involved a further 4 babies who had the same typing. ENHHT established an action plan which continues.

Strep A: Notifications of Group A streptococcal infections, including scarlet fever, invasive infections (iGAS) and severe pulmonary infections are higher than normal in England and causing significant public concern.

Next steps and ongoing monitoring

PAHT, ENHHT and WHTHT have all developed action plans to address CDI. Progress is monitored via the trust IPC committees and strategic ICS IPC group. The PAHT focus is primarily in relation to antimicrobial stewardship (PAHT has been an antibiotic prescribing outlier in region). The WHTHT action plan focusses on the general environment and shortage of isolation facilities, and the ENHHT plan on improving cleaning standards (also included on risk register).

The ICB IPC Team has drafted terms of reference to establish place level HCAI oversight groups where ICS data will be reviewed, peer case reviews undertaken and learning from case reviews better collated and shared across organisational boundaries. The process for collection of data in relation to community cases has also been reviewed. Sign off is awaited from key stakeholders prior to implementation.

To address healthcare associated blood stream infections (including MSSA BSI), the 3 acute trusts are currently jointly implementing an IV access project, designed to improve IV cannula insertion, after care, and prompt removal, as well as staff training in relation to IV access. PAHT also has a working group focussing on MSSA BSI reduction. This reports to the trust IPC Committee which is attended by the ICB.

Meetings are also booked for this month within the ICB and county councils to discuss improved triangulation of HCAI and general quality data in relation to care homes.

Re-establishment of the Urinary Tract Infection workstream is underway to address Gram negative BSIs, with appropriate membership currently being established

Incident Management Team (IMT) meetings continue to be implemented on a regular basis. Advice and support is provided at these meetings.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**27/01/2023**	
Report Title:	**HWE Quality Dashboard**				**Agenda Item:**	**11.1**	
Report Author(s):	Kate Chand, Interim Associate Programme Director, Nursing and Quality, HWE ICB						
Report Signed off by:	Jane Kinniburgh, Director of Nursing and Quality HWE ICB						
Purpose:	**Approval**	☒	**Decision**	☐	**Discussion**	☐	**Information** ☐
Report History:	Presented to the HWE Quality Committee on 12/01/2023						
Executive Summary:	• NHS England/Improvement (NHSE/I) have requested that Integrated Care Systems (ICS) develop a Quality Dashboard to bring together a range of quality metrics from across commissioned services. • HWE ICB is presenting the first draft of the Quality Dashboard to the January 2023 Board to demonstrate the progress made in the development of the document and to review the quality position against a number of metrics and organisations. • It is noted this is an iterative process. Feedback from the Quality Committee has been provided and now feedback from Board is also requested regarding both the draft Quality Dashboard and the proposed next steps to continue its development, specifically relating to the identification of metrics for social care.						
Recommendations:	To provide feedback on the first draft of the Quality Dashboard and to agree the proposed next steps.						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			
	N/A						

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☐
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☒

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Quality Dashboard

1) Introduction

The purpose of this report is to provide the January 2023 Quality Committee with an update of the progress made to the development of the Hertfordshire and West Essex Integrated Care System Quality Dashboard. The information laid out in this paper builds on the details previously shared with the November 2022 Committee.

The Committee will recall that an options paper was previously presented, and a decision was made that Option D was the preferred way forward. Option D set out that:

A local Quality Dashboard is provided to the Quality Committee setting out a reduced number of metrics (no more than 30-40) which are identified based on known areas of risk... the Quality Dashboard is presented to the Quality Committee and can also be shared with System Quality Group.

…an accompanying programme of Deep Dives or Focus Areas to occur at Quality Committee where the relevant metrics and other sources of quality intelligence is provided to build a complete picture of quality within a workstream or service.

This paper is to be read alongside the first draft of the Quality Dashboard and also the initial programme of suggested Deep Dives/Focus Areas. To ensure a joined-up process, the existing 'suggestion log' developed for the Quality Committee has been referred to and built on to complement the topics covered within both the Quality Dashboard and the Quality Report.

It is important to note that the development of the Quality Dashboard is an iterative process to continuously improve, testing and tweaking the format and content with the goal of getting closer to the final product. The progress that has occurred to date has been helpful to identify opportunities to build this document.

Overall, it has been clear that to develop an effective dashboard a whole system approach is required to collectively agree which metrics to measure and report on.

2) Metrics

To start the process of identifying the metrics to be covered within the first draft of the Quality Dashboard consideration was given to a number of existing documents, such as the Hertfordshire and West Essex Integrated Care System Nursing and Quality Risk Register, local quality requirements within contracts and also the metrics set out within the NHS Oversight Framework.

The NHS Oversight Framework provides data on several areas which are already a focus for the Hertfordshire and West Essex Integrated Care Board such as staffing, mortality, maternity and children's health, mental health, infection prevention and control as well as Care Quality Commission ratings. Further information regarding the NHS Oversight Framework can be found via the following link https://www.england.nhs.uk/publication/nhs-oversight-framework-22-23/ There is a NHS Oversight Framework national dashboard where all the data is collected and also allows for local and national benchmarking to occur.

For the first draft of the Quality Dashboard the following topics have been covered:

- Care Quality Commission ratings for all key system partners
- Summary Hospital level Mortality Indicator
- Infection Prevention and Control
- Learning Disabilities
- Mental Health, and
- Our People

3) Format

The format used replicates the format used for the Hertfordshire and West Essex Integrated Care Board's Performance Report. This is a report that sets out statistical process control (SPC) graphs (which is the preferred way to report performance data) and also provides short and concise supporting information setting out what the charts say, the issues and what action is being taken. There is also an indication within the Quality Dashboard on whether the quality performance is linked to the Nursing and Quality risk register.

Although statistical process control graphs are the preferred way to present data it is not always the easiest way to interpret data. Therefore the Quality Dashboard has laid out information in a number of different ways for the Committee. This is an element that will continue to be explored.

4) Challenges and opportunities

As previously referred to there have been several challenges encountered when developing this first draft of the Quality Dashboard. Below sets out some of those challenges:

- For the purpose of a dashboard adequately measuring the patient experience across the system has been difficult. Counting the number of formal complaints is not effective or meaningful. Therefore, for the first draft there are not any patient experience measures.
- System partners are measuring elements of quality differently and therefore it is difficult to present a consistent and accurate picture as the data is not always 'like for like.' For example the measurement of falls with harm and the number of hospital acquired pressure ulcers is reported slightly different across organisations.
- There is a lack of consistently measured quality metrics in areas such as primary care, mental health and community care. Each system partner has their own effective metrics however there is a lack of commonality across the system.
- Some of the data collected from the NHS Oversight Framework did not provide the level of information expected or required.
- Adequately measuring the quality impact on patients with a protected characteristic and measuring equality and health inequality.
- Not wanting to duplicate information that is covered within the Quality Report – instead the intention of the Quality Dashboard is to complement the Quality Report.
- The Nursing and Quality Team does not have an in-house data analyst to support this piece of work. Therefore access to Business Intelligence was based on their availability and capacity.

It is also acknowledged that due to the time lag in the national reporting it is not possible to report real time and validated data within the Dashboard. The narrative within the first draft of the Quality Dashboard will provide the most up to date position where possible. The most recent information will also be provided verbally at the Committee, if possible.

5) Next Steps

As previously outlined the development of the Quality Dashboard is an iterative process. The Committee is asked to approve the following next steps to be taken to continue building the Dashboard's document:

- To establish a series of Task and Finish Groups to work with colleagues from across the Integrated Care System, including the two social care organisations, acute trusts, primary care, community trusts and mental health trusts to identify a range of effective quality metrics which can be measured and reported against.
- To collectively explore how to equally be able to measure metrics across the three domains of quality; patient experience, patient safety and clinical effectiveness.
- To consider how best to benchmark performance.
- To ensure that equality and diversity is considered and built into the development of metrics.
- To consider the impact of the Care Quality Commission System Oversight Reviews and how the metrics could align and be included within the Quality Dashboard.
- To consider how the Quality Dashboard complements the Quality Report to ensure effective and streamlined reporting and to reduce duplication.
- To continue with the development of the suggested Deep Dives/Focus areas in line with the development of the Quality Dashboard.
- To continue to ensure any learning and sharing of ideas occurs with the regional NHS England Team who are keen to also develop a Quality Dashboard (to date no timeline has been shared regarding this).
- To keep the Quality Committee updated with the progress of the development of the Quality Dashboard will be presented in March 2023.

6) The Committee is asked to:

- Review the initial draft of the Quality Dashboard, including format and content and provide feedback.
- Provide feedback on the proposed programme of suggested topics for Deep Dives.
- Provide feedback on the proposed next steps.

A further update will be provided in March 2023.

Hertfordshire and West Essex Integrated Care System Quality Dashboard January 2023

Hertfordshire and West Essex Integrated Care System

Essex County Council

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Hertfordshire and West Essex Integrated Care System

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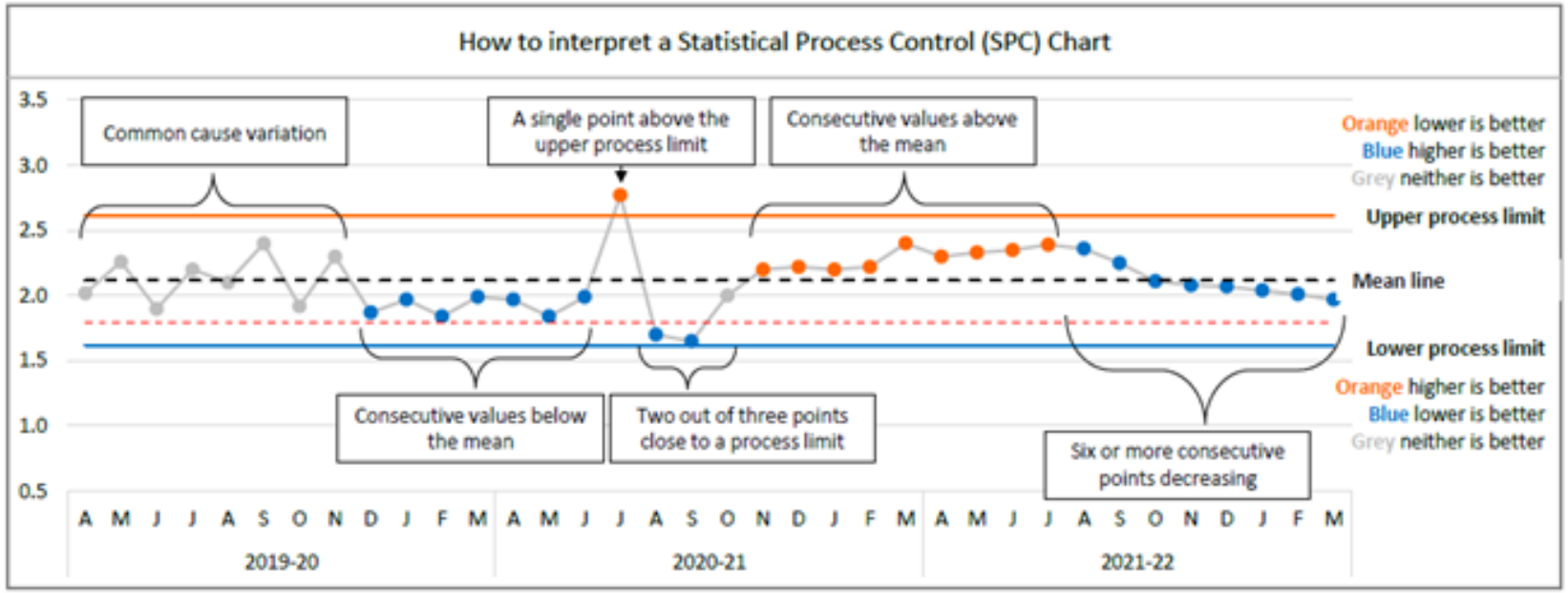
Executive Summary

Topic/Area	Headline	Slide Number
Care Quality Commission 	All acute trusts across the Integrated Care System have been rated as Requires Improvement and the East of England Ambulance Trust has been placed in the Recovery Support Programme	Slide 6
Summary Hospital - level Mortality Indicator 	All acute trusts across the Integrated Care System all within the 'lower than expected' banding or 'as expected banding'	Slide 7
Infection Prevention and Control - Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia - Clostridium difficile - E. coli bloodstream 	Overall the picture in Hertfordshire and West Essex is broadly in line with the wider East and England region Rates of Methicillin-resistant Staphylococcus aureus remain low Rates of Clostridium difficile are increasing both in hospital and in the community Rates of E. coli have exceeded the acute trust rates. To date in 22/23 70% of cases are community associated	Slides 8-12
Learning Disability 	The number of people aged 14 and over with a learning disability in receipt of an annual health check by their GP is currently not in line with trajectory.	Slide 13
Mental Health 	The number of people with a severe mental illness in receipt of an annual physical health check is under the target. Focussed work with primary care is occurring. The number of bed days for out of area placements is increasing although the number of beds has decreased. Collaborative work is occurring to increase performance.	Slide 14
Our People 	The number of healthcare staff leaving the NHS is out weighing the number of staff joining. Sickness absence is also high. This reflects the national position. A number of initiatives are in place across the system.	Slide 15

Statistical Process Control (SPC)

Not all charts within this Quality Dashboard are Statistical Process Control charts as there are a number of areas where this type of chart is inappropriate. However, for those that are Statistical Process Control charts the below provides some helpful information regarding how they are interpreted.



Variation	
H L	Special cause variation of concerning nature due to Higher or Lower values
H L	Special cause variation of improving nature due to Higher or Lower values
	Common cause variation No significant change

Assurance	
F	Consistent Failing of the target Upper / lower process limit is above / below target line
P	Consistent Passing of target Upper / lower process limit is above / below target line
?	Inconsistent passing and failing of the target

Hertfordshire and West Essex Integrated Care System

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Metrics Reported on within this Quality Dashboard

Overarching Quality

- Care Quality Commission ratings and position for Herts and West Essex Integrated Care Board

Patient Safety

- Summary Hospital - level Mortality Indicator
- Clostridium difficile infection rate
- E. coli bloodstream infection rate
- Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate
- Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check
- Inappropriate adult acute mental health placement out -of -area placement bed days
- Number of people with severe mental illness receiving a full annual physical health check and follow -up interventions as a % of trajectory

Patient Experience

- None. Patient Experience metrics will be agreed with system colleague in readiness to report for the next Quality Committee in March 2023

Our People/Workforce

- Leaver rate
- Sickness absence rate

Performance by Work Programme

Hertfordshire and West Essex Integrated Care System

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Care Quality Commission Overview

The below table provides an overview of the Care Quality Commission ratings and Warning Notices currently in place across the main organisations in the Hertfordshire and West Essex Integrated Care System:

Organisation Name	Care Quality Commission Rating	Warning Notices
East and North Hertfordshire NHS Trust	Requires Improvement (Jul-Sep 2019)	Section 29A notice regarding the maternity department (final report due to be published 20/01/23)
Hertfordshire Partnership NHS Foundation Trust	Outstanding (Mar 2019) 	None in place. One warning notice has recently been closed (Section 29A)
Hertfordshire Community NHS Trust	Good (Feb-Mar 2020)	None in place
Princess Alexandra Hospital NHS Trust	Requires Improvement (Jul-Sep 2021)	Section 31 notice regarding the emergency department
Essex Partnership NHS Foundation Trust	Good (Jul-Aug 2019)	None in place.
West Hertfordshire Teaching Hospitals NHS Trust	Requires Improvement (Feb-Mar 2020)	None in place
Central London Community Healthcare NHS Trust	Good (Feb-Mar 2020)	None in place
East of England Ambulance Service NHS Trust	Requires Improvement (Jul 2020)	The Trust entered the Recovery Support Programme (previously known as special measures) in 2020 due concerns around its leadership and safeguarding measures. A re-inspection occurred in

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Standard Hospital Mortality Indicator

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS using a standard and transparent methodology. It is produced and published monthly. It is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Summary Hospital-level Mortality Indicator values for each trust are published every quarter along with bandings indicating whether a trust's SHMI is 'higher than expected', 'as expected' or 'lower than expected'.

Below is the Summary Hospital-level Mortality Indicator performance of the Hertfordshire and West Essex Integrated Care System acute provider services with their bandings. The bandings have been referenced to the Trust's most recent performance.

The Summary Hospital-level Mortality Indicator is not a measure of quality of care. A higher than expected number of deaths should not immediately be interpreted as indicating poor performance and instead should be viewed as a prompt which requires further investigation. Similarly, an 'as expected' or 'lower than expected' should not immediately be interpreted as indicating satisfactory or good performance.

NB: A relative risk of 100 would indicate performance exactly as expected. A relative risk of 95 would indicate a rate 5% below (better than) expected, with a figure of 105 indicating a performance 5% higher (worse than) expected.

Trust	Target	SHMI Rate	SHMI Rate July 2021-Jun 22	SHMI Rate Aug 2021-July 2022	Banding
East & North Herts NHS Trust	100	0.90	0.90	0.91	Lower than expected
Princess Alexandra NHS Trust		1.00	1.02	1.04	As expected
West Hertfordshire Teaching Hospitals NHS Trust		0.94	0.94	0.95	As expected

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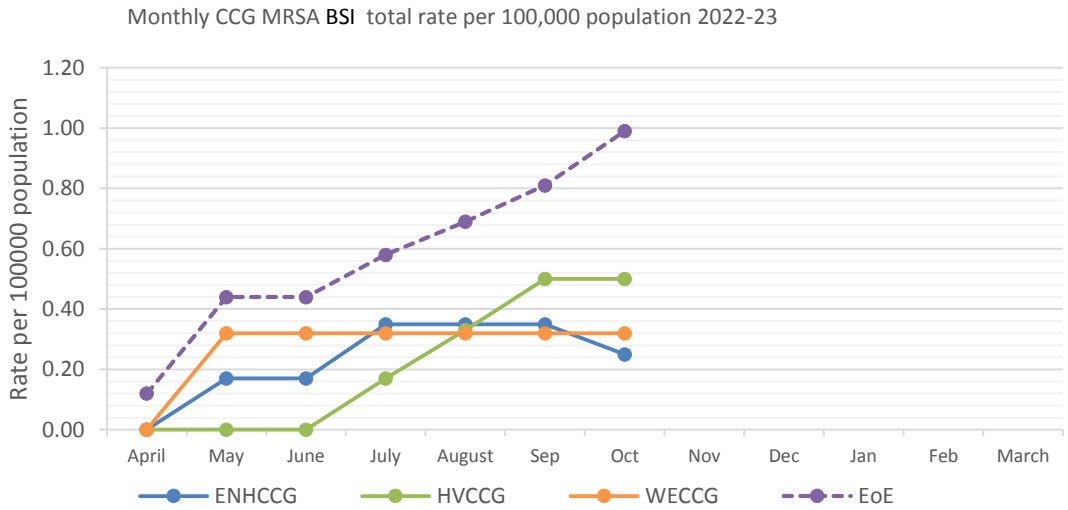
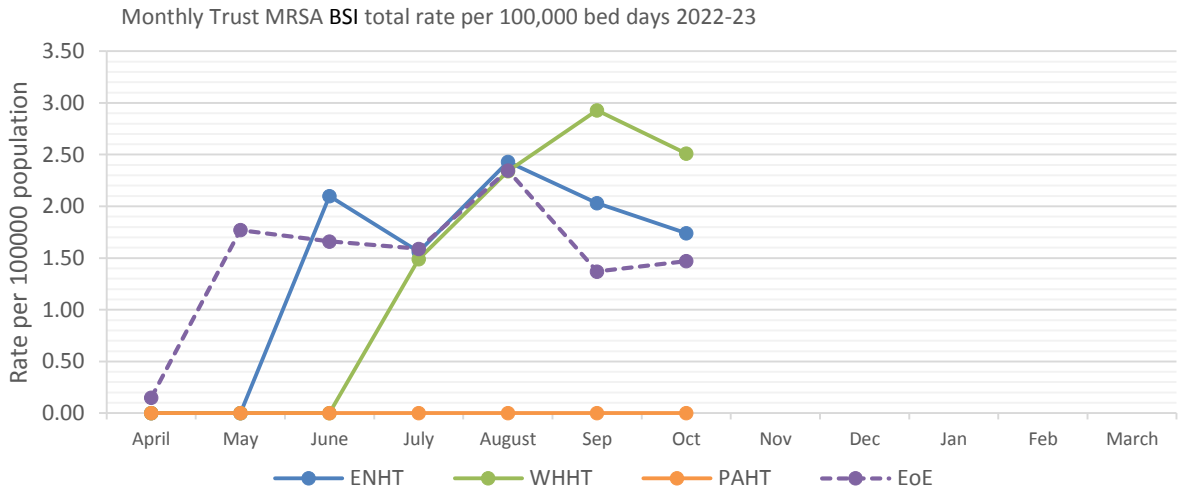
Infection Prevention and Control

Methicillin resistant Staphylococcus aureus (MRSA) Blood Stream Infection





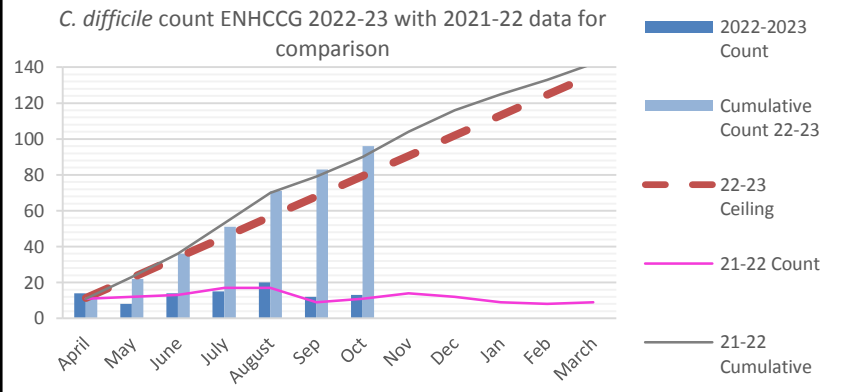
ICB Risk	What the charts tell us	Issues	Actions	Mitigation
No	The number of MRSA blood stream infections remain relatively low. East and North Herts Hospital Trust and West Herts Teaching Hospital Trust rates are therefore above those of the region.	Learning identified through joint case reviews has included device management (urinary catheter / IV access), and MRSA screening etc. This reflects the national picture. Unlike previous years, all cases reported so far in 2022/23 within the ICS have been associated with healthcare.	The Infection and Prevention Control Team has drafted terms of reference to establish place level HCAI oversight groups where data will be reviewed, peer case reviews undertaken and learning from case reviews better collated and shared across organisational boundaries. The process for collection of data in relation to community cases has also been reviewed. To address healthcare associated blood stream infections the 3 acute trusts are jointly implementing an intravenous access project, designed to improve cannula insertion, after care, and prompt removal, as well as staff training in relation to IV access. Princess Alexandra Hospital Trust also has a working group focussing on MSSA BSI reduction.	• Monthly ICS HCAI data reports widely disseminated which allows for accurate benchmarking • Implementation of an IV access project across the 3 acute Trust • Implementation of post infection case reviews with discussion occurring at divisional governance meetings • Discussion at the quarterly Infection Prevention and Control meetings to discuss shared themes and learning

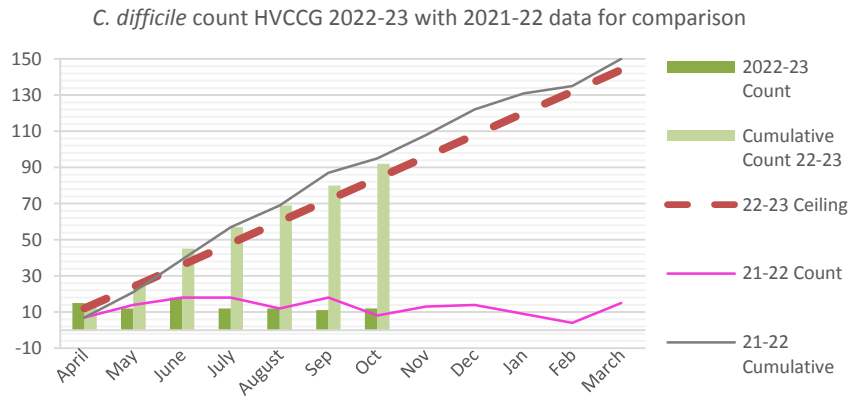
Hertfordshire and West Essex Integrated Care System

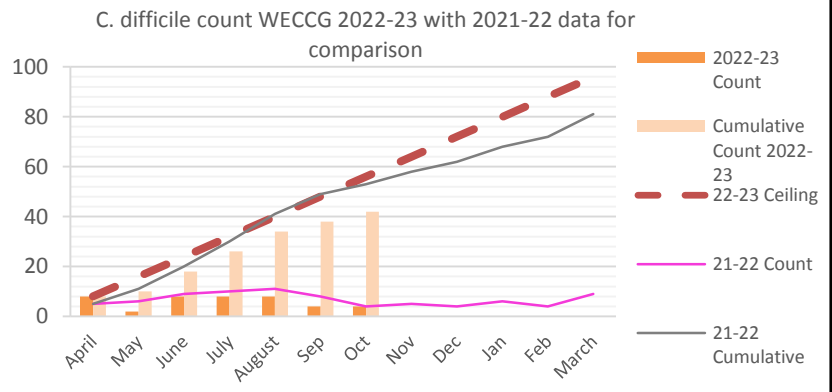
Infection Prevention and Control

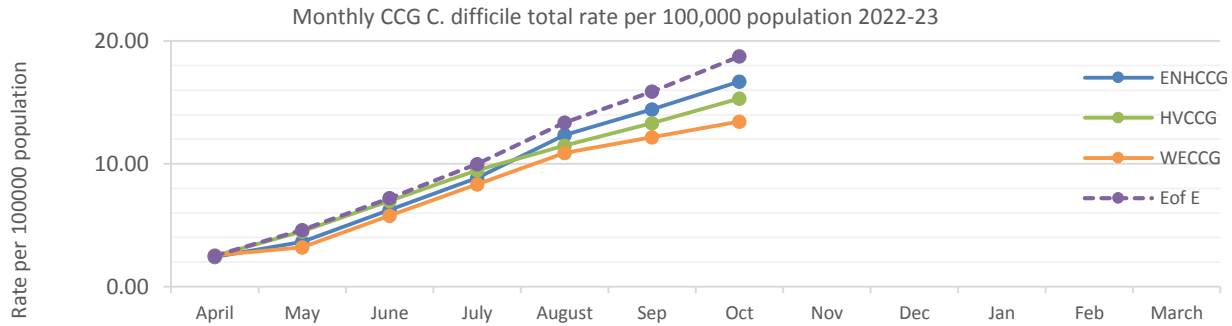
Clostridioides difficile infection (CDI) – CCGs

HCAI data produced by UKHSA is allocated per CCG but will be aligned to ICB in the near future









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Infection Prevention and Control

Clostridioides difficile infection (CDI) – Acute Trusts

ICB Risk	What the charts tell us	Issues	Actions	Mitigation
No	• Regional rates continue to increase above pre-pandemic levels, particularly healthcare associated cases. • By the end of October 2022, the overall number of cases was above ceiling in both the acu East and North locality and South West Herts. However, the rates of infection were below that for East of England. • Approx. 50% were associated with healthcare. • Both acute trusts in Hertfordshire were above their ceilings and their infection rates remained above those of the region.	During April 2021 to March 2022, there was a large increase in the total number of cases nationally. This increase occurred in both hospital-onset and community-onset cases. Consequently, the April 2021 to March 2022 increases in the total and hospital-onset cases represented a 9-year high, and a 3-year consecutive increase in incidence rates	• All 3 acute trusts have all developed action plans to address *Clostridioides difficile* infections. Progress is monitored via the trust infection, prevention and control committees and strategic integrated care system group. • The ICB Infection Prevention and Control Team has drafted terms of reference to establish place level oversight groups where system data will be reviewed, peer case reviews undertaken and learning from case reviews better collated and shared across organisational boundaries. The process for collection of data in relation to community cases has also been reviewed. • Meetings are also booked for this month within the integrated acre board and county councils to discuss improved triangulation of healthcare acquired infections and general quality data in relation to care homes. • Learning from attendance at a recent NHS England Clostridioides difficile infection workshop will be disseminated to local providers	• Monthly cross system data reports widely disseminated which allows for accurate benchmarking • Implementation of post infection case reviews including anti biotic prescribing with discussion occurring at divisional governance meetings • Discussion at the quarterly cross system meetings to discuss shared themes and learning • Structured peer reviews undertaken involving key internal and external stakeholders • Trust Clostridioides difficile infection action plans developed and monitored bi monthly • Monthly trust-wide antibiotic usage data continues to be monitored via trust antimicrobial stewardship groups • Integrated Care System Antimicrobial Stewardship Technical Working Group now established

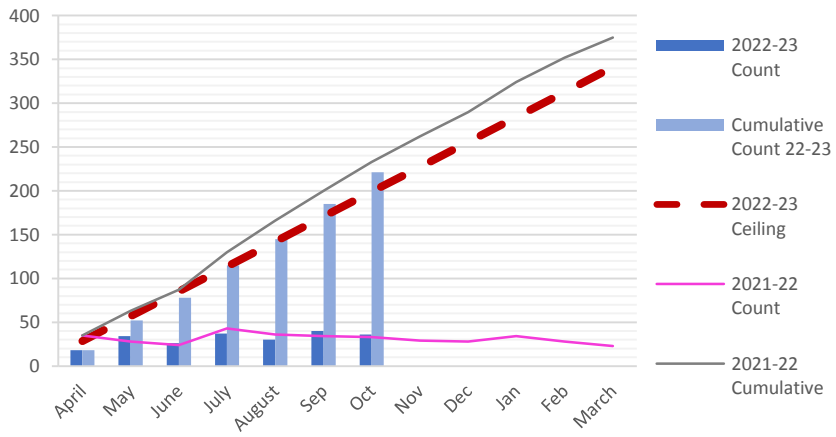
Hertfordshire and West Essex Integrated Care System

Infection Prevention and Control

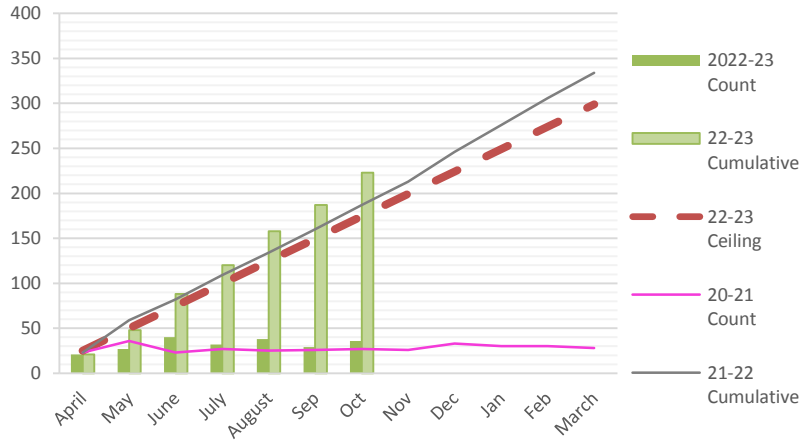
E.coli blood stream infection – Clinical Commissioning Groups

HCAI data produced by UKHSA is allocated per CCG but will be aligned to ICB in the near future

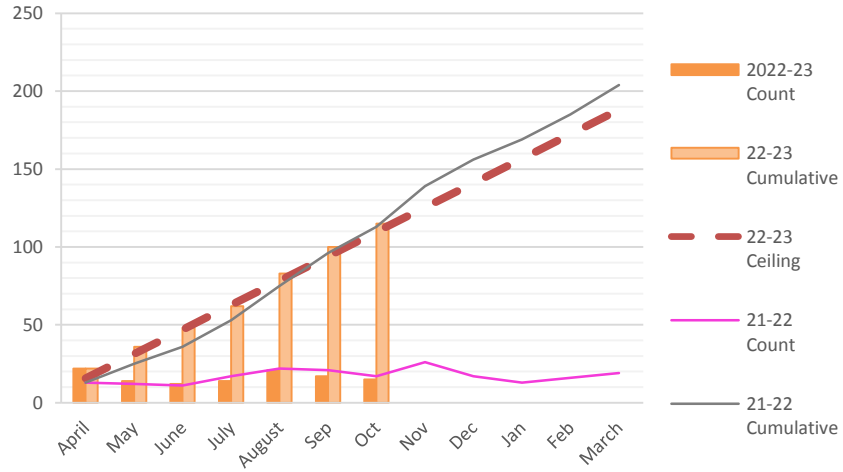
E. coli BSI count ENHCCG 2022-23 with 2021-22 data for comparison



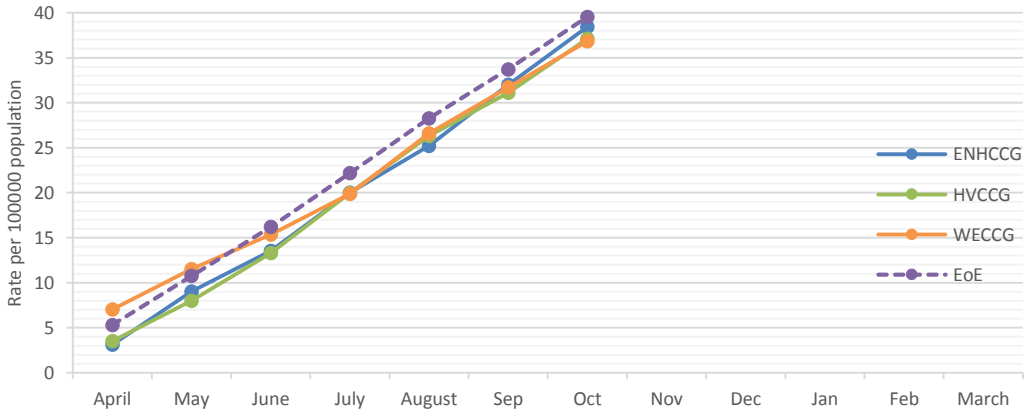
E. coli BSI count HVCCG 2022-2023 with 2021 -22 data for comparison



E. coli BSI count WECCG 2022-2023 with 2021-22 data for comparison



Monthly CCG *E. coli* BSI total rate per 100,000 population 2022-23



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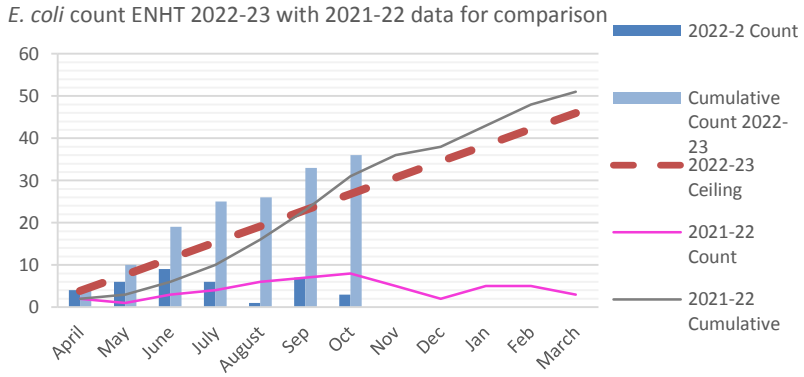
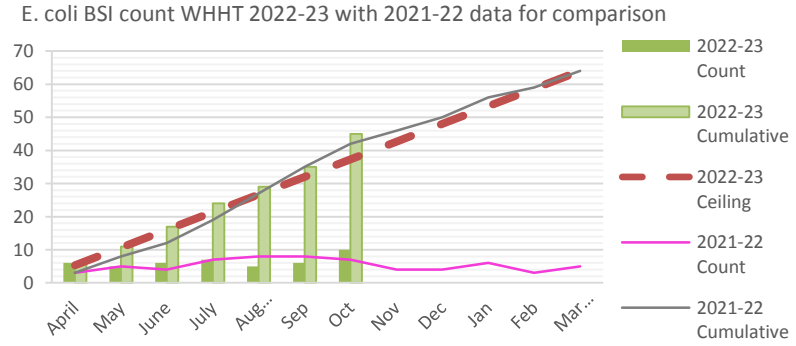
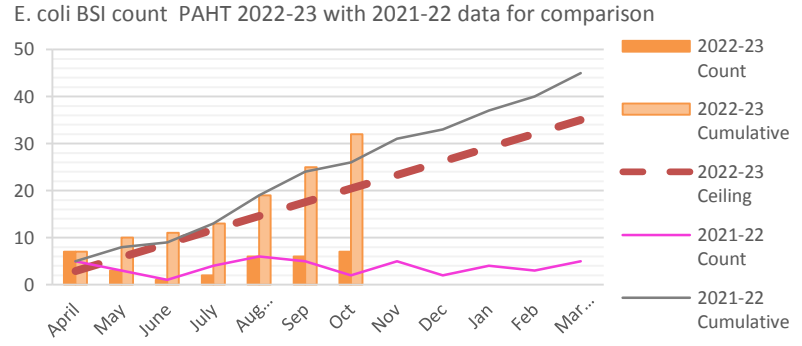
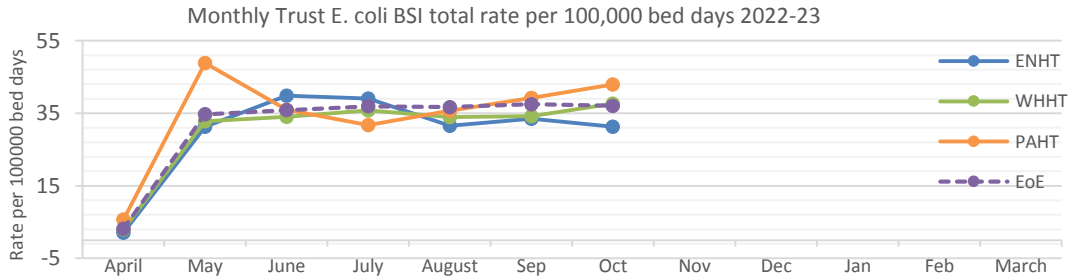
Infection Prevention and Control

E.coli blood stream infection- Acute Trusts









ICB Risk	What the charts tell us	Issues	Actions	Mitigation
No	Although the objectives for each of the CCGs have been exceeded, the infection rate of each CCG is below that of East of England. Similarly, the objectives for each of the acute trusts have been exceeded so far this year, but at the end of October only Princess Alexandra Hospital and West Hertfordshire Teaching Hospitals Trust were above regional rate.	• During 22-23 approximately 70% of cases within the system are community associated • National data shows that approx. 50% of all cases have a primary source of the urinary tract	• Re-establishment of the Urinary Tract Infection workstream is underway • The Integrated Care Board Infection Prevention and Control Team has drafted terms of reference to establish place level oversight groups where system data will be reviewed, peer case reviews undertaken and learning from case reviews better collated and shared across organisational boundaries. The process for collection of data in relation to community cases has also been reviewed. • Meetings are also booked for this month within the Integrated Care Board and county councils to discuss improved triangulation of data and general quality data in relation to care homes.	• Monthly data reports widely disseminated which allows for accurate benchmarking • Implementation of post infection case reviews • Discussion at the quarterly system meetings to discuss shared themes and learning

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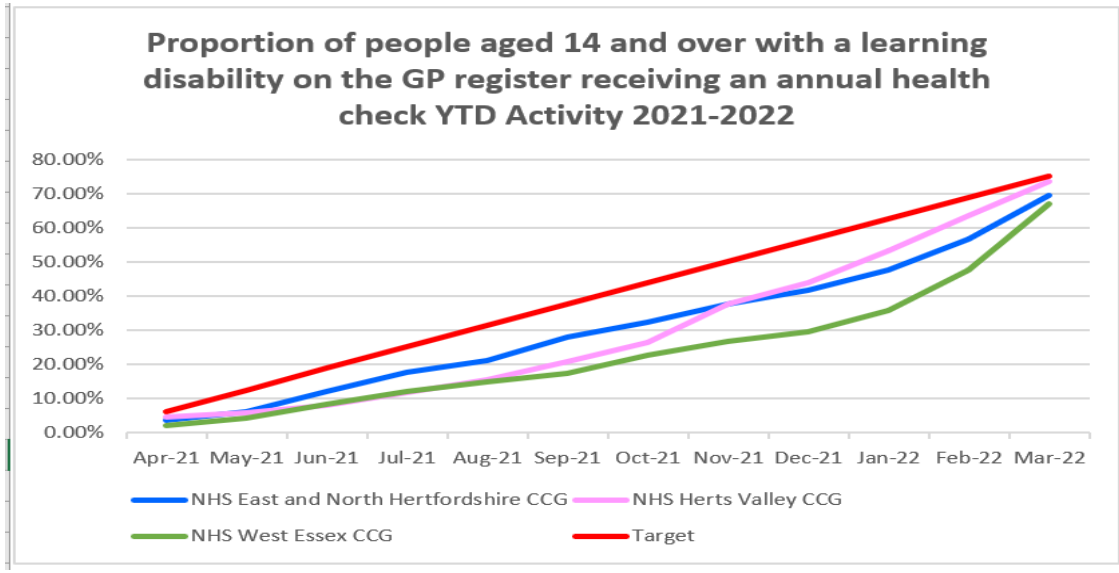
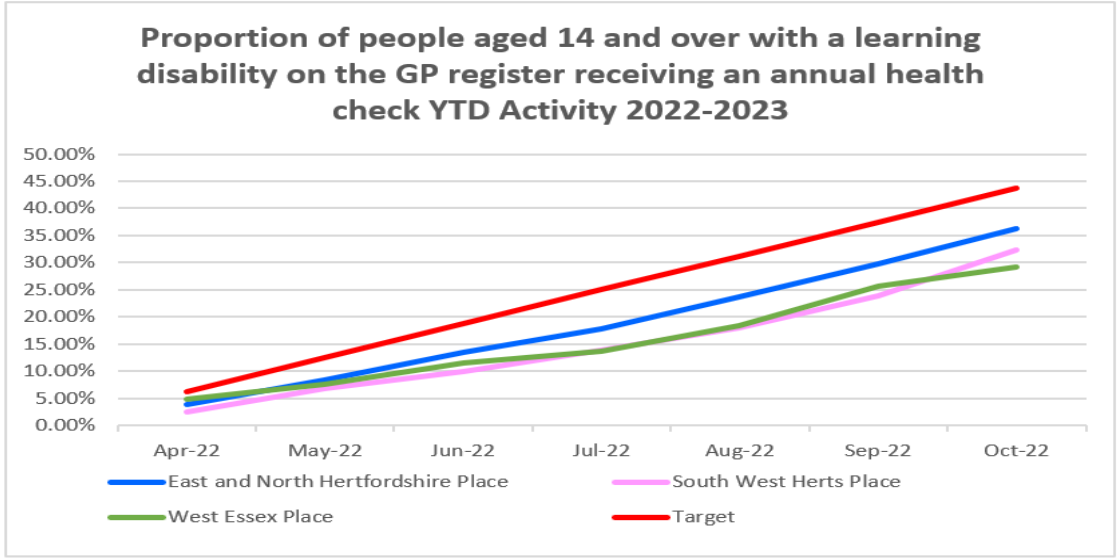
Learning Disability

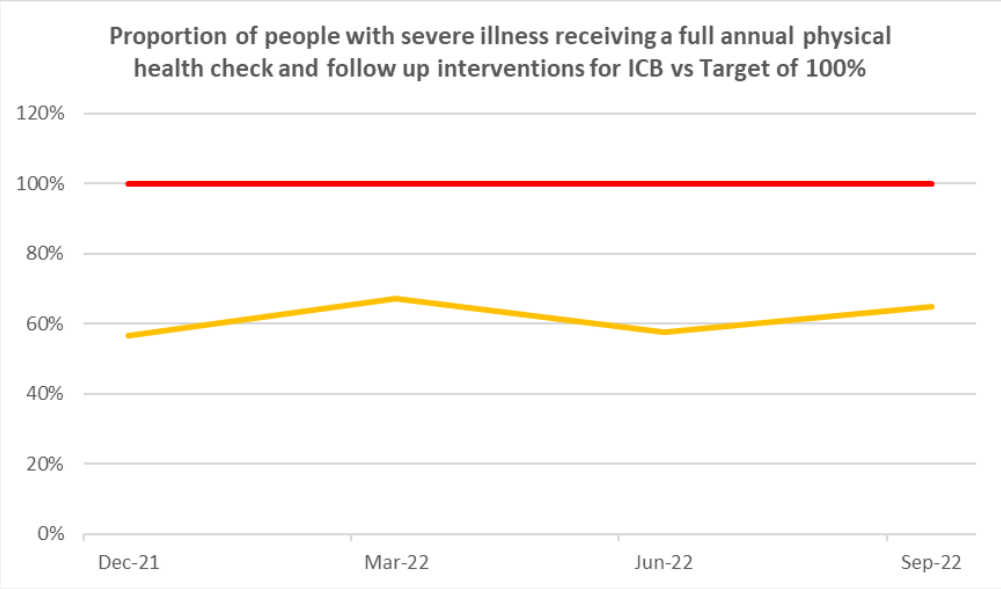


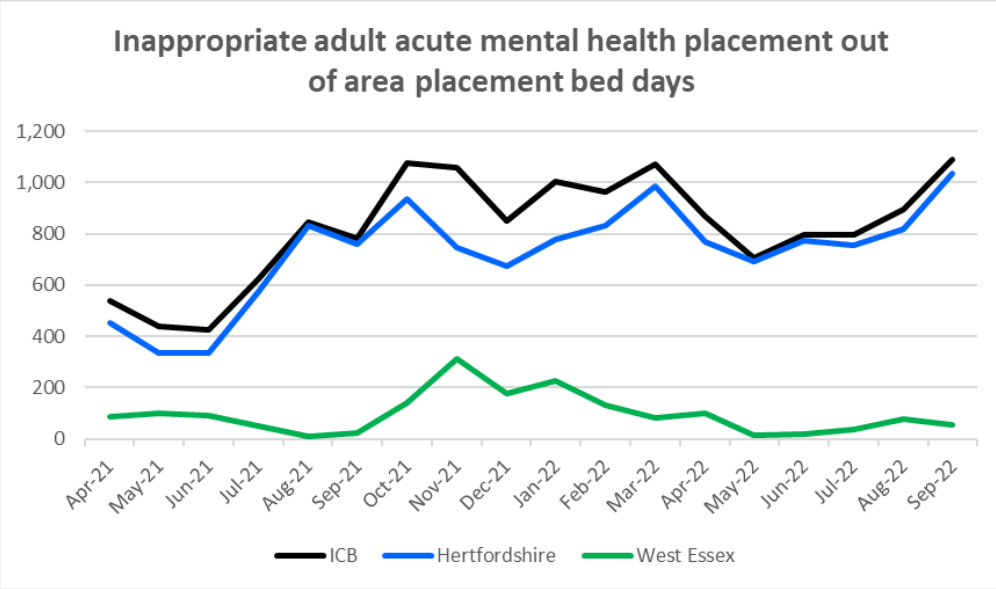


ICB Risk Register	What the charts tell us	Issues	Actions	Mitigation
Yes – Risk347	• The aim is for 75% of people with a learning disability is offered an annual health check (AHC) with their GP by the end of 2023. • Both Hertfordshire and West Essex are showing improvement but not in line with the expected trajectory	• AHCs are generally carried out in Q3 and Q4 - this is improving but will take time to see a change in Q1 and Q2. • Delivery can be impacted by lack of dedicated resource for coordination/administration of the processes to deliver AHCs. • Winter pressures and the impact of vaccination programmes on resources/capacity. • Developing care providers understanding of their role in early identification and increasing health awareness.	**West Essex** - Pilots are in place across to encourage uptake. Increased engagement with the Primary Care Networks (PCN). **Hertfordshire** - Evaluating the impact of a Learning Disability Care Coordinator in underperforming PCNs with other PCNs adopting similar roles. Learning Disability Community Nurses are contacting practices with offers of support, promoting and encouraging greater uptake. **Hertfordshire & West Essex Integrated Care Board** – Communications to GPs, aligned templates and the GP Clinical Lead and commissioners working together to support engagement.	Enhanced Commissioning Framework (ECF) targets for 2022/23, includes specific AHC expectations for General Practice.

Hertfordshire and West Essex Integrated Care System

Mental Health





ICB Area	What the charts tell us	Issues	Actions	Mitigation
Yes - Risk 157	**Physical Health Checks –** Targets achieved in 21/22. 22/22 achievement is currently below the trajectory	There is a gap with the number of referrals due to engagement with hard to reach groups.	A recovery action plan is in place implementing actions such as monthly emails to GPs and close monitoring of the number of health checks delivered. Support packs are shared with GPs Including template letters and guidance.	Recovery action plan
	Out of Area Placements measured by number of bed days – Demand is increasing and this is mirrored in the increasing number of bed days	Demand and complexity is high. Wider system support is required regarding housing and financial issues.	Mental Health Trusts with local and regional system colleagues, including NHS England are working together as part of the national Getting It Right First Time programme to identify areas of improvement. A national review meeting also occurred in November 2022. The quality impact is measured by triangulating quality intelligence such as complaints, MP enquires etc at Quality Review Meetings.	Purchasing additional beds and developing joint working protocols with private providers

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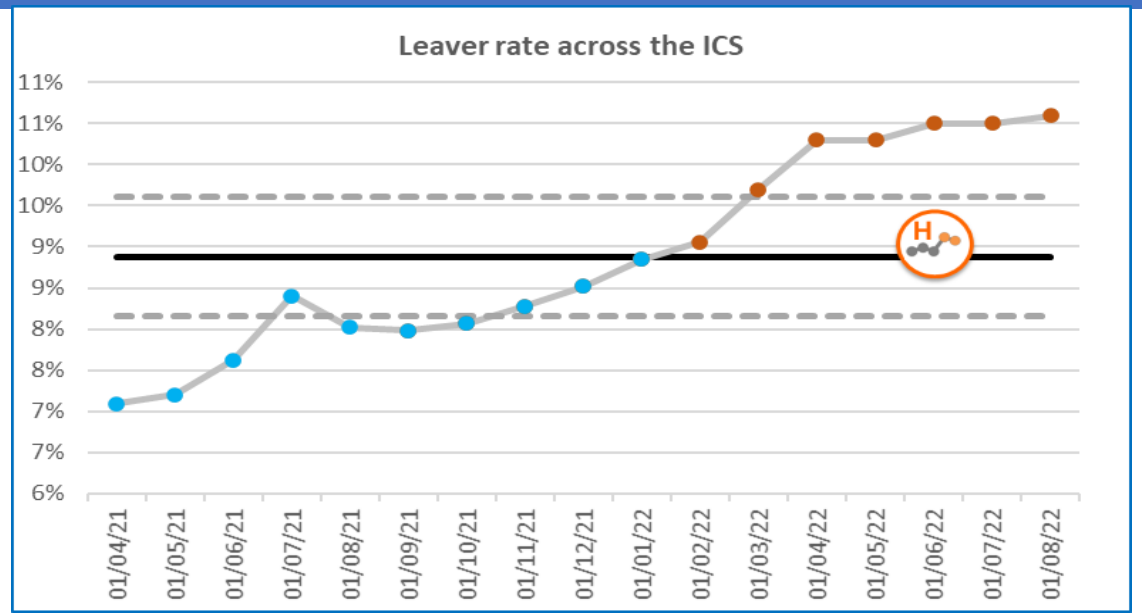
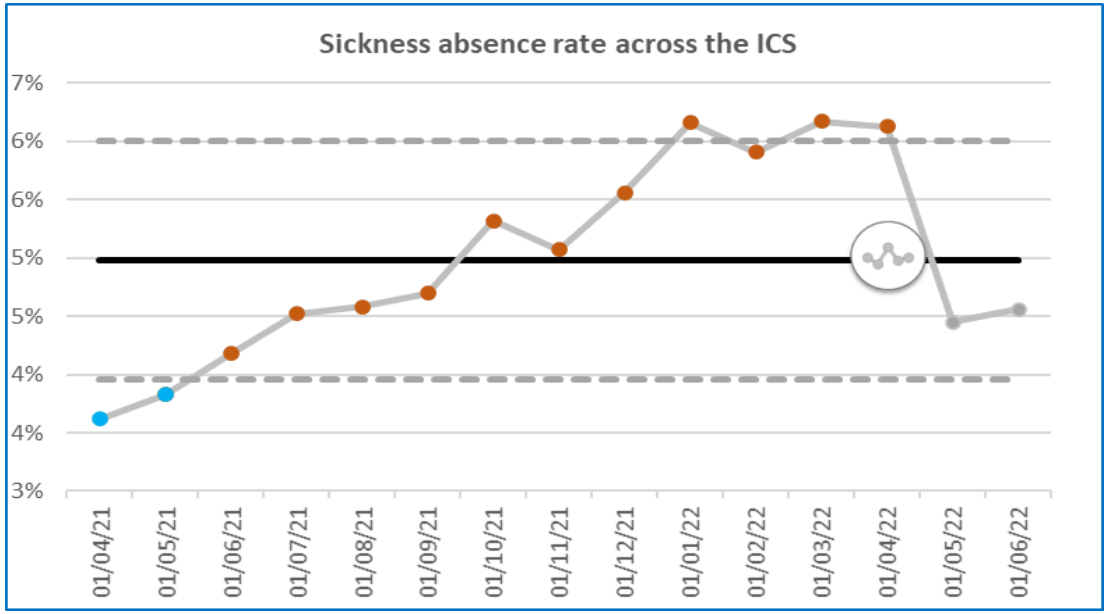
Our People





ICB Area	What the charts tell us	Issues	Actions	Mitigation
Yes Risk 498	Overall the number of staff leaving the NHS is outweighing the staff joining. Sickness absence is stable but increasing.	• National challenge for recruitment and retention and staff sickness • Impact on quality and safety • The number of 'mental health sickness' is increasing	• The workforce challenges are articulated within all system provider risk registers. • All system partners have a wide range of initiatives in place to manage the workforce challenges and are working collaboratively across the Integrated Care System. • A broad range of staff health and wellbeing programmes are in place, organisational value work is being developed, international recruitment is underway and partners are reporting to the Executive Boards with the current position and progress against actions. • Triangulation with patient harm is occurring. Some trusts are reporting an increase in some safety metrics due to workforce, such as the number of falls.	All system partners have plans in place to monitor, measure and work collaboratively to improve these workforce issues. Quality Dashboards which triangulate intelligence are in place to understand hot spots for focus

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Metrics To be Reported in the Next Quality Dashboard (March 2023)

Overarching Quality

- To build on the Care Quality Commission ratings to include details regarding inadequate aspects that have been identified within reports, and also Care Quality Commission rating for GP practices and care homes.

Patient Safety

- To provide additional data and information regarding other mortality indicators, such as Hospital-Standardised Mortality Ratio (HSMR) and Crude mortality rates.
- To provide rates of pressure ulcers and falls with harm within inpatient units and in the community
- Venous thromboembolism assessment rates and associated harms

Patient Experience

- Complaints process compliance across the Integrated Care System
- Friends and Family Test results
- End of life data, such as patients with whom their preferred place of death was discussed

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**27/01/2023**	
Report Title:	**HWE ICS Performance Report**				**Agenda Item:**	**12**	
Report Author(s):	• Stephen Fry, Head of Performance West Essex, Hertfordshire & West Essex ICB • Alison Studer, Head of Performance, South and West Herts, Hertfordshire & West Essex ICB • Jo O'Connor, Deputy Director of Performance, Hertfordshire & West Essex ICB						
Report Signed off by:	• Frances Shattock, Director of Performance and Delivery, Hertfordshire & West Essex ICB						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	ICB Performance Committee						
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. New developments in this month's report include regional and national benchmarking data, Community Services performance and Productivity data. Performance is challenged across the board as highlighted under the Executive Summary on page 2 of the report. Urgent and Emergency Care (UEC) and Mental Health (MH) are the main areas for escalation at the Performance Committee which is to take place the day before Board (26th January); as such, a verbal update will be given at Board on outcome of discussions.						
Recommendations:	The ICB Board are asked to note the contents of the report and escalation items from the Performance Committee to be verbally updated.						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			
	N/A						

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☒

Hertfordshire and West Essex Integrated Care System Performance Report January 2023

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Executive Summary

URGENT CARE, Slides 6-12: Calls abandoned performance = better than national position but worse than regional and ED 4 hour performance = worse than regional and national position

- 111 performance improvements were seen in September with percentage of abandoned calls returning to meet standard; performance has since declined however although remains ahead of the national position, and will be further impacted by a significant increase in demand in December;
- Ambulance response times and ambulance handover performance continues to decline and remains an area of significant concern;
- ED 4 hour performance declined further in November and remains worse than both regional and national position. A deterioration was also seen in the % of patients spending more than 12 hours in department. ED attendances continue above historical averages;
- Data does not yet suggest plans are delivering overall improvement; trajectories for UEC priority metrics agreed with actions aiming to return performance to 21/22 levels, however did not meet in first month.

CANCER, Slides 20-21: 62 day first performance = better than regional and national position

- Continued high levels of 2 week wait referrals following significant spike in May;
- Although continuing below standard, October saw a marked improvement in 62 day first performance with the ICB ranking the 6th highest nationally. The number of patients waiting >62 days continues to decrease but remains behind recovery plan;
- ENHT have been de-escalated from Tier 1 to Tier 2 in line with performance improvements and WHTHT have been removed completely from the tiering system with consistent week on week improvements;
- Although not meeting standard, improved performance levels continue to be delivered against 28 day Faster Diagnosis Standard.

PLANNED CARE, Slide 17: 18 week performance = worse than regional and national position

- Continued delivery of 104 week recovery with zero capacity breaches;
- System focus on reducing the number of patients waiting over 78 weeks with activity currently ahead of revised plan trajectory; pressure remains predominantly in Trauma and Orthopaedics, Gastro and Community Paediatrics which are not forecast to meet 0 by March 23. ENHT have been de-escalated from Tier 1 to Tier 2 for 78 week recovery, with WHTHT remaining in Tier 1 due to data quality issues;
- The number of patients waiting over 52 weeks continues to increase and remains of concern.

DIAGNOSTICS, Slide 18: 6 week performance = better than regional position and worse than national position

- The number of patients waiting over 6 weeks for a diagnostic test continues at similar levels with performance improvement remaining fairly flat; some improvements were seen in October however;
- The system-wide diagnostic improvement plan was submitted in November to NHSE/I including recovery trajectories for all challenged modalities.

Community, Slides 13-17:

- Increased demand on adults & children's services resulting in waiting lists continuing at historically high levels & overall performance remaining below target. Longest wait of 63wks for adults & 76wks children;
- The percentage of children waiting less than 18 weeks has continued to significantly decline since April 22 with pressures in community paediatrics, therapies and audiology services.

MENTAL HEALTH, Slides 25-31:

- Demand continues to remain high in Adult, Older Adult and CAMHS services and is almost double pre-pandemic levels for non-inpatient urgent services (crisis services);
- Pressure for Mental Health Assessments and acute beds continues, with Out of Area Bed Days continuing to increase in October;
- Dementia diagnosis remains challenged in Hertfordshire however has seen an improvement in performance in the latest data;

PRIMARY CARE AND CONTINUING HEALTHCARE, Slides 32-33:

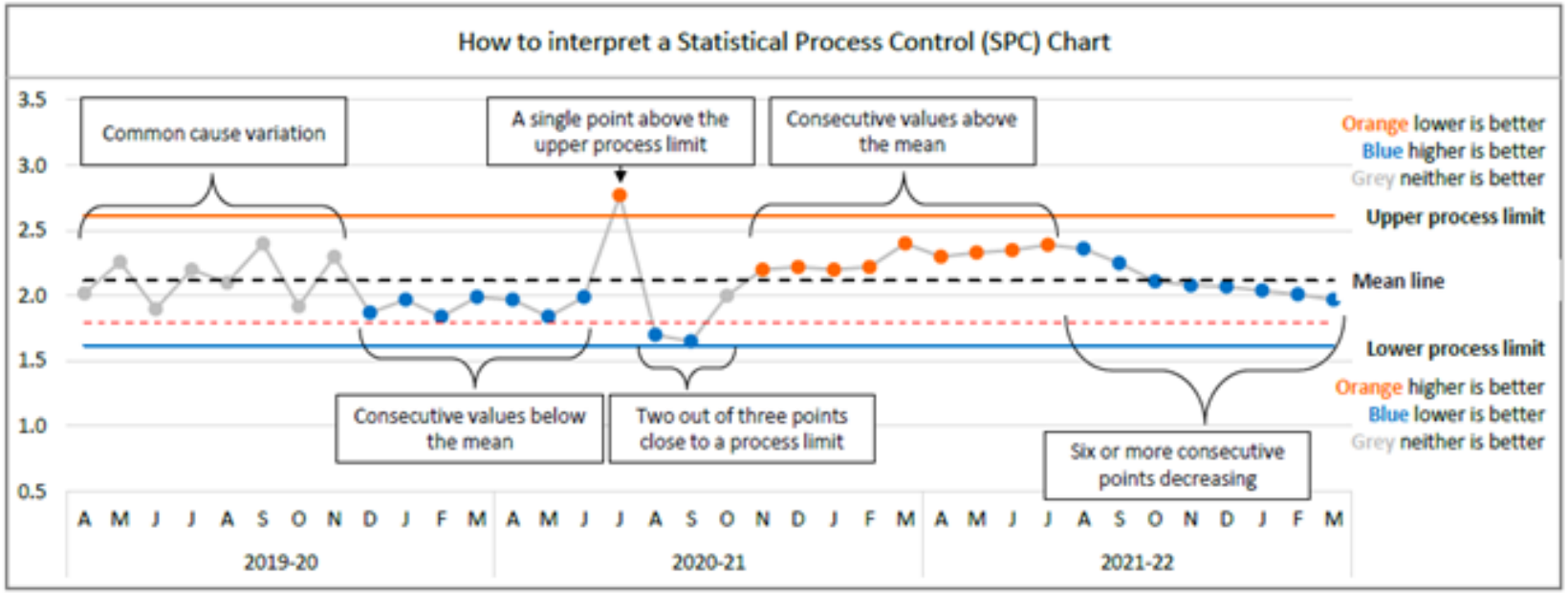
- Significant pressure from Respiratory illness and rapid increase in 'spot booking' from hotels set up by Home Office; total number of GP appointments remain higher than pre-pandemic levels and increased significantly in October with proportion of face to face appointments continuing to increase, reaching over 70% in October and November;
- The number of CHC assessments completed within 28 days remains a challenge in South West Herts however performance improved in October.

Executive Summary – Performance Overview

Metric	Latest month	Measure	Variation	Assurance	Mean	Lower process limit	Upper process limit
A&E - 4 Hour Standard	Nov 22	59.1%			67.9%	62.5%	73.3%
A&E - % spending more than 12 Hours in Dept	Oct 22	9.3%			6.4%	4.8%	8.1%
A&E - ED Average Attendance	Nov 22	41645			40296	34468	46124
Trolley Waits	Nov 22	192			170	-36	375
2 Hour Community Response	Oct 22	85.9%			83.9%	66.8%	101.0%
14 day LOS	Oct 22	13.7%			12.4%	10.3%	14.4%
Ambulance - Handover >60 Mins	Oct 22	1334			921	630	1213
EEAST: Cat 1 - Mean (<7min)	Oct 22	00:10:39			00:09:31	00:07:53	00:11:10
EEAST: Cat 2 - Mean (<18 Mins)	Oct 22	01:19:21			00:51:11	00:21:39	01:20:43
RTT - 18 Weeks	Oct 22	51.7%			58.5%	55.2%	61.9%
RTT - 52 Week Waits	Oct 22	9744			6759	5314	8204
RTT - PTL Size	Oct 22	145881			118434	111044	125824
RTT - 74 weeks	Oct 22	697			1039	689	1389
Diagnostics - 6 Week Wait	Oct 22	62.9%			65.3%	57.9%	72.6%
Diagnostics - PTL Size	Oct 22	24424			24625	20411	28839
Cancer - 2 Week Wait Standard	Oct 22	76.1%			79.5%	66.8%	92.2%
Cancer - 2 Week Wait Referrals	Oct 22	6171			5244	4174	6314
Cancer - 62 Day Standard	Oct 22	73.7%			74.6%	65.8%	83.4%
Cancer - 62 Day Total Waiting	Nov 22	547			610	387	834
Cancer - 104 Day Total Waiting	Nov 22	173			149	96	202
Cancer - 28 Day Faster Diagnosis Standard	Oct 22	68.0%			69.0%	58.6%	79.3%
Mental Health - Out of Area Placements	Oct 22	1322			850	496	1204
Mental Health - Dementia Diagnosis	Sep 22	61.6%			61.4%	60.8%	62.0%
Mental Health - IAPT Entering Treatment	Oct 22	2309			2387	1707	3068

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

Statistical Process Control (SPC)

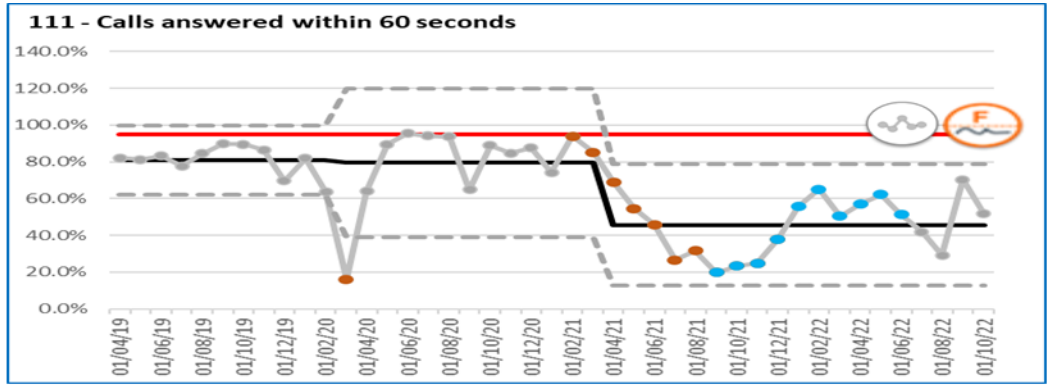


Variation	
H L	Special cause variation of concerning nature due to Higher or Lower values
H L	Special cause variation of improving nature due to Higher or Lower values
	Common cause variation No significant change

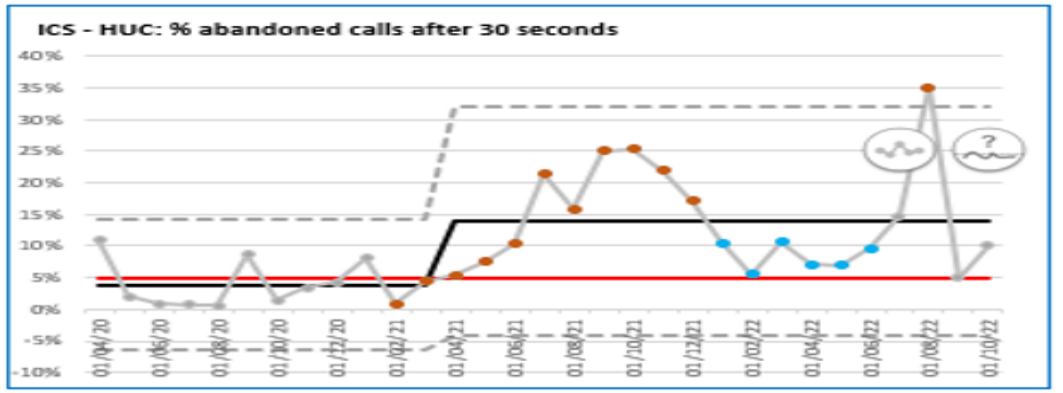
Assurance	
F	Consistent Failing of the target Upper / lower process limit is above / below target line
P	Consistent Passing of target Upper / lower process limit is above / below target line
?	Inconsistent passing and failing of the target

Performance by Work Programme

NHS 111



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	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
Hertfordshire	31,71	31,69	30,27	31,95	29,62	27,73	30,12	33,34	41,11	32,85	37,12	75,77	38,47	35,15	31,51	31,16	35,55	40,33	34,00	33,32	41,20	35,15	26,87	354	1740,96	44,29	42,71	47,28	41,15	41,25	48,10	59,03	67,42	58,72	50,28	580	1140,99	38,10	44,67	39,74	33,48	30,01	35,97
West Essex	8,460	8,368	7,903	8,208	7,409	6,831	7,084	8,333	9,938	7,972	8,788	18,48	9,752	8,593	7,090	7,572	8,586	9,523	8,378	8,229	10,30	8,718	6,717	8877	10,19	11,29	10,45	12,19	10,59	10,78	12,17	10,98	12,41	9,549	8,013	9377	9,904	9,165	10,64	9,452	8,020	7,255	8,861
ICS	40,17	40,05	38,17	40,16	37,03	34,56	37,20	41,67	51,05	40,82	45,90	94,25	48,22	43,74	38,60	38,74	44,14	49,85	42,38	41,55	51,51	43,86	33,58	44,29	51,16	55,58	53,17	59,47	51,74	52,04	60,27	70,01	79,84	68,27	58,29	67,38	50,89	47,26	55,32	49,19	41,50	37,26	44,84



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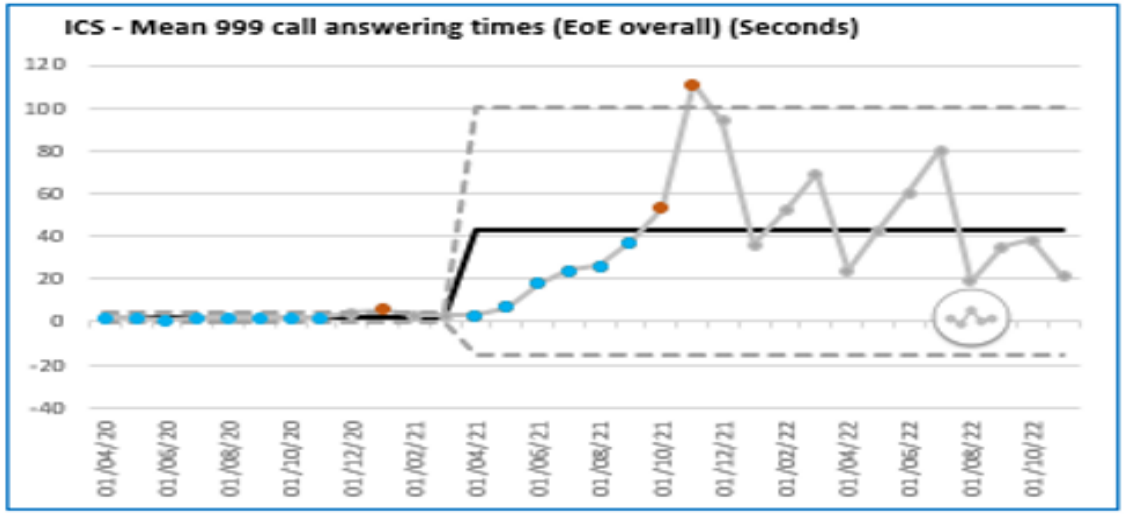
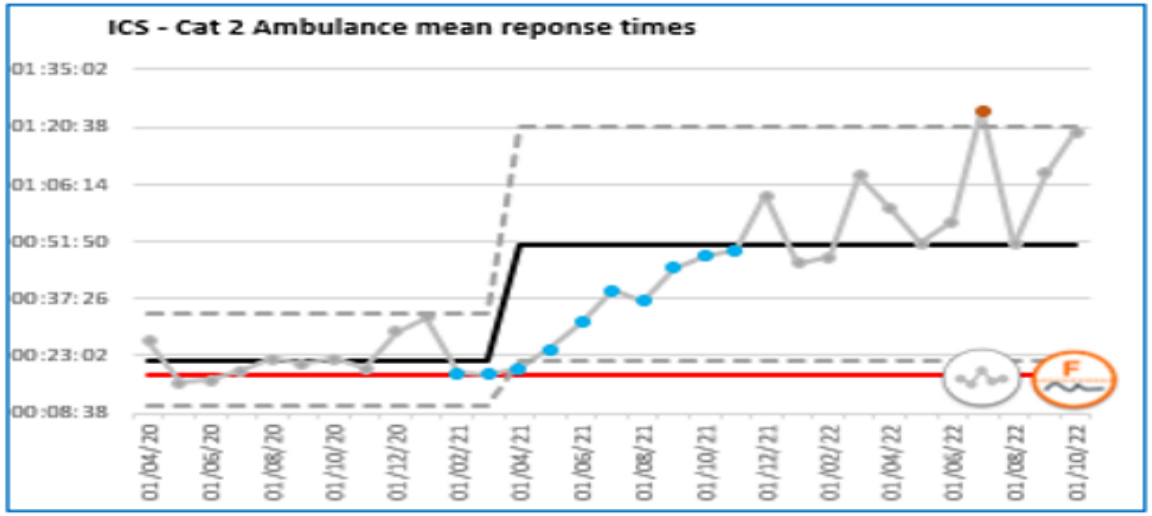
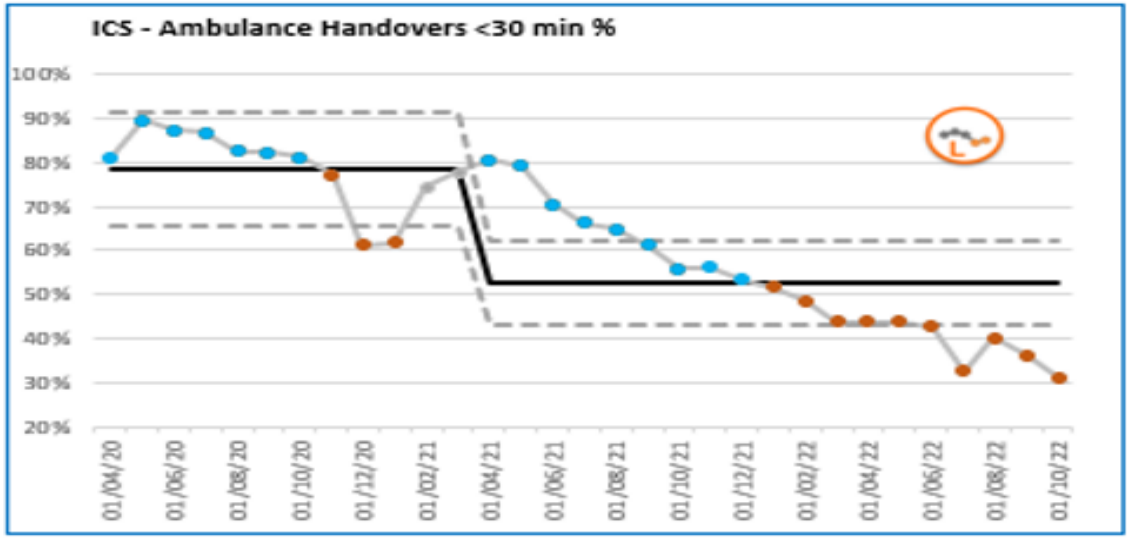
Hertfordshire	2.9%	4.0%	3.8%	5.3%	3.0%	1.7%	1.6%	2.1%	7.1%	3.9%	10.1%	45.6%	10.6%	2.1%	0.9%	0.7%	0.6%	8.4%	1.4%	3.3%	4.1%	7.7%	0.8%	4.2%	5.2%	7.2%	10.1%	20.6%	15.3%	24.3%	24.6%	21.3%	16.9%	10.4%	5.6%	10.5%	7.0%	6.6%	9.4%	14.0%	34.4%	4.8%	9.7%
West Essex	5.0%	6.3%	9.5%	7.0%	3.9%	1.8%	2.7%	3.0%	7.8%	4.0%	10.9%	46.9%	12.3%	1.6%	0.6%	0.8%	0.7%	9.6%	1.6%	4.0%	5.0%	9.6%	1.0%	5.2%	6.2%	8.3%	11.3%	24.1%	18.2%	28.0%	27.9%	24.1%	18.1%	11.1%	5.6%	11.1%	7.7%	8.6%	10.7%	17.6%	37.7%	5.4%	11.1%
ICS	3.3%	4.5%	5.0%	5.6%	3.2%	1.7%	1.8%	2.3%	7.2%	3.9%	10.2%	45.8%	10.9%	2.0%	0.8%	0.7%	0.7%	8.6%	1.5%	3.5%	4.3%	8.1%	0.9%	4.4%	5.4%	7.4%	10.3%	21.4%	15.9%	25.1%	25.3%	21.9%	17.1%	10.5%	5.6%	10.6%	7.1%	7.0%	9.7%	14.7%	35.0%	5.0%	10.0%
Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%

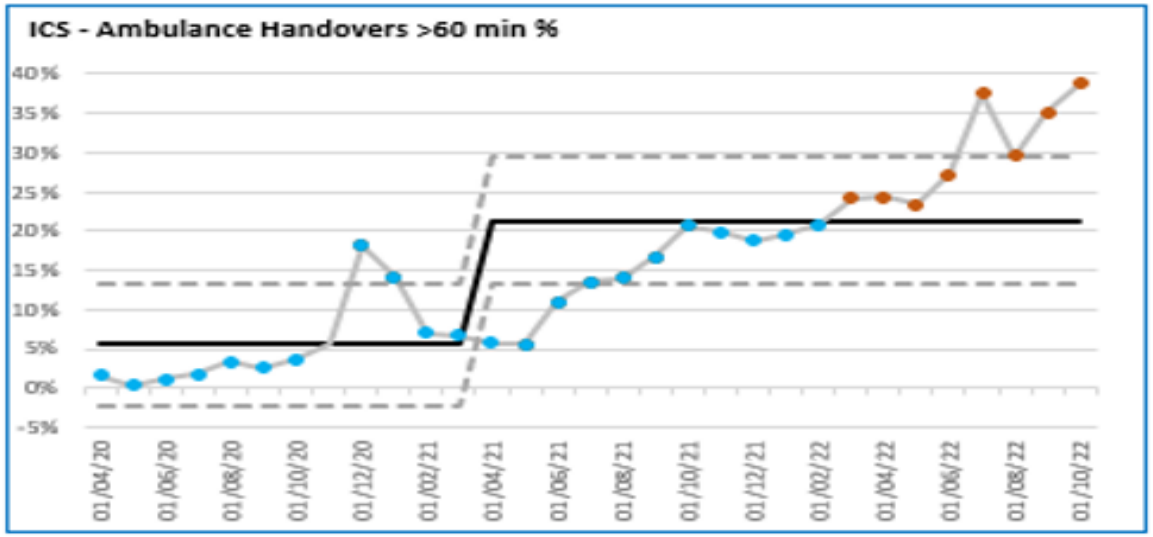
ICB Area	What the charts tell us	Issues	Actions	Mitigation
HUC	• Calls answered within 60 seconds saw improved performance levels from September, but December will see a sharp deterioration as a result of a significant increase in call volumes • After returning to meet standard in September, performance deteriorated to 10% in October for abandoned calls • Latest data for December shows abandonment rates as high as 40% due to exceptionally high call rates	• Critical Incident declared in December due to significant increase in call volumes • Strep A alert contributing towards high call volumes, longer queues and higher abandonment rates • Ongoing disruption from Adastra outage and the updated version created post August cyber attack • Post Event Messaging (PEM) remains an issue for all affected Providers	• Escalation calls established to manage response in respect of high call volumes in December • Two respiratory hubs established in Stevenage with work in progress to create further hubs • Most urgent PEMs already communicated to Practices. The remainder of PEMs created during Adastra outage now being discussed at national level • ADVANCED in communication with 111 Providers regarding new Adastra imperfections • HUC footprint Task & Finish Group in place to address challenges and actions across three ICBs (HWE, BLMK, C&P) • Weekly IUC Overview Reports from the Provider with monthly updates on workforce	• Rapid development of Respiratory Hubs to redirect from NHS 111 and ED • Exploring the opportunity to redeploy staff from the wider system for support • AiHVS initially redeployed to support longer queues • Range of staff support and welfare measures put in place by HUC

UEC - Ambulance Response and Handover



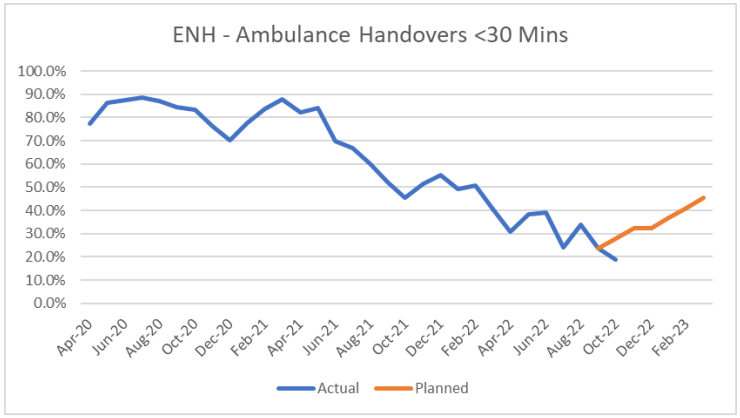


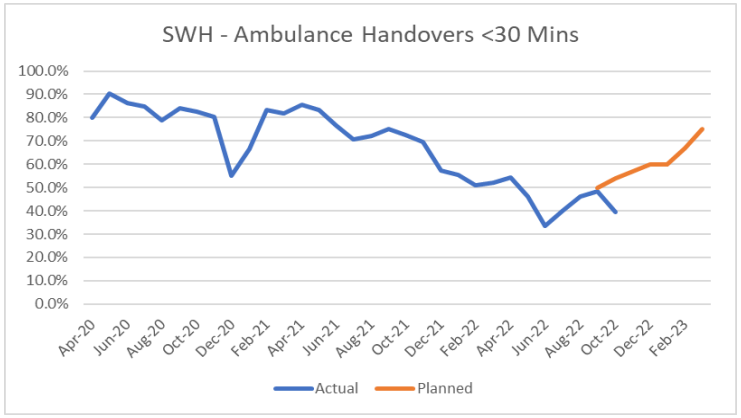


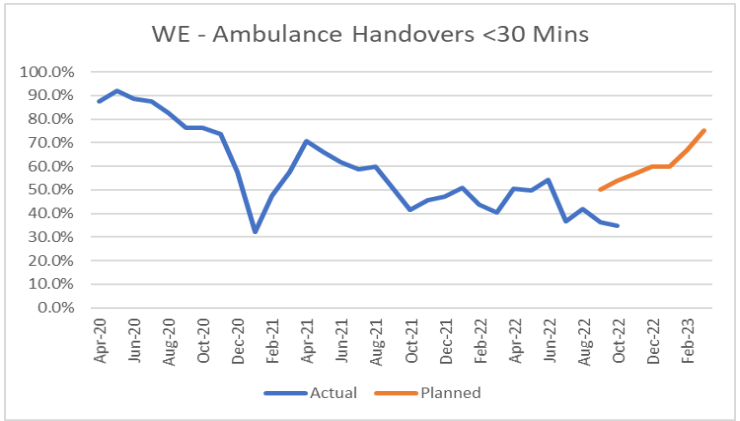


UEC - Ambulance Handover Improvement Trajectories

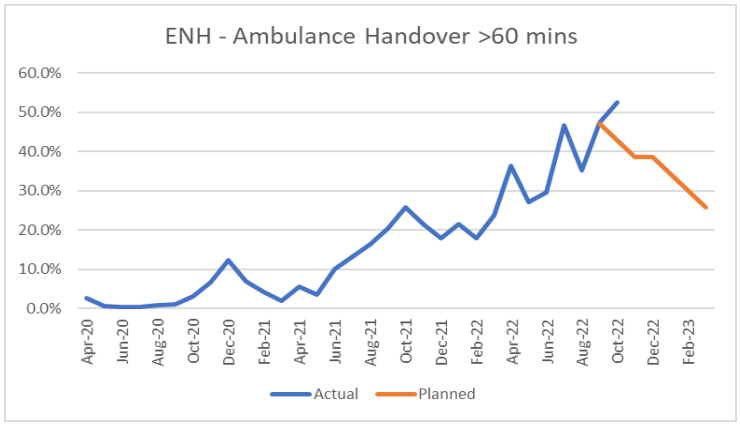
< 30 Minute Ambulance Handover Trajectories

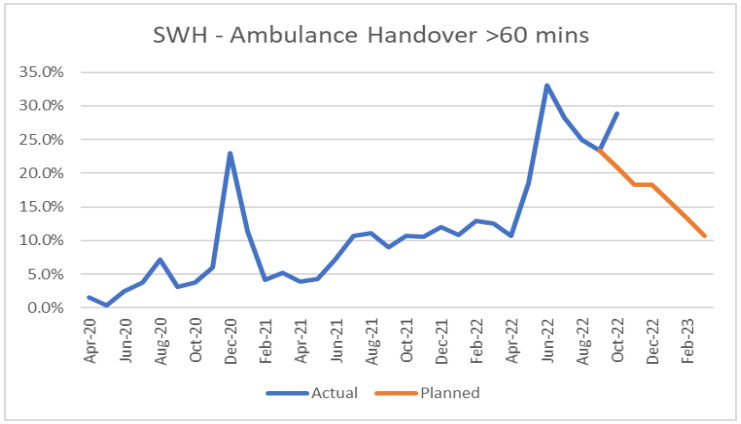


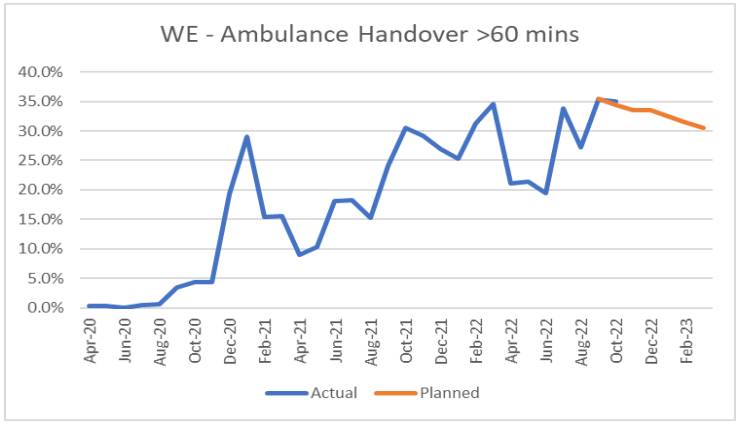




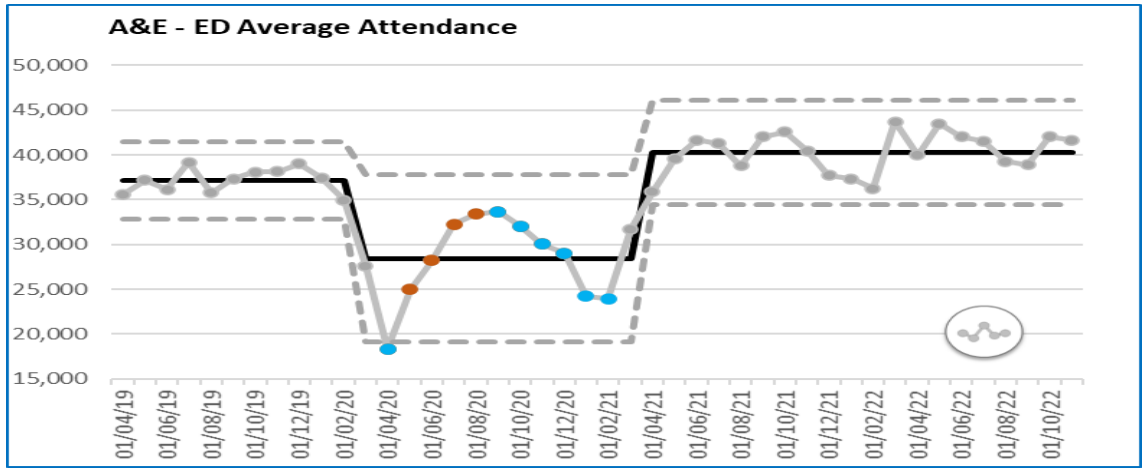
> 60 Minute Ambulance Handover Trajectories







Urgent & Emergency Care (UEC)



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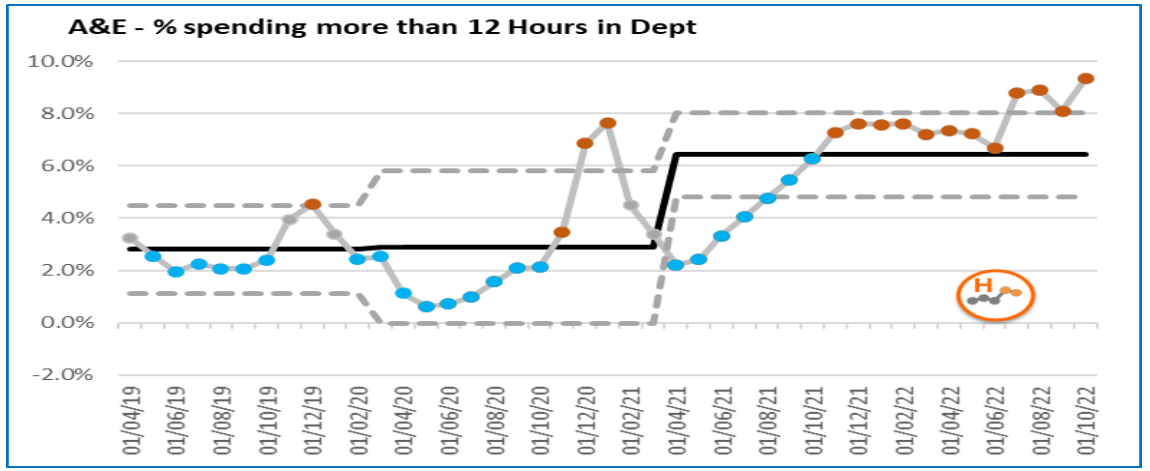
East And North Hertfordshire NHS Trust	13,4	14,3	13,6	14,8	13,6	14,0	14,6	14,5	14,8	14,2	13,2	10,4	7,22	9,83	11,0	12,2	12,5	12,8	12,1	11,3	10,8	9,31	9,07	11,9	13,4	14,7	15,8	15,6	14,9	16,3	16,5	15,6	14,6	14,1	14,0	16,7	14,7	16,4	15,4	15,6	14,6	14,4	15,6	15,4
West Hertfordshire Hospitals NHS Trust	13,1	13,7	13,5	14,5	13,1	13,8	13,8	13,9	14,3	13,5	12,8	10,2	6,61	8,85	9,99	11,7	12,3	12,0	11,3	10,6	10,7	8,86	8,68	11,4	13,2	14,4	15,1	15,2	13,9	14,9	15,2	14,5	13,4	13,5	13,0	15,5	14,7	15,6	15,6	15,1	14,8	14,1	15,5	15,5
The Princess Alexandra Hospital NHS Trust	9,00	9,15	8,93	9,82	8,92	9,42	9,55	9,62	9,75	9,63	8,90	6,94	4,48	6,29	7,15	8,21	8,47	8,82	8,50	7,99	7,40	6,03	6,15	8,34	9,22	10,4	10,5	10,3	9,89	10,6	10,7	10,3	9,59	9,63	9,23	11,4	10,4	11,4	10,9	10,7	9,77	10,3	10,8	10,6
ICS	35,5	37,1	36,1	39,1	35,7	37,3	38,0	38,1	38,9	37,4	34,9	27,6	18,3	24,9	28,2	32,2	33,3	33,6	32,0	30,0	29,0	24,2	23,9	31,7	35,8	39,5	41,6	41,2	38,7	42,0	42,5	40,4	37,6	37,3	36,2	43,6	39,9	43,4	42,0	41,5	39,2	38,8	42,0	41,6



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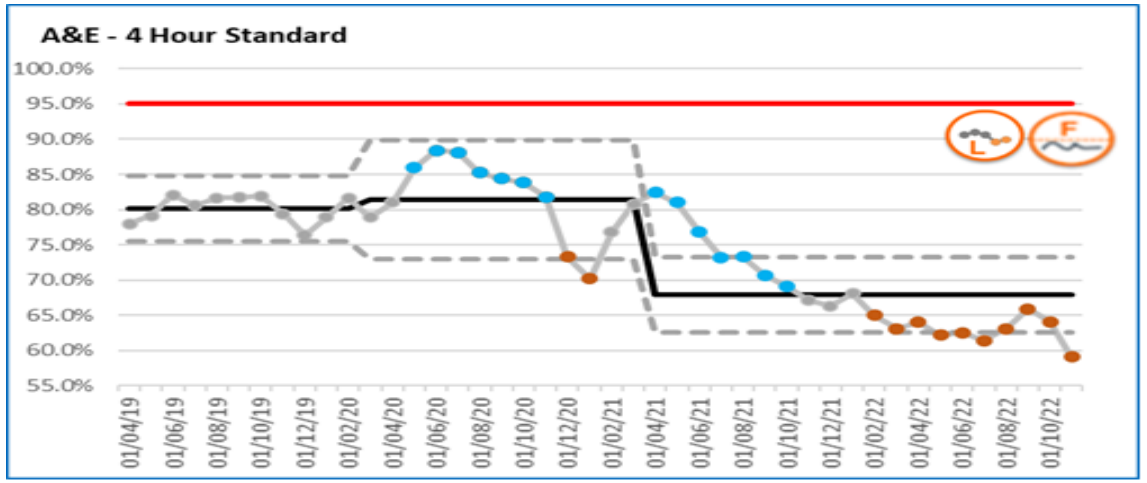
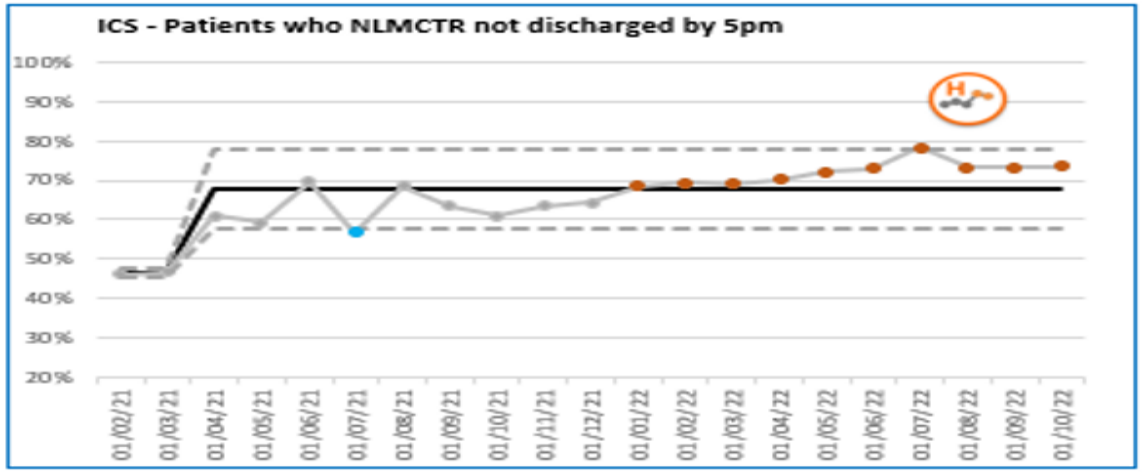
NHS EAST AND NORTH HERTFORDSHIRE CCG	3.1%	2.2%	2.0%	2.5%	1.5%	2.3%	2.3%	3.8%	4.5%	3.8%	2.9%	3.7%	1.7%	0.7%	0.6%	0.9%	1.3%	2.7%	2.4%	4.1%	6.3%	7.2%	4.4%	2.7%	2.7%	2.7%	4.1%	5.1%	6.4%	7.4%	9.1%	9.6%	9.7%	10.5%	10.4%	10.1%	9.4%	8.5%	9.1%	11.0%	8.9%	9.6%	10.2%
NHS HERTS VALLEYS CCG	2.0%	2.2%	1.7%	1.7%	2.3%	1.8%	2.5%	2.1%	2.2%	2.0%	2.0%	2.2%	1.3%	0.7%	0.7%	0.8%	1.5%	1.3%	1.3%	1.8%	6.4%	6.9%	2.0%	1.3%	1.1%	1.4%	1.7%	2.2%	2.4%	2.5%	3.1%	3.7%	5.0%	5.1%	4.9%	5.0%	4.8%	4.9%	5.4%	5.7%	6.9%	5.5%	7.3%	
WEST ESSEX CCG	3.2%	2.6%	2.0%	1.7%	1.8%	2.3%	3.2%	5.4%	6.3%	4.8%	3.0%	2.7%	0.8%	0.4%	0.9%	1.1%	1.9%	2.4%	3.0%	4.3%	7.3%	7.9%	5.8%	4.7%	3.2%	3.2%	4.5%	5.7%	5.7%	7.6%	8.3%	9.8%	9.0%	7.9%	8.1%	9.3%	9.5%	9.6%	8.9%	12.3%	11.9%	11.1%	11.7%	
ICS	2.8%	2.3%	1.9%	2.0%	1.9%	2.1%	2.7%	3.7%	4.3%	3.5%	2.6%	2.9%	1.3%	0.6%	0.7%	0.9%	1.6%	2.1%	2.3%	3.4%	6.7%	7.3%	4.1%	2.9%	2.1%	2.3%	3.2%	4.0%	4.6%	5.4%	6.4%	7.1%	7.5%	7.6%	7.6%	7.8%	7.4%	7.1%	7.0%	8.8%	8.7%	8.2%	9.3%	



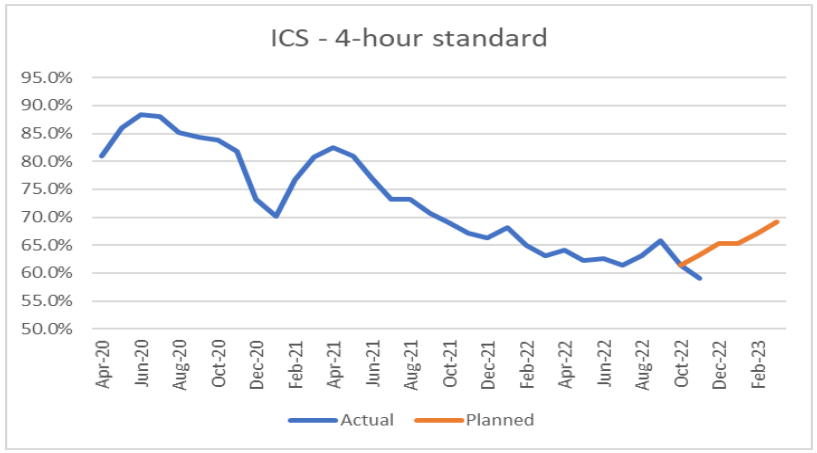
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
East And North Hertfordshire NHS Trust	80.5%	81.6%	84.5%	81.5%	86.1%	85.1%	85.8%	81.5%	78.9%	81.5%	85.3%	90.2%	97.8%	88.3%	84.8%	88.1%	90.1%	87.1%	84.8%	84.5%	82.4%	78.2%	75.2%	78.8%	85.2%	82.8%	84.1%	78.6%	74.8%	73.3%	69.5%	70.1%	68.8%	69.5%	69.8%	67.1%	66.6%	66.0%	66.4%	65.2%	62.4%	67.3%	66.4%	64.4%	61.2%
West Hertfordshire Hospitals NHS Trust	81.2%	79.9%	82.1%	81.3%	80.5%	80.5%	80.3%	81.1%	82.2%	79.4%	81.7%	80.7%	67.1%	78.9%	83.3%	89.7%	85.9%	83.0%	84.3%	84.4%	82.1%	68.4%	65.2%	79.8%	89.3%	86.1%	83.0%	80.9%	79.1%	77.6%	73.6%	69.0%	70.5%	63.3%	65.7%	62.7%	68.8%	62.1%	58.2%	60.5%	63.2%	59.6%	65.0%	62.2%	60.2%
The Princess Alexandra Hospital NHS Trust	69.6%	74.0%	78.2%	78.3%	76.5%	74.9%	74.2%	72.2%	68.2%	72.1%	72.7%	79.7%	88.9%	89.2%	89.0%	87.8%	83.9%	88.3%	88.3%	89.3%	84.4%	80.7%	79.3%	79.8%	79.0%	73.9%	72.1%	70.0%	69.4%	62.9%	61.1%	59.6%	65.5%	67.9%	69.1%	65.1%	63.8%	64.1%	61.7%	61.6%	57.5%	64.0%	69.1%	62.6%	64.4%
ICS	78.0%	79.1%	82.1%	80.6%	81.7%	81.7%	81.9%	79.4%	79.6%	79.8%	81.7%	78.9%	81.1%	80.6%	80.8%	84.4%	88.1%	85.3%	88.4%	84.3%	83.9%	81.8%	79.3%	70.2%	76.8%	80.8%	82.5%	81.0%	76.8%	73.3%	73.3%	70.7%	69.1%	67.1%	66.5%	68.1%	65.1%	63.3%	61.9%	64.0%	62.2%	59.2%	61.4%	63.1%	65.9%	61.4%	69.1%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



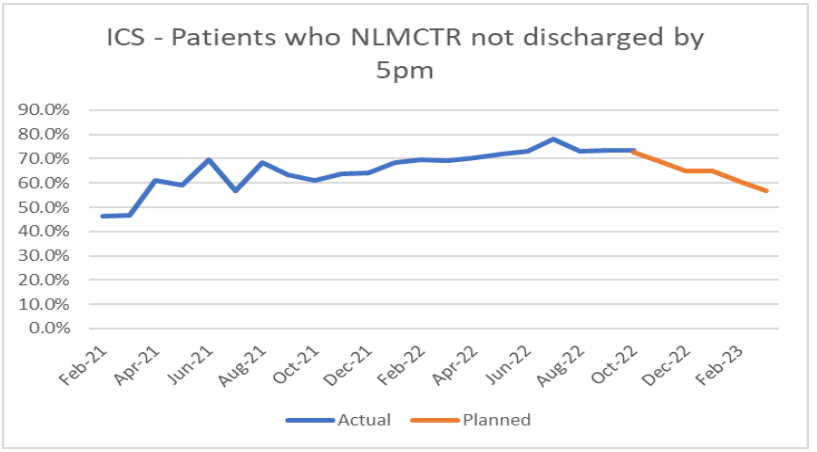
Place	Patient Journey	Area	Indicator	Target	Previous Month	Current Month	Latest Month	Month Change
WE CCG	At Hospital	Hospital flow	Patients who NLMCTR not discharged by 5pm	-	70.7%	71.7%	October	↑
SWH CCG	At Hospital	Hospital flow	Patients who NLMCTR not discharged by 5pm	-	75.3%	75.6%	October	↑
ENH CCG	At Hospital	Hospital flow	Patients who NLMCTR not discharged by 5pm	-	72.7%	72.6%	October	↓

Urgent & Emergency Care (UEC) Improvement Trajectories

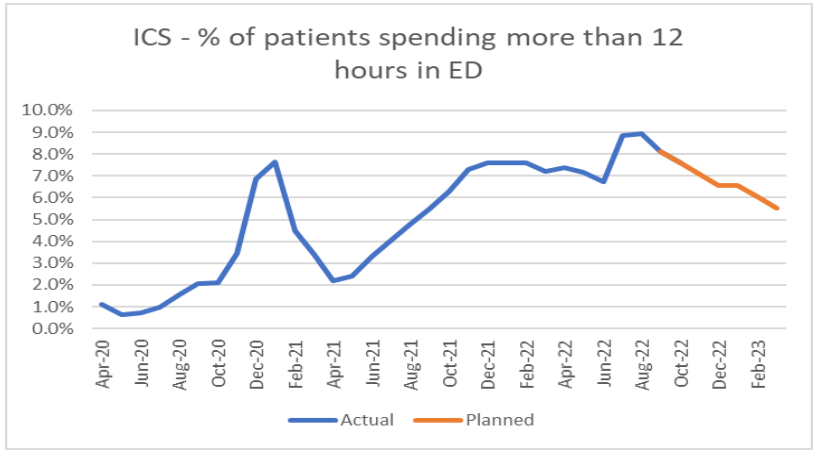
4 Hour Standard Improvement Trajectory



No Longer Meet Criteria to Reside (NLMCTR) Improvement Trajectory



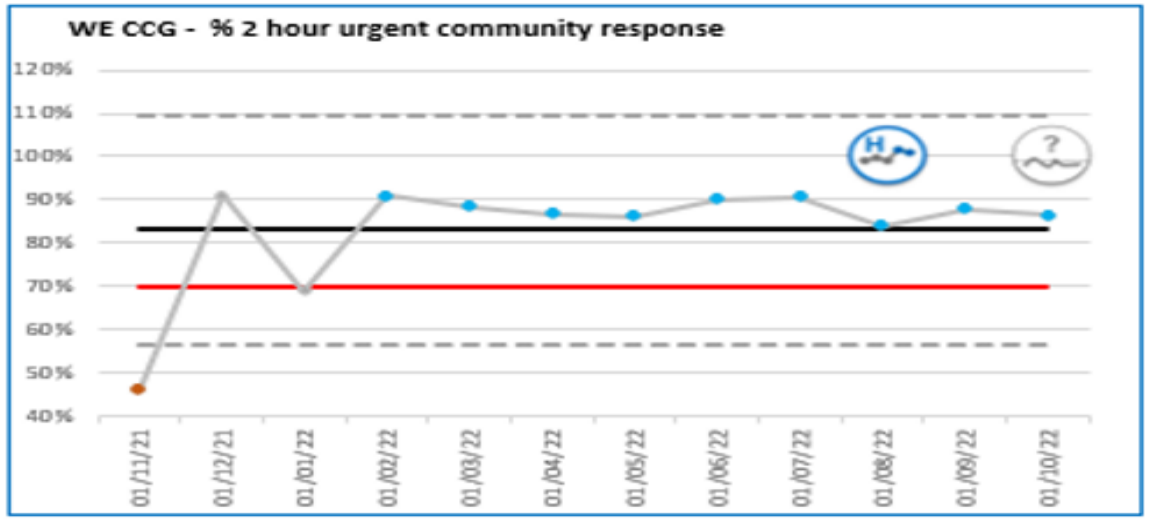
12 Hours in ED Improvement Trajectory

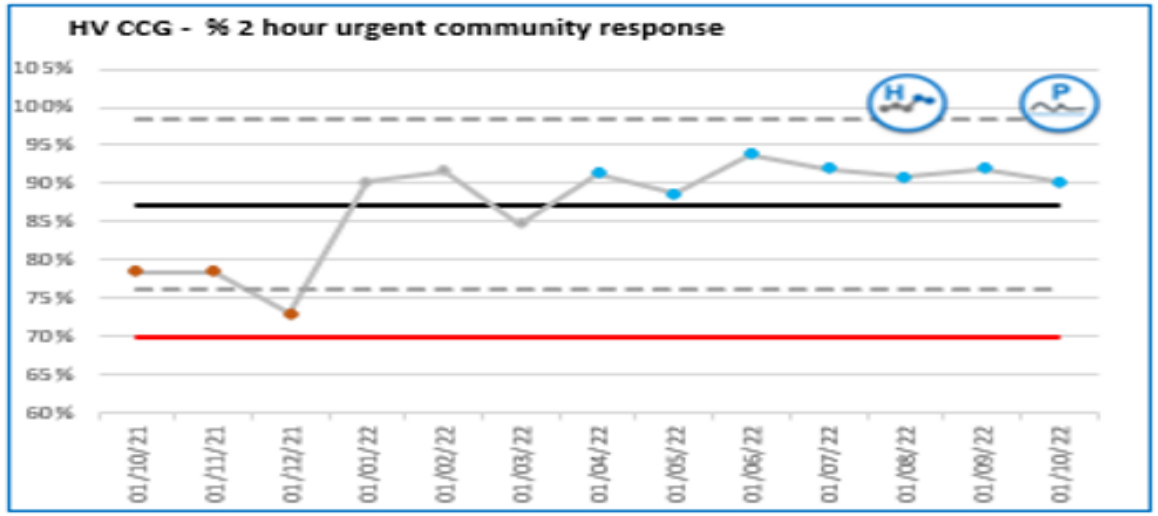


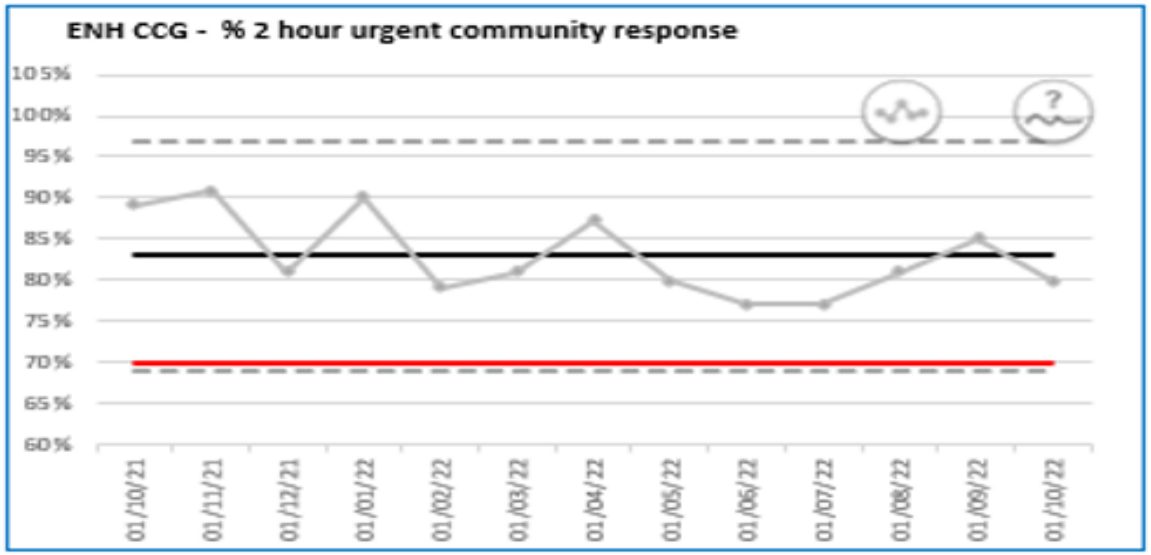
Urgent & Emergency Care (UEC)

ICB Area	What the charts tell us	Issues	Actions
ICB	• Category 2 ambulance response times deteriorated to October and remain of concern; • Performance against ambulance handover (withing 30 minutes and over 60 minutes) has also deteriorated and remains of significant concern; • ED attendances have remained consistently above historical averages over the last 12 moths coinciding with a continuing deterioration in performance against the 4hr standard; • 4-hour performance remains of concern and has declined across October and November; • The percentage of patients spending more than 12 hours in the ED department remains high, having further increased in October; • The percentage of patients who no longer meet the criteria to reside and who have not been discharged by 5pm have remained at significantly higher levels throughout 2022; • Above data points suggest EDs are experiencing exit block due to issues with discharge from wards. • Whilst only the first month, performance improvement trajectories for ambulance handover and 4hr standard performance are not being met. • Please see Appendix B, slide 35 for detail of performance by Place.	• Continued high demand for UEC services • Ambulance Handover delays • Increased Covid/Flu admissions and acuity of patients • Workforce availability and impact of Covid/Flu on the UEC workforce • MH assessment delays and bed shortages • Strep A impact from December onwards • Acute capital build in some areas impacting on the management of current and future demand until completion in December	**Alternatives to ED/reducing attendances:** • Implementation of the HARIS/Unscheduled Care Co-ordination (which includes call before convey and access to the Stack) to provide health care professionals working within our system access to appropriate clinical support to make the best use of services across the system and to reduce delays to improve performance. This program has commenced with support to EEAST Ambulance service (East of England Ambulance service); the HARIS proof of concept week was successful in reducing ambulance conveyance and demonstrated a related improvement in 30 & 60 minute handover times. Challenges continue with establishing a sustainable model and work continues with colleagues and region to develop. **System Strategy:** • Participation in the integrated Urgent and Emergency Care (iUEC programme) supported by the National Improvement team. The ICB is one of two systems that are participating in the pilot programme. The aim of the programme is to support development of a UEC strategy, support UEC recovery and reduce overcrowding in the EDs through diagnostics based on population health needs and service redesign. • Agreed Winter Action Plan and performance improvement trajectories set against Board Assurance Framework UEC priority metrics, aligned to Action Plan. New UEC Performance report to monitor delivery against trajectories with further supporting metrics covering the 8 Winter Domains. Adult Social Care Discharge fund agreed in December. • Strengthening of ICB and Place oversight and assurance arrangements linked to local escalation surge plans, and quality and performance frameworks. • Each acute provider has its own internal UEC improvement plan. • Please see Appendix B, slide 35 for detail of actions by Place.

UEC - Urgent 2 Hour Community Response





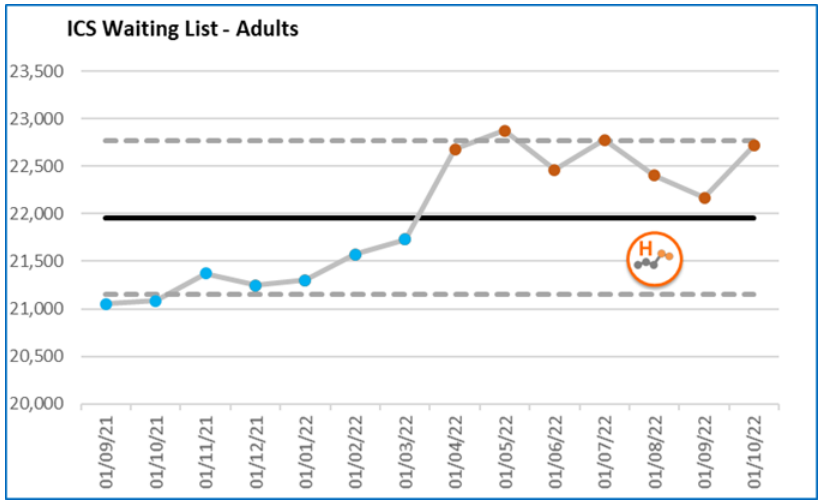


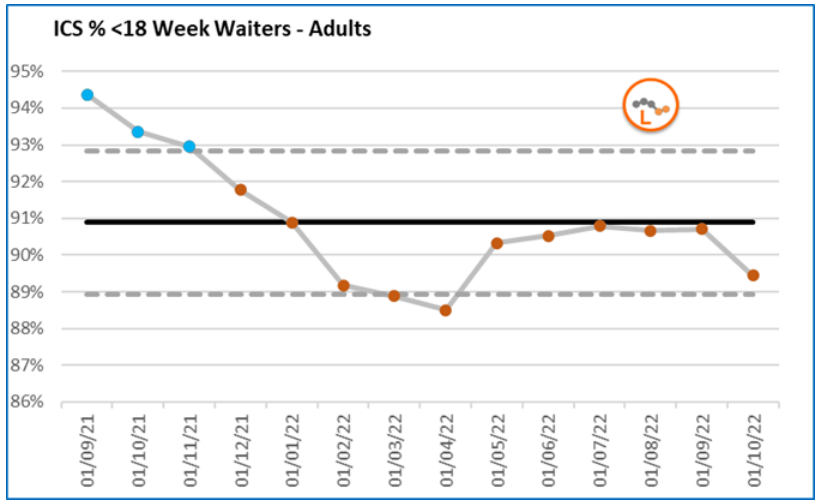
Activity	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
West Essex	289	353	468	465	428	337	451
East & North Herts	94	145	166	160	195	204	168
South & West Herts	147	142	157	162	165	124	163

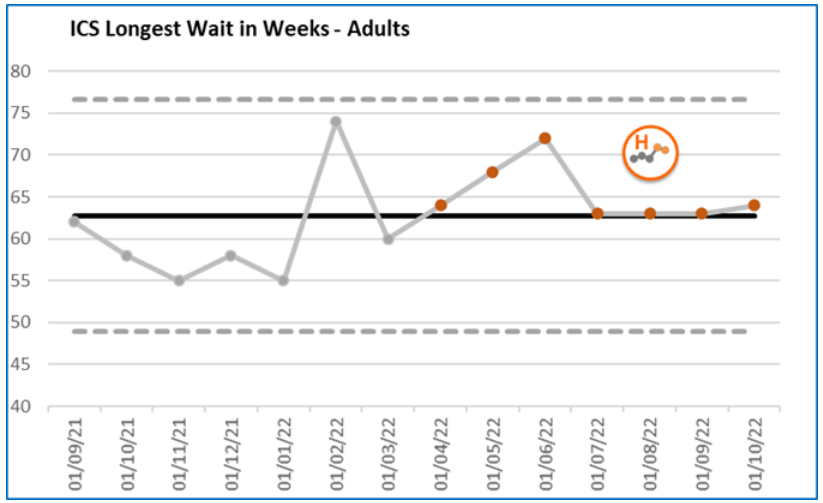
ICB Issues, escalation and next steps

- Improving or Common Cause Variation – no areas of concern
- Target being achieved in all three Places
- Provider BI leads have investigated the variances between West Essex and Hertfordshire activity and confirmed that the data is correct
- Service leads will undertake further work to understand the differences in activity levels by Place

Community Waiting Times (Adults)







		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	Latest data
ICS	Adults	22167	22719	↑	90.71%	89.44%	↓	63	64	↑	October

		Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	9976	10196	↑	86.63%	84.30%	↓	52	47	↓	October
ENH	AJM/Millbrook	358	353	↓	86.87%	79.60%	↓	63	64	↑	October
ENH	**All**	**10334**	**10549**	↑	**86.64%**	**84.14%**	↓	**63**	**64**	↑	**October**

		Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	CLCH	2493	2541	↑	90.13%	88.71%	↓	52	52	→	October
SWH	Connect	5871	5871	→	94.65%	94.65%	→	52	52	→	October
SWH	HCT	1045	972	↓	94.35%	96.09%	↑	41	43	↑	October
SWH	AJM/Millbrook	399	393	↓	84.96%	78.37%	↓	38	43	↑	October
SWH	**All**	**9808**	**9777**	↓	**93.08%**	**92.59%**	↓	**52**	**52**	→	**October**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT	1894	2265	↑	100.00%	99.91%	↓	16	22	↑	October
WE	EPUT - Wheelchairs	131	128	↓	100.00%	99.22%	↓	17	21	↑	October
WE	**All**	**2025**	**2393**	↑	**100.00%**	**99.87%**	↓	**17**	**22**	↑	**October**

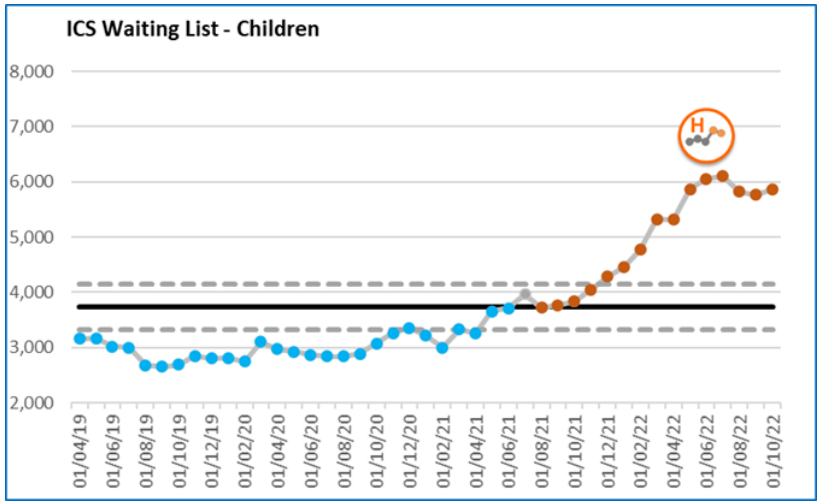
*** NOTE: Connect data has not been refreshed for October due to a data warehousing issue**

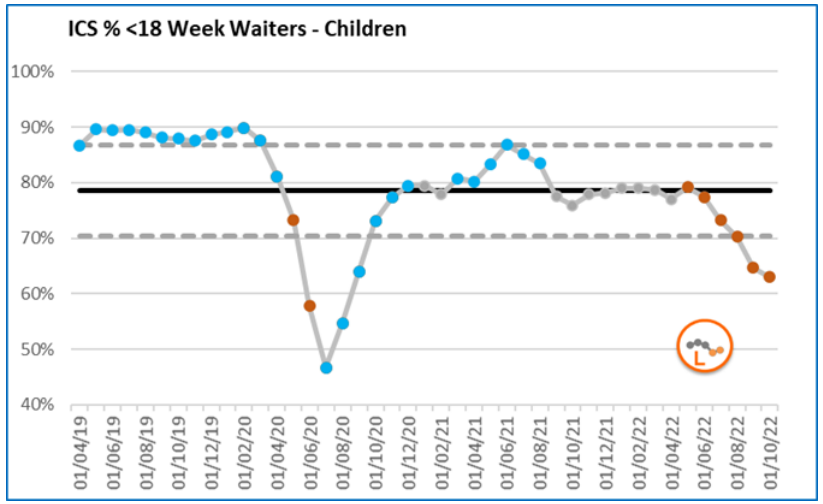
Community Waiting Times (Adults)

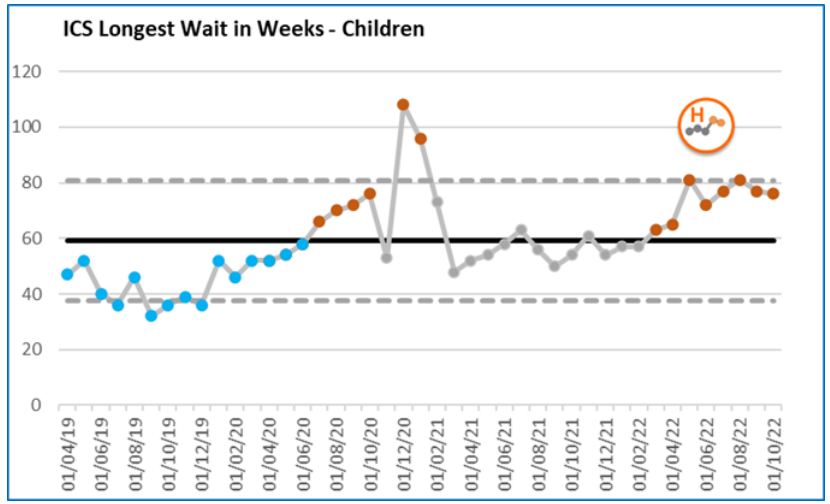
The NHS 18 week Referral to Treatment (RTT) standard only applies to consultant led services. For Adult community services this include Skin Health (ENH), Respiratory (S&W), and Podiatric Surgery (WE). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18 week target for an overall view of waiting time performance. Full details of commissioned services in HWE is contained with Appendix D, slide 39.

ICB Area	What the charts tell us	Issues	Actions
ICB	• Overall, the total number of adults waiting on waiting lists remains statistically high. Across the system there were 552 more patients waiting in October than in September • Total patients waiting increased by 215 in ENH, and by 368 in WE • SWH waiting lists reduced by 31 overall. In particular, Community Neuro has made good progress to clear long waits. The longest waiter is currently at 52 weeks • The % of patients waiting less than 18 weeks shows a statistically significant trend of below average performance. October performance of 89.4% is the lowest since April 22 • There was a period of waiting time recovery in 2021, but this was followed by a sustained period of increased referrals • Consultant led 18 week RTT performance: ENH Skin Health – 91% SWH Respiratory – 74% WE Podiatric Surgery – 100%	Current referral rates are showing a pattern of statistical increase, demonstrating that there has been a sustained period of additional demand on adult community services. **East & North Hertfordshire (ENH)** • Waiting times for the Neuro Service in ENH remain below target, with referrals up YTD by 11% • Waiting times for the MSK Triage and Physio Service in ENH remain below target, with reduced activity compared to 2019/20 • Pain Management waiting lists and contacts have increased due to demand from Long Covid. Wait list performance is 39% lower than baseline **South & West Hertfordshire (SWH)** • Referrals have increased across multiple services • Staff sickness across some services has impacted wait times. However, this is now improving • Respiratory service currently holds the majority of long waiters. Demand cannot be met with current provision of consultant clinics **West Essex (WE)** • Whilst 18 week RTT was achieved, MSK services were breaching contracted standard in October due to workforce / recruitment issues	**East & North Hertfordshire (ENH)** • Neuro service has been reconfigured to increase capacity, with more virtual appointments and self-management • Increasing MSK Physio capacity though estates and recruitment. Also continuing to review pathways. MSK Triage piloting self booking for routine patients • Pain Management Service pilot screening tool agreed to assist with signposting on the Covid Rehab pathway. Anticipated to positively impact **South & West Hertfordshire (SWH)** • Continue to review respiratory long waits daily, prioritising those waiting the longest • Sourcing temporary Respiratory consultant capacity via bank and alternative Hospital Trusts • Continue to monitor long waits weekly **West Essex (WE)** • Vacancies in MSK services have been recruited to and performance has improved since October

Community Waiting Times (Children)







		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	Latest data
ICS	Children	5770	5868	↑	64.70%	63.04%	↓	77	76	↓	October

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	930	914	↓	75.48%	76.04%	↑	72	76	↑	October
ENH	AJM/Millbrook	84	91	↑	89.29%	78.02%	↓	43	48	↑	October
ENH	**All**	**1014**	**1005**	↓	**76.63%**	**76.22%**	↓	**72**	**76**	↑	**October**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	4108	4158	↑	56.96%	54.28%	↓	77	75	↓	October
SWH	AJM/Millbrook	65	76	↑	78.46%	78.95%	↑	50	55	↑	October
SWH	**All**	**4173**	**4234**	↑	**57.30%**	**54.72%**	↓	**77**	**75**	↓	**October**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT - Wheelchairs	33	34	↑	93.94%	97.06%	↑	27	25	↓	October
WE	HCRG/Virgin	550	595	↑	97.09%	97.98%	↑	26	46	↑	October
WE	**All**	**583**	**629**	↑	**96.91%**	**97.93%**	↑	**27**	**46**	↑	**October**

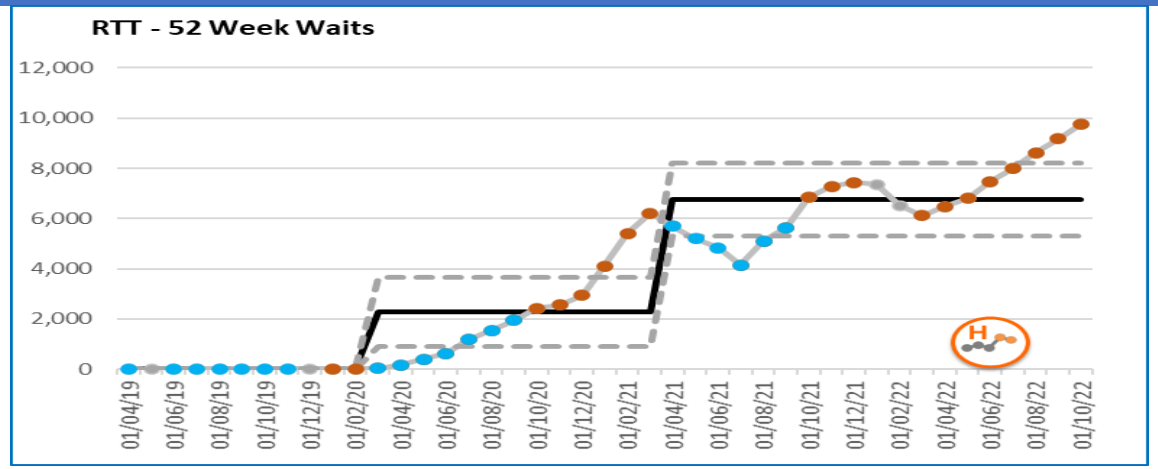
*** NOTE: Community Paediatrics data for ENH Place is not currently included in the above data. Development work underway with ENHT to include in future reporting**

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. Full details of commissioned services in HWE is contained with Appendix D, slide 40.

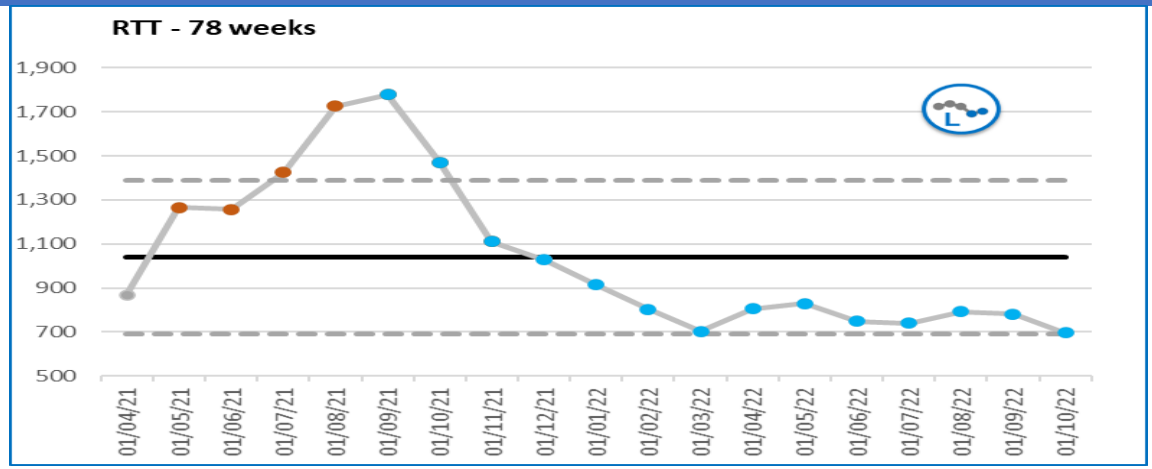
ICB Area	What the charts tell us	Issues	Actions
ICB	• Overall, the total number of children waiting on waiting lists has increased. There are 98 more children waiting in October than in September across the system • The % of patients waiting less than 18 weeks is showing a statistically significant trend of decline since April 22. SWH performance is the most challenged, followed by ENH • There was a period of waiting time recovery in 2021, but this was followed by a sustained period of increased referrals • Current referral rates are showing a pattern of statistical increase demonstrating that there has been a sustained period of additional demand on children's community services • Consultant led 18 week RTT performance: SWH Community Paediatrics – 47% SWH Children's Audiology – 42% ENH Community Paediatrics – 73% WE Community Paediatrics – 93%	**Hertfordshire** • Waiting times across Hertfordshire for Children's Therapies (OT, Speech & Language and Physiotherapy) are below target • Waiting times in the SWH HCT Community Paediatrics service remains challenged. Referrals have increased by 27%, although service productivity has also improved - up by 28% • The Paediatric Audiology service in SWH remains challenged, with only 42% being seen within the target wait time **West Essex (WE)** • The most challenged service in WE is Community Paediatrics. Whilst still achieving the 92% standard, long waiters have increased, with one patient at 46 weeks in October. Indicative data for November shows improvement to c.97%	**Hertfordshire** • Children's Therapies – increasing capacity through recruitment, waiting list initiatives and outsourcing • Working closely with commissioners on wider improvements across Special Education Needs (SEN) / Education, Health & Care Plan (EHCP) processes • Community Paediatrics in SWH is receiving non-recurrent additional investment, increasing workforce capacity and introducing new specialist nursing posts. Risk remains on recruitment to these roles. Transformation Programme group established to take forward service redesign • Paediatric Audiology in SWH is focusing on higher priority appointments, especially follow up appointments. Signposting to interim advice whilst awaiting assessment. Analysis underway for workforce business case, as capacity is not currently sufficient to meet demand **West Essex (WE)** • WE Community Paeds Business Case approaching completion and will then progress through Place and ICB governance for review and decision

Planned Care – 52 & 78 Week Breaches



	Apr 1	May 2	Jun 3	Jul 4	Aug 5	Sep 6	Oct 7	Nov 8	Dec 9	Jan 10	Feb 11	Mar 12	Apr 1	May 2	Jun 3	Jul 4	Aug 5	Sep 6	Oct 7	Nov 8	Dec 9	Jan 10	Feb 11	Mar 12	Apr 1	May 2	Jun 3	Jul 4	Aug 5	Sep 6	Oct 7
						201920												202021												202122		
Other	8	4	5	2	3	4	6	9	8	9	11	17	101	179	391	564	741	917	1021	1068	1197	1577	2004	4082	3740	5162	2782	2578	2447	2441	2394
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	0	0	0	0	0	0	0	0	0	0	2	27	60	140	213	272	363	420	467	657	914	1177	1286	1302	1249	1143	1269	1394	1536	2141	2321
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	2	3	4	4	1	3	0	0	0	0	1	3	53	135	302	484	669	855	1075	1112	1151	1463	1733	1702	1462	1162	898	789	800	838	878
EAST AND NORTH HERTFORDSHIRE NHS TRUST	4	5	21	19	21	18	16	15	25	22	24	37	90	209	190	483	604	735	931	987	1158	1724	2499	3221	2936	2791	2785	2095	2910	3259	3818

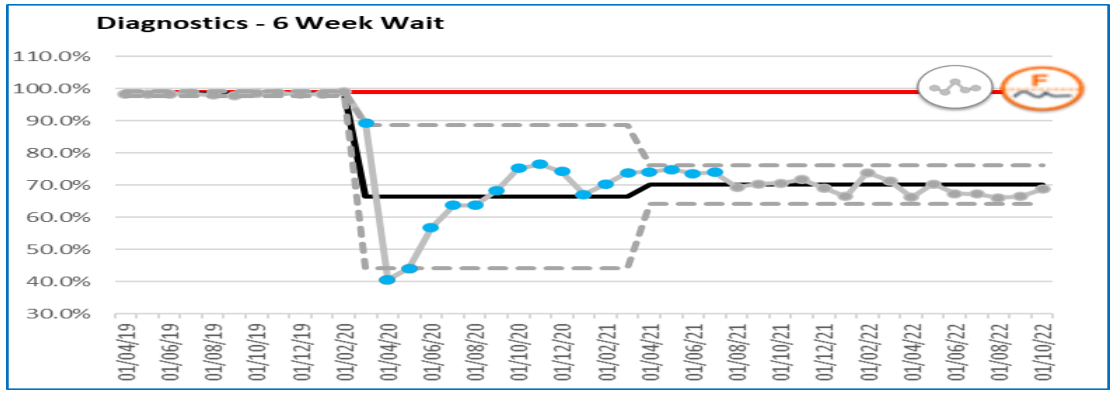
	Jan 10	Feb 11	Mar 12	Apr 1	May 2	Jun 3	Jul 4	Aug 5	Sep 6	Oct 7	Nov 8	Dec 9	Jan 10	Feb 11	Mar 12	Apr 1	May 2	Jun 3	Jul 4	Aug 5	Sep 6	Oct 7	Nov 8	Dec 9	Jan 10	Feb 11	Mar 12	Apr 1	May 2	Jun 3	Jul 4	Aug 5	Sep 6	Oct 7
										202122												202223											
Other	2296	2321	3348	2853	3033	2496	2412	2648	2532	2437	2533																						
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	2486	2613	2221	1737	1818	1674	1785	1911	1909	1898	1804																						
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	927	1006	1105	1059	1193	1431	1660	1783	2078	2587	3413																						
EAST AND NORTH HERTFORDSHIRE NHS TRUST	4102	4016	3739	3184	3313	3473	3699	4027	4294	4628	4688	4527																					

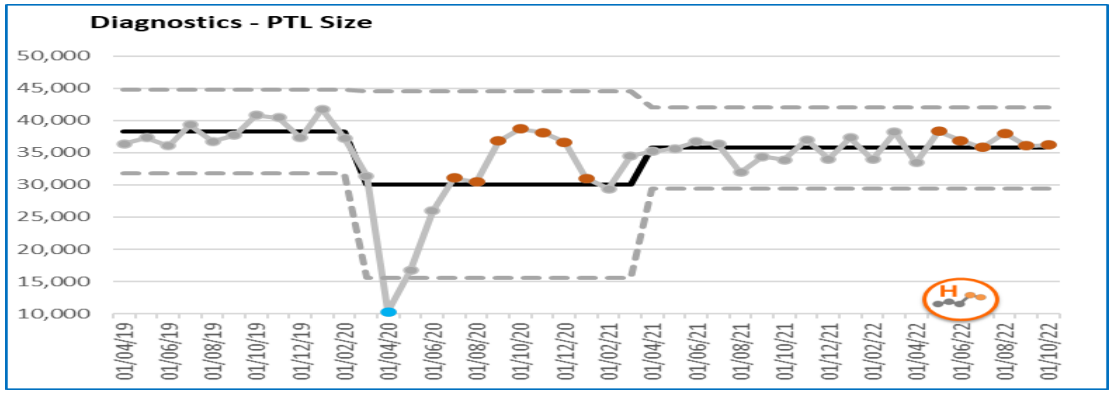


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	0	231	218	288	378	434	399	325	283	260	243	190	223	266	281	296	248	208	141
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	353	389	364	388	407	362	271	189	169	162	140	111	144	155	143	133	137	116	92
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

ICB Area	What the charts tell us	Issues	Actions	Mitigation
HWE	• No capacity breaches over 104 weeks • Continued overall improvement in number of patients waiting over 78 weeks however numbers have fluctuated across last 6 months • The number of patients waiting over 52 weeks continues to increase and remains a cause for concern	• Whilst there has been a reduction of longest waiting patients, not enough activity is being delivered to manage backlog effectively • 78 wks not projected to deliver '0' by March 23 • High referral volumes in early 21/22 now reaching their 52 week wait • UEC pressures impacting operating & bed capacity • Diagnostic waiting times • Staffing remains a challenge, particularly around anaesthetics • Lack of WLI additional capacity due to rate change • "Pop-ons" of long waiting patients identified through increased validation • Trauma and Orthopaedics, Gastroenterology and Community Paediatrics remain the main areas of pressure for long waiters	**Management of waiting lists:** • System focus on reducing number of patients waiting >78 weeks, with regional and national oversight; • ENHT has been de-escalated from Tier 1 to Tier 2 for 78 weeks with WHTHT remaining in Tier 1 due to data quality issues; • Demand, capacity & recovery plans in place with weekly specialty trajectories to monitor 78 weeks; • Weekly KLOEs in place with NHSEI to track 78 week position; • Fortnightly performance meetings with NHSEI support; • Validation and robust PTL management in place. **Increasing Capacity and Improving productivity:** • Pro-active identification of pressured specialties with mutual aid sought vial local, regional & national processes; • All providers signed up to Digital Mutual Aid System (DMAS) and have completed training; • Maximising use of ISP capacity and WLIs where possible • Community Paediatrics escalated to national level for mutual aid to support recovery; • Business case completed and going through ICB governance for a system high volume low complexity elective hub to add elective capacity from 24/25; • Mapping of elective programme in the UEC Winter Plan; • Theatre Utilisation Programmes in place; • Anaesthetist recruitment	• Actions delivering reductions in long waiting patients • National emphasis on prioritising patients in order of clinical need resulting in longer waits for routine patients • Clinical harm reviews and regular patient contact to manage patient safety and experience.

Planned Care – Diagnostics





ICB Area	What the charts tell us	Issues	Actions	Mitigation
HWEICB	• Some improvement seen this month, but 6 week wait recovery is fairly flat • Demand has increased between September and October and is a mix of Routine, Cancer and UEC • WHHT Imaging is performing well, with the exception of DEXA • PAH position is improved overall, particularly for CT. Endoscopy however is challenged • ENHT is performing well in Audiology and Cystoscopy, but Imaging is challenged • Physiological Measurement is challenged in all Places	• The biggest challenge remains workforce, particularly for DEXA, Audiology, NOUS and ECHO • Urgent/ Cancer referrals have increased and a review is being undertaken to understand if these are appropriate referrals. Initial work indicates they are • There is no additional revenue funding available for mobile units • ENHT have had issues in terms of estate and staffing for mobilising the CDC DEXA service • Staffing challenges have meant that the CDC NOUS service has not delivered the expected activity at the New QEII • Despite successful international recruitment of radiographers at ENHT and PAH, it takes time for onboarding and training to take place	• Over 8000 additional examinations have been undertaken at the New QEII CDC, with CT, MRI, X-ray and NOUS all performing above the revised trajectory • ENHT have an interim DEXA solution which will see activity increase in early 2023. Delay is due to staff training and sickness. WHHT are looking at insourcing and mobile options and will share resources with ENHT. Imaging Network also supporting looking at options to improve the DEXA position • PAH have recruited to a fixed term post and additional agency sonographers. NOUS position is looking better • iRefer CDS has been implemented at PAH and early signs are showing that it is having a positive impact • WHHT is working through internal governance processes to offer ENHT mutual aid for MRI • The system-wide diagnostic improvement plan was submitted in November to NHSE/I. This includes recovery trajectories for all challenged modalities. All modalities are expected to be DMO1 compliant by March 23 with exception of following challenged areas with longer recovery trajectories: Audiology, Non-Obstetric Ultra Sound, MRI (ENHT), ECHO (WHHT) and DEXA (WHTH and ENHT). • ENHT have commenced ECHO CDC services using an insourcing company; there was an issue with reporting but that has been resolved. This has seen an improvement in DM01 position. Activity is above revised trajectory. • There have been initial system-wide conversations regarding Audiology. Challenges are at PAH and WHTH. Initial actions are to review the ENHT service for learning, await analysis of the benchmarking data, and looking at mutual aid for PAH. WHHT has bid for 2 Audiology booths from underspend (1 x new and 1 x replacement) • The LOAs and MOUs for the CDCs have been received. Mobilisation can commence, but as PAH and WHHT will not be operational until late 23/24 this will not have an immediate impact. ENHT are due to submit a further business case for additional MRI at the CDC in 23/24	• CDC at ENHT is starting to see an impact on waiting times, but the service remains challenged due to staffing • WHHT are flexing their operational hours for each modality as and when required • PAH is using an MRI mobile unit on an ad-hoc basis to try and manage waiting times • System wide improvement plan finalised including trajectories for March 2023 ambitions

Planned Care – Theatre Utilisation

March 22

Theatres	ENH	PAH	W Herts
Utilisation - Capped	77%	62%	68%
Utilisation - Uncapped	80%	65%	77%
Average late starts (Minutes)	30	48	50
Average inter case downtime (minutes)	14	18	28
Average early finish (Minutes)	81	109	80
Average unplanned extensions (Minutes	30	61	96
Average cases per 4 hour session	2.6	1.8	2
BADS Day Case	79%	60%	71%

Source: Model Health System, NHSE & I

October 22

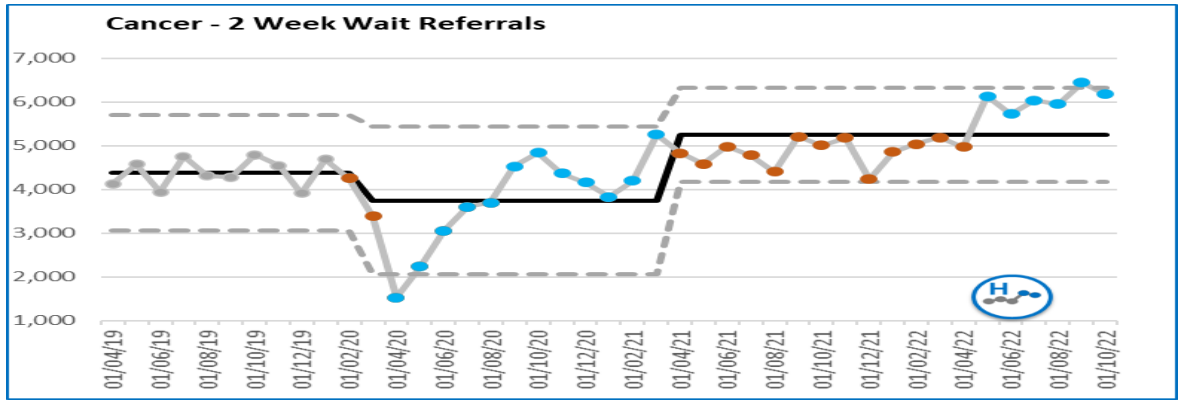
Theatres	ENH	PAH	W Herts
Utilisation - Capped	83%	69%	59%
Utilisation - Uncapped	85%	73%	62%
Average late starts (Minutes)	29	61	38
Average inter case downtime (minutes)	15	16	22
Average early finish (Minutes)	57	76	128
Average unplanned extensions (Minutes	32	51	125
Average cases per 4 hour session	2.5	1.8	1.7
BADS Day Case	83%	77%	67%

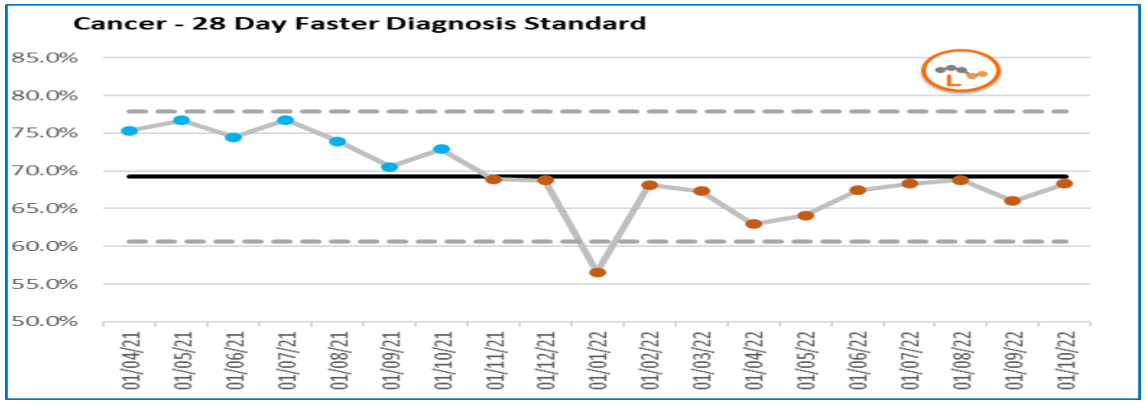
Source: Model Health System, NHSE (9/10/22)

Worst quartile — Best Quartile

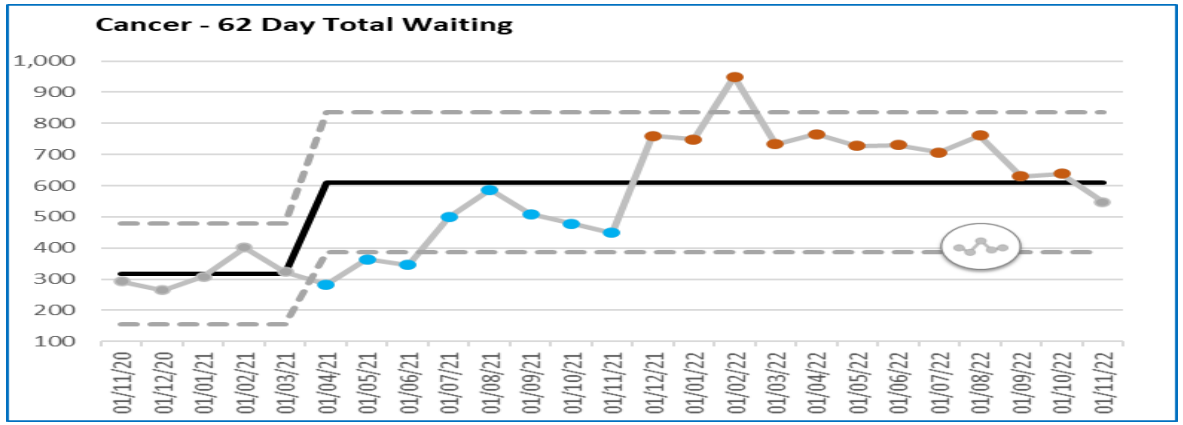
ICB Area	What the charts tell us	Issues	Actions
HWEICB	• Comparison of Model Hospital theatre utilisation data from March 22 to October 22, rag rated against quartile performance; • Both capped and uncapped utilisation has improved at ENHT and PAH but declined at WHTHT; • BADs Day Case Rates have improved at ENHT and PAH but declined at WHTHT.	• All Trusts need to further improve their theatre capped touch time utilisation to reach the 85% target • All Trusts need to further improve their BADs Day Case Rates to reach the 85% target • Self assessment of current status will identify specific issues and actions to form delivery plan	GIRFT High Value Low Complexity Targets (HVLC): 1. Theatres Capped Touch time Utilisation = 85% 2. Theatres Capped Touch time Utilisation for HVLC = 85% 3. BADS Day Case Rates = 85% • A system wide theatre efficiency and productivity group has been established which first met in December 2022; • The group will pull together the work programmes of each of the three providers which are already established; • The three focus points will be; delivery plan to improve compliance to the 85% target, a self assessment of the current status, and looking at right procedure, right place.

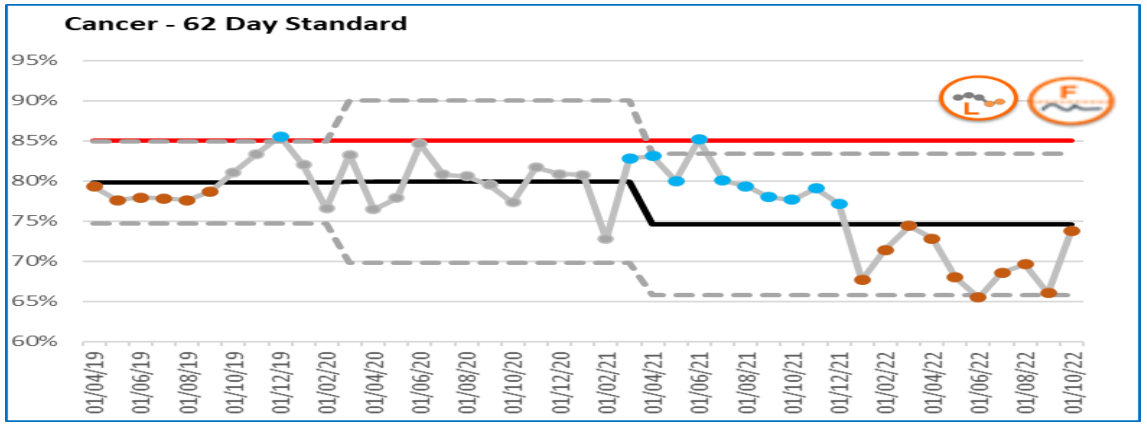
Cancer





	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
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%	68.0%	64.2%	70.6%	71.7%	72.6%	69.7%	71.5%
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%	51.3%	57.7%	55.6%	60.3%	60.2%	57.8%	63.2%
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%	74.3%	72.3%	72.8%	68.3%	70.4%
ICS	75.6%	76.9%	75.4%	78.9%	75.3%	71.1%	73.8%	69.3%	68.9%	54.4%	67.3%	65.6%	60.8%	62.4%	66.4%	67.5%	68.3%	64.8%	68.0%





	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	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
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	73	76	96	105	79	83	109	88	132	179	130	128	129	331	347	374	307	261	297	297	277	270	257	233
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	129	118	200	187	127	107	141	161	212	224	201	190	127	175	176	303	194	182	156	128	125	162	152	163
EAST AND NORTH HERTFORDSHIRE NHS TRUST	90	70	120	106	117	92	114	96	155	184	178	160	193	253	226	272	232	322	275	306	304	329	221	242

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	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
EAST AND NORTH HERTFORDSHIRE NHS TRUST	80.6%	75.4%	75.5%	79.8%	74.5%	69.6%	81.1%	85.4%	87.6%	83.5%	79.7%	87.4%	87.3%	85.9%	87.3%	89.2%	85.3%	90.1%	86.9%	86.6%	87.0%	86.5%	83.4%	87.4%	81.1%	88.2%	85.0%	80.3%	86.1%	87.5%	86.1%	89.9%	86.2%	79.5%	87.6%	84.1%	86.0%	81.1%	82.4%	86.0%	82.7%	86.1%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	77.8%	83.3%	81.2%	72.8%	81.7%	86.7%	78.2%	78.9%	81.9%	83.0%	76.0%	80.0%	68.8%	69.7%	73.9%	86.4%	74.7%	85.7%	83.7%	80.0%	86.3%	81.1%	86.3%	73.4%	84.5%	84.9%	75.0%	86.8%	80.1%	79.3%	78.0%	70.9%	75.0%	77.2%	74.5%	76.2%	69.2%	56.7%	62.6%	56.2%	61.4%	66.1%	69.8%	68.3%	66.0%	62.6%	68.7%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	78.7%	74.7%	76.5%	82.6%	70.8%	79.5%	82.2%	85.3%	87.2%	87.7%	83.7%	76.7%	79.7%	85.8%	87.1%	89.3%	84.6%	80.8%	80.6%	79.5%	87.7%	83.1%	79.4%	84.9%	67.3%	68.4%	66.8%	68.3%	68.9%	78.4%	69.2%	64.1%	62.5%	63.8%	67.7%	61.4%	68.5%	68.1%	62.7%	69.2%	64.5%	68.6%	69.6%	66.6%	67.3%	73.7%
ICS	79.3%	77.6%	77.9%	77.8%	77.6%	78.7%	81.0%	83.3%	85.5%	85.2%	80.6%	76.6%	83.2%	76.5%	79.7%	89.4%	84.6%	80.8%	80.6%	79.5%	87.7%	83.1%	77.6%	80.8%	80.7%	79.2%	78.2%	83.1%	79.8%	80.0%	85.1%	79.0%	79.3%	78.0%	77.7%	79.0%	77.2%	67.6%	67.1%	71.4%	69.2%	68.8%	69.5%	68.6%	68.9%	66.6%	73.7%
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

Cancer

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• 2 ww cancer referrals continue at significantly higher levels but saw a slight decrease in Oct • 28d FDS performance continues at improved levels in Oct, however delivery by March at risk • Following a dip in Sept 62 day performance remains below standard, but saw a significant improvement in Oct to 73.7% • Continued overall reduction in 62 day backlog; further work required to meet March 23 ambition of 427 – see slide 23	• Continued high referral levels • Cancer management, tracking and coding capacity • Urology, Lower GI, Skin & Gynaecology capacity – other tumour sites are achieving, or close to plan • Notable proportion of longest waiters are at tertiary centres	• Substantive Head of Cancer now in post • Pathway Transformation Manager has recently been appointed and will focus intensively on Urology in the first instance, then Lower GI • Rolling programme of Super PTL days is in place to target booking and validation on a service by service basis • Plans in place to maintain Christmas operating capacity • New Tele-Dermatology service is scheduled to launch in January	• System support and oversight in place with bi-weekly meetings • Weekly Key Lines of Enquiry (KLOE) process in place with Cancer Alliance • Cancer Harm Review process in place
South West Herts / WHTHT		• Overall there has been an improvement in cancer performance however delays in the 2 week wait pathway have affected performance against the 28 day faster diagnosis standard (63%) although this is better than last month's position (58%). • Increased level of referrals and workforce challenges are the main issues • Demand continues to outstrip capacity and remains a challenge to manage the new demand and backlog particularly in Breast and Skin for 2 week waits • Staffing challenges particularly in the Breast service • 62 day issues are due to slow diagnostic pathways and delays for outpatient capacity	• Trust moved out of Tiering system altogether (from Tier 1) with consistent improvement • Additional consultant posts (substantive + locum) for Upper GI, Breast, Radiology, Urology • Additional prostate template biopsy capacity created • Outsourcing (Gastro/Endoscopy, Breast, Prostate MRI capacity) • Nurse led clinics in Dermatology for imaging • Increasing straight to test (STT) pathways • Trust wide A&C recruitment events • Established a cancer long waits (90+ days) review meeting • Collaboration with PC to develop Breast pain clinic in community & continued roll out of dermoscopy • Breast 2ww referral form changes made to support demand • Substantive Lead for Cancer and Palliative care now in post • Continuation of the spotlight on cancer huddles and weekly cancer long waits reviews • Renewed focus on delays; clinical reviews and letter production • Dermatology advice & guidance service for lesions of diagnostic uncertainty launched	• Weekly Key Lines of Enquiry (KLOE) process in place with CA • All patients on PTL are tracked • Implemented clinical harm reviews for pts >28 days and diagnosed with cancer • Clinical review requested by MDT trackers and escalated to Divisional Directors • Current 62 day first performance is at 68% and an improvement from September • Good improvement in 62 day backlog, now with 9% of pathways over 63 days.
East & North Herts / ENHT		• Increased 2 ww referral levels and growth in PTL • Radiology continues to face major issues with capacity and staffing, likely to affect 62-day cancer performance and backlog for coming months • 31-day performance for Radiotherapy affected in September and October due to staffing issues; unable to recruit Band 6 staff • Histopathology challenges • Lack of WLI additional capacity due to rate change • Challenges with late referrals to ENHT as a tertiary centre impacting PTL waits >62 days	• Trust has been moved from Tier 1 to Tier 2 based on progress in reducing 62-day backlog • Histopathology and Radiology to improve MDT follow-up, reporting and more timely communication of diagnosis and next steps, particularly for patients who after diagnosis do not have cancer • Deep dives for tumour sites continue. Additional scrutiny and support leading to improved performance • Timed pathways now in place for all Tumour sites to improve and sustain 62-day standard • Work continues to improve and deliver the Faster Diagnosis Standard performance • Radiology and histopathology continue to prioritise cancer patients to avoid delays; offering WLI work to increase capacity • Team continue to analyse breaches by Tumour Site to identify issues and resolve pathway delays	• Weekly Key Lines of Enquiry (KLOE) process in place with Cancer Alliance • Fortnightly Tier 2 performance meetings and review of recovery • Robust weekly PTL management in place; clinical and operational review of patients waiting >62 and 104 days with clinical harm reviews in place

Performance v. 22/23 Operational Plans

Herts and West Essex Providers (please see Appendix C, slide 36 for performance by Place)

Baseline	22/23 Activity Plan	22/23 M1-7 Activity Plan
246,604	330,131	179,445
	+34%	
N/A	0	2
N/A	0	615
6,109	6480	7174
956,620	890,984	532,894
	-7%	
N/A	3.1%	1.5%
8%	25%	25%
N/A		
417,182	448,818	261,726
	+8%	
289	267	418
69%	69%	70%

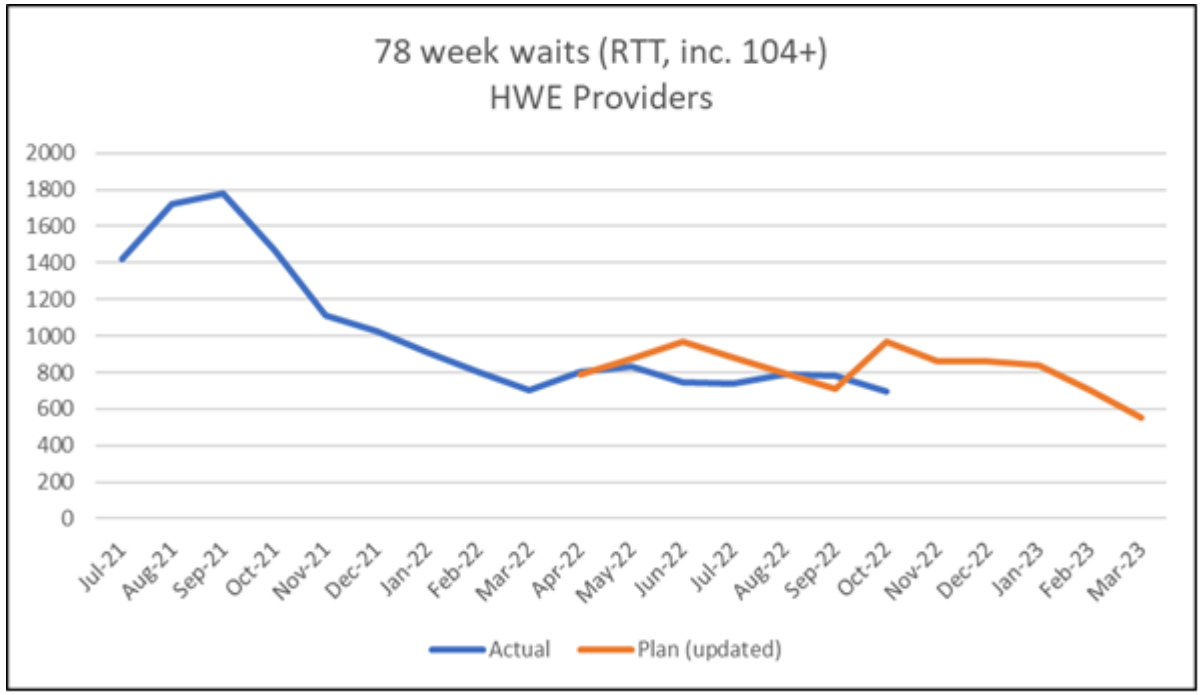
Area	Target
Activity	10% elective activity increase (19/20 levels RTT pathw ay)
Waitlist	104 w eek w aits eliminated by Jul 22 (w aitlist, end of Jun 22)
	Eliminate 78 w eek w aits by Apr 23 (w aitlist, end of Mar 23)
	52 w eek w aits trending dow n across 22/23
Outpatients	25% reduction in outpatient follow -ups by 2023
	5% of outpatients moved or discharged to PIFU
	25% of consultations via video/telephone
	16 specialist advice requests per 100 outpatient firsts
Diagnostics	20% increase in diagnostic capacity against 19/20 levels
Cancer	Reducing cancer 62+ day w aitlist to pre-pandemic levels
	Reduction in missed 28 day cancer decisions *(Measure is % decisions delivered in 28 days or less)*

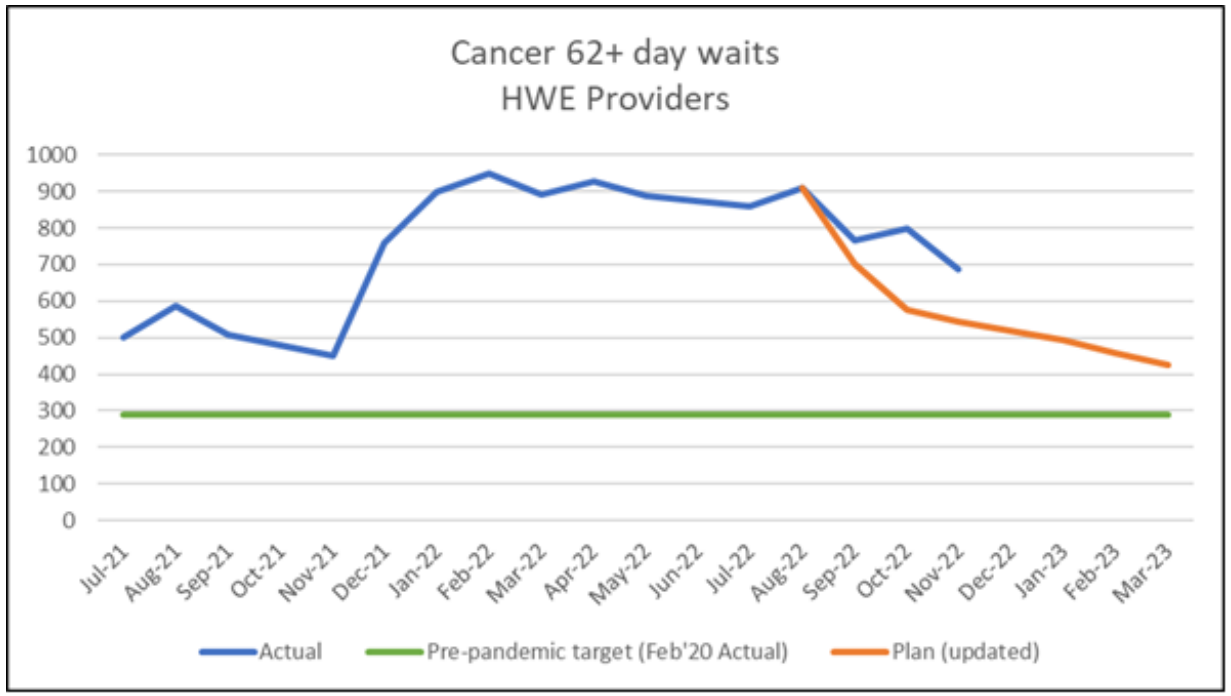
	M1-7 Actual							
	April	May	June	July	August	September	October	Total
Plan	16,815	19,497	22,586	30,620	29,143	30,317	30,467	**179,445**
Actual	16,815	20,581	19,866	18,336	18,833	20,939	21,207	**136,577**
Variance	0	1,084	-2,720	-12,284	-10,310	-9,378	-9,260	**-42,868**
Actual	124	77	35	15	9	5	4	**4**
Actual	806	829	748	741	792	782	697	**697**
Actual	6484	6804	7472	7988	8615	9173	9744	**9744**
Plan	72,089	76,682	73,718	82,239	74,852	75,573	77,741	**532,894**
Actual	70,256	79,357	72,553	71,481	72,114	72,555	72,864	**511,180**
Variance	-1,833	2,675	-1,165	-10,758	-2,738	-3,018	-4,877	**-21,714**
Actual	0.7%	0.9%	0.9%	0.7%	0.8%	0.8%	0.8%	**0.8%**
Actual	23%	22%	23%	23%	20%	21%	21%	**22%**
Actual	25	25	26	28	27	25	22	**26**
Plan	33,749	36,708	35,018	39,879	37,842	38,186	39,654	**261,036**
Actual	30,029	33,868	31,968	32,034	33,068	32,603	32,543	**216,792**
Variance	-3,720	-2,840	-3,050	-7,845	-4,774	-5,583	-7,111	**-44,244**
Actual	928	887	875	860	911	767	798	**767**
Actual	61%	62%	66%	68%	68%	65%	68%	**66%**

ICB Issues and escalations

- Activity significantly off planned levels for both elective and diagnostics (as seen nationally);
- Revised recovery trajectories agreed with NHSE/I and planning submissions updated;
- Good delivery against patients waiting over 104 weeks, with remaining patients a result of choice;
- Patients waiting over 78 weeks continues to reduce and whilst is not forecast to deliver zero by March 23, is currently ahead of revised trajectory – see next slide;
- 52 week waits are increasing and remain a significant area of concern;
- Overall, remain on track with Out Patient programmes of work;
- Cancer backlogs have reduced, however further work required to reduce to the revised March 23 ambition of 427 – see next slide.

Performance v. 22/23 Operational Plans

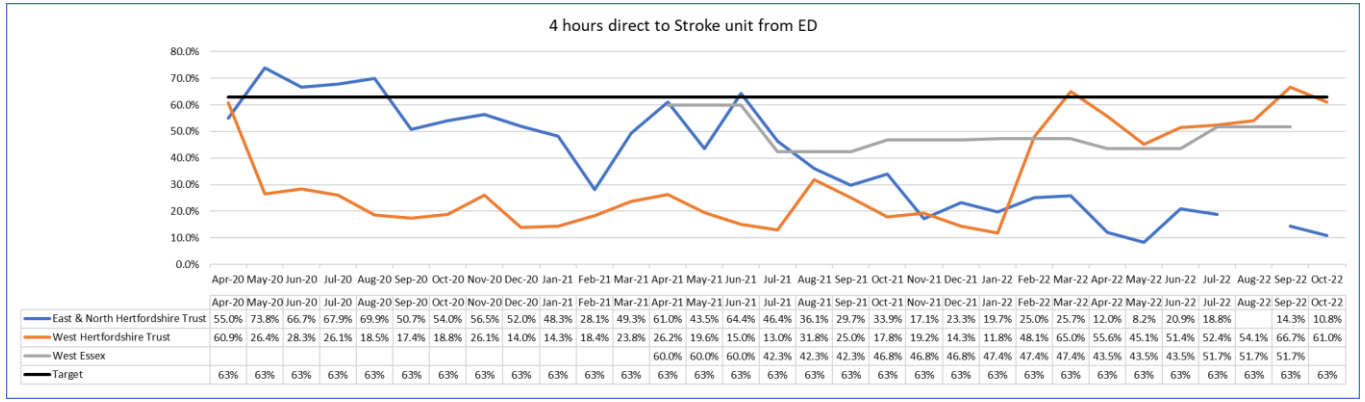




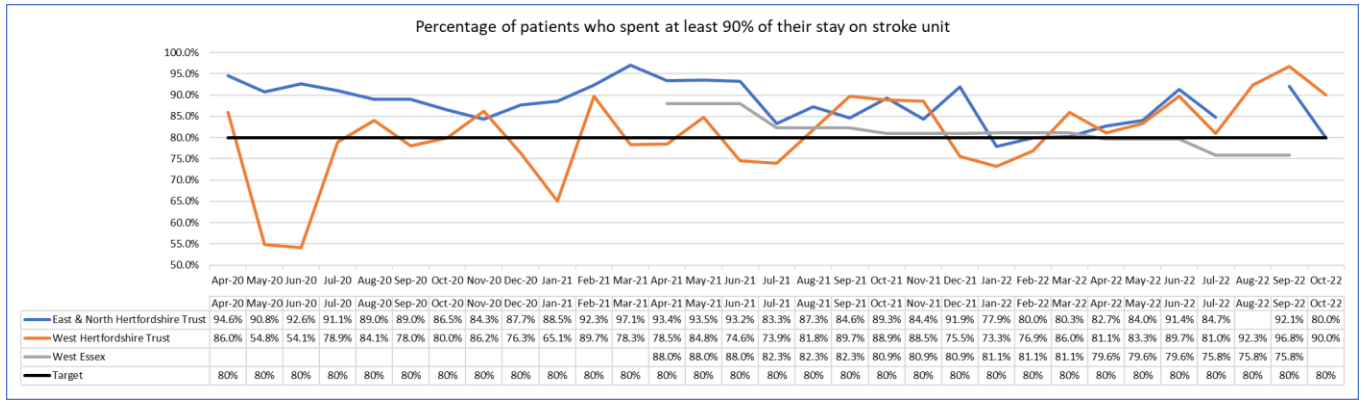
ICB Issues and escalations

- 78 week activity is currently ahead of revised plan, with the number of patients continuing to reduce overall;
- Cancer 62 day backlogs are reducing, however further work is required to reduce to the revised March 23 ambition of 427, with activity currently behind plan. Delivery of 62 day backlog trajectory in March 23 is at potential risk.

Stroke



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	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
East & North Hertfordshire Trust	55.0%	73.8%	66.7%	67.9%	69.9%	50.7%	54.0%	56.5%	52.0%	48.3%	28.1%	49.3%	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%		14.3%	10.8%
West Hertfordshire Trust	60.9%	26.4%	28.3%	26.1%	18.5%	17.4%	18.8%	26.1%	14.0%	14.3%	18.4%	23.8%	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%	66.7%	61.0%
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%	
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%



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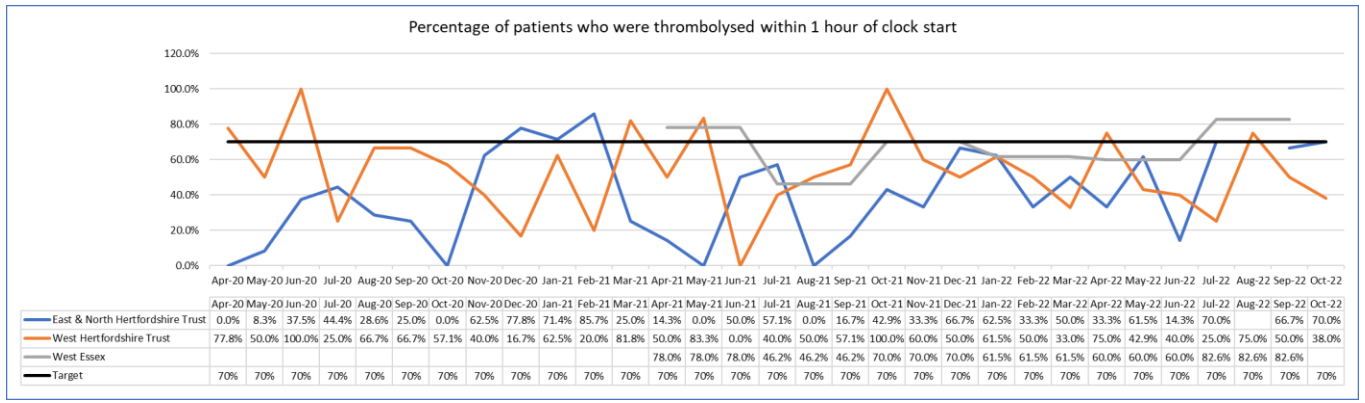
East & North Hertfordshire Trust	94.6%	90.8%	92.6%	91.1%	89.0%	89.0%	86.5%	84.3%	87.7%	88.5%	92.3%	97.1%	93.4%	93.5%	93.2%	83.3%	87.3%	84.6%	89.3%	84.4%	91.9%	77.9%	80.0%	80.3%	82.7%	84.0%	91.4%	84.7%		92.1%	80.0%
West Hertfordshire Trust	86.0%	54.8%	54.1%	78.9%	84.1%	78.0%	80.0%	86.2%	76.3%	65.1%	89.7%	78.3%	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%	92.3%	96.8%	90.0%
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%	
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%



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East & North Hertfordshire Trust	0.0%	8.3%	37.5%	44.4%	28.6%	25.0%	0.0%	62.5%	77.8%	71.4%	85.7%	25.0%	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%		66.7%	70.0%
West Hertfordshire Trust	77.8%	50.0%	100.0%	25.0%	66.7%	66.7%	57.1%	40.0%	16.7%	62.5%	20.0%	81.8%	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%	38.0%
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%	
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%

ICB Issues, escalation and next steps

West Essex:

Barking, Havering and Redbridge Trust (BHRT) is the main provider of Stroke for West Essex patients. Reporting remains on a quarterly basis via the national SSNAP database.

- Q2 saw an 8% improvement in 4 hour admission performance, and thrombolysis performance improved by over 22%
- West Essex Stakeholder Programme Meeting scheduled for January. PAH / BHRT / EPUT
- T&F group established to review the pathway between PAH and Queens. Specific concerns re staffing to meet HASU standards, and increased DNAs from patient reluctance to travel
- Stroke Association contract extended to March 23. Business case to be presented to January Transformation Committee for approval to commence procurement
- ICB Squire and Catalyst funding bids successful

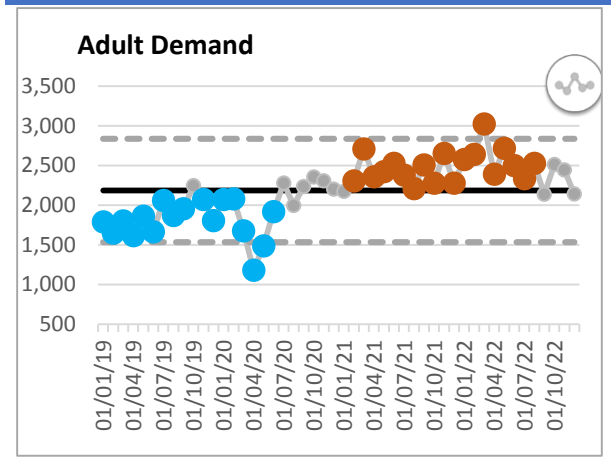
Herts (note: awaiting clarification of Aug 22 data):

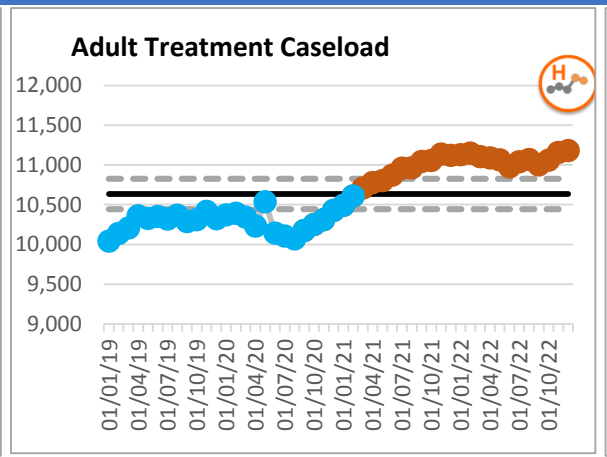
Performance continues to meet standard for the percentage of patients who spent at least 90% of their stay on a stroke unit, at 90% in WHTHT and 80% at ENHT in October. Performance further declined at WHTHT against the percentage of patients who were thrombolysed within 1 hour at 38% in October but returned to meet standard at ENHT at 70%. Performance remains below standard for 4 hours direct to stroke unit from ED at both Trusts, however WHTHT have seen an improvement in performance at 62.8% in October with ENHT performance further declining to 10.8% in October.

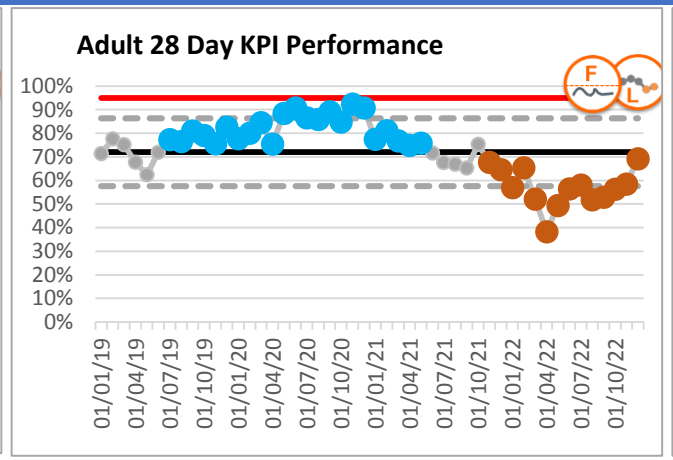
Next Steps

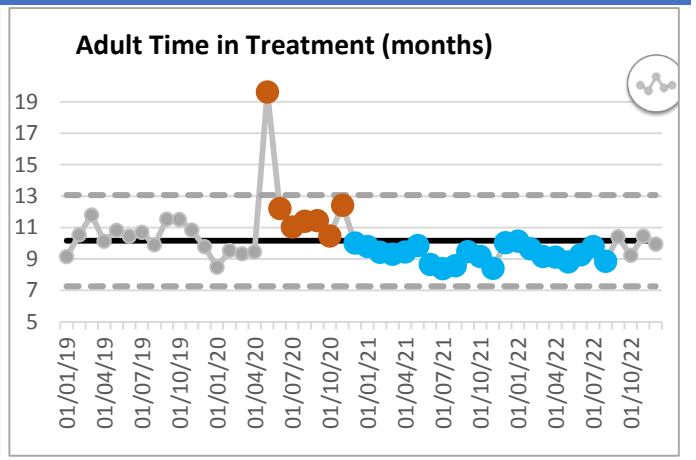
- WHTHT are undertaking a review of the noncompliant patient pathways to understand themes which need to be addressed. Maintaining ring fenced beds on the HASU and a ring-fenced side room for patients requiring thrombolysis whilst awaiting swab results. A review and validation of the reasons patients were not thrombolysed within the one hour window, was undertaken which showed clinical factors and complexity on presentation.
- WHTHT are working to their SSNAP improvement plan in response to their ISDN SSNAP review. This focuses on improving KPIs around access to MRI, reporting of CT Angio and workforce issues. Improvements have been made in access to MRI for people with suspected TIA.
- ENHT Stroke team are working with ED and external ICS working group on pathway review to support Stroke pathway from admission to discharge.
- ENHT have ringfenced Stroke bed capacity increasing it from 3 to 4 beds.

Mental Health – Adult Services



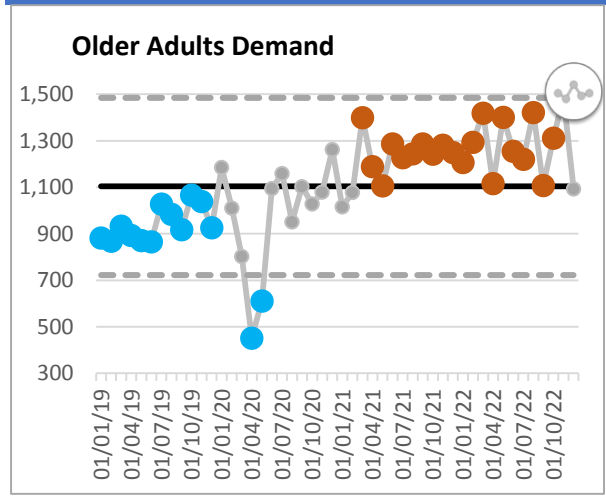


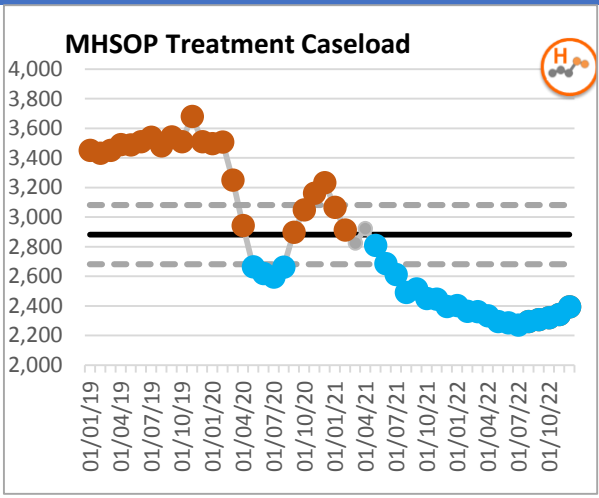


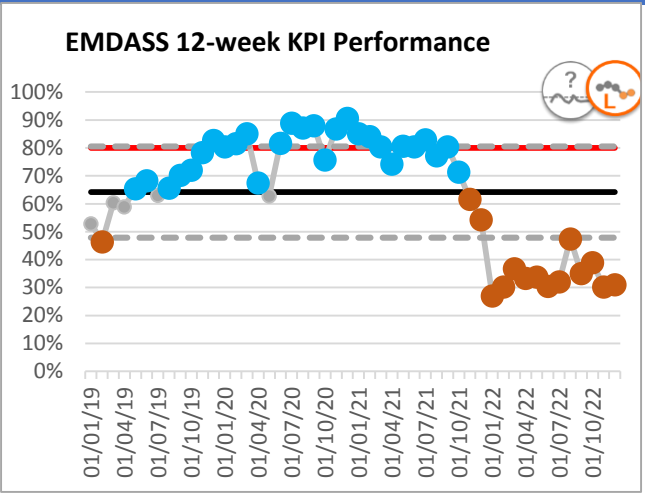


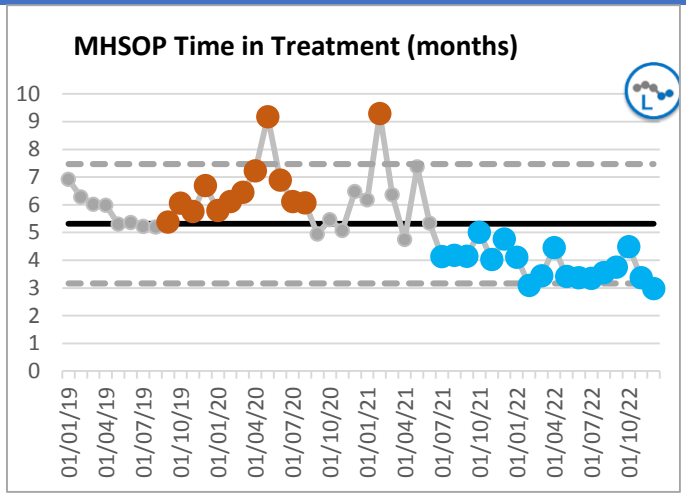
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Adult Community Mental Health Services (HPFT and EPUT)	Referral demand has been on long term upward trajectory in the post pandemic period, however in Q3 referral demand has levelled off. There are 800 more service users in treatment now than there were at the start of the pandemic. The time it takes from referral to assessment has improved over the last quarter but we are still not meeting our 28 day assessment targets across the ICB.	Sustained high demand has resulted in a waiting list for HPFT's initial assessments, with high levels of vacancies in some teams, where recruitment is particularly challenging. In Dec 95% of service users were assessed within 48 days of referral, which is an improvement from Q2 (56 days). Sickness rates in December along with regular winter pressures have seen staff shortages compounded.	Agency staff recruited, who are currently undertaking additional assessments every week. Additional administrative support extended to community mental health teams to improve efficiency and responsiveness Commissioned external process efficiency consultant (LEAN) to optimise current processes Out of hours clinics to provide extra capacity from substantive staff and make access easier for service users	Flow continues across the adult community pathways with 95% of service users being seen within 48 days. Community Transformation continues to see more service users in primary care. Recovery for performance is expected in Q4 2022/23.

Mental Health – Older Adults Services



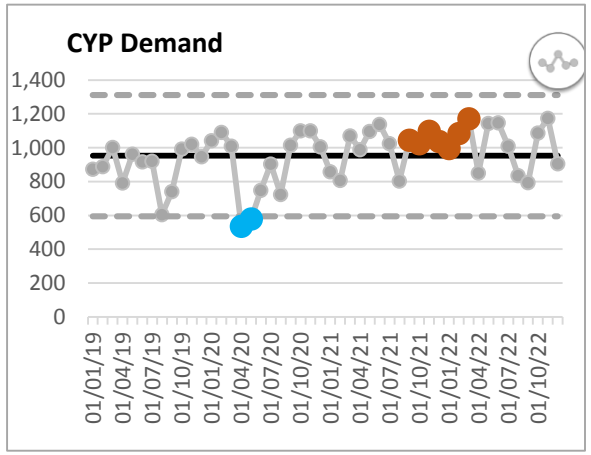


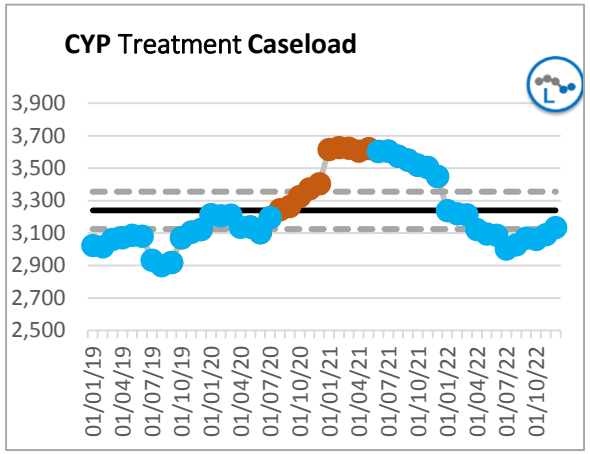


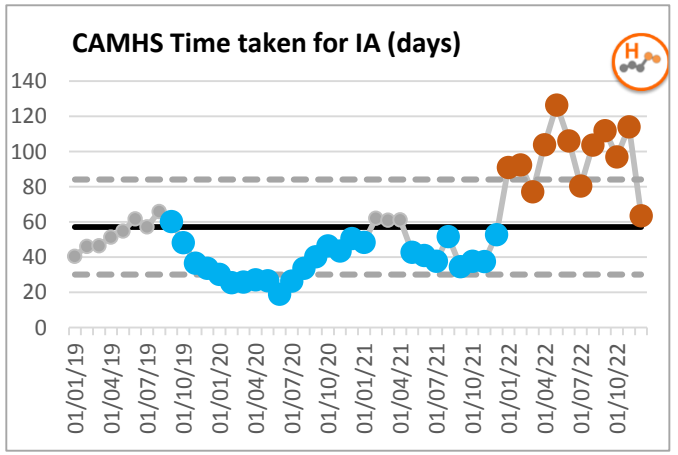


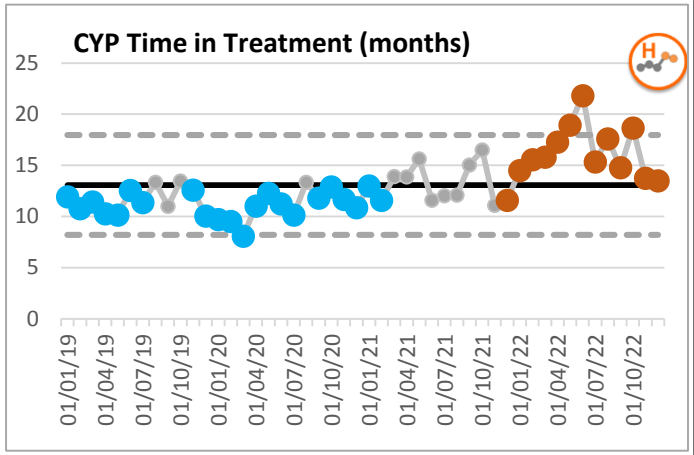
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Older Adult Community Mental Health Services (HPFT and EPUT)	Increase in referral demand since Jan 2021 was initially due to suppressed demand during COVID and has continued to remain high. Increase in older population in Harlow + Uttlesford compared to national data. New partnership working arrangements with Alzheimer's UK has led to a reduction in overall caseloads in MHSOP in Herts. In Herts the EMDASS service was temporarily halted due to re-deployment of staff over the winter in 2021-2 which led to a backlog of diagnosis. Overall time spent on treatment pathways has stayed the same.	Not meeting access standards for referral to diagnosis for Dementia (EMDASS) Recruitment vacancies for Consultants, Registered Nurses, OT's in West Essex – impact Occupational Therapists Access to specialist brain imaging/scanning in West Essex	Recovery programme activity for EMDASS diagnosis service – expected to recover in Q4 West Essex International Recruitment programme; challenges around recruitment remain but not impacting on delivery of dementia diagnostic and treatment pathway Future expansion of community diagnostic capacity across ICB is being mobilised Targets being achieved in West Essex, with best practice to be shared across the system	Risk review and prioritisation for service users who have been waiting Additional clinics for evening and weekends to improve waiting times Primary care dementia diagnosis nurses improving activity with a focus in West on care home population. EMDASS recovery is planned for Q4 2022/23 but delivery at risk of slippage to Q1 23/24

Mental Health – CAMHS Services



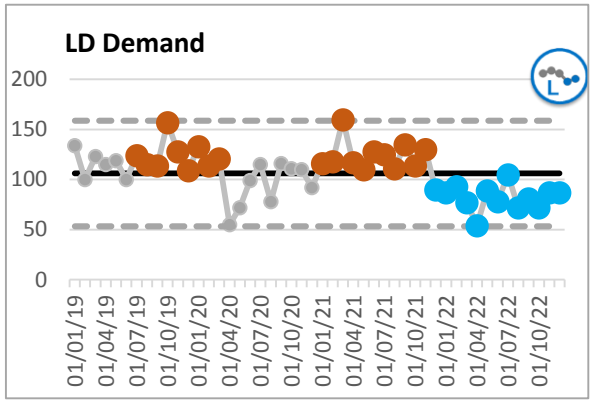


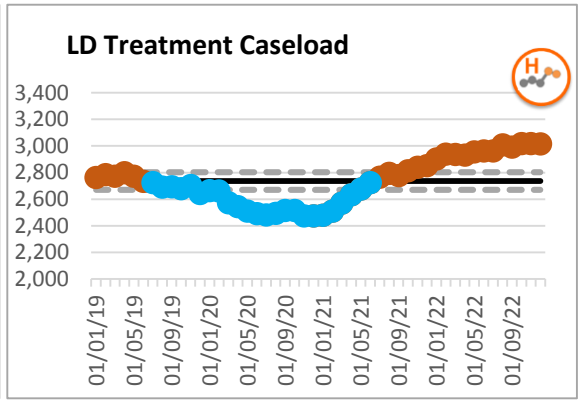


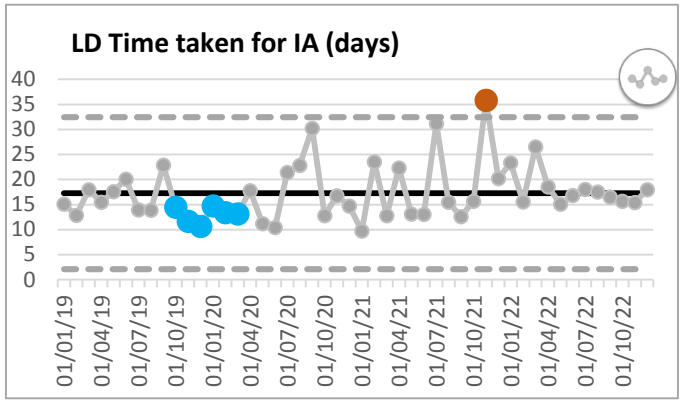


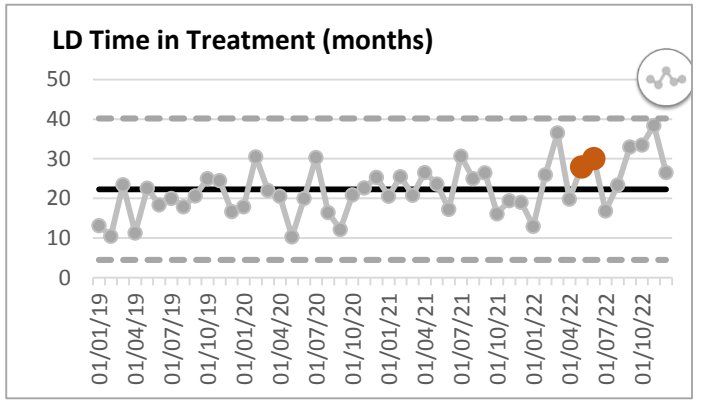
ICB Area	What the charts tell us	Issues	Actions	Mitigation
CAMHS (Herts and West Essex; HPFT and the Collaborative, HCT data to be added Q4)	Referrals into CAMHS have passed 1,000 per month over the last 12 months (20% up from pre-pandemic levels). This has translated to pressure on initial assessments but has not yet converted into increased caseloads in CAMHS. From Jan 2022 we have not met the performance KPI for initial assessments (Choice) Length of time from referral to discharge has grown by 5 months over the last year from a mean of 12 months to 17 months. This may be an indication of increased acuity.	Referral demand has led to an increase in the number of triage activity we need to provide in the single point of access. ADHD referrals are now beginning to flow through secondary mental health services into the newly commissioned primary care ADHD service. Some services have seen unexpected demand (e.g. Tier 3 Specialist CAMHS ED, Crisis, and Looked after children).	Recovery programmes for CAMHS ED, CAMHS Targeted and CAMHS crisis have completed in Q3 in line with projections. Recovery programme remains in place for CAMHS 28 days, due to complete in Q4 2023 Mobilisation and implementation of the new CAMHS ADHD service underway in Q3 and the first 100 cases transfer to primary care in Jan 2023. HCT's Data to be integrated in Q4 report	SPA Triage Tool improved to meet 5 day pass on to teams undergoing testing Job planning to continue in all quadrants to ensure qualitative approach Demand and capacity review commissioned to assess post-covid requirements in Q4. Recovery for referral to assessment times to 28 days expected in Q4 2022/23

Mental Health – Learning Disabilities Services



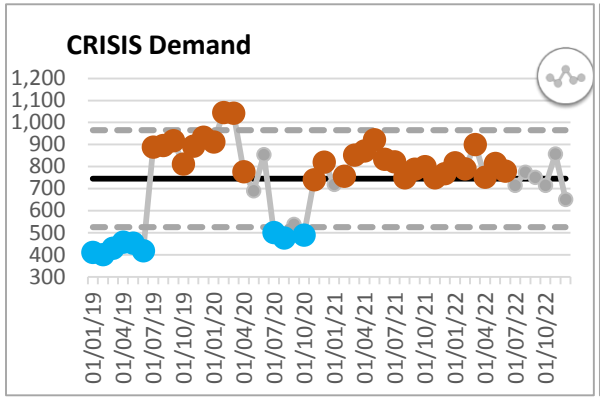


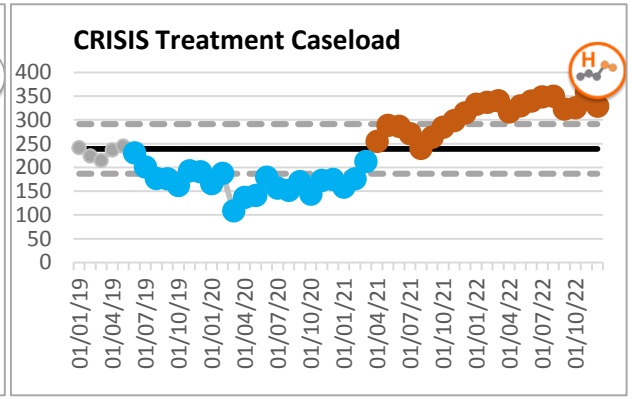


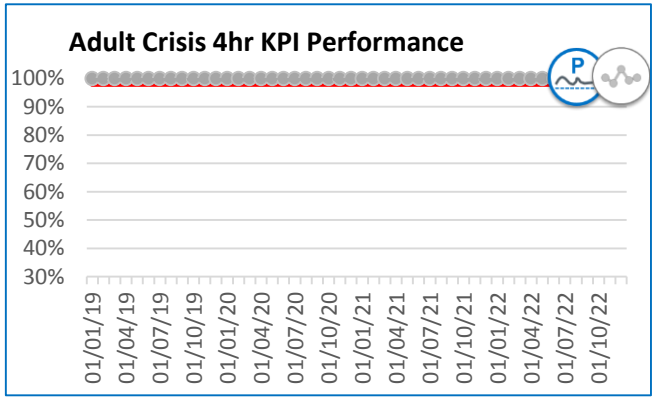


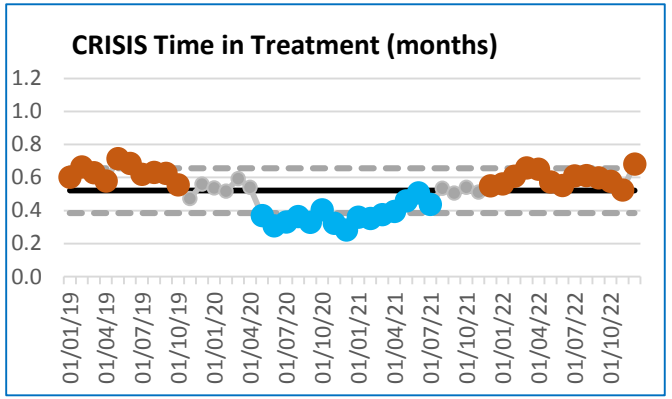
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Learning Disabilities Service (Herts and West Essex)	Referrals and caseloads services dropped during Wave 1 and Wave 2 of the pandemic but have returned to pre-pandemic levels. Service Users are seen consistently within 28 days of referral and the average time it takes from referral to a completed assessment is 17 days	Successful re-integration of LD services in Essex enabling further opportunities for integrated learning and service delivery. Since the integration of Essex LD there appears to have been a growth in treatment caseloads. This is to do with data integration issues rather than a rising increase in actual cases.	Data cleansing programme in place to address post migration data cleansing issue in Q4. New service user and carer engagement and involvement programme aimed at improving care planning, service delivery and outcomes for LD service users across Herts and Essex.	Focus on reducing secondary waits and care co-ordination and risk management during wait periods. Working with commissioners ensure that GPs are aware and know how to refer directly into LD services

Mental Health – Non Inpatient Urgent Services



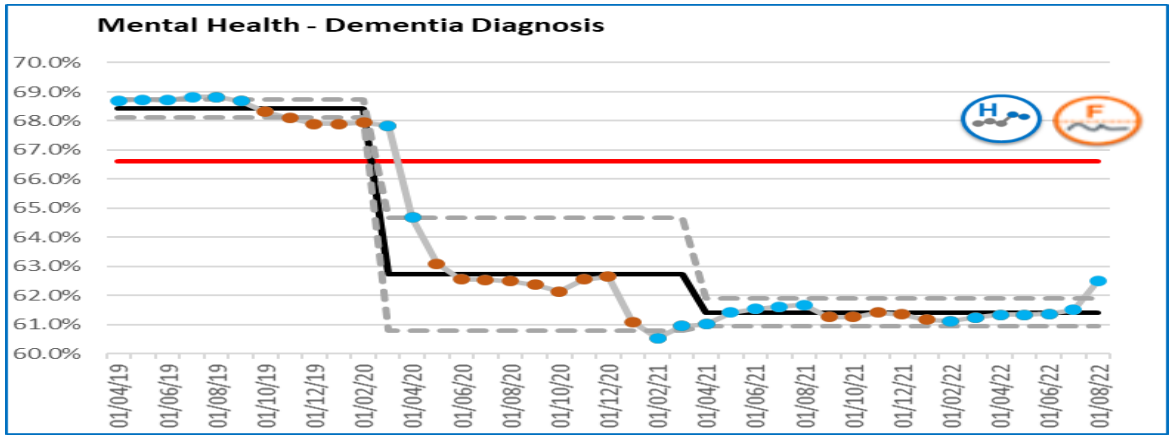


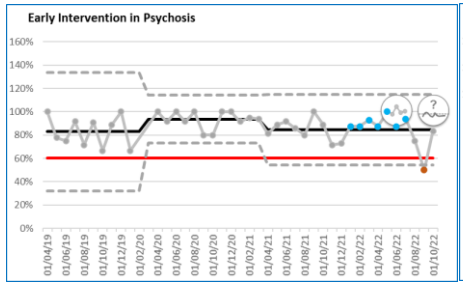




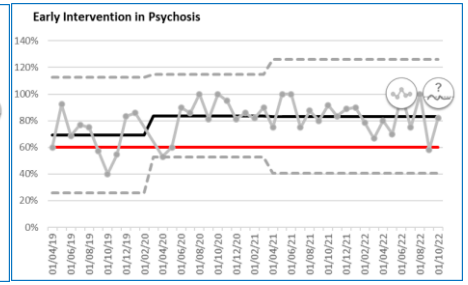
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Crisis Services – Adults and Older Adults (HPFT Herts only, EPUT to be added Q4)	Crisis demand peaked in the 6 months following Wave 1 and Wave 2 of the pandemic. Demand levels did not grow in Q3 however the current crisis referral level is almost 100% higher than pre-pandemic. Caseloads are on high against historical baselines which reflects an increase in service user need and complexity. Service Users are seen consistently within 4 hours of referral and the average time under caseload management in the Crisis and Home Treatment Team is 1 month Note: In Essex, Crisis teams do not own team caseloads in favour of being an extension of the community team. Home First Team data to be added.	High demand and turnover on the Crisis and Home Treatment Team (CRHTT) led to pressure on the service.	Rolling recruitment and training for CRHTT has led to three new appointments in Q3. West Essex Home First Team data to be added for Q4	Agency support for Community Team releasing staff stepping up into CRHTT roles. Crisis teams expected to be fully recruited by end of Q4 2022.

Mental Health – Dementia Diagnosis and Early Intervention in Psychosis (EIP)

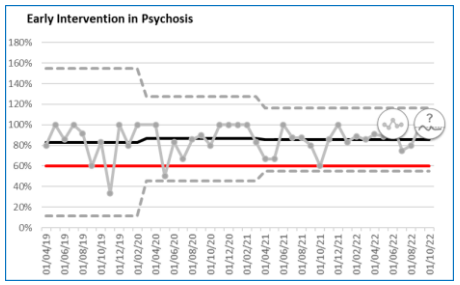




East and North Herts



South and West Herts



West Essex

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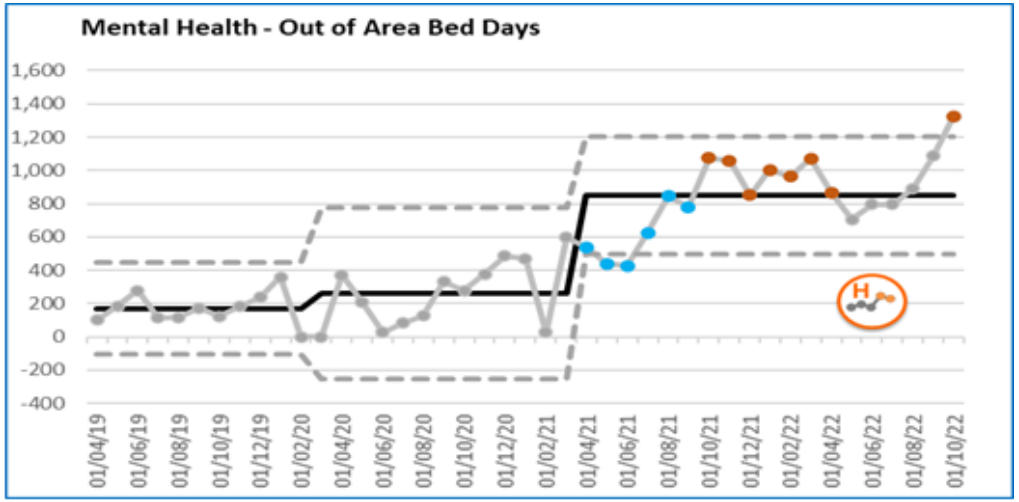
NHS EAST AND NORTH HERTFORDSHIRE CCG	66.6	66.6	66.7	66.9	67.1	67.0	67.4	66.9	66.8	66.6	66.6	66.4	64.1	62.5	61.7	61.8	62.0	61.5	61.3	61.6	61.1	59.5	59.2	59.6	59.4	59.7	60.2	60.2	60.2	59.5	59.3	59.5	59.2	59.0	58.8	59.2	59.2	59.2	59.0	59.1	60.9
NHS HERTS VALLEYS CCG	69.4	69.4	69.3	69.1	69.3	69.1	68.1	68.2	68.0	67.7	67.9	67.6	63.2	61.4	61.0	60.4	60.1	60.4	59.8	60.2	61.0	59.3	58.4	58.9	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
NHS WEST ESSEX CCG	71.2	71.2	71.4	71.7	71.0	71.0	70.3	70.0	69.7	70.7	70.6	71.0	68.6	67.5	67.2	67.9	68.1	67.8	68.1	68.9	68.7	67.5	67.0	67.4	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
ICS	68.7	68.7	68.7	68.8	68.8	68.7	68.3	68.1	67.9	67.9	68.0	67.8	64.7	63.1	62.6	62.5	62.5	62.4	62.1	62.6	62.6	61.1	60.5	61.0	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
Target	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6	66.6

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	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
ENHCCG	100%	77.7	75.0	91.6	71.4	90.9	66.6	88.8	100%	66.6			100.	91.7	100.	91.7	100.	80.0	80.0	100.	100.	91.7	94.7	93.8	81.3	88.9	91.7	85.7	80.0	100.	88.9	71.4	72.7	87.5	87.5	92.9	87.5	100.	87.5	93.8	75.0	50.0	83.3
HVCCG	60.0	92.3	68.7	76.9	75.0	57.1	40.0	54.5	83.3	85.7			52.9	60.0	90.0	85.7	100.	81.3	100.	95.0	81.3	85.7	81.8	90.0	75.0	100.	100.	75.0	87.5	80.0	91.7	83.3	88.9	90.0	78.6	66.7	80.0	70.0	100.	75.0	100.	58.3	81.8
WECCG	80.0	100.	85.7	100.	91.6	60.0	83.3	33.3	100.	80.0	100.		100.	50.0	83.3	66.7	85.7	90.0	80.0	100.	100.	100.	100.	83.3	66.7	66.7	100.	87.5	87.5	80.0	60.0	85.7	100.	83.3	88.9	85.7	90.9	88.9	100.	75.0	80.0	100.	100.
Target	56%	56%	56%	56%	56%	56%	56%	56%	56%	56%	56%	56%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• Recorded Dementia Diagnosis September 2022 will be the last monthly publication in this series until early 2023. This is due to a change in the national data collection for these publications. • ICS performance improved in August to 62.5% and the 66.6% standard continues to be met in West Essex. • The EIP national standard is being achieved in all three Places.	**Dementia Diagnosis Herts** • Recovery action plan agreed, actions commencing January 2023 • Data capture and coding • Staffing: Three of the four Dementia Specialist Nurses Recruited, who will be working at the Primary Care Services for older people	**Dementia Diagnosis Herts:** • Enhanced Commissioning Framework (ECF) for GPs to complete coding exercise to capture true diagnosis rate. Admin role in Primary Care Diagnosis Service to free Nurse Specialists . Practice Data reviewed monthly to target support. Focus on physical LTC - respiratory, MSK and older people **EIP:** • Work continuing to collate data at ICS level for SPC presentation in next report	**Herts:** • Continue with current actions to increase access to Dementia Diagnosis and IAPT services • Dementia Diagnosis actions will deliver recovery on trajectory by 2023/24 • Bring Recovery Action Plans into one forum to ensure central oversight • Support around identifying causes of low conversion rates at memory clinics and understanding/incorporating demographics such as age, deprivation, Etc. into the estimated prevalence figures that Herts are trying to meet
Herts				

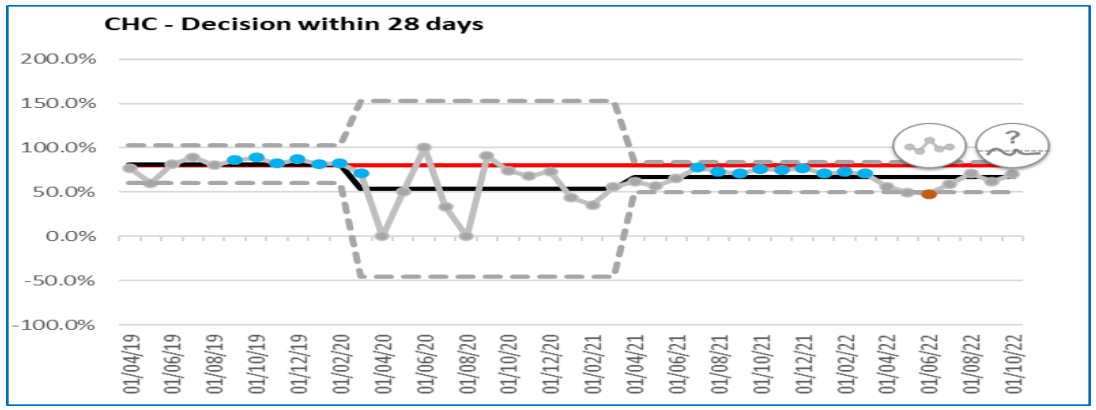
Mental Health – Out of Area Bed Days



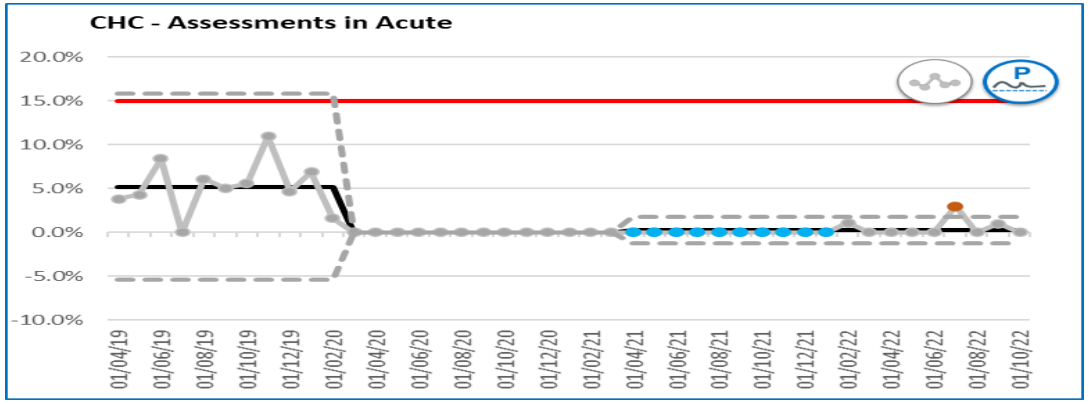
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Hertfordshire	100	185	277	114	118	172	124	182	239	360			372	207	26	83	125	331	277	376	486	471	26	596	452	337	336	574	834	759	936	745	674	779	830	987	767	691	775	757	817	1034	1177
Hertfordshire Target	66	132	200	58	116	175	50	100	150	42			33	33	34	20	20	20	10	10	10	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

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• Out of Area Bed Days for West Essex increased considerably in October • A further rise is expected in Nov, however indicative data for Dec shows a significant improvement	• Pressure for Mental Health beds has increased substantially over the Covid, and has continued post-Covid, leading to a national shortage of beds, high occupancy rates and use of OOA beds	• SMART (Surge Management and Resilience Toolset) - providing real time ward data • Essex review of bed model and stock. Essex commissioners meeting to review outcomes in January • Multi Agency Discharge Event (MADE) scheduled for Jan	Out of Area Placement (OOAP) Elimination & Sustainability Impact System Group (Essex wide) in place to monitor the impact of the NHSE OOAP Action Plan. Continue to engage with additional expertise as part of the national Getting It Right First Time programme to identify areas of improvement. • Bed management system New arrangements in place to monitor demand and capacity. In addition, new standard operating procedures in place to tighten standardise practice. • Integrated Discharge Team approach is being scoped out in Herts to improve coordination of discharges
Herts	• Continued increase in Out of Area Bed Days in October 22.	• Low number of beds per population • Pressure for MH beds increased substantially over Covid, and has continued post-Covid, leading to a national shortage of beds, high occupancy rates and use of OOA beds and this is likely to continue into Q4 2022/23 • Challenges in finding suitable placements for service users with complex needs • Ongoing refurbishment in Kingfisher Court resulting in closure of 2 beds	• Reduce admission through gatekeeping • Adopt purposeful Inpatient Admission Model • Daily OOAP reviews /dedicated clinical ownership for OOAPs • Reviewing what other areas are doing I.e. voluntary service input to pathways. Review community demand and capacity, to avoid admissions • Multi Agency Discharge Event (MADE) took place in November	

Continuing Health Care (CHC)



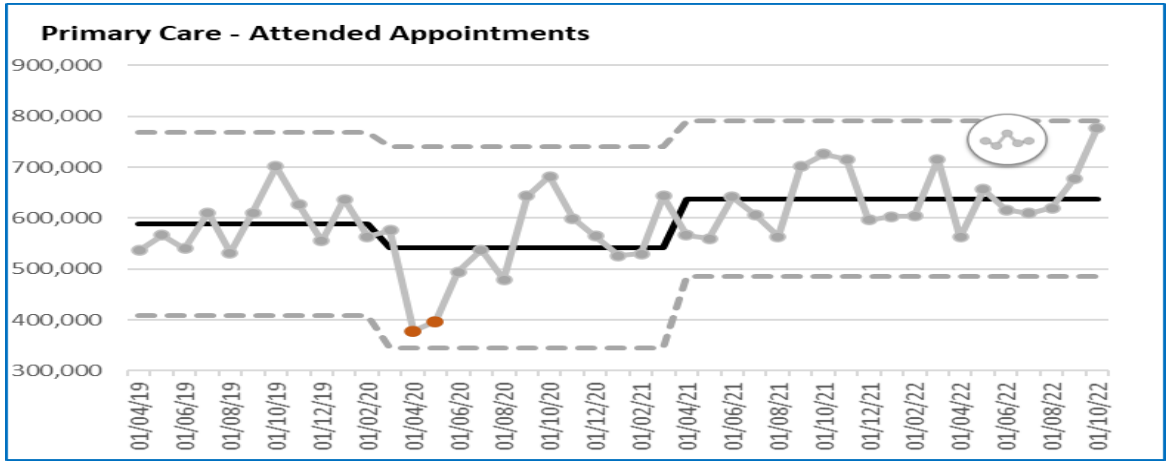
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
East & North Hertfordshire CCG	55.0	33.3	72.0	91.2	57.1	68.0	71.4	68.4	75.0	53.3	57.9	71.4	0.0	50.0	100.0	33.3	0.0%	57.1	21.1	34.2	30.8	21.1	18.4	25.6	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
Herts Valleys CCG	84.5	69.6	84.3	88.3	88.5	91.9	92.1	87.0	89.7	87.5	93.0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0	91.4	87.7	86.6	69.7	66.7	75.8	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%
West Essex CCG	58.3	39.4	54.0	55.6	58.3	50.0	34.5	63.2	57.1	52.2	88.2	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%	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%
ICS	76.9	60.2	81.1	89.4	80.5	85.9	88.9	82.2	86.9	81.6	82.3	71.4	0.0%	50.0%	100.0	33.3	0.0%	90.6	74.0	68.0	73.1	43.7	35.6	56.0	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%
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

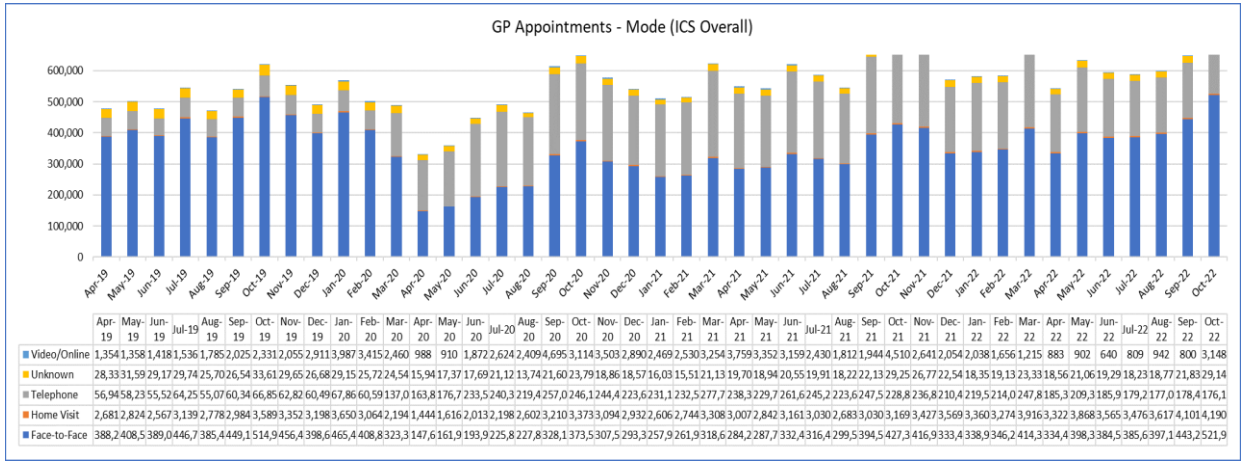


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
East & North Hertfordshire CCG	0%	8%	0%	0%	0%	4%	0%	11%	5%	0%	5%	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%	5%	0%	6%	0%
Herts Valleys CCG	5%	3%	11%	0%	8%	5%	7%	11%	5%	8%	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%	2%	0%	0%	0%
West Essex CCG	0%	17%	23%	0%	11%	13%	8%	6%	7%	21%	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	4%	4%	8%	0%	6%	5%	6%	11%	5%	7%	2%	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%	1%	0%	0%	0%
Target	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• 100% of CHC referrals in West Essex resulted in a decision within 28 days, surpassing the standard of 80% • No patients received assessments in an acute setting	• 80% standard is unlikely to be reached in December due to a lower than expected volume being processed. Community Teams and staff vacancies continue. • Delayed allocations of Social Workers from out of area, particularly from London Boroughs. • Ongoing increasing backlog of CHC, FT and FNC reviews due to prioritising new assessments.	• The West Essex CHC Team continues to work alongside EPUT to provide additional resource and support. • The team is confident that Quarter 3 performance will be achieved. Recruitment for vacancies ongoing. 1 nurse recruited in the last round of interviews. • New reviews project about to commence to try and reduce increasing backlog.	• SWH action plan in place, supported by NHSEI • Performance standards continue to be monitored, issues escalated and risks mitigated • Agency cover requested for vacancies whilst recruitment continues • Setting trajectory and drive on clearing cases over 28 days
South West Herts / WHTHT	• Performance against decisions within 28 days remains below the expected 80%; however improvement continues, reaching 63% in November. • No patients received assessments in an acute setting	• Workforce issues, recruitment • Ongoing backlog of CHC & FNC reviews due to prioritising new DSTs • Referrals numbers continue to be high • Workforce issues including long term sickness absence in place-based senior leadership.	• Recruitment drive continues, interim cover in place to support the gaps • Prioritisation of fast track and 1:1 reviews. • Allocation and weekly tracking of 28 day assessments remains a priority • Case management in place for all cases over 6 weeks • Collaborative working with system partners; weekly meetings with LA • Face to face Nursing needs assessments are completed and evidenced. • Support/cover from senior leaders within the other two place areas	
East & North Herts / ENHT	• 100% of CHC referrals in East & North resulted in a decision within 28 days. • No patients received assessments in an acute setting	• Workforce issues such as sickness and annual leave • Ongoing delays receiving signed assessment paperwork from community, particularly Mental Health, may impact performance going forward	• The Team is confident that Quarter 3 performance will be achieved. • Weekly tracking of referrals over 28 days by caseload and CHC manager • Performance levels expected to be achieved in July	

Primary Care





	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	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
Video/Online	1,354	1,358	1,418	1,536	1,785	2,025	2,331	2,055	2,911	3,987	3,415	2,460	988	910	1,872	2,624	2,409	4,695	3,114	3,503	2,890	2,469	2,530	3,254	3,759	3,352	3,159	2,430	1,812	1,944	4,510	2,641	2,054	2,038	1,656	1,215	883	902	640	809	942	800	3,148
Unknown	28,3	33	1,5	9	29,1	7	29,7	4	25,7	0	26,5	4	33,6	1	29,6	5	26,6	8	29,1	5	25,7	2	24,5	4	15,9	4	17,3	7	17,6	9	21,1	2	13,7	4	21,6	0	23,7	9	18,8	6	18,5	7	16,0	3	15,5	1	21,1	3	19,7	0	18,9	4	20,5	5	19,9	1	18,2	2	22,1	3	29,2	5	26,7	7	22,5	4	18,3	5	19,1	3	23,3	3	18,5	6	21,0	6	19,2	9	18,2	3	18,7	7	21,8	3	29,1	4
Telephone	56,9	45	8,2	3	55,5	2	64,2	5	55,0	7	60,3	4	66,8	5	62,8	2	60,4	9	67,8	6	60,5	9	137,0	1	63,8	1	76,7	2	33,5	2	40,3	2	19,4	2	57,0	2	46,1	2	44,4	2	23,6	2	31,1	2	32,5	2	77,7	2	38,3	2	29,7	2	61,6	2	45,2	2	23,6	2	47,5	2	28,8	2	36,8	2	10,4	2	19,5	2	14,0	2	47,8	1	85,3	2	09,3	1	85,9	1	79,2	1	77,0	1	78,4	1	76,1
Home Visit	2,681	2,824	2,567	3,139	2,778	2,984	3,589	3,352	3,198	3,650	3,064	2,194	1,444	1,616	2,013	2,198	2,602	3,210	3,373	3,094	2,932	2,606	2,744	3,308	3,007	2,842	3,161	3,030	2,683	3,030	3,169	3,427	3,569	3,360	3,274	3,916	3,322	3,868	3,565	3,476	3,617	4,101	4,190
Face-to-Face	388,2	408,5	389,0	446,7	385,4	449,1	514,9	456,4	398,6	465,4	408,8	323,3	147,6	161,9	193,9	225,8	227,8	328,1	373,5	307,5	293,3	257,9	261,9	318,6	284,2	287,7	332,4	316,4	299,5	394,5	427,3	416,9	333,4	338,9	346,2	414,3	334,4	398,3	384,5	385,6	397,1	443,2	521,9

ICB Area	What the charts tell us	Issues	Actions	Mitigation
ICB	• Total number of GP appointments decreased slightly in June and July, likely reflecting seasonality. Total appointments increased in August and again significantly in Sept and October • Proportion of face to face appointments continue to increase, reaching 67% of total attended appointments in August and over 70% in October and November	• General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal • Significant pressure from Respiratory illness • Rapid increase in 'spot booking' hotels set up without notice by Home Office to house asylum seekers with significant health need including scabies and diphtheria outbreaks	• Continue to implement actions funded through the Winter Access Fund, including advanced telephony and offsite storage of notes • An MDT group has been established to review the National GP Patient Survey (GPPS) data, and to develop an access framework and work programme • Working closely with BI team to develop an access dashboard for better monitoring of pressures • Primary Care Commissioning Committee (PCCC) has approved ICB funding to support additional capacity in general practice over winter. Funding level is the same as last year at £1.43 per weighted patient • There is national repurposing of Investment & Impact Fund monies to support additional capacity • Acute Respiratory Infection hubs set up to assist with system pressures and minimise flow back to General Practice from 111 and ED • Enhanced Commissioning Framework re-prioritised to assist with practice capacity	• Continue to support return of business as usual to General Practice through the relaunch of the ECF across the ICB, supported by investment • Continue to monitor access trends in the 3 places and to pick up individual practices with poor access through complaints and patient contacts • PCCC and Primary Care Board oversight of the GPPS results, and action plan developed through the Access MDT Group • Recruitment & Retention of Primary Care Workforce – a number of initiatives are offered to the Primary Care Workforce to support recruitment and retention which are supported by the HSE ICB Training Hub • Funding for spot booking hotels for health checks and MDT site visits agreed by PCCC until end March 23 • Daily review of OPEL reporting by practices and follow up by place Primary Care Teams with individual practices

Appendix A – Performance Dashboard

October 2022

Herts & West Essex ICS (Commissioner)

Area	Activity	Target	Latest published data	Data published	Trend *1	Variation	Assurance	National position (ICB vs National)	Regional position (ICB vs EoE Region)	ICB Ranking
111	Calls answered < 60 seconds	95%	51.8%	October 22	-35.63%			44.8% (Better)	50.8% (Better)	18th highest
	Calls abandoned after 30 seconds	5%	10.0%	October 22	50.34%			12.9% (Better)	9.7% (Worse)	15th highest
A&E	% Seen within 4 hours	95%	59.1%	November 22	-3.93%		F	68.9% (Worse)	65.7% (Worse)	6th lowest
	12 Hour Breaches	0	192	November 22	-76.04%			37,837	3,134	8th highest
Cancer	2ww All Cancer	93%	77.2%	October 22	7.62%		F	77.8% (Worse)	72.4% (Better)	26th (middle)
	2ww Breast Symptoms	93%	71.9%	October 22	10.85%			75.7% (Worse)	68.0% (Better)	18th lowest
	31 day First	96%	95.5%	October 22	1.36%			92.0% (Better)	91.7% (Better)	10th highest
	31 day Sub Surgery	94%	84.5%	October 22	2.72%			80.9% (Better)	81.7% (Better)	17th highest
	31 day Sub Drug	98%	100%	October 22	0.92%			98.8% (Better)	99.3% (Better)	14th highest
	31 day Sub Radiotherapy	94%	82.7%	October 22	-2.52%	L		90.8% (Worse)	87.9% (Worse)	7th lowest
	62 day First	85%	69.9%	October 22	10.49%		F	60.3% (Better)	62.1% (Better)	6th highest
	62 day Screening	90%	68.9%	October 22	18.71%			67.1% (Better)	72.2%(Worse)	22nd (middle)
	62 day Upgrade	85%	72.9%	October 22	5.27%			73.9% (Worse)	72.7% (Better)	22nd lowest
RTT	Incomplete Pathways <18 weeks	92%	55.5%	October 22	1.15%		F	60.1% (Worse)	56.7% (Worse)	8th lowest
	52 weeks	0	11,137	October 22	5.92%	H	F	383,724	56,394	8th lowest
Diagnostics	6 week wait	1%	31.2%	October 22	-7.36%		F	27.5% (Worse)	31.9% (Better)	19th lowest

Individual Trust

ICS Aggregate Provider	Trend	ENHT	Trend	PAH	Trend	WHTHT	Trend
51.8%	-35.63%	See individual CCG performance in the table below					
9.99%	50.34%						
59.08%	-3.93%	61.23%	-5.14%	54.41%	3.37%	60.15%	-7.32%
192	-76.04%	48	-214.58%	144	-29.86%	0	0.00%
76.13%	8.67%	93.47%	1.02%	67.90%	22.83%	67.84%	9.98%
72.35%	10.41%	95.95%	8.80%	88.00%	-1.21%	44.54%	43.87%
96.07%	1.23%	97.58%	1.41%	94.87%	3.70%	94.27%	-0.50%
97.18%	9.39%	95.56%	6.03%	100%	33.33%	100%	8.33%
100%	0.75%	100%	0.46%	100%	5.88%	100%	0.00%
85.79%	-1.72%	85.79%	-1.72%	N/A		N/A	
73.71%	10.44%	80.68%	-1.33%	65.31%	51.20%	68.66%	12.36%
65.38%	32.92%	62.50%	13.85%	84.62%	63.07%	56.52%	17.86%
66.67%	-1.69%	69.39%	18.54%	64.15%	-7.51%	66.67%	-9.46%
51.72%	1.25%	54.36%	1.11%	50.88%	-0.09%	49.45%	1.79%
9,744	5.86%	4,527	-3.56%	1,804	-5.21%	3,413	24.20%
37.14%	-6.41%	46.52%	-7.59%	27.36%	-4.54%	28.89%	-1.40%

Herts & West Essex ICS (Commissioner)

Area	Metric	Target	Latest published data	Data published	Trend *	Variation	Assurance	National position (ICB vs National)	Regional position (ICB vs EoE Region)	ICB Ranking
111	Calls answered < 60 seconds	95%	51.8%	October 22	-35.63%			44.8% (Better)	50.8% (Better)	18th highest
	Calls abandoned after 30 seconds	5%	10.0%	October 22	50.34%			12.9% (Better)	9.7% (Worse)	15th highest
Mental Health	Dementia Diagnosis rate *2	66.6%	61.6%	September 22	-1.43%		F	62.2% (Worse)	59.5% (Better)	n/a
	OOA placements *3	0	1,322	October 22	17.62%			54,865	11,250	n/a
CHC	% of eligibility decisions made within 28 days	80%	69.9%	October 22	11.61%		F	74.3% (Worse)	68.3% (Better)	11th lowest
	% of assessments carried out in acute	15%	0.0%	October 22	0.00%		P	n/a	n/a	n/a

Individual CCGs

ICS Aggregate Provider	Trend	East & North Herts	Trend	South & West Herts	Trend	West Essex	Trend
N/A		52.13%	-35.50%			50.61%	-36.15%
		9.73%	50.19%			11.06%	50.78%
		59.03%	-3.22%	60.89%	-0.53%	67.60%	-0.09%
		1177	12.15%			145	62.07%
		100%	16.67%	50%	33.33%	89.47%	5.00%
		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

Variation: Special Cause Concerning variation | Special Cause Improving variation | Common Cause

Assurance: Consistently hit target | Hit and miss target subject to random variation | Consistently fail target

*1 Against last month's performance

*2 **Temporary suspension of publication:** Recorded Dementia Diagnosis September 2022 will be the last monthly publication in this series until early 2023. This is due to a change in the data collection for these publications. When the publication resumes in 2023 all data will be back dated to April 2022 to provide a coherent time series.

*3 The October data for West Essex's Out of Area Placements is not currently available due to a query regarding data accuracy. The data shown in the table above is for Hertfordshire only.

*4 Compared to latest quarterly position.

Appendix B: Urgent & Emergency Care (UEC) by Place

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• High number of patients presenting at ED, but comparable to recent months • Number of patients experiencing handover delays >30 minutes continues to increase, and the planned recovery trajectory is not being achieved • 11.7% of patients spent >12 hours in ED, continuing a 12 month above average trend • The number of patients treated, admitted or discharged in under 4 hours improved slightly in November, but remains low at 54.4%	• Continued high attendances • Ambulance Handover Delays • ED staffing, vacancies & sickness • Covid patients within the Trust and contact beds closed impacting capacity and flow • MH assessments and bed shortages (national issue) • Estate footprint & size of dept	• Daily joint working with all system partners to create ED capacity aligned to local oversight arrangements • Daily calls and CCG support with discharges and Transport • Daily calls with EEAST to review pressures across local Trusts and enact “load levelling” • Nightingale Ward (18 beds) available as per escalation plans and staffing availability • Continue with established safety huddles and harm review arrangements • March 23 improvement ambitions for the 6 national UEC priority metrics have now been agreed across the ICS and will be overseen in West Essex at the Local Delivery Board (LDB) • IN / OUT patient flow programmes established • Recent appointments of an ED Nurse Consultant and a UEC Head of Nursing • Relocation of the discharge lounge to create additional ED capacity - delayed until February	Actions in place to ensure that patient safety is maintained; Jan UEC Board focusing on Safety
South West Herts / WHTHT	• Following an increase in September (14,100) attendances continued to rise further throughout Oct & Nov, reaching an average of 15,500 • 4 hour ED performance has declined since September (70%). October 64.7% with November dipping further to 60.3% • 12 hour total time in ED improved in Sept (5.5%) but saw a decline in October to 7.3% • Patients who NLMCTR not discharged by 5pm remains high but stable at around 75%	• High number of MH presentations, both in ED and on the wards. • MH bed shortages. Workforce issues across all providers . • WHTHT regularly having 60+ surge beds open • Staffing vacancies and sickness impacting all providers • Flu numbers beginning to increase	• A MADE has been arranged for week commencing 3rd January 2023. The two workstreams have been confirmed as NMCTR and prevention of admission • St Albans Integrated Urgent Care HUB (IUCH) phased launch from 31.10.22. Capacity for 70 pts per day, directly booked from GP & NHS 111. Minor Illness appointments full and increasing usage from GPs. • Reduced minor injury capacity as radiology process to WHTH is delayed & GP Connect not fully functional for GP bookings (workaround in place). HUC to progress urgently as part of mobilisation. Currently running with bank staff, substantive staff start in Jan ‘23. • VH - from October the soft launch of Community Onboarding for Heart Failure and COPD went live • StrepA Hubs being developed in Hemel Hospital, St Albans IUCH and Potters Bar Hospital (still TBC) to manage the increase in children's viral presentation and additional activity in CED	SRG/LDB work plans agreed in line with NHSE planning guidance and Board Assurance Framework.
East & North Herts / ENHT	• Handover performance continues to deteriorate however improvements seen towards end of Oct; • ED attendances remain at higher levels with further increases seen over Oct and Nov; • ED 4 hour performance continues to decline, dropping to 61.2% in November; • The % of patients spending more than 12 hours in the department also saw a decline over the last two months, at 10.2% in October; • % of patients not meeting criteria to reside & not discharged by 5pm remains high but did see an improvement in October.	• Continued high demand in number of attendances with average acuity also at its highest rate since February 2022 • Ambulance handover delays • ED staffing - vacancies and sickness/isolation • Covid and Flu patients within the Trust, contact beds closed impacting capacity and flow • MH assessments and bed shortages	• UEC Transformation action plan continues to be implemented • New SDEC area opened increasing capacity • New UTC style streaming model developed and came online in late November • A zero tolerance to handover delays above 3 hours introduced and demonstrated a notable reduction in handover delays towards end of October; actions are being taken to sustain this including joint working with EEAST to implement a new handover SOP with the aim to eliminate >60min offloads • Reverse boarding is becoming increasingly embedded as a business as usual practice • Focus on discharges and use of hospital @ home continues • Using SDEC as escalation space continues to be restricted • March 23 improvement ambitions for UEC priority agreed across the ICS and will be overseen in ENH through the SRG	Performance Improvement Trajectories agreed aligned to action plans.

Appendix C: Performance v. 22/23 Operational Plans by Place

East and North Herts Trust

Baseline	22/23 Activity Plan	22/23 M1-7 Activity Plan
104,880	138,641	77,505
	+32%	
N/A	0	0
N/A	0	377
3313	2914	3291
400,242	359,706	223,183
	-10%	
N/A	4.7%	1.7%
0%	26%	26%
N/A		
180,261	184,372	112,105
	+2%	
87	87	180
75%	74%	78%

Area	Target
Activity	10% elective activity increase (19/20 levels RTT pathw ay)
Waitlist	104 w eek w aits eliminated by Jul 22 (w aitlist, end of Jun 22)
	Eliminate 78 w eek w aits by Apr 23 (w aitlist, end of Mar 23)
	52 w eek w aits trending dow n across 22/23
Outpatients	25% reduction in outpatient follow -ups by 2023
	5% of outpatients moved or discharged to PIFU
	25% of consultations via video/telephone
	16 specialist advice requests per 100 outpatient firsts
Diagnostics	20% increase in diagnostic capacity against 19/20 levels
Cancer	Reducing cancer 62+ day w aitlist to pre-pandemic levels
	Reduction in missed 28 day cancer decisions

	M1-7 Actual							
	April	May	June	July	August	September	October	Total
Plan	7,816	8,554	11,535	12,112	12,688	12,688	12,112	**77,505**
Actual	7,816	9,494	9,139	8,072	8,241	9,353	9,015	**61,130**
Variance	0	940	-2,396	-4,040	-4,447	-3,335	-3,097	**-16,375**
Actual	96	56	21	9	7	2	2	**2**
Actual	439	408	324	312	407	458	464	**464**
Actual	3473	3699	4027	4294	4628	4688	4527	**4527**
Plan	33,377	33,990	31,737	34,856	28,372	28,950	31,901	**223,183**
Actual	30,904	34,899	31,661	31,545	32,011	32,832	32,734	**226,586**
Variance	-2,473	909	-76	-3,311	3,639	3,882	833	**3,403**
Actual	0.6%	0.7%	0.7%	0.6%	0.8%	0.8%	0.9%	**0.9%**
Actual	26%	26%	26%	27%	20%	21%	22%	**24%**
Actual	24	24	23	24	24	21	19	**23**
Plan	14,839	16,359	16,071	16,432	15,611	15,674	16,429	**111,415**
Actual	11,414	13,529	13,068	12,957	13,040	13,439	13,731	**91,178**
Variance	-3,425	-2,830	-3,003	-3,475	-2,571	-2,235	-2,698	**-20,237**
Actual	377	327	366	368	415	275	308	**308**
Actual	68%	64%	71%	72%	73%	70%	70%	**70%**

Appendix C: Performance v. 22/23 Operational Plans by Place

PAH

Baseline	22/23 Activity Plan	22/23 M1-7 Activity Plan
70,011	75,816	43,197
	+8%	
N/A	0	0
N/A	0	194
1737	3,059	3,225
225,486	271,151	156,570
	+20%	
N/A	2.0%	1.5%
4%	27%	27%
N/A		
110,523	117,630	68,370
	+6%	
121	75	75
61%	73%	75%

Area	Target
Activity	10% elective activity increase (19/20 levels RTT pathway)
Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)
	Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)
	52 week waits trending down across 22/23
Outpatients	25% reduction in outpatient follow-ups by 2023
	5% of outpatients moved or discharged to PIFU
	25% of consultations via video/telephone
	16 specialist advice requests per 100 outpatient firsts
Diagnostics	20% increase in diagnostic capacity against 19/20 levels
Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels
	Reduction in missed 28 day cancer decisions

	M1-7 Actual							
	April	May	June	July	August	September	October	Total
Plan	5,317	5,941	6,678	6,643	5,902	6,232	6,484	**43,197**
Actual	5,317	6,088	5,911	5,646	5,644	5,953	6,076	**40,635**
Variance	0	147	-767	-997	-258	-279	-408	**-2,562**
Actual	14	12	10	3	0	0	0	**0**
Actual	223	266	281	296	248	208	141	**141**
Actual	1818	1674	1785	1911	1909	1898	1804	**1804**
Plan	19,736	22,231	23,018	23,120	22,398	22,968	23,099	**156,570**
Actual	19,754	22,354	19,593	18,917	18,371	17,497	18,088	**134,574**
Variance	18	123	-3,425	-4,203	-4,027	-5,471	-5,011	**-21,996**
Actual	0.9%	1.4%	1.5%	1.3%	1.4%	1.4%	1.4%	**1.4%**
Actual	27%	27%	28%	28%	27%	28%	28%	**28%**
Actual	5	5	6	6	7	6	5	**5**
Plan	9,258	9,852	9,852	9,852	9,852	9,852	9,852	**68,370**
Actual	9,258	9,793	9,073	9,604	10,193	9,242	9,491	**66,654**
Variance	0	-59	-779	-248	341	-610	-361	**-1,716**
Actual	252	220	178	177	199	204	219	**219**
Actual	64%	66%	74%	72%	73%	68%	68%	**70%**

Appendix C: Performance v. 22/23 Operational Plans by Place

West Herts Teaching Hospitals Trust

Baseline	22/23 Activity Plan	22/23 M1-7 Activity Plan
71,713	115,674	58,743
	+61%	
N/A	0	2
N/A	0	44
1059	507	658
330,892	260,127	153,141
	-21%	
N/A	2.1%	1.2%
8%	25%	22%
N/A		
126,398	146,816	81,251
	+16%	
81	105	163
72%	69%	74%

Area	Target
Activity	10% elective activity increase (19/20 levels RTT pathway)
Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)
	Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)
	52 week waits trending down across 22/23
Outpatients	25% reduction in outpatient follow-ups by 2023
	5% of outpatients moved or discharged to PIFU
	25% of consultations via video/telephone
	16 specialist advice requests per 100 outpatient firsts
Diagnostics	20% increase in diagnostic capacity against 19/20 levels
Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels
	Reduction in missed 28 day cancer decisions

	M1-7 Actual							
	April	May	June	July	August	September	October	Total
Plan	3,682	5,002	4,373	11,865	10,553	11,397	11,871	**58,743**
Actual	3,682	4,999	4,816	4,618	4,948	5,633	6,116	**34,812**
Variance	0	-3	443	-7,247	-5,605	-5,764	-5,755	**-23,931**
Actual	14	9	4	3	2	3	2	**2**
Actual	144	155	143	133	137	116	92	**92**
Actual	1193	1431	1660	1783	2078	2587	3413	**3413**
Plan	18,976	20,461	18,963	24,263	24,082	23,655	22,741	**153,141**
Actual	19,598	22,104	21,299	21,019	21,732	22,226	22,042	**150,020**
Variance	622	1,643	2,336	-3,244	-2,350	-1,429	-699	**-3,121**
Actual	0.7%	0.9%	1.0%	0.8%	0.8%	0.6%	0.4%	**0.4%**
Actual	15%	13%	14%	13%	13%	14%	14%	**14%**
Actual	47	46	46	50	48	45	39	**46**
Plan	9,652	10,497	9,095	13,595	12,379	12,660	13,373	**81,251**
Actual	9,357	10,546	9,827	9,473	9,835	9,922	9,321	**58,960**
Variance	-295	49	732	-4,122	-2,544	-2,738	-4,052	**-22,291**
Actual	299	340	331	315	297	288	271	**271**
Actual	51%	58%	56%	60%	60%	58%	58%	**58%**

Appendix D: 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 D: HWE Children's Community Services

Children's Services within Hertfordshire and West Essex ICS is 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

Glossary of Acronyms

>104 days	Cancer backlog greater than 104 days
>104 weeks	Elective Care backlog greater than 104 weeks
>62 days	Cancer backlog greater than 62 days
A&E	Accident & Emergency
AAU	Ambulatory Assessment Unit
AHC	Annual Health Check
BAME	Black Asian & Minority Ethnic
BAU	Business As Usual
CAMHS	Children & Adolescent Mental Health Service
CCATT	Children Crisis Assessment & Treatment Team
CCG	Clinical Commissioning Group
CDC	Cancer 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
CO	Carbon Monoxide
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
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
ENHCCG	East & North Herts Clinical Commissioning Group
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 Adolescent Unit
FNC	Funded Nursing Care
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
HUC	Hertfordshire Urgent Care
HVCCG	Herts Valley Clinical Commissioning Group
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

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
LFT	Lateral Flow Test
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 / I	NHS England & Improvement
NICE	The National Institute for Health & Care Excellence
NLMCTR	No Longer Meets Criteria To Reside
NO	Nitrous Oxide
NOK	Next Of Kin
OHCP	One HealthCare Partnership
OOAP	Out of Area Placements
OT	Occupational Therapy
PAH / PAHT	The Princess Alexandra Hospital NHS Trust
PCN	Primary Care Network
PCR	Polymerase Chain Reaction (test)

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
SRG/LDB	System Resilience Group / Local Delivery Board
SSNAP	Sentinel Stroke National Audit Programme
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
WECCG	West Essex Clinical Commissioning Group
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)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**27/01/2023**	
Report Title:	**Finance Report for Month 8 2022/23**				**Agenda Item:**	**13**	
Report Author(s):	Andy Marendaz, Senior Head of Finance – ICB Financial Planning and Reporting Debbie Griggs, Deputy Chief Finance Officer						
Report Signed off by:	Alan Pond, Chief Finance Officer						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	This report has been presented and noted at the Finance and Investment Committee on 10 January 2023.						
Executive Summary:	This report provides the Hertfordshire and West Essex (HWE) Integrated Care Board (ICB) with information on the financial position of the HWE ICB for Month 8 2022/23. At Month 8, the ICB is reporting a year to date and forecast outturn position of breakeven, which is in line with the agreed plan. Continuing Healthcare (CHC) continues to experience cost pressures, and remedial actions continue to be taken by the CHC Team. This affects both West Essex (WE) and South and West Herts (SWH) Healthcare Partnerships (HCP), where SWH is a continuation of the pressures experienced in the legacy Clinical Commissioning Group (CCG) of Herts Valleys. Further work is also being undertaken by the Finance Team to review the forecast assumptions. GP Prescribing is experiencing cost pressures deriving from areas of spend which are difficult to mitigate because they are either national issues or issues which pose a reputational risk if the ICB does not implement changes to guidance. The Pharmacy and Medicines Optimisation Team (PMOT) are working towards mitigating some of these pressures.						
Recommendations:	It is recommended that the Board: ▪ Note the Month 8 forecast financial position of breakeven ▪ Note the risks to the financial position specifically linked to CHC and GP Prescribing ▪ Note the delivery of the financial performance targets for the year						

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

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☐
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☒
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☐

1. Executive summary

The Herts and West Essex (HWE) Integrated Care Board (ICB) was established on 1 July 2022, following the demise of the three CCGs, namely East and North Hertfordshire, Herts Valleys and West Essex CCGs.

This report provides the Board with information on the financial position of the ICB for its fifth month, Month 8 (November) 2022/23. At Month 8, the ICB is reporting a year to date and forecast outturn position of breakeven.

There is potential headroom available to the ICB through non-recurrent benefits and contingency reserves, which is currently being held back and will be released to the bottom line to mitigate any financial pressures within the HWE ICS System, currently estimated to be c£10m.

2. Background

It was originally intended that the ICB would be established on 1 April 2022, to coincide with the NHS Financial Year End and NHS England issued the annual allocation for 2022/23 to the ICB on this basis.

However, with the delay on the start date of the ICBs to 1 July 2022, this required the ICB allocation to be distributed for Quarter 1 (April to June 2022) to the three CCGs and for those CCGs to report on financial performance for the Quarter and produce the Annual Accounts for this period.

The intention remains that the ICBs will be responsible for the System as a whole, including the CCGs that they replaced. To support this achievement, the three CCGs were allocated with the funding needed to achieve a breakeven position, with the balance of the funding to be carried over to the ICB.

3. Financial Performance

Allocations notified

The table below shows the notified allocations of £21.795m that the ICB has received in Month 8 2022/23. Of these allocations, £16.703m is historic surplus, leaving £5.092m, of which £3.126m relates to Tranche 1 of the Discharge Funding. All allocations are for identified funding streams and will have committed expenditure plans against them.

A comprehensive breakdown of the allocations for the year can be seen in Appendix 1.

HWE ICB Financial Plan	CCGs Q1	ICB Q2-Q4		TOTAL
		Recurrent	Non Recurrent	
	£'000	£'000	£'000	£'000
Allocations Q1	667,042			667,042
Allocations Month 4-Month 7		2,000,441	167,073	2,167,514
Closing Allocation at Month 7	667,042	2,000,441	167,073	2,834,556
New Allocations Month 8				
MH Capital Grants from central budgets			384	384
DOAC Rebate Q1 22/23			536	536
East of England Cancer Alliance Cytosponge Q3			34	34
East of England Cancer Alliance Tier 1 additional Funds EOES			24	24
SDF - Diabetes: CYP equitable provision technology project WHHT			58	58
SDF - Innovation: ICS REND Programme			40	40
POD delegation			150	150
GP Nursing funding – Q3/Q4			36	36
Implementation of GP CPCS			5	5
SQuIRe delivery of the Integrated Community Stroke Service planning			13	13
NHSE BSBC AT - 5 Year Primary Care Strategy			30	30
PCT GP Fellowships			40	40
Workforce - International recruitment GPs			203	203
CYP hospice match funding scheme - 2nd allocation 2022/23.			40	40
SDF Diabetes: Treatment and care, recovery and impln part 2			328	328
Independent Senior Advocate (ISA) Pilot Phase			45	45
CCG Historic Surplus greater than 1% surplus requirement 21/22			16,703	16,703
22/23 discharge funding - tranche 1			3,126	3,126
Sub-Total New Allocations Month 8			21,795	21,795
Closing Allocation at Month 8	**667,042**	**2,000,441**	**188,868**	**2,856,351**

Historical Surplus

CCG Name	2021/22 CCG cumulative historical position	2021/22 Proxy Recurrent Allocation	2021/22 1% Requirement	2022/23 Historic Surplus to be loaded to the ledger
	£'000	£'000	£'000	£'000
NHS East & North Hertfordshire CCG	18,983	831,153	(8,312)	**10,671**
NHS Herts Valleys CCG	8,999	862,078	(8,621)	**378**
NHS West Essex CCG	10,000	434,721	(4,347)	**5,653**
TOTAL	37,983	2,127,952	(21,280)	16,703

In Month 8, the ICB received the return of the historical CCG Surplus as an allocation from NHS England (NHSE). This surplus had been revised down nationally by £21.3m from the original reported values to a notional 1% underspend, based upon the 2021/22 proxy recurrent allocation.

The total value received was £16.7m however, as laid out as a national directive, the ICB is not able to access this funding without prior approval from NHSE and NHSE has not given approval for any drawdown in 2022/23.

Expenditure as at Month 8 2022/23

The summary position of the ICB at Month 8 2022/23 is a year to date and forecast outturn position of breakeven, following adjustment for the return of historical CCG surpluses and anticipated allocation to be received from NHSE for expenditure for Primary Care Additional Roles Reimbursement Scheme (ARRS) not in the original baseline allocation.

Summary Expenditure Position as at Month 8 (November) 2022/23								
	Year to Date				Forecast			
	Budget £'000	Actual £'000	Variance £'000	Expenditure Category	Total Budget Mths 4 to 12 £'000	Outturn £'000	Variance £'000
1	654,766	653,091	(1,675)	Acute Services	1,164,205	1,163,405	(801)
2	58,205	64,415	6,210	Continuing Healthcare Services	104,530	115,417	10,887
3	10,552	10,552	0	Corporate Services	22,826	22,826	0
4	125,244	126,003	760	Mental Health Services	218,855	219,292	436
5	117,777	119,216	1,439	Primary Care Services	224,917	224,173	(743)
6	91,736	94,803	3,068	Prescribing	164,729	171,647	6,918
7	116,092	115,556	(536)	Community Services	206,043	204,992	(1,051)
8	6,871	7,158	287	Other Commissioned Services	12,478	14,353	1,874
9	13,267	12,842	(425)	Other Programme Services	28,137	27,349	(788)
10	20,262	0	(20,262)	Reserves	47,653	14,217	(33,436)
	1,214,771	1,203,636	(11,135)	Sub-Total Expenditure	2,194,374	2,177,671	(16,703)
11	(11,135)	0	11,135	Historical Surplus Adjustment	(16,703)	0	16,703
	1,203,636	1,203,636	0	Total Expenditure	2,177,671	2,177,671	0

Reserves

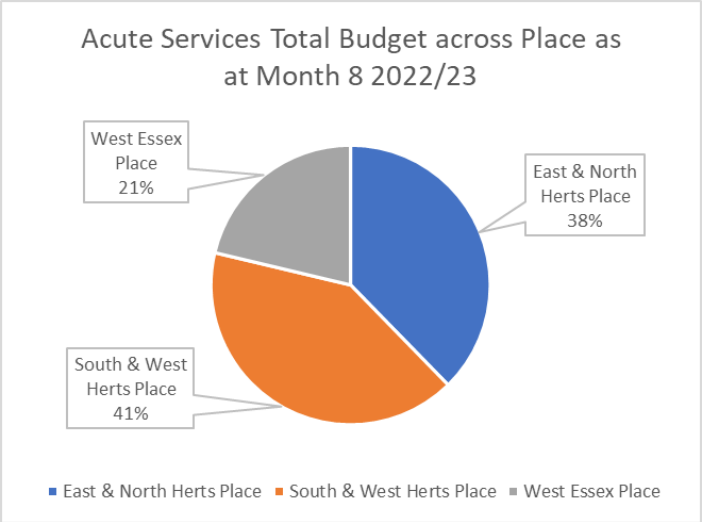
The forecast free reserves following adjustment for historical surplus and committed expenditure is £10.047m as shown in the table below.

Reserves	Total Allocated £'000	Frozen £'000	Committed £'000	Total Available £'000
Historical Surplus	16,703	(16,703)		0
Recurrent	4,148		(4,148)	0
Non Recurrent	26,802		(16,755)	10,047
Total Free Reserves	47,653	(16,703)	(20,903)	10,047

Acute Services

The reported position at Month 8 is a year to date underspend of £1.675m and forecast underspend of £0.801m.

1. Acute Services by Place								
	Year to Date				Forecast			
	Budget £'000	Actual £'000	Variance £'000	Expenditure Category	Total Budget Mths 4 to	Outturn £'000	Variance £'000
1	246,204	244,370	(1,834)	East & North Herts Place	438,106	435,930	(2,176)
2	269,801	269,832	31	South & West Herts Place	478,059	478,742	683
3	138,761	138,674	(87)	West Essex Place	248,040	248,733	693
4	0	215	215	Unaligned/ICB	0	0	0
	654,766	653,091	(1,675)	Total Expenditure	1,164,205	1,163,405	(801)



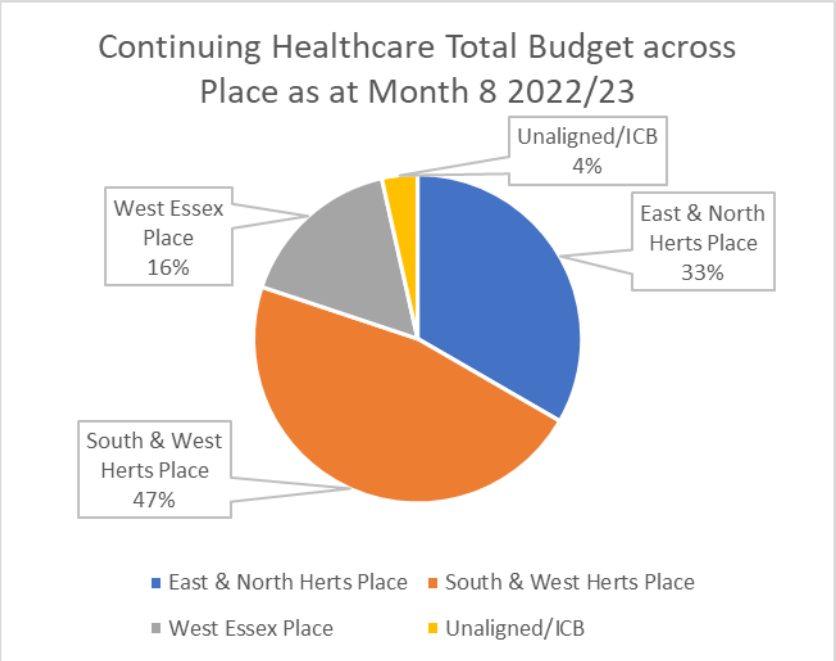
Continuing Healthcare (CHC)

The reported position at Month 8 is a year to date overspend of £6.21m and a forecast year end position of £10.887m above plan.

The identified remedial action continues to be undertaken by the CHC Team, with further analysis of spend and trend analysis being undertaken by the Finance Team. There is additional information in the 'Identified Issues' section later in the report.

2. Continuing Healthcare by Place

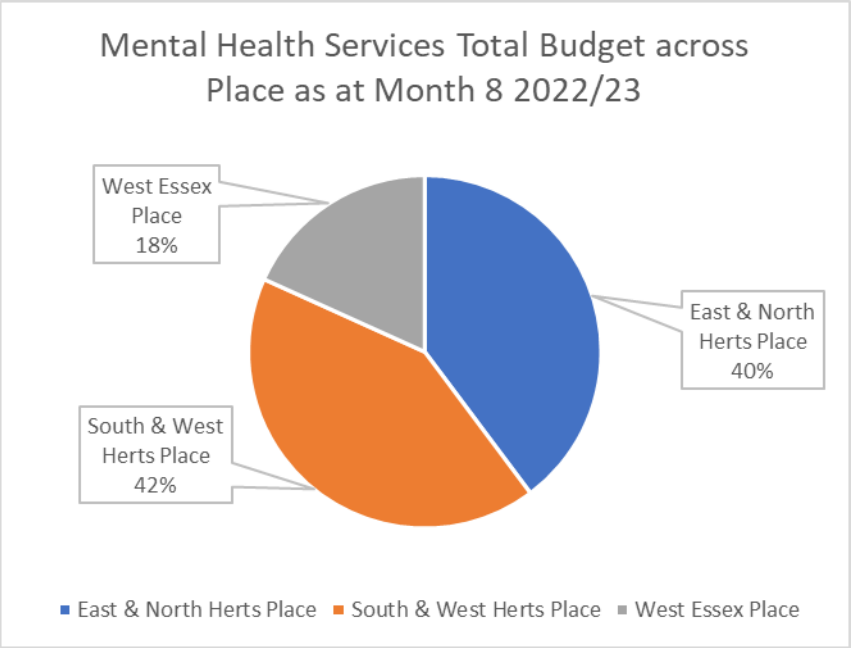
	Year to Date				Forecast		
	Budget £'000	Actual £'000	Variance £'000	Expenditure Category	Total Budget Mths 4 to 12 £'000	Outturn £'000	Variance £'000
1	19,358	18,581	(777)	East & North Herts Place	34,845	34,283	(562)
2	27,295	32,402	5,107	South & West Herts Place	48,894	56,562	7,668
3	9,510	11,596	2,086	West Essex Place	17,118	20,898	3,780
4	2,041	1,835	(206)	Unaligned/ICB	3,674	3,674	(0)
	58,205	**64,415**	**6,210**	**Total Expenditure**	**104,530**	**115,417**	**10,887**



Mental Health Services

The reported position at Month 8 is a year-to-date overspend of £0.760m and forecast overspend of £0.436m. The forecast outturn is on track to achieving the Mental Health Investment Standard (MHIS) with an increased investment of 5.39% rather than the required 5.36%.

4. Mental Health Services by Place	Year to Date				Forecast		
	Budget £'000	Actual £'000	Variance £'000	Expenditure Category	Total Budget Mths 4 to 12 £'000	Outturn £'000	Variance £'000
1	51,359	52,000	641	East & North Herts Place	88,127	89,443	1,316
2	50,596	50,794	198	South & West Herts Place	90,723	90,347	(376)
3	23,289	23,209	(80)	West Essex Place	40,005	39,502	(503)
4	0	0	0	Unaligned/ICB	0	0	0
	125,244	126,003	760	Total Expenditure	218,855	219,292	436



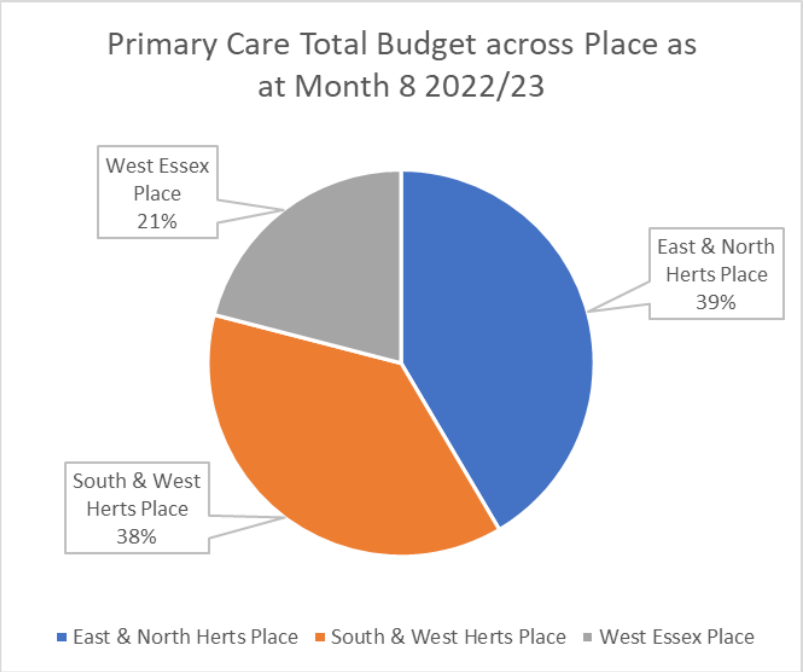
Primary Care

The reported position at Month 8 is a year-to-date position of £1.439m overspend and a year-end forecast of underspend of £0.743m. This is a result of the expenditure for the Primary Care Additional Roles Reimbursement Scheme (ARRS) which is more than the ICB baseline allocation. NHS England is holding the excess allocation centrally and will make a retrospective adjustment to reimburse the amount spent above the baseline allocation.

The ICB is expecting to receive an additional £5.065m to offset the forecast ARRS spend which will mean Primary Care will have a year-end underspend of £0.743m.

5. Primary Care by Place

	Year to Date				Forecast		
	Budget £'000	Actual £'000	Variance £'000	Expenditure Category	Total Budget Mths 4 to 12 £'000	Outturn £'000	Variance £'000
1	46,378	47,922	1,544	East & North Herts Place	84,207	85,118	911
2	46,720	47,338	617	South & West Herts Place	86,805	89,390	2,585
3	23,519	23,587	67	West Essex Place	45,934	46,759	826
4	1,159	369	(790)	Unaligned/ICB	7,971	2,906	(5,065)
	117,777	119,216	1,439	Sub -Total Expenditure	224,917	224,173	(743)



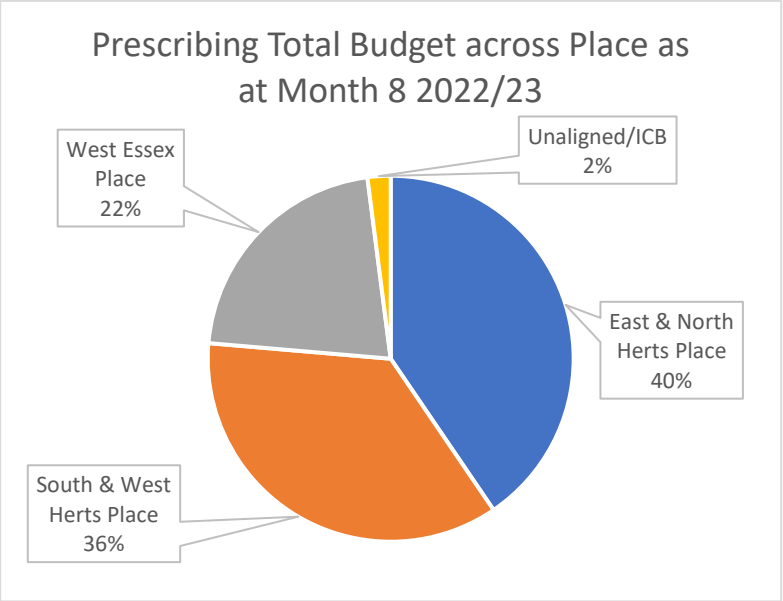
Prescribing

The reported position at Month 8 is a year to date overspend of £3.068m, which is expected to increase by the end of the year as an overspend position of £6.918m.

More detail on the pressures in prescribing is explained in the Identified Issues section that follows later in this report.

6. Prescribing by Place

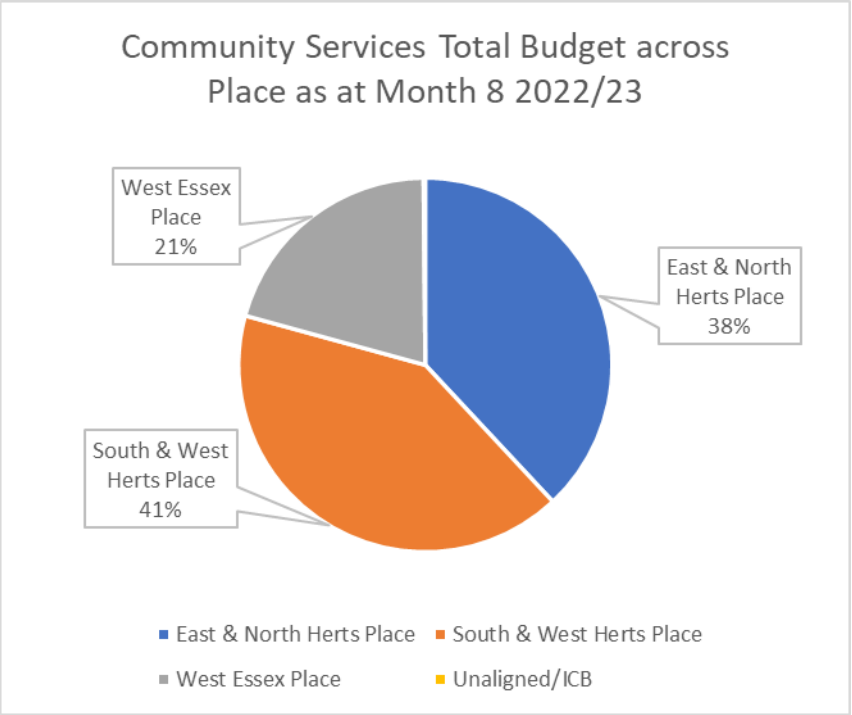
	Year to Date				Forecast		
	Budget £'000	Actual £'000	Variance £'000	Expenditure Category	Total Budget Mths 4 to 12 £'000	Outturn £'000	Variance £'000
1	36,232	37,182	950	East & North Herts Place	65,964	68,523	2,559
2	33,387	34,783	1,396	South & West Herts Place	59,329	62,731	3,401
3	20,247	20,834	586	West Essex Place	36,070	37,028	958
4	1,870	2,005	135	Unaligned/ICB	3,366	3,366	0
	91,736	**94,803**	**3,068**	**Total Expenditure**	**164,729**	**171,647**	**6,918**



Community Services

The reported position at Month 8 is a year to date underspend of £0.536m, which is expected to end the year as an underspend position of £1.051m.

7. Community Services by Place	Year to Date				Forecast		
	Budget £'000	Actual £'000	Variance £'000	Expenditure Category	Total Budget Mths 4 to 12 £'000	Outturn £'000	Variance £'000
1	44,577	44,296	(281)	East & North Herts Place	78,696	78,444	(252)
2	47,247	47,220	(27)	South & West Herts Place	84,340	83,988	(351)
3	24,083	23,938	(144)	West Essex Place	42,672	42,225	(448)
4	186	101	(85)	Unaligned/ICB	335	335	0
	116,092	115,556	(536)	Total Expenditure	206,043	204,992	(1,051)



Identified Issues

The Board is asked to note the following identified risks:

Continuing Healthcare

Continuing Healthcare (CHC) continues to experience significant cost pressures, despite the remedial actions being taken by the Team.

The main drivers for the increase in expenditure are:

- Increased 1:1 spend due to Covid isolation requirements
- Discharge to Assess (DTA) breaches which have occurred due to staffing shortages and delayed 7-stage Decision Support Tool (DST) assessments
- Backlog of reviews due to staffing shortages.
- Increases in demand for CHC Placements
- Increase in overall cost of care packages - SW Herts Place reported the highest cost pressure contributed by increased number of over £40k a month care packages compared to previous year and an increased average cost of less than £40k packages despite a reduction of the number of patients becoming newly eligible in year.
- Outstanding reconciliation of Personal Health Budgets (PHB) accounts

To mitigate the pressures, the CHC team is concentrating on the initial 3-month CHC/Fast Track (FT) package reviews as opposed to12 month reviews, as the initial reviews are more likely to reduce the cost of the packages due to the patient settling into their care. This has resulted in a decrease in the number of outstanding reviews but there are still challenges in recruiting CHC staff in order to achieve the level of capacity required.

For PHBs, work has been undertaken to ensure that PHB account reconciliations are now up to date and correctly recoded on the ICB's software system iChord. Also, reviews of support plans are now booked routinely, and the protocol has been changed so that funding authorisation is sought after the costing calculation has been updated on the funding authorisation forms. Plans are in place to further

upskill CHC nurses via working in the PHB team, to provide sufficient capacity to support with PHB activity where required.

Response to question from the last Board meeting
At the last Board meeting it was highlighted that on Continuing Healthcare (CHC) the South and West Herts Place (SWH) had a higher proportion of both budget and expenditure than its population share of the ICB. It was agreed that further analysis and review would be undertaken to understand the reasons for this. An initial review was undertaken to ensure consistency of reporting across service lines and nothing specific was identified. It was therefore concluded that there was a real difference in costs. In addition to reviewing costs of placements, other hypotheses were explored. The one hypothesis which appears valid and is outside the control of the ICB and SWH is set out further below.

Hypothesis – SWH has more care home beds and this leads to increased patient numbers accessing CHC

SWH has proportionately more care home beds overall and particularly more residential care home beds (43.6% compared to 40.6% of weighted population).

	East and North Herts	South and West Herts	West Essex	TOTAL
Nursing beds	1,989	2,150	1,183	**5,322**
Residential beds	2,184	2,527	1,227	**5,938**
Combined Nursing and Residential beds	0	110	0	**110**
	4,173	**4,787**	**2,410**	**11,370**
Percentage of total beds	**36.70%**	**42.10%**	**21.20%**	
Population split of Areas	**38.44%**	**40.60%**	**20.96%**	

Whilst additional supply can sometimes lead to additional utilisation, e.g., as the threshold for treatment reduces, or a reduction in unmet need; neither of these are considered to be significant drivers. But what may be happening is that extra capacity being provided in SWH is being utilised by people from outside the boundaries of SWH. This could be either through self-funding patients choosing to relocate to SWH or indeed Local Authorities using capacity in SWH to buy packages of care for their residents. Who Pays? published by NHS England and Improvement (NHSEI) has some important rules that create an impact.

The general rule for determining the responsible ICB for payment states “Where an individual is registered on the list of NHS patients of a GP practice, the ICB with core responsibility for the individual will be the ICB with which that GP practice is associated. Where an individual is not registered with a GP practice, the ICB with core responsibility for the individual will be the ICB in whose geographic area the individual is usually resident”. This general rule applies to Funded Nursing Care (FNC – which is included within the costs recorded under CHC). So, where a patient in receipt of FNC moves to a care home outside the area of the ICB in which they were originally registered with a GP practice and they register with a new local practice in the area of the care home, under the general rule the “receiving” ICB will then become the responsible commissioner. So, if SWH has more care home beds and attracts people from outside SWH, they will become the responsible commissioner and will pick up the FNC costs.

The table below shows that SWH picks up 45.3% of total FNC costs, which exceeds its share of the population.

	East and North Herts		South and West Herts		West Essex		TOTAL	
	Number of Patients	Monthly Cost	Number of Patients	Monthly Cost	Number of Patients	Monthly Cost	Number of Patients	Monthly Cost
July 2022	691	616,117	869	777,658	354	310,341	**1,914**	**1,704,117**
August 2022	684	610,388	853	763,253	349	308,584	**1,886**	**1,682,225**
September 2022	684	582,941	833	730,208	352	300,457	**1,869**	**1,613,607**
October 2022	664	596,854	825	739,003	352	309,361	**1,841**	**1,645,218**
November 2022	648	566,401	812	711,689	340	295,646	**1,800**	**1,573,736**
August 2025	625	576,287	783	716,560	322	294,509	**1,730**	**1,587,355**
		3,548,988		4,438,371		1,818,898		9,806,258
Percentage of total costs		36.19%		45.26%		18.55%		
Population split of Areas		38.44%		40.60%		20.96%		

Whilst this only relates to FNC which is a relatively small part of the overall CHC budget and cost, the Who Pays? rules are different for CHC. Here, the responsible ICB is determined, under the normal rules, at the time eligibility for CHC is assessed and agreed. Where in order to meet an individual's CHC needs, the responsible ICB (or the placing ICB) arranges to provide them with accommodation in a care home located outside of the ICB's geographical area; the placing ICB retains commissioning responsibility for CHC for that person, regardless of which GP the individual is registered with. This exception only applies where CHC is provided in a care home. Where an individual in receipt of CHC in their own home moves house from the area of one ICB to another and re-registers with a GP practice in the new ICB, commissioning responsibility will transfer to the new ICB from the date of re-registration.

Whilst not an automatic progression, individuals in receipt of FNC may be more likely at a later date to be eligible for CHC. As the responsible ICB is determined at the point an individual becomes eligible for CHC, those individuals who moved in SWH utilising the "excess" care home beds would have become the responsibility of SWH, potentially leading to a higher proportionate number of people and costs of CHC in SWH.

Prescribing

GP Prescribing is experiencing cost pressures deriving from areas of spend which are difficult to mitigate because they are either national issues or issues which pose a reputational risk if the ICB does not implement and follow guidance.

Chiefly these areas are:

- **Supply difficulties** leading to nationally rising prices - stock outages of essential medication causing costs to rise.
- **High tech diabetes monitoring is recommended by NICE** to be used in more cohorts, spend is rising and expected to continue.
- **NICE technical appraisals** (TAs) and guidance have had financial impacts.
- **Workload increase due to Streptococcus A outbreaks** leading to increased numbers of GP, 111 & A&E consultations, increased prescribing and causing antibiotic shortages in some pharmacies.

The Pharmacy and Medicines Optimisation Team (PMOT) continues to work to mitigate some of these cost pressures.

Financial Control

Better Payment Practice Code

The ICB is required to pay 95% of invoices within 30 days of receipt of a valid invoice. This has been achieved in the five months to Month 8.

BPPC Paid Period	Invoice Count	Invoice Count (Passed)	% Passed	BPPC Amount	Invoice Amount (Passed)	% Amount Passed
Jul-22	2,207	2,204	**99.86%**	198,395,267.62	198,391,180.92	**100.00%**
Aug-22	6,030	5,929	**98.33%**	218,646,321.29	217,819,695.55	**99.62%**
Sep-22	5,423	5,269	**97.16%**	245,498,285.17	244,659,079.70	**99.66%**
Oct-22	4,585	4,495	**98.04%**	204,401,661.42	203,033,669.91	**99.33%**
Nov-22	5,123	4,957	**96.76%**	225,769,354.67	222,937,258.91	**98.75%**
YTD	23,368	22,854	**97.80%**	1,092,710,890.17	1,086,840,884.99	**99.46%**

Year To Date						
Period Covered	**Jul-22**	**to**	**Mar-23**			
	Number of Bills Paid			**Value of Bills Paid**		
	In Total Period	**Within Target**	**%**	**In Total Period £'000**	**Within Target £'000**	**%**
Non NHS	22,738	22,248	**97.85%**	355,549,759.88	351,881,884.51	**98.97%**
NHS	630	606	**96.19%**	737,161,130.29	734,959,000.48	**99.70%**
Total	**23,368**	**22,854**	**97.80%**	**1,092,710,890.17**	**1,086,840,884.99**	**99.46%**

ACCOUNTS RECEIVABLE

Nov 2022 ACCOUNTS RECEIVABLE						
ORG. TYPE	**Total Amount £**	**Current £**	**1-30 Days £**	**31-60 Days £**	**61-90 Days**	**90+ £**
NHS	8,010,600.19	224,607.85	6,406,165.27	542,321.21	657,648.86	179,857.00
Non NHS	416,373.83	100,447.81	31,031.31	10,347.30	251,454.00	23,093.41
Unspecified	-47,747.58	0.00	-39,300.58	-8,447.00	0.00	0.00
Local Authorities	346,851.39	87,341.45	39,457.25	198,255.00	0.00	21,797.69
TOTAL DEBTORS	8,726,077.83	412,397.11	6,437,353.25	742,476.51	909,102.86	224,748.10
Paid since 30 Nov	- 4,246,622.37	- 30,560.26	- 4,170,054.11	-	-	- 46,008.00
Balance remaining	4,479,455.46	381,836.85	2,267,299.14	742,476.51	909,102.86	178,740.10

Of the £179k over 90 Days, £141k relates Central London Community Healthcare (CLCH) NHS Trust and £38k relates to East of England Ambulance Service NHS Trust (EEAST). CLCH have advised that there is a shorfall on their Purchase Order which they are addressing. EEAST requested further backing on 12 Dec.

ACCOUNTS PAYABLE

ACCOUNTS PAYABLE Nov 2022 INVOICES APPROVED NOT YET PAID - to be paid on next payment run.

ORG. TYPE	Total Amount	1-30 Days	31-60 Days	61-90 Days	90+
NHS	0.00	0.00	0.00	0.00	0.00
NHSE	41,132.80		41,132.80		
ICB	0.00	0.00	0.00	0.00	0.00
NON NHS	1,918.62	1,918.62			
OTHER	0.00	0.00			
TOTAL	43,051.42	1,918.62	41,132.80	0.00	0.00

ACCOUNTS PAYABLE Nov 2022 INVOICES NOT YET APPROVED

ORG. TYPE	Total Amount	1-30 Days	31-60 Days	61-90 Days	90+
NHS	3,181,747.83	2,839,211.77	76,856.67	52,540.33	213,139.06
NHSE	20,908.10	20,908.10	0.00	0.00	0.00
ICB	223,842.29	77,871.97	0.00	121,639.54	24,330.78
NON NHS	19,936,992.20	11,668,972.67	1,199,399.46	739,322.75	6,329,297.32
OTHER	865,080.36	539,433.98	132,472.41	41,125.81	152,048.16
TOTAL	24,228,570.78	15,146,398.49	1,408,728.54	954,628.43	6,718,815.32

TOTAL CREDITORS OUTSTANDING	**24,271,622.20**	**15,148,317.11**	**1,449,861.34**	**954,628.43**	**6,718,815.32**

Of the £6.329m Non NHS over 90 Days, £1.864 relates to Hertfordshire County Council invoices relating to CHC, £1.286m relates to Hertfordshire Eye Hospital, and £531K relates to NHS Property Services. Work is currently ongoing to the clear all outstanding balances.

8. Other Areas to Note

In May 2022, NHS England notified the ICB of additional inflationary funding that would be allocated to support with in-year pay (1.7%) and non-pay (0.7%) inflationary pressures. The receipt of the additional funding was contingent on ensuring there were appropriate spend controls in place:

Financial Framework Governance

Each NHS organisation is required to complete a self-assessment using the Healthcare Financial Management Association (HfMA) checklist – 'Improving NHS Financial Sustainability: are you getting the basics right?'.

The checklist, comprising an initial assessment and 72 questions over 7 domains, was submitted on 30 September 2022 and reviewed by the Internal Auditors during November 2022. The findings of the final report with recommended actions will be presented at the next ICB Audit Committee on 17th January 2023.

The main areas that need to be addressed from the findings were:

- Ensure there was a robust process in place for the development of cost improvement/waste reduction plans
- Ensure there was compliance for Budget Holder sign-off of the 2022/23 budgets.
- Strengthen budget reports at service level.

Related to this, there was also a benchmarking report produced by The Internal Audit Network (TIAN) which showed that HWE was ranked 8th out of 16 ICBs across the audited areas.

Key Theme/Domain	Average for 16 ICBs	HWE	RAG
Business & Financial Planning	3.61	3.80	
Budget Setting	3.88	4.10	
Budget Reporting & Monitoring	3.47	3.80	
Forecasting	3.77	4.00	
Cost Improvement & Efficiency Plans	3.08	2.30	
Board Reporting	3.61	4.30	
Financial Governance Framework (highest)	3.93	3.60	
Culture Training and Development (lowest)	3.15	2.90	
OVERALL AVERAGE SCORE	3.56	3.60	

Controls on Agency Spend

From 1 September 2022, the controls and oversight measures on agency spend will be re-established to support systems in continuing to reduce agency costs.

There will be an agency expenditure limit given for the NHS Providers within an ICB System and this will be monitored through the NHS Oversight Framework. The System Agency Expenditure Limit for Hertfordshire and West Essex Integrated Care System will be £42.603m. The limits are based on planned reductions and have been set to reduce agency spend across systems by at least 10% compared to 2021/22.

It is expected that Providers will use 'on-framework' agency providers and remain within national capped rates and NHS England will use monthly financial returns to monitor performance.

9. Recommendations

The HWE ICB Board is asked to note the following:

- The ICB's year to date and forecast outturn position of breakeven.
- The potential risks to the financial position linked to the Continuing Healthcare (CHC) costs and GP Prescribing.
- The delivery of financial performance targets for the year.

Appendix 1: Detailed Allocations 2022/23

The table below provides additional information on the allocations received by the original three CCGs, which together gives the total allocation for the current financial year.

It should be noted that there are 58 individual funding streams below £100k which have been grouped together in the table, totalling £1,981k.

NHS Hertfordshire and West Essex (HWE) Integrated Care Board (ICB)
ICB Planned Allocations for 2022/23

HWE ICB Financial Plan	CCGs Q1	ICB Q2-4		TOTAL
		Recurrent	Non-Recurrent	
	£'000	£'000	£'000	£'000
ICB Programme allocation	604,610	1,772,481	41,351	**2,418,442**
ICB Primary Medical Care Services	59,350	178,051		**237,401**
ICB Running Costs	7,249	21,746		**28,995**
ICS Elective Services Recovery Funding	11,344		34,031	**45,375**
ICS Service Development Funding	10,903		34,287	**45,190**
Balance of CCG Allocations at end of Q1 - transferred to ICB	(26,414)		26,414	**0**
ICS Pay Award Funding		31,860	5,227	**37,087**
ICS Removal of Employers' National Insurance Contributions		(3,915)		**(3,915)**
ICS Demand and Capacity Funding (Winter)			6,886	**6,886**
Virtual Ward Funding			3,402	**3,402**
System Risk Share Repayment - BLMK			2,334	**2,334**
Funding for Long Covid Services			2,141	**2,141**
NHS 111			1,218	**1,218**
Non-recurrent schemes - where scheme is below £100k in value			1,981	**1,981**
Cancer Alliance			872	**872**
CYP Eating Disorders			523	**523**
PCT Transformational Funding			452	**452**
DWP Employment Advisors in IAPT			404	**404**
LDA Autism and Keyworkers			388	**388**
Audit and Salary costs for double running in 22/23 Q1			328	**328**
Treatment and care, recovery and implementation costs			327	**327**
COVID Programme System Funding			300	**300**
DOAC Rebates			299	**299**
Legacy Remote Monitoring project extension (Babylon funding)			238	**238**
Partnership Awards - Digital Care Models			190	**190**
Tobacco (Maternity and Inpatient)			163	**163**
Pulmonary rehabilitation services			136	**136**
Children and Young People's Transformation Programme			115	**115**
The Families' SPOC			110	**110**
FTA 2223 Adjustment			(153)	**(153)**
Virtual Wards - to be paid in month 7			3,261	**3,261**
Cancer Fair Shares Distribution Q3			797	**797**
InHIP Project Funding. David Saunders, david.saunders9@nhs.net			100	**100**
Diagnostics Recovery and Renewal Programme			167	**167**
Imaging Network - diagnostics			500	**500**
ICB System Capability & Tobacco Top Slice Funding			135	**135**
Reversed - ENIC funding removed from ICB ESRF allocations		218		**218**
Reversed - ENIC funding for 01Apr22-06Nov22 - ICB ESRF allocations - in year			(130)	**(130)**
West Essex - NHS 111 capacity			288	**288**
SDF Mental Health - M6 - Winter Pressures 19.1			223	**223**
M7 quarterly payment Tobacco			163	**163**
Supporting people at home Regional Scaling Programme 22/23			273	**273**
Virtual Wards - to be paid in month 7 - reversal as paid in month 5			(3,261)	**(3,261)**
ICB Covid Therapeutics Allocation - Tranche 1			958	**958**
MH Capital Grants from central budgets			384	**384**
DOAC Rebate Q1 22/23			536	**536**
Delegation of Pharmacy, Optometry & Dental staffing (POD)			150	**150**
Workforce - International recruitment			203	**203**
SDF Diabetes: Treatment and care, recovery and impln part 2			328	**328**
CCG Historic Surplus greater than 1% surplus requirement 21/22			16,703	**16,703**
22/23 discharge funding - tranche 1			3,126	**3,126**
Total Allocation	**667,042**	**2,000,441**	**188,868**	**2,856,351**

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**27/01/2023**	
Report Title:	**HWE ICS Planning Report**				**Agenda Item:**	**14**	
Report Author(s):	Alison Studer, Head of Performance, South and West Herts, Hertfordshire & West Essex ICB						
Report Signed off by:	Frances Shattock, Director of Performance and Delivery, Hertfordshire & West Essex ICB						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	ICB Performance Committee						
Executive Summary:	The planning report gives an overview of the requirements of the 2023/24 operational planning guidance, a summary of the ICB's current status and a timeline for process and completion.						
Recommendations:	The ICB Board are asked to note the contents of the report, any escalation items from the Performance Committee to be verbally updated.						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			
	N/A						

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☒

Hertfordshire and West Essex Integrated Care System

Operational Planning Report 2023/24

January 2023

Working together
for a healthier future

Overview

The three tasks for 2023/24 are:

- Recovering our core services and productivity
  - Improve **ambulance response** and **A&E waiting times**, reduce **elective long waits** and **cancer backlogs**, and improve performance against the core **diagnostic standard**; make it easier for people to access **primary care**, particularly **general practice**

- Make progress in delivering the key NHS Long Term Plan ambitions
  - Core commitment **to improve MHLDA services** and embed measures to **reduce inequalities** (including CYP services)
  - **Primary and secondary care prevention priorities** and the effective management of **long term conditions** to improve population health and curb demand

- Transforming the NHS for the future
  - Putting the **workforce on a sustainable footing** for the long term
  - Levelling up **digital infrastructure** and drive greater connectivity

Overview

Key themes

- Supporting local decision making: **empowering local leaders** to make the best decisions for their local populations
- **Fewer, more focused national objectives**: a greater emphasis on outcomes and less prescription on how to achieve them
- The financial allocation growth only meets the forecast inflationary pressures. The **sustained recovery in core services and productivity improvements (2.2% efficiency target) have to be delivered within the same funding envelope as 2022/23, in real terms**. The exceptions are: additional funding when elective recovery targets are exceeded; growth of the Better Care Fund to support timely discharge

Guidance still to come (risk that this changes planning requirements/assumptions)

- Submission requirements and deadlines (narrative template)
- Revenue finance and contracting guidance for 2023/24 and Capital guidance update 2023/24 (no indication)
- UEC and general practice access recovery plans (early in the new year)
- Single maternity delivery plan (Early 2023)
- Refreshed What Good Looks Like (Early 2023)
- NHS Long Term Workforce Plan (Spring)

Draft Timeline – Summary

Date	Action
23.12.22	23/24 Operational planning guidance released
11.1.23	ICS weekly planning meetings commence
12.1.23	**Technical guidance and non-functional templates received**
6.2.23 (12pm)	**Finance flash submission (frequency after this TBC)**
10.2.23	Providers to submit plans to ICB. Agreed that minor updates may follow as a result of triangulation with finance and workforce
15.2.23	Checkpoint 1 – Each Trust to present draft plans ensuring input from finance and workforce reviewing against the technical and finance guidance.
10.2.23 – 17.2.23	ICB programme leads to draft narrative sections ICB BI leads to collate onto functional template and overlay commissioner activity
17.2.23	Cut off for any updates to be sent to the planning team for the interim submission – narrative and activity
22.2.22	Checkpoint 2 – check and challenge of draft submission
20.2.23 – 23.2.23	Sign off by ICB planning team/ SRO and ICB Exec
23.2.23 (12pm)	**Interim submission to NHSE at 12pm**
23.3.23 – 2.4.23	Board update / discussion of draft plan
TBC	**Feedback from NHSE**
23.2.23 – 10.3.23	Trusts to make any changes to create the final plan
13.3.23 – 17.3.23	ICB programme leads and BI team to make any required changes
22.3.23	Checkpoint 3 – final check and challenge
23.3.23 -27.3.23	Sign off by ICB planning team/ SRO and ICB Exec
24.3.23	Board review of final plan
30.3.23	**Final submission to NHSE at 12pm**

NHS Objectives 2023/24

	Performance Objective	Target	Time frame	Current Status
UEC	• Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 • Improve category 2 ambulance response times to an average of 30 minutes across 23/24 with further improvements towards pre-pandemic levels in 24/25 • Reduce G&A bed occupancy equal to 92% or below	76% 30 mins 92%	March 24 March 24 TBC	Nov'22: 59.1% within 4 hours Nov'22: Avg. 1hr10m16s
Community Health	• Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard • Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	70% TBC	TBC TBC	Nov'22: 83.82% achievement
Primary Care	• Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks • Urgent GP contacts assessed the same or next day according to clinical need • Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024 • Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	100% 100% TBC TBC	TBC TBC March 24 March 24	Oct'22: 81.2% appointments within 2 weeks

NHS Objectives 2023/24

	Performance Objective	Target	Time frame	Current Status
Elective Care	• Zero waits over 65 weeks by end of year excluding patient choice and/or specific specialties • Deliver agreed activity plans as per operational plan	Zero>65w TBC	March 24 March 24	Oct'22: 3,296 waiting 65 weeks or more
Cancer	• Reduce number of over 62 day patients • Meet faster diagnostics within 28 days standard for all 2ww suspected cancer cases to rule it in or out • Increase % of stage 1 & 2 cancer cases being diagnosed as per 75% faster diagnosis ambition by 2028	389 75% 75%	March 24 March 24 March 28	Oct'22: 798 waiting 62 days or more Oct'22: 68% diagnosed within 28 days 53.7%
Diagnostics	• Improve DM01 diagnostics within 6 weeks performance working towards 95% by March 2025 • Deliver agreed diagnostic activity levels to support elective and cancer backlog reductions and DM01	95% TBC	March 25 March 24	Oct'22: 62.9% tested within 6 weeks Oct'22: 32,543 per month
Maternity	• Improve performance by reducing stillbirths, neonatal & maternal mortality and serious intrapartum brain injury • Increase workforce fill rates against funded establishments	TBC	TBC	ICB is top quartile performance nationally for still birth rate
Use of resources	• Deliver a balanced net system financial position in year	TBC	March 24	

NHS Objectives 2023/24

	Performance Objective	Target	Time frame	Current Status
Mental Health	• Increase access for CYP in line with the national ambition for 345k more 0-25 years olds accessing services • Increase number of older people accessing IAPT treatment • 5% growth in number of adults and older people supported by community MH services • Work towards eliminating adult acute out of area placements • Recover dementia diagnosis rate to 66.7% • Improve access to perinatal MH services	TBC TBC TBC TBC 66.7% TBC	TBC	Nov'22: 87.7% Oct'22: 1,322 Out of Area Bed Days 61.6%
Learning Disability and Autism	• 75% of over 14 years olds on GP LD registers have an annual health check and action plan by end of the year • <30 adults with LD&A per million and =/ <12-15 under 18s are inpatients in a designated facility by the end of the year	75% <adults =/<12-15 under 18s	March 24 March 24	21/22: 62.5% 22/23 cumulative until Nov 22: 37.6% Adults: 30 CYP: 20
Prevention & Health inequalities	• 77% of patients with hypertension treated to NICE guidance by end of the year • Achieve 60% of 25-84 year olds with a CVD risk score of >20% being on lipid lowering therapies • Address health inequalities by delivering the CORE20PLUS5 approach	77% 60% TBC	March 24 TBC TBC	21/22: 61.2% Mar 22: 58.4%

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**27/01/2023**	
Report Title:	**ICP Integrated Care Strategy**				**Agenda Item:**	**15**	
Report Author(s):	Stephen Madden, Associate Director for Strategy and Transformation						
Report Signed off by:	Beverley Flowers, Director of Strategy						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	< Group/Committee where previously reported, including date and any recommendations, if none then state N/A > ▪ Integrated Care Partnership (ICP) Board 15th December 2022 – strategy approved. ▪ Herts Health and wellbeing Board 13th December 2022– strategy endorsed ▪ Essex Health and wellbeing Board – 25th January 2023 – strategy tabled for endorsement ▪ The strategy has been widely shared and discussed with partner organisations and various boards across HWE including each Health Care Partnership.						
Executive Summary:	The Health and Care Act 2022 requires Integrated Care Partnerships (ICP) to write an Integrated Care Strategy (ICS) to set out how the assessed needs of local people of all ages can be met through the exercise of the functions of the Integrated Care Board and partner local authorities. The Strategy was agreed by the HWE ICP Board on 15th December 2022 and published on the ICP website on 23rd December 2022. The strategy was initially developed with local strategy leads through a series of workshops and then further developed through stakeholder engagement via a survey, focus groups and various groups and boards across the HWE system. The proposed strategy is a 10-year strategy covering 2023-2033 and has 6 specific priorities, which are outlined below: • Priority 1: give every child the best start in life						

<table>
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Priority 2: support our communities and places to be healthy and sustainable
Priority 3: support our residents to maintain healthy lifestyles
Priority 4: enable our residents to age well and support people living with dementia
Priority 5: improve support to people living with life-long conditions, long term health conditions, physical disabilities, and their families
Priority 6: improve our residents' mental health and outcomes for those with learning disabilities and autism.

Following approval of the strategy the next steps are to develop a delivery plan to support delivery of the strategy including key metrics to monitor success. This work will link in with the development of our 5-year Joint Forward Plan which is to be completed and published by 30th June 2023.
</td></tr>
<tr><td>Recommendations:</td><td colspan="4">< Outcome required from Board / Committee >
▪ To review the enclosed strategy
▪ To support and endorse the strategy and proposed next steps</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☒</td><td>Non-Financial Professional</td><td>☒</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">Various members of the ICB Board are also members of ICP Board which have already approved the strategy.</td></tr>
</table>

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☐
	Helping the NHS support broader social and economic development	☒
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☐

Hertfordshire and
West Essex Integrated
Care Partnership

Hertfordshire and West Essex Integrated Care Strategy

Improving health and care through early help and prevention

2023 – 2033

Contents

Foreword

Caring for our residents' wellbeing and supporting those who face the biggest challenges to living healthy, independent lives, is at the heart of everything we do in Hertfordshire and west Essex.

This strategy sets out the ways in which we will work to ensure that we can all live, work and play in healthy and safe communities where everyone's contributions are valued, and we all have the opportunities and support we need to thrive.

We know that each person's health and wellbeing is shaped by their childhood experiences, the home and environment they grew up in, their finances, education, employment opportunities, and access to vital public services.

We have developed our 10-year strategy by listening to the views and experiences of residents and staff, looking at the information which shows where the needs are greatest, and focusing on those priority areas where we can make the biggest positive impact together.

Together, we will work to:

- give every child the best start in life
- support our communities and places to be healthy and sustainable
- support our residents to maintain healthy lifestyles
- enable our residents to age well and support people living with dementia
- improve support to people living with life-long conditions, long term health conditions, physical disabilities, and their families
- improve our residents' mental health and outcomes for those with learning disabilities and autism.

Our response to the COVID-19 pandemic showed what can be achieved when communities come together to support each other, and the NHS, councils, and the voluntary and community sector work together with a common aim.

With our combined commitment, expertise and resources, our partnership of 28 organisations, which have joined forces through the Integrated Care Partnership, will help to deliver these priorities together, building a brighter and healthier future for everyone who lives and works in our area, so that we can all enjoy the very best that Hertfordshire and west Essex have to offer.

Cllr Richard Roberts, Leader of Hertfordshire County Council, Chair of Hertfordshire and West Essex Integrated Care Partnership, and Chair of Hertfordshire Health and Wellbeing Board

Rt.Hon. Paul Burstow, Independent Chair of Integrated Care Board, and Vice Chair of Hertfordshire and West Essex Integrated Care Partnership

Cllr John Spence, Cabinet Member for Health and Adult Social Care, Essex County Council

About the strategy

The opportunity for change

Hertfordshire and West Essex are great places to live, work, learn and do business. Home to 1.6 million people and more than 60,000 businesses, we have many excellent schools and other local services. Many residents live in vibrant urban centres or in rural communities in stunning countryside.

In Hertfordshire and in West Essex there was already a strong tradition of partnership working prior to the pandemic. Mental health, learning disability and Child and Adolescent Mental Health Services (CAMHS) services for both counties are jointly commissioned by both local authorities and the NHS. There are established processes for joint commissioning in many other areas. The level of integrated commissioning and joined up service delivery accelerated significantly during the pandemic – particularly through the Hertfordshire Discharge to Assess (DTA) model for co-ordination of health and care support which allows people to leave hospital as soon as they are fit to do so and the integrated delivery of adult mental health services in Essex

New integrated care systems (ICSs) build on that spirit of common purpose, collective action, and innovation that we saw during the pandemic. ICSs are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

The purpose of ICSs is to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

In Hertfordshire and West Essex a track record of integrated working offers firm foundations on which to build. Partners across our ICS are eager to scale up their ambition and to demand of ourselves that we work differently together to achieve a step change in health and care outcomes for our residents.

Partners across our ICS have come together to form the Hertfordshire and West Essex Integrated Care Partnership (ICP). The ICP is a statutory joint committee, established by the Hertfordshire and West Essex Integrated Care Board, Essex County Council and Hertfordshire County Council, to improve health and care across Hertfordshire and west Essex. The ICP facilitates its members to take joint action to improve health and care services, to influence the wider determinants of health and to promote broader social and economic development.

Scope of the strategy

Our integrated care strategy sets out our vision, its scope, and our approach. Drawing on the assessed needs from the Hertfordshire and Essex joint strategic needs assessments, it outlines how we will work together to improve the health and wellbeing of people living and working in Hertfordshire and West Essex, including increasing the years that people live in good health and reducing the gap between the healthiest and the least healthy in our community.

Our approach is grounded in an understanding that our health is the product of a complex interplay of factors including education, employment, housing as well as our networks of friends and family, and the neighbourhoods and communities in which we live. This is outlined below in Figure 1 and the Robert Wood Johnson model (Figure 2), which provides a framework that recognises these factors and the need for us to tackle all these elements focussing on those that both have the biggest impact on health and are amenable to system action. Health and care services play their part too. But in seeking to improve health outcomes we recognise the need to head upstream, act earlier and create the conditions in which people have the best chance of living a healthy life.

Figure 1: The factors that influence an individual's health and wellbeing (source: The Health Foundation, 2019)

Figure 2: Robert Wood Johnson Foundation and University of Wiisconsin Population Health institute health status ranking model

Our strategy outlines how we will do things differently, whether by accelerating the pace of integration already underway or by identifying new opportunities to join up health and care. It also sets out how we will reach beyond services to join up work with local authorities and the voluntary and community sector on those things that influence health, such as employment, housing, and education.

The strategy sets out our six strategic priorities for integrated work across the system. Each priority describes the outcomes we are seeking to achieve through this strategy. Delivery will be supported by the ICB 5-year Forward Plan and by the strategies and plans of County Councils and other system partners.

We have taken the decision as system leaders to focus on a few specific priorities, where there is the greatest need, and we can have the biggest impact by working collectively to make progress. We recognise that system working is challenging, it requires give and take. Having fewer priorities does not mean the areas of needs not covered in this strategy will not be addressed. On the contrary, these will continue to be addressed through the organisations in our system as part of their business as usual.

It is also for this reason that our strategy does not include the usual business that each of the partners carry out as part of their statutory responsibilities. For example, it does not set out the NHS's responsibilities for meeting NHS Constitutional Standards, nor the County Councils' statutory responsibilities for social care and children's services. These 'must dos' will be covered by operational plans and business as usual governance. Instead this strategy focuses on the interface between the responsibilities of the NHS and local authorities and those issues that impact on the health and wellbeing of our population which are beyond the ability of any single partner to resolve.

Relationship to other plans and strategies

The Integrated Care Strategy is closely linked to a number of other strategies and plans, including the following:

Health and Wellbeing strategies

In Hertfordshire and Essex the JSNAs have informed the recent development of the Essex and Hertfordshire Health and Wellbeing strategies. These strategies were approved by the Health and Wellbeing Boards of Essex and Hertfordshire in May and June 2022.

In Hertfordshire and Essex the JSNAs have informed the recent development of the Essex and Hertfordshire Health and Wellbeing strategies. These strategies were approved by the Health and Wellbeing Boards of Essex and Hertfordshire in May and June 2022, respectively. The two Health and Wellbeing strategies are similar in approach and content, each setting out a basket of priorities for local action and innovation, focused on improving health and wellbeing outcomes and reducing health inequalities.

Essex Joint Health and Wellbeing Strategy 2022 - 2026

Hertfordshire Health and Wellbeing Strategy 2022 – 2026

Hertfordshire Joint Strategic Needs Assessment

Essex's Joint Strategic Needs Assessment

Hertfordshire Corporate Plan 2022 – 2025

The corporate plan sets out Hertfordshire County Council's vision for a cleaner, greener, and healthier Hertfordshire. The plan includes four priorities to deliver that vision: improving the health and wellbeing of our people, protecting, and improving our environment, supporting the sustainable and responsible growth of our county, and providing excellent services that are accessible for all.
Hertfordshire County Council - Corporate Plan 2022-25

Everyone's Essex 2021-2025

Everyone's Essex sets out Essex County Council's vision for renewing the economy, seeking equality, and being ambitious for the people of Essex as well as focusing on four key areas - the economy, the environment, children, and families, and promoting health, care, and wellbeing for all ages. Embedded in the plan is a renewed commitment to addressing inequalities and levelling up life chances for residents.
Everyone's Essex: our plan for levelling up the county 2021 to 2025

NHS Long Term Plan and other local NHS Strategies

The NHS Long Term Plan (LTP), published in January 2019, sets the direction for NHS organisations delivering care to patients across the country. The plan identifies five priorities and specifies in detail the action to be taken to meet these:

- Targeted care built around the patient
- Preventing illness and tackling health inequalities
- Boosting recruitment and retention of a highly skilled workforce
- Making better use of data and digital technology
- Maximising value for the taxpayer

Commissioners and providers of health services in HWE have plans in place to deliver the targets of the LTP. When the LTP is updated, this Integrated Care Strategy will be updated, as required, to ensure that it reflects any future requirements.

Hertfordshire and West Essex ICS Digital Strategy 2022-2032

This strategy covering health service provision focuses on enabling our professionals to transform services to meet the needs of our residents. It will do this by providing the right digital capabilities, including technology and infrastructure. It is these capabilities that will enable those that provide care to work together to create the best outcomes for people living in Hertfordshire and west Essex. It will enable improved access for residents, patients, service users and carers to information about themselves and allow them to interact digitally with their clinical and care professionals when it is appropriate and convenient to do so.

Hertfordshire and West Essex ICS People Strategy 2023-2025

This strategy supports integrated workforce planning, innovation and new ways of working, a sustainable workforce supply, improved staff wellbeing, experience, and education, talent, and leadership development.

VCSFE Alliance Hertfordshire and West Essex and Hertfordshire and West Essex ICS Health Creation Strategy

The Strategy has been co-designed with the Voluntary, Community, Faith and Social Enterprise (VCFSE) Alliance for HWE ICS to value, promote and enhance the unique role of the sector in promoting health and wellbeing and addressing the wider determinants of health. This strategy enables the ICS to achieve NHSE's expectations that the VCFSE should be treated as an equal strategic partner in plans to tackle the wider determinants and ensures VCFSE partnership is embedded as an essential part of how our system operates at all levels and promotes a more joined up and strategic approach to commissioning of the sector based on evidence of need and impact.

The strategy has the following ambitions:

- To build on community assets
- To make every contact count
- To find out who is missing out and improve their wellbeing
- To ensure there is always someone who can help

It aims to deliver its ambitions through:

- Representation and engagement

- Maximising efficiencies through collaboration & partnership opportunities
- Shifting the lens towards the wider determinants of health
- Promoting the voices of people with lived experience to shape and influence strategic decisions

Sustainability – the 2030 landmark

The effect of climate change is one of the biggest challenges of our time. The 2030 landmark is the target date that many organisations within the partnership have set themselves for becoming carbon neutral or for reaching milestones along this journey. Climate change has serious implications for our health and is already playing out in real time as witnessed through extreme weather events, such as heat waves, droughts, pollution and floods, which are caused by warming temperatures, which have become more severe in the past few years because of carbon emissions. Organisations within the ICP need to respond to these risks.

Adopting sustainable practices within our own organisations and across the ICS system, developing leadership and staff buy-in for efforts to improve environmental sustainability, influencing sustainable practices in the community including through helping shape community environments, behaviours and influencing local suppliers, will in turn influence and impact on our residents' health and wellbeing and contribute to a cleaner and healthier environment.

Hertfordshire County Council declared a Climate Emergency in Hertfordshire in 2019 and is committed to being a carbon neutral organisation by 2030 and has set out steps to embed sustainability in everything it does. Essex County Council is committed to becoming a net zero county by 2050 and has set itself a number of key targets to achieve this objective. The NHS launched the Greener NHS campaign in 2020 and a net zero commitment based on two major goals and a series of targets. The two main goals defined against the 1990 emissions baseline are:

- achieving net zero by 2040 for emissions that the NHS directly controls (the NHS Carbon Footprint), with an 80 per cent decrease by 2028 to 2032.
- Emissions that the NHS can influence (NHS Carbon Footprint plus) net zero by 2045, with an 80 per cent decrease by 2036 to 2039.

Acting sustainably will foster a green economy, energy independence, great places and a better quality of life. There is much to be done to meet the Climate Change Act target of net zero carbon emissions by 2050. To achieve this, environmental sustainability needs to be a golden thread that runs through every aspect of how organisations across our system operates, from how we deliver services, to the energy we consume, and the way organisations use their estates to how they embed, champion and influence businesses and local communities to support actions on environmental sustainability.

This will require leaders across the system to put sustainability firmly on the agenda, ensuring there are ambitious environmental targets in their organisations plans and in the ICB 5-year joint forward plan. When considering how we will deliver the strategy

priorities we will ensure consideration is given to how our actions support our sustainability ambitions.

Our approach to developing the strategy

We established a multi-agency strategy development steering group with participation from the organisations and sectors represented on the Hertfordshire and West Essex ICP. Members of the group supported the development of the strategic priorities, including identifying need, gathering data to understand need, and providing challenge and sense-checking.

Engagement and involvement

A multi-agency communications and engagement group was established to develop and agree our approach to the public involvement and engagement which has informed this strategy.

We have gathered the views of residents, staff, communities and organisations in Hertfordshire and west Essex, and their insight has been invaluable. We have taken particular care to learn from those people that we typically hear from the least, and the people who advocate for them, as they often face the biggest challenges to leading healthy lives. This includes gathering views from people living with poverty, people living with addictions, people from minority ethnic groups and disadvantaged children and young people. The priorities in this strategy have been influenced and amended as a direct result of this work. The wealth of insight we have gained will be shared with everyone involved in delivery this strategy.

Guided by best practice and the requirements of the Health and Care Act 2022 we have:

- analysed some of the wealth of existing insight and recommendations gathered through qualitative and quantitative research by the public and voluntary sector, through a desk-based research exercise
- conducted four themed focus groups to understand the issues facing our people and communities, and to gather their recommendations for change
- surveyed the people who are employed by, or volunteer for those organisations which make up the Integrated Care Partnership, to understand their priorities and learn from their expertise as professionals and residents
- undertaken three strategy development workshops with representatives from ICP organisations
- attended a number of meetings and boards across the area to promote engagement and involvement with the developing strategy.

Engagement and involvement should be an active, ongoing process, which provides clear feedback about the way in which involvement has led to improvements. We are committed to fully involving people and communities across Hertfordshire and west Essex as the strategy is further developed and delivered.

Appendix 1 sets out a fuller description of our approach to involvement and engagement in the development of this strategy.

Our 10-year strategy

Our draft 10-year strategy on a page:

Our vision

A healthy Hertfordshire and West Essex, enabling everyone to live their best lives, with the greatest possible independence.

We are striving for a healthy Hertfordshire and west Essex where we can increase the years that our residents live in good health and lead their best possible lives with the greatest amount of independence. This includes ensuring our residents have a place they can call home, in supportive communities with the people and things that they love and opportunities to succeed.

Four core principles underpin our vision and strategic priorities:

Principle 1

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 swings where a more joined-up approach will bring local authority, NHS, and voluntary sector services much closer together to maximise the chances for health gain at every opportunity.

Principle 2

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 do more than just talk about prevention. We will act and make use of local good practice that supports personalised care such as the Connected Lives model for social care in Hertfordshire. 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.

Principle 3

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 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.

Principle 4

We will **involve 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.

Our strategic priorities

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.

Strategic 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.

Where we are now

The World Health Organisation's Global Strategy for Women's, Children's and Adolescent's Health, the NHS Long Term Plan, the Public Health Strategy: Giving every child the best start in life and the UNICEF Baby Friendly Initiative agree that the first 1001 days from conception to age 2 lay the foundations for a child's later

cognitive, emotional, and physical development. We would extend that 'best start' through until a child is 5 years old.

The national independent review of Children's Social Care (2022) shifts the lens towards locality based multi-agency family help and family safeguarding integrated service delivery. National Independent Review of Children's Social Care Report

The National Panel Review of Child Deaths (2022) emphasises the need to strengthen information sharing and decision-making across all agencies and to build on the skills of our workforce. National Panel Review of Child Deaths Report

In Hertfordshire and west Essex:

- There are health concerns linked to social disadvantage, increasing social and emotional difficulties in young children, mapping through to school exclusions (including primary), youth justice entrants and increasing numbers of children with social and communication difficulties.
- There is a gap in attainment and attendance for vulnerable children including Children Looked After (CLA) Special Educational Needs and Disability (SEND) and Youth Justice cohort.
- In Essex 22.3% and in Hertfordshire 20.1% of children aged 4-5 years old are classified as being overweight or obese. This increases to 33.1% in Essex and 30% in Hertfordshire for 10–11-year-olds (2019-20 data).
- Emergency hospital admissions for children aged under 18 years are significantly higher in East and North Hertfordshire and rates of A&E attendances are higher in West Essex for children aged under 5 years than the national average.
- There are increasing numbers of children needing crisis intervention, with numbers of CLA and those needing mental health specialist hospital provision increasing.

Outcomes we want to achieve

As a parent:

- I can access appropriate services in my community and meet with other parents/carers and develop local support networks
- I know who I can contact for professional advice and support if I have a concern about the physical, cognitive, and emotional health needs of my child

  I know what I can do to help my child's development and I am helped to understand and respond to any additional needs my child has

As a child:

- I am safe, happy, and cared for in my home
- I enjoy learning and have friends and opportunities to play and socialise
- I am supported to be the best I can be

What will change

We will:

- Work together to coordinate support, make every contact count and reduce duplication between services
- Prioritise early help and early intervention so that families are supported early or as needs emerge, working together with early years providers, schools, youth services, and collaboratively with communities and families.
- Ensure children will achieve their best potential by the time they start school by working in partnership to remove barriers to early learning.
- Work with the Voluntary Community Faith and Social Enterprise Sector (VCFSE) sector and other partners to ensure a joined-up approach to supporting children and their families
- Ensure children's physical and mental health have parity of esteem
- Jointly plan and develop family centres into family hubs, with a focus on commissioning of community based and locality provision, embedding the continuum of support across universal, early family help and targeted help
- Jointly plan and commission family help and family safeguarding, with multi-disciplinary teams focused around community settings such as schools and family hubs, with services tailored to neighbourhood needs.
- Jointly plan and deliver early help across the SEND system, so that children with additional needs and their families have the right support at the right time and before statutory assessment; with continued planning of early help for children with emotional wellbeing concerns including school mental health support and parental advice and guidance.

Strategic 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 acting on the wider determinants of health including housing, employment and the environment.

Where we are now

Housing costs and accessibility issues have significantly increased in England and with the current rising cost of living on top of this, the impact will be most felt by lower income households. Poor-quality housing, overcrowded housing, and unaffordable housing harm health. Evidence shows that exposure to poor housing conditions (including damp, cold, mould, noise) is strongly associated with poor health, both physical and mental[1]. Children living in cold homes are more than twice as likely to suffer from a variety of respiratory problems as children living in warm homes and mental health is negatively

[1] Michael et al (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity

affected by fuel poverty and cold housing for all age groups[2].

The 2020, UK Climate Change Commission (UKCCC) Health Equity Report highlights how direct and indirect impacts of climate change will widen existing health inequalities in the UK. It warns that the most vulnerable will be hit hardest unless health equity is considered alongside future government greenhouse gas targets. Air pollution is the largest environmental risk to the public's health, contributing to cardiovascular disease, lung cancer and respiratory diseases. Poor air quality contributes to shortening life expectancy and disproportionately impacts the most vulnerable in society.

Access to good quality green space improves physical and mental health, improves community cohesion, and supports actions to mitigate the effects of climate change and protect biodiversity. Green spaces have been shown to improve cognitive and immune functions and to reduce mortality rates and health inequalities[3]. Access to and use of green spaces tends to reduce as the level of deprivation increases, which was highlighted during COVID-19 pandemic.

In Hertfordshire and west Essex health outcomes are mostly favourable when compared with the national picture however there are persistent health inequalities, especially in poorer areas and for specific groups such as people of all ages providing care. The COVID-19 pandemic exposed and widened these inequalities and led to many more people experiencing ill-health. For example:

- Unpaid carers provide critical support for people with health and social care needs. The support provided by carers is often physically and emotionally demanding, with consequences for carers' own health and wellbeing.
- Those in the most deprived areas in Hertfordshire and west Essex die 3-4 years earlier and spend up to 18 years longer in a state of poor health than those in the least deprived areas.
- On average, rough sleepers die 30 years earlier than the general population4.
- Health inequalities are most stark in Harlow, Stevenage, Watford, Welwyn Hatfield, and Broxbourne.
- Harlow at £545 and Stevenage at £476 are both significantly below the East of England average (£602) for median weekly pay for residents and workers (2021).
- In Hertfordshire and west Essex there are four districts that are below the East of England average (81%) percentage of people that are economically active. These are Stevenage, Welwyn Hatfield, Hertsmere and Harlow.

Outcomes we want to achieve

- I live in a safe, decent place that I can call home, which is accessible according to my needs, and designed so that I can be as independent as possible.
- I have access to benefits that I am entitled to, and I can afford access to paid activities.

[2] Michael et al (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity
[3] Allen J, Balfour R (2014) Natural solutions for tackling health inequalities. Institute of Health Equity
4 Marmot et al (2020). Build Back Fairer: The Covid-19 Marmot Review

- I have people in my life who care about me – family, friends, and people in my community.
- I know about and can access social groups, leisure, as well as health and care services.
- I feel welcome and safe in my local community, and I am satisfied with the local place where I live.
- I have opportunities to learn, volunteer and work, and I can do things that match my interests, skills, and abilities.
- I live in an environment which supports me to be healthy.

What will change

We will:

- Step-up our support to and engagement with communities and groups at risk of the worst health outcomes.
- Support people with disabilities or health conditions to get back to work or remain in work through inclusive employment practices.
- Increase recruitment from our most deprived communities and work with our supply chains to create local economic opportunities.
- Work in partnership to support the delivery of more homes, including key worker housing and implement the adoption of decent home standards in all social and private rented sector accommodation.
- Take shared action to increase the supply of good quality, decent and accessible supported accommodation for people with learning disabilities and autism, and physical disabilities.
- Increase community participation by embedding Asset Based Community Development (ABCD) principles (citizen-led, relationship-oriented, asset-based, placed-based, inclusion-focused) in our organisations, adopting a joined-up approach to social prescribing, and securing social value.
- Work with partners to put health, equity, wellbeing, and sustainability at the heart of local planning and strategy and actively support health involvement in statutory local development plans.
- Ensure that consideration is given to reduce pollution and waste as well as to protect our natural areas.
- Work with partners to create healthy streets and places by promoting green spaces and working with partners to prioritise provision of new green spaces in areas of higher deprivation with better signage and signposting.
- Use the NHS England ‘Core20PLUS5’ framework to direct our approach with a focus on the five clinical areas prioritised in the NHS Long Term Plan i.e. continuity of maternity care for women in the most deprived areas and those from Black, Asian and minority ethnic groups; annual health checks for those with severe mental illness, chronic obstructive pulmonary disease management (with a

focus on COVID-19, flu and pneumonia vaccination uptake), early cancer diagnosis and hypertension case-finding.

- Tackle unhealthy environments by delivering improved infrastructure for safe walking and cycling and by providing easy access to reliable public transport in local areas and promoting a more efficient transport network.

Strategic priority 3: support our residents to maintain healthy lifestyles

We will support people to be physically active, eat healthily, maintain a healthy weight and provide support and advice to prevent tobacco, alcohol and substance misuse.

Where we are now

Good nutrition, healthy weight and regular physical activity are essential for physical and emotional health. Poor diet and nutrition are key contributors to health problems, including tooth decay, excess weight, and frailty, as well as a number of diseases including type 2 diabetes, heart disease and stroke, and cancers.

Physical inactivity is a leading cause of premature mortality. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis, and colon/breast cancer and with improved mental health. In older adults' physical activity is associated with increased cognitive and functional capacity.

Health behaviours including tobacco, alcohol and substance use account for 30% of the influence on health and wellbeing. Smoking and alcohol use are two of the six common risk factors for premature death, and the main causes of ill health such as cancer, heart disease and respiratory disease. Substance misuse is a significant factor in crime including homicide and domestic and intimate partner violence. Around 7% of the population of Great Britain (adults and children) were found to be negatively affected by someone else's gambling. Almost half (48%) of people who were affected by a spouse or partner's gambling reported a severe negative impact.

In Hertfordshire and west Essex:

- Areas with higher levels of deprivation (including Harlow, Broxbourne, Watford, and Stevenage) have the highest rates of childhood obesity. Rates of obesity at year 6 in Harlow are much higher than the national average.
- The number of adults who are overweight was similar to that of England in 2020/21, and still notably high at 62%, with wide variation between districts.
- Around 1 in 5 adults across our geography are physically inactive, which means around 20% of the adult population are at increased risk of a range of health conditions and diseases which are preventable through increased physical activity.

- Smoking prevalence in adults is similar or better than the England average for all districts in HWE; however, there is some variation between the areas with the lowest rates (St Albans at 5.4%) and the highest (Harlow at 18.9%).
- Whilst east and north Herts, south and west Herts and west Essex are all better than the national average for smoking rates in early pregnancy and at delivery, in west Herts 1 in 10 women and in Hertfordshire as a whole 1 in 15 women are smokers at this vital time.
- The relationship between drug use and mental health problems among young people is a particular concern. Research shows that mental health problems are experienced by the majority (70%) of drug users in community substance misuse treatment. Death by suicide is also common, with a history of drug misuse being recorded in 34% of all suicides in people experiencing mental health problems between 2008 and 2018-9.
- Whilst alcohol-related mortality is statistically similar to the national average across most districts, there is variation, with more deprived areas experiencing higher rates or alcohol-related mortality (Harlow highest at 38.8 per 100,000 compared to 27.1 in North Hertfordshire).
- The rates of admissions for alcohol specific conditions, by district, are all better than England average, yet vary across HWE from 291 per 100,000 in Broxbourne to 522 in Harlow.
- Poor mental health is a stronger predictor of at-risk gambling than both poor physical health and negative health behaviours, with the notable exception of alcohol.

Outcomes we want to achieve

- I can take care of my own health and wellbeing
- I know how to live a healthy life
- I feel supported by my community and local services to stay healthy
- I live in a smoke-free home, and I do not smoke during pregnancy
- I am physically active
- I am and my household is free of addiction

What will change

We will:

- Develop a new physical activity offer for our residents which:
    - Increases opportunities for physical activity for children, young people and adults in parks, schools, and community centres
    - Explores opportunities to give people on low incomes affordable access to exercise classes and leisure centres
    - Provides information to adults about how to integrate more physical activity into their daily lives and increases provision of support, advice, and

services, including those who are housebound and frail, to help improve strength and mobility.

- Offer all people admitted to hospital who smoke access to NHS-funded tobacco treatment services and adapt the NHS-funded tobacco treatment service model for expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments. A new universal smoking cessation offer will be made available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services.
- Improve pathways and outcomes for people who have a mental health issue and experience drug and alcohol problems and ensure an integrated new universal smoking cessation offer is also available as part of specialist mental health services for long-term users of specialist mental health, and services for people with learning disabilities and autism.
- Support hospitals with the highest rate of alcohol dependence-related admissions to establish hospital/community-based alcohol care teams to support people living with alcohol dependency and who have significant physical complications and or those with repeated hospital admissions.
- Support our residents in low-income households to have access to affordable healthy food and facilities to store and cook it.
- Support our residents most at risk of poor outcomes from being overweight including those with mental health conditions, physical disability or learning disability and autism.
- Support children and young people to have access to information, advice, and support to maintain a healthy weight and access to leisure activities in their communities. Including access to effective local weight management services, specialist treatment and surgery for those that need it.
- Ensure people have access to education, information and advice on how to reduce harm from tobacco, gambling, alcohol and other substances and promote awareness of the risks and harm from tobacco, alcohol, gambling and other substances. Those most at risk will have access to targeted support, advice and treatment.

Strategic 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.

Where we are now:

- The population and proportion of those aged 65 and over is growing in both Herts, from 17.2% in 2020 to an expected 23.2% in 2043) and Essex (number of over 65-year-olds expected to grow by 28% in the next decade, and number of over 85s by 55%).

- Other data demonstrate social isolation, hospital admissions due to falls and fractures, reablement following hospital discharge as areas for improvement. Whilst there is a range of initiatives to improve clinical outcomes, ageing well is broader than this. Prevention is going to be key to ensure that the population keeps well for as long as possible, as the ageing population will inevitably result in a greater demand for our services.
- Pre-COVID-19 carers were approximately 10% of the population, this is expected to have grown since the pandemic.
- Those living with dementia face great personal uncertainty both during its early stages and as their condition progresses. Dementia poses serious challenges for health and care services and has a higher health cost than cancer and heart disease. The condition is sometimes difficult to identify early, and once a diagnosis is given, it can be difficult to find the right support.
- People with dementia face an increased risk of health or care crisis, sometimes resulting in unplanned admission to hospital, often not the best place for them.
- Approximately 43% of NHS budget is spent on those aged 65+ years, who account for approximately 12% of the population.
- It is estimated that between 20% and 30% of hospital admissions in over 85s could be prevented by proactive case finding, frailty assessment, care planning and use of services outside of hospital

Outcomes we want to achieve:

- I know how to plan for older years to I can reach them in the best health
- I can live independently and take care of my own health and wellbeing, and manage the challenges life may throw at me for as long as I want
- I have choice, control and independence over my health and care support needs
- I feel socially connected and a valued and respected member of my community
- I know what support is available and how to access it
- I am treated with dignity and respect
- I will be asked for my end of life wishes and will be able to die, where practically possible, in my preferred place of care.

What will change:

We will:

- Work in an integrated way to support people to live well for longer, maintain independence and improve early diagnosis and support for those at risk of becoming frail, living with dementia and their families.
- Support people to increase physical activity and reduce loneliness and cognitive decline through connecting with their local communities by working collaboratively to provide information, advice, and support.

- Ensure local services, communities and the environment, including outdoor space, transport and buildings, are integrated and are age and dementia friendly.
- Improve support for people who look after family members, partners or friends because of their illness, frailty, or disability.
- Develop and support capacity of care homes and discharge arrangements, align specialist services with primary/ community and social care and resolve pathway issues around health and social care to improve flow of patients out of acute settings.
- Promote and encourage take up of the NHS Heath Check for people aged between 40 and 74 to help prevent the onset of disease (diabetes, heart disease, kidney disease, cancer, stroke and dementia).
- Improve provision of extra care housing for older people with health and care services embedded so our older residents can maintain their health, wellbeing, and independence into old age.
- Strengthen multi-disciplinary team approaches where professionals and the voluntary sector work together in an integrated way to provide tailored support that helps people live independently at home for longer.
- Ensure our information and advice offer is accessible to people affected by dementia throughout the course of their condition, including social and wellbeing opportunities in their local community.
- Review and strengthen our support offer to those diagnosed with Mild Cognitive Impairment (MCI) to reduce the likelihood of, or extend the period between, the development of dementia.
- Work to review and rollout dementia training for our workforce across health and care services.

Strategic priority 5: improve support to those 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 live.

Where we are now

- People with long-term conditions are 2-3 times more likely to experience mental health problems.
- 27.5% of the HWE population are estimated to be living with a long-term health condition.
- £7 out of every £10 spent in the NHS is spent caring for people with a long-term condition.

- Physical disability is defined as a “limitation on a person's physical functioning, mobility, dexterity or stamina” that has a “'substantial' and 'long-term'” negative effect on an individual’s ability to do normal daily activities. (Equality Act,2010). Approximately 6% of the HWE population consists of adults with a serious physical disability. With 14.3% of people having their day-to-day activities limited by their health (based upon Hertfordshire data).
- There is potential underdiagnosis for a range of long-term conditions, particularly hypertension and chronic kidney disease.
- Rates of emergency admissions are high for COPD (East & North Herts & South & West Herts), CHD (South & West Herts and West Essex) and heart failure (South & West Herts).
- Outcomes are worse, relative to the ICS average, in areas with higher levels of deprivation (Broxbourne, Harlow, Stevenage, Watford and Welwyn Hatfield).
- Services are not always person-centred in a way that allows individuals to become involved in decisions about their care. The model of care needs to move away from a disease-specific model to a more integrated approach, considering all existing conditions, ‘risk of’ conditions and the wider determinants of health that can impact on an individual.

Outcomes we want to achieve

- I feel supported to manage my long-term health condition or disability and the care I receive is co-ordinated.
- I understand my condition, feel in control of my care, and know where to go for help and can access support when I need it.
- I can care for my own health as well as the person that I care for.
- I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes that are important to me.
- I can access services and support.

What will change:

We will:

- Work more effectively as a system to develop and provide joined up integrated health and care services and facilities to support those living with long-term or life-long conditions or physical disability.
- Ensure robust and seamless transition pathways into adulthood that promote choice and independence.
- Support and empower people with long-term health conditions, physical disabilities, and their carers, to live healthily and independently, with better control over the care they receive.

- Support engagement in person-centred care through a range of activities including identifying and supporting champions to be local change agents.
- Work with our population, particularly those who are not currently accessing services, to lower risk factors and improve detection, diagnosis, and early-intervention for those developing long-term conditions. This includes delivering annual health checks for people with severe mental illness, learning disabilities and autism.
- Support our residents with physical disabilities, including neurological conditions, to improve their physical health and access preventative health services.
- Ensure women are supported through the menopause and encouraged to take up activities and use medication (where appropriate for their needs) to counteract the impact of hormone deficiency thereby reducing risks of cardiovascular disease, dementia and hip fractures in later years (Women's Health Strategy for England).
- Increase the number of residents who receive NHS health checks, including annual health and physical checks for those with a severe mental illness (SMI) or learning disability (LD) and annual reviews for residents that are frail or at risk of frailty.

Strategic 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.

Where we are now

- Mental disorders represent the second largest single cause of disability in the UK across all ages, with 1 in 4 adults experiencing at least one diagnosable mental health problem each year.
- The cost of mental-ill health to the UK economy is estimated at £105 billion a year, almost the cost of the entire NHS
- Mental health is known to be mutually and intrinsically linked with physical health and has been implicated as a risk factor for the development and progression of diseases, such as cardiovascular disease and diabetes
- Mental health problems are associated with higher rates of smoking and alcohol and drug abuse, lower educational outcomes, poorer employment prospects, social disadvantage, that in turn increase the risk for physical health problems. Poor physical health is common in people with an SMI. It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented
- In England and Wales, suicide was the leading cause of death in people aged 5-34 years in 2018. In males aged 20-34 years, almost 26% of deaths were by suicide. Research indicates that the impact of someone dying by suicide can

impact 135 people with an estimated fiscal impact to the economy and those impacted of £1.7m (Knapp et al 2011) HWE has a similar suicide rate when compared to the national average. The suicide rate in Harlow is statistically higher than the national average.

- Social disadvantage and poverty are well documented as both consequences and causes of common and severe mental illness. The prevalence of severe mental illness is higher in more deprived areas. Housing issues and food insecurity have frequently been cited as having a negative impact on mental health.
- People with LD experience increased exposure to social determinants of poor health such as inadequate housing, unemployment, living in areas of deprivation, financial hardship, violence, discrimination, and social isolation. Rates of paid employment are substantially lower than the general population for those with LD known to local authorities. Exposure to these factors leads to adverse impacts on health and wellbeing, whereas paid employment is associated with better physical and mental health in people with LD. Employed adults are around half as likely to have a common mental disorder than those who were economically inactive or unemployed.

- In Hertfordshire, the excess mortality rate for adults with a SMI is above the regional average and in Essex, the rate of premature mortality for those with a SMI is similar for cancer, cardiovascular disease, and respiratory illnesses. (HWE ICS Health Needs Analysis Overview, 2022).
- Mental health is a contributor to the gap in life expectancy between the most and least deprived areas in Hertfordshire and West Essex, 6.9% for males in Hertfordshire and 2.9% in West Essex and 10.3% for females 7.6% in West Essex, (Hertfordshire Public Health Evidence and Intelligence, 2022 and Essex Joint Strategic Needs Assessment 2021-22).
- In HWE there has been an increase each year over the last 3 years in percentage of adults reporting a long-term mental health condition.
- People with a learning disability on average die 23 years younger for men and 27 years younger for women than the wider population.

Outcomes we want to achieve:

- I am supported to have good mental health and I know how to access activities that promote my wellbeing
- My care and support are driven by my needs and what is important to me, rather than the needs of systems and processes
- I do not see multiple professionals to manage my health and I can access support through digital and online options should I want them
- I am supported to think about what will happen in the short, medium, and long-term. There will not be any surprises about the support and care I receive
- I have access to employment and volunteering opportunities

- My school/education setting, or workplace understands my neurodiversity and makes reasonable adjustments to ensure my participation
- My family and I are supported to get a diagnosis of my condition and support is provided whilst I await diagnosis.

What will change

We will:

- Reduce the gap in life expectancy between people with a learning disability and SMI compared to the general population.
- Ensure there are clear pathways and timely access to psychological therapies for children, young people and adults who require this support
- Develop and implement an integrated whole life approach for children, young people and adults with autism that includes a focus on home and school life, diagnosis and transition into adulthood, housing support, adult learning, and work opportunities.
- Improve integrated pathways to access housing, education, employment, and skills, particularly for people with learning disabilities and autism, physical disabilities and severe mental illness, embedding support within models of care.
- Work more effectively as a system to improve outcomes for our population with a mental health diagnosis or learning disabilities or autism by ensuring that reasonable adjustments are integrated in all pathways through implementing the NHS Accessible Standards.
- Develop and deliver an integrated neurodiversity service for children and young people
- Improve the physical, mental, emotional health and social wellbeing of people with learning disabilities and autistic people of all ages and their carers.
- Reduce suicide through a focus on system support of suicide prevention and having addressed the seven national priorities as set out Suicide Prevention: policy and practice
- Work with local employers and partners to ensure they develop suitable opportunities and roles for people with LD and SMI to access and maintain employment and to develop new skills and help employers feel able and confident to be making the reasonable adjustment required to help them to prosper in work.

Key enablers

The following will support the delivery of our strategic priorities:

Workforce

Our workforce, including the voluntary sector and volunteers (including carers), are crucial to the delivery of our ambitions. By supporting and utilising our existing and

future workforce effectively through strengthening integrated working across our system, we will be able to avoid unhelpful competition between partners that could make workforce challenges worse. We must recognise the critical role of the care workforce in the private market and the key role the voluntary sector and carers plays in supporting better outcomes and supporting system resilience. We must also continue to give a strong voice to our staff – giving them time and resource to tell us where there needs to be improvement and innovation. It is important that we develop our workforce and address our workforce challenges and that all partners are engaged in the delivery of the ICS People Strategy.

Delivery at the right place

The Integration White Paper set out an expectation that partners work together at place level and that "places need to think *Housing & Communities* when developing a local partnership to plan and deliver health and care." We commit to building strong and inclusive local partnerships, joining up care and support with local partners, including with district councils, schools and communities, NHS, and the local voluntary and community sector.

Given the geography of our ICS which runs across county boundaries, we will make sure we always identify the right place for commissioning, service delivery and programme implementation. The contributions of both County Councils, the 13 district and borough councils and the four health and care partnerships will be crucial in this context.

Collaborative and joint commissioning

To support delivery of our integrated plans, we will identify further opportunities for collaborative and joint commissioning, learning from the strengths and challenges of arrangements currently in place between the NHS and the County Councils. We will particularly seek out further progress in continuing health care (CHC), integrated accommodation, children's and young people's health, and public health. In 2022/23 we will draw up plans for increased use of joint appointments, section 75 agreements, joint contracts, and a broader use of the Better Care Fund.

Data and insight

These are fundamental enablers for the strategy. The strategy has regard to the joint strategic needs assessments of both counties and the development of population health management approaches. This data and insight will continue to inform and shape the work of the ICP, ensuring that decision-making will be deeply rooted in the evidence and insights we collect. Data and technology will be leveraged to support the delivery of our priorities and improve independence and outcomes for our population.

To support population health management approaches access will be required to the widest set of data and analytical capability in our systems across the partnership. This will promote and enable more joint work and data-sharing, so it becomes the norm rather than the exception.

Research and innovation

To support the delivery of our strategic priorities, we need to utilise evidence from data, research, and practice to build our understanding of our population's health and care needs. We will also identify gaps and opportunities for research and utilise this information to inform the delivery of the strategy through continuous learning and improvement. we will adopt, test, and utilise proven innovation to address our population needs.

Digital and technology

Alongside the Hertfordshire and West Essex ICS Digital Strategy 2022-32 and other digital strategies, we need to drive plans to increase the use of digital and technology to promote flexible and efficient working practices; to enable quicker and better data sharing between organisations; to enable communities, families and individuals to self-help and self-serve; and to support digital inclusion and the digital maturation of organisations in the health and care sector. Our delivery plan for the strategy will include details how utilisation of digital and technology will support delivery of each priority.

How we will deliver the strategy

Translating the strategy into plans and action

The integrated care strategy will provide strategic direction for all of our partners. It will also inform the development of the NHS ICB 5-year joint forward plan. Other partners' including both local authorities, our district councils, placed based alliances and health care partnerships along with the VCFSE alliance will also reflect the strategy in their plans and will have an important role in delivering this strategy, along with our communities and residents.

The initial ICB plan is due for completion and publication by 31st March 2023 and will be refreshed annually, other partners will consider how they will align and publish their plans and the actions they are committing to take in support of this strategy.

Governance and accountability

The strategy will be submitted for approval at the December 2022 meeting of the Hertfordshire and West Essex Integrated Care Partnership Board.

The ICP is the owner of the strategy. It will:

- support and encourage organisations/partnerships within the system to work together on local services and initiatives that support the priority
- agree a single organisation/partnership to lead on coordination of activity to deliver each priority
- establish a framework for mutual oversight and assurance of delivery of the strategy. It will do this by receiving regular reports on delivery against each priority and holding partners to account if delivery is ineffective.

The ICP will support delivery of the strategy by agreeing two or three areas for its annual work programme, facilitating our organisations to work together, as well as providing focus, appropriate challenge and support to them.

The ICP recognises that it is one of three ICPs that has a focus on the Essex area. We will work in conjunction with our neighbouring partners to align and deliver our collective ambitions, reduce duplication, improve consistency of experience for our residents and share learning and opportunities for transformation. We will also link in and work with our other neighbouring ICPs and ICBs where it will benefit our population.

Dashboard for key metrics

Progress and delivery of each of the six priorities will be monitored by information dashboards which will collect data on key metrics. These will be co-produced with key stakeholders and developed in line with the ICB 5 year forward plan and the plans of other partners.

Annual monitoring and review

We will produce an annual report which provides a narrative account of our progress and challenges, and measures progress. We will ensure we incorporate residents' insights and feedback into this review.

Continuing to improve our strategy

As 2022/23 is a transition year, we will review our strategy in one year time to look for opportunities to improve its ambitions and content. We will also consider revising our strategy when a new JSNA is produced in line with Government expectations.

Appendices

Appendix 1: our approach to engagement in the development of the strategy – ‘Start with people’

Effective engagement empowers people to shape, understand and access the services and support that are available to help them to lead healthier, happier lives. The Health and Care Act 2022 mobilises partners within Integrated Care Systems to work together to improve physical and mental health outcomes, and places legal duties on organisations to ensure that their actions are informed by the needs, experiences and aspirations of the people and communities they serve.

In drawing up this strategy, we have used a variety of methods to learn from the people and communities in Hertfordshire and west Essex, observing the Health and Care Act’s requirement to use existing insight about the needs and experiences of those living and working in our area, and to work with the partner organisations that have close links to them.

Guidance on developing ICP strategies cites the following groups as those who face the biggest health inequalities, and who therefore should be engaged when drawing up the priorities of our strategy:

- black and minority ethnic voices
- children and young people
- children and young people with SEND
- disabled people
- inclusion health groups
- LGBTQ+ people
- Maternity Voices partnerships
- members of the Armed forces and their families
- older people
- parent and carer panels
- parents, carers and families (including new and expectant parents, and foster parents)
- peer supporters and informal advocates
- people in contact with the Criminal Justice System including offenders, and prisoners
- people living in deprived areas
- people who draw on care and support
- people who draw on mental health services, (including children and young people)

- people with a learning disability, autism and other neurodevelopmental disorders
- people with lived experience of suicide and self-harm
- religious and faith groups
- transient populations
- unpaid carers including people providing care at a distance, and young carers
- women's and men's health and care groups.

Our approach has sought to make the most of the information available to our system through the wealth of engagement work which has taken place in recent years, seeking out the views and experiences of people of those (such as the groups listed above) who face the biggest challenges to living healthy lives. Our learning from this work has been strengthened through additional engagement activities commissioned in order to shape the priorities of this 10-year strategy.

In summary, we have:

- analysed existing insight through a literature review of surveys and studies
- conducted targeted focus groups
- surveyed the ICP workforce and voluntary sector
- held system wide meetings to involve partner organisations and gather their input.

Literature review

Rich feedback on public and voluntary sector services in Hertfordshire and west Essex, capturing people's lived experiences, and their views and suggestions, is available through reports, surveys and feedback documents. These source studies vary widely in scale, methodology and scope – from qualitative studies of 12 young people living in a secure mental health unit, to quantitative, demographically representative studies of 1,000 Hertfordshire residents and 15,500 NHS employees from across our ICB area. We developed a template to enable us to summarise each report/survey/feedback document considered, pulling out key findings, recommendations and where possible, direct quotes from participants.

This work was then fed into and cross-referenced with our developing ICP strategy. As well as insight into specific areas, such as caring, addiction, or dementia, for example, some themes emerged, including loneliness and mental health concerns. The importance of, and access to timely, culturally sensitive and appropriate information and sources of support was revealed as a priority for many people.

Some of the studies reviewed include:

- Addressing obesity in Stevenage, Hertfordshire: a consultation with young people, 2019
- CDA (Community Development Action) COVID recovery survey, August 2021
- Healthwatch Essex 2017 – Dementia Voices
- Essex Health and Wellbeing Survey Report, 2022-2026
- Sweet!3 - Healthwatch Essex into experiences of young people in secure MH unit 2018/19
- HCC's Children and Young People's Health and Wellbeing Survey 2021
- Hertfordshire Health and Wellbeing Survey Report, Jan-Feb 2022
- Healthwatch Hertfordshire: Making local healthcare equal: Healthcare concerns in Black and Asian communities. September 2022
- NHS staff survey, Autumn 2021
- Addiction: gambling, drugs and alcohol - Healthwatch Essex - April 2022
- Mental health self-care in Essex, 2016-2017
- Young mental health ambassador discussions on body image - Healthwatch Essex August 2022
- Consultation on health and wellbeing services in Hertfordshire

A directory of the source studies drawn from (where these have been made publicly available) will be created on the ICS website, in the ICP section, where they will form an 'insight bank' resource for service providers and commissioners from both the public and voluntary sector. They will be shared with the strategy development team in order to inform the ongoing development and delivery of the strategy.

Focus Groups

In order to ensure that the priorities of people who can struggle to make their voices heard through traditional engagement activities have been taken into account in developing this strategy, a specialist research organisation was commissioned to hold targeted focus groups.

Four separate groups were held, attended by public and voluntary sector representatives who work with and advocate for:

1. people living with poverty
2. inclusion health groups
3. people from Black and Minority Ethnic backgrounds
4. parents, children and young people.

Each group was asked:

- What are the main issues and challenges that impact on the health and quality of life of the people you work with?
- What are the measures that could be taken that would help?
- How can organisations be more joined up to deliver the change being suggested?

- What can your organisation do to support?
- Are the developing priorities in our strategy the right priorities?
- Is there anything else we should include?

The summary findings from each group follow below:

Focus group one – recommendations from participants working with people living with poverty

- Need to be flexible and tailor actions and measures to neighbourhoods; 'centralisation' can be a problem.
- People need to better understand the long-term impact of a poor diet and obesity; there is still lack of understanding.
- Access to services can be difficult – need to make this simple and sometimes 'human' rather than always online.
- Replicate the good things that happened during covid pandemic: consistent messaging; outreach activity; covid marshals
- Better to use trusted community members, not the council
- Need all partners to know what everyone else is doing – still fragmented. There are some examples of where this works.
- Make more use of social prescribers – and not just responsive, but could be more proactive
- Value in people taking more control themselves, rather than expecting or waiting for something
- There is lots happening, but funding is a problem (including public health funding)
- Businesses who want to help (as they did in covid) and to give something to communities should be supported and matched to community.

Views on the draft strategy priorities from participants working with people living with poverty

- The environment was seen as a key concern which has an impact on all our priorities – however there was some doubt as to whether environmental improvements could be delivered.
- Prioritising children is important as there are long term benefits from this. There should be much more engagement with schools – make use of them as the centre of their communities,
- Scepticism about delivery of strategy – requires so many partners and if it is just NHS delivering then won't work as so much else that is important.
- How are we going to measure the effectiveness of the strategy and whether its priorities are delivered?

Focus group two – recommendations from participants working with 'inclusion' health groups

- Problem that health professionals don't live in same communities/understand the people they support -they can't see that someone might need to choose between paying a bus fare to the foodbank or to the GP.
- Relationship between GP practices and local people can become confrontational, and opportunities are missed to identify other issues where help could be provided.
- Services need to signpost well – not rebuff. There is always a group who can help – even if just advice or a cup of tea.
- People get used to certain services – GPs and hospitals – and the shift to others can be difficult.
- Services work in an isolated way and have their own priorities, rather than everyone looking at the community or situation as a whole. They don't see how what they do (e.g. planning dept) has impact on health, for example.
- More joined-up working has started but needs much more co-ordination; sharing workspace could help.
- Make better use of social prescribers.
- Resources in voluntary sector a problem as number of volunteers has dropped since height of covid pandemic. Fewer volunteers to support.

Views on the draft strategy priorities from participants working with 'inclusion' health groups:

- Priorities need to be more precisely and simply worded so people can understand.
- Targeting to help reduce inequalities is good and it happens; need to be careful doesn't come at the expense of wider improvements in healthcare.
- Priorities feel just like normal business – what we should be doing anyway.
- Carers should feature more prominently in the strategy – family carers.
- Women should feature more prominently in the strategy.

Focus group three - recommendations from participants working with people from Black, Asian and Minority Ethnic Groups

- The impact of the cost of living is huge – 70% of calls to Herts Help advice line concerning cost of living.
- The accessibility of services to South Asian communities is important - language barriers and the cultural sensitivity and understanding of staff on the front lines of the services.
- Lack of trust in authorities and health and wellbeing services because of overt racism. Several examples were given.
- Lack of trust in police amongst these communities – trust damage by 'stop and search' policies.
- Lack of continuity of care (mental health services).
- Cultural insensitivity – e.g., mental health counsellors who do not understand or try to challenge people's religious beliefs.

- Challenges VCFSE face because of the increase in pressure on their services. One of the participants runs a charity but also is also runs a shop and works full time. Their business gets busy towards Christmas – just as there is increased demand and pressure on the VCFSE sector.
- Funding goes to established VCFSE organisations for outreach into communities that these organisations have limited experience with – this comes at the expense of smaller organisations that have better links but are less well known.
- Participants wanted to see a greater emphasis on supporting grassroots organisations to support people from South Asian communities.
- Having places of worship was seen as an important way in which issues of mental health could be addressed. Places of worship could also be places where authorities reach out to these communities. Difficulties with securing planning permission to build a temple in Watford.
- Participants discussed the need for people within these communities to have decision making power, rather than to simply be consulted.

Views on the draft strategy priorities from participants working with people from Black, Asian and Minority Ethnic Groups:

- Participants were generally supportive of the priorities and their comments were related to checking that specific groups were included in these priorities – for instance carers. There was a particular concern for young carers from South Asian communities who are often involved in care and support for adult relatives because they are often more fluent in English and better placed to navigate systems in the UK.

Focus group four - recommendations from participants working with children and young people

- Mental health problems and lack of access to services was mentioned by most in the group as being the biggest issue affecting the wellbeing of young people.
- Teachers are struggling to cope with issues their students present with due to lack of time, training or awareness of what support is most appropriate.
- An increasing issue at present is young people who are struggling with their gender identity, particularly common among those with autism.
- Social prescribing is an important way of supporting young people.
- A Scottish initiative which is training all teachers in nurture-based practice which is seen to be working very well and reducing exclusions from school.
- Having spaces where young people can speak to adults who are separate from family and friends is beneficial.
- We need to link up our community organisations and their activities.
- Tackling cross border issues and infrastructure barriers is important.
- We need to have agreed targets and outcomes and long-term funding in place.
- Support for teachers, parents and others in contact with vulnerable young people is key.

Views on the draft priorities from participants working with children and young people

- A number of the issues linked to the priorities could be closely related to adverse childhood experiences. Preventative measures could mitigate against these.
- The workforce priority is critical across the NHS and other partners.
- Funding that is on short-term cycles is deemed a problem that could mitigate the ability to deliver some long-term priorities
- Some felt there were too many priorities, how will they all be delivered?
- How would priorities be monitored?
- Reducing health inequalities was seen as underlying all the other nine and the group was not sure whether this needs to be a priority, or a general principle

Responding to the focus group findings

The insights obtained as a direct result of these focus groups have helped shape our strategy. For example, although there was generally positive feedback about the 10 priorities that participants reviewed, there was concern there could be too many, and that they would not therefore be achievable. The number of priorities has since been reduced.

It was also noted that the priorities need to be expressed in clear language that can be understood by everyone. This has been taken on board by the strategy development team. Some themes, such as the importance of early help, the need for services to be 'joined up', the need for effective signposting of services and better awareness of services will need to run throughout the delivery of every priority.

The importance of identifying ways and means of evidencing actions that lead to the delivery of the strategy's priorities was highlighted. This is an area where ongoing public and staff engagement and involvement will be vital in order to maintain confidence in the strategy and the organisations which have developed and own it.

The detailed insight gathered will contribute to the development of the Joint Forward Plan, which will be our system's delivery plan for the integrated care strategy.

Surveying the ICP workforce and voluntary sector

An anonymous survey seeking the views of staff and volunteers working for Integrated Care Partnership organisations was distributed across our system, with the support of system partners. More than 750 responses were received over a two-week period.

Respondents were largely drawn from the NHS and local government (both district and county councils), with the voluntary, community, faith and social enterprise sector and other public services, including the police service, also represented. 66% of respondents reported having some contact with, or offering support to, service users, patients, or members of the public.

The survey offered respondents the opportunity to give their views on some or all of the 10 draft priorities they were presented with, both in terms of the personal potential impact of those priorities on themselves and their families, and the wider potential impact on their communities and the people they serve through their work.

The majority of respondents (59%) chose to comment on workforce as a priority, selecting 'Recruit, develop and retain the people we need to provide health and care services for our population, ensuring that we have enough people with the right skills to deliver the best possible services'. This suggests that as the survey was taken primarily by people living and working in Hertfordshire and West Essex, respondents were interested in the priority most relevant to their career and progression.

Just under half of respondents chose to comment on a priority relating to mental and emotional health (48%) and a priority which focused on measures to ensure people maintain a healthy weight (47%). A priority which focused on addiction and its impact on health and wellbeing, had the fewest responses (24%), although of those 24%, more than half said that this priority would have an impact on them as individuals, and two thirds said this would impact their family or friends.

When asked in an open question whether they wanted to comment on the strategy priorities overall, 180 respondents raised the following issues:

- Generally positive sentiments (41%)
- Needs adequate staff/skills processes to be delivered (14%)
- Needs detail on delivery, monitoring and evaluation (12%)
- Needs adequate funding to be delivered (11%)
- Improved partnership working needed for this to work (9%)
- Co-production needed/would be useful (7%)
- People need to be enabled to take ownership of their own health/have access to right information and services (6%)
- Focus on those most in need/do a small set of things well rather than too many not very well (2%)

When completed, the detailed survey report will be made available to the strategy team and the public, via the ICP web pages on the Hertfordshire and West Essex Integrated Care System website.

System Wide Meetings

As part of our engagement plan in developing this strategy we have attended over 30 meetings with senior leaders to present the draft strategy and obtain feedback. This engagement has been crucial in ensuring that our strategy meets the needs of all our partners.

HWE Integrated Care Partnership	Hertfordshire Mental Health, Learning Disabilities and Autism	Children's Services Core Board - HCC

	(MHLDA) Collaborative Board	
Healthwatch Community Assembly (Hertfordshire)	Healthwatch Community Assembly (Essex)	District & Borough CEO Group (HCC)
HWE ICS Health Inequalities Strategic Board	Hertfordshire Health & Wellbeing Board	Health & Wellbeing Board (ECC)
ICB Primary Care Senior Management Team Meeting	Public Health Management Board - HCC	HCC Cabinet Members Panel - webinar
Scrutiny Committee (HCC)	Health Overview & Scrutiny Committee (Essex CC)	Adult Care Services Senior Management Board (ACSMB) HCC
Essex Children's Board	HWE Integrated Care Partnership Committee	Essex Partners Board (ECC)
ICB Board Meeting	HWE ICB Design & Delivery Board	ICS PMO Team Meeting
East & North Hertfordshire Health Care Partnership Board	South and West Herts Health Care Partnership Board	West Essex Health & Care Partnership Board

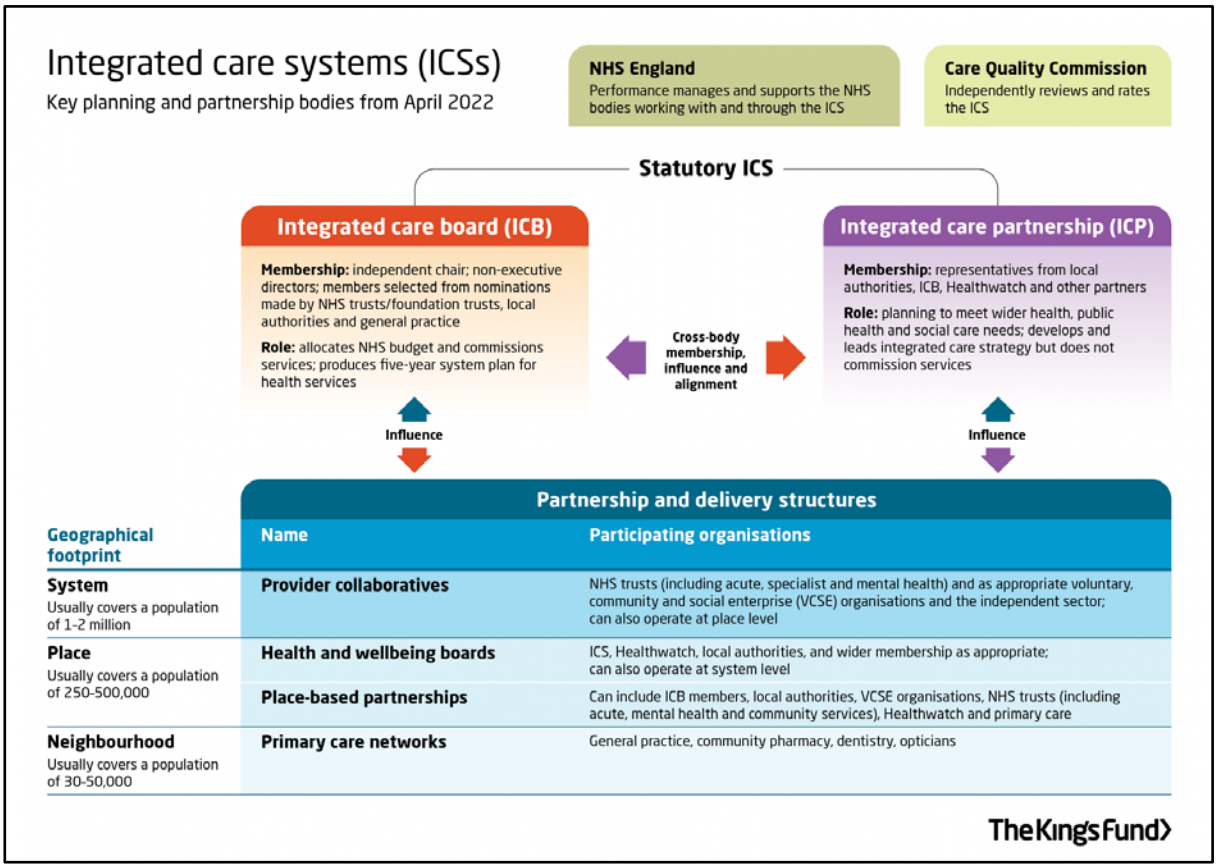
Conclusion

Engagement and involvement should be an active, ongoing process, which provides clear feedback about the way in which involvement has led to improvements. We are committed to fully involving people and communities across Hertfordshire and west Essex as the strategy is further developed and delivered. Updates will be posted to the ICP pages of the Hertfordshire and West Essex Integrated Care System website and through a wide range of communications channels. Those directly involved will be kept informed so that they can see the impact that their views have made.

Appendix 2: glossary of acronyms

ABCD	Asset Based Community Development (ABCD) principles *(citizen-led, relationship oriented, asset-based, placed-based, inclusion focused)*
ADHD	Attention Deficit Hyperactivity Disorder
BCF	Better Care Fund *[government fund to support the integration of health and care]*
CAMHS	Child and Adolescent Mental Health Services
CLA	Children Looked After
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
DTA	Discharge to Assess
EOE	East of England
HCP	Health Care Partnership *[an alliance of health and care organisations organised on a geographical footprint or within a sector (e.g. mental health)]*
HWE	Hertfordshire and West Essex
ICB	Integrated Care Board *[NHS organisation responsible for NHS services]*
ICP	Integrated Care Partnership *[statutory committee for improving health and wellbeing outcomes]*
ICS	Integrated Care System *[made up of the ICB and ICP and other elements]*
JSNA	Joint Strategic Needs *Assessment [a responsibility of Health and Wellbeing Boards]* – The JSNA is an umbrella term to describe a series of topic-specific analyses of the health and care needs of the local population
LD	Learning Disability
LeDeR	Learning Disabilities Mortality Review *[a requirement to review the deaths of people with learning disabilities for learning]*
LMNS	Local Maternity and Neonatal System
LTP	NHS Long Term Plan
MCI	Mild Cognitive Impairment
SEND	Special Educational Needs and Disability
SMI	Severe Mental Illness
VCFSE	Voluntary Community Faith and Social Enterprise Sector

Appendix 3: integrated Care Systems Explained



Source: Integrated care systems: how will they work under the Health and Care Act? The King's Fund (www.kingsfund.org.uk)

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*		☐		
	HWE ICB Board Meeting held in Public			**Meeting Date:**	**27/01/2023**		
Report Title:	**Hertfordshire & West Essex Better Care Fund Adult Social Care Discharge Fund Allocations 2022/23**			**Agenda Item:**	**16**		
Report Author(s):	Jo Burlingham, Head of Resilience and Response, HWE ICB						
Report Signed off by:	Elizabeth Disney, Director of Operations, HWE ICB						
Purpose:	**Approval**	☐	**Decision**	☒	**Discussion**	☐	**Information** ☐
Report History:	N/A						
Executive Summary:	On the 22nd of September 2022 the then Minister for Health and Social Care announced there would be a national Adult Social Care Discharge Fund to bolster social care workforce and increase capacity for packages of care to support more discharges from hospital and to prioritise activity most effective in freeing up hospital beds and reducing bed days lost, including from Mental Health Inpatient settings. Discharge to Assess (DTA) and provision of homecare are recognised as options for discharging more people in a safe and time manner. The fund can also be used to boost more general adult social care workforce capacity, and where needed to focus on complex care needs. This paper outlines the process that has been undertaken by the ICB and the Local Authorities to award NHSE funding allocations to providers to bolster social care workforce and increase capacity for packages of care.						
Recommendations:	The Board is asked to note the process undertaken and the arrangements being put in place for implementation of these schemes until the end March 2023.						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***		☐		
	Financial	☐	***Non-Financial Personal***		☐		
	None identified				☒		

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	To be reviewed and completed, as applicable
	Quality Impact Assessment:	To be reviewed and completed, as applicable
	Data Protection Impact Assessment:	To be reviewed and completed, as applicable
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☐
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☐

1. Executive summary

On the 22nd September 2022 the then Minister for Health and Social Care announced there would be a national Adult Social Care Discharge Fund (ASCDF) to bolster social care workforce and increase capacity for packages of care to support more discharges from hospital and to prioritise activity most effective in freeing up hospital beds and reducing bed days lost, including from Mental Health Inpatient settings. Discharge to Assess (DTA) and provision of homecare are recognised as options for discharging more people in a safe and time manner. The fund can also be used to boost more general adult social care workforce capacity, and where needed to focus on complex care needs.

This paper outlines the process that has been undertaken by the ICB and the Local Authority (LA) to award NHSE funding allocations to providers to bolster social care workforce and increase capacity for packages of care.

2. Background

The ASCDF for Hertfordshire constitutes allocations from both NHS Hertfordshire and West Essex (HWE) and from NHS Cambridge and Peterborough. The fund is provided subject to the following conditions being met, including the exclusion of Prevention of Admission schemes:

- Funding is pooled into the Better Care Fund (BCF) and agreed by the LA and ICB Chief Executives and signed off by the Health and Wellbeing Board.
- LA and ICB work together to plan the spending report by 16 December 2022, showing use against their BCF plan which has been agreed jointly.
- Provides fortnightly activity reports and a final spending report alongside end of year BCF reports.
- LA with their ICB and hospital trusts improve all existing NHSE discharge data collections.
- The Capacity Tracker data is updated in line with the Adult Social Care Provider Provisions statutory guidance.
- Funding is not to be used against expenditure already incurred, or already allocated against or to fund inflationary pressures.
- Engage with a progress review at the end of January 2023, with additional scrutiny of spending and planning approach by NHSE in collaboration with the National Discharge Taskforce.

3. Process for allocation of ASCDF

From the period 22nd September 2022, the ICB and Local Authority tasked core members of the Hertfordshire Joint Strategic Partnership Board to work as a Task and Finish Group with the role of identifying and prioritising schemes that should be put in place to deliver the social care Discharge schemes. This process was overseen by Systems Resilience Group and Local Delivery Board leads alongside senior LA senior adult social care representatives.

Within West Essex the Local Authority worked with a host of partner organisations to identify and prioritise schemes in order to utilise the ASCDF. These discussions took place at Intermediate Care Board and in ad hoc workshops. The approach was then signed off at System Resilience Group and by senior directors across the LA and West Essex Health and Care Partnership.

The NHSE allocations, conditions and processes supporting the ASCDF were published on 17th November following the Autumn Statement. The ASCDF was awarded to systems divided on a 60:40 share between ICBs and Local Authorities. For the Hertfordshire and West Essex ICB, the allocation was £7.815m split as follows:

- Hertfordshire NHS £6.193m
- West Essex NHS £1.622m

The allocation for Hertfordshire County Council was £3,445m; totalling £9.638m with 40% being released in December and the remaining 60% released in January. The allocation for Essex County Council was £4.93, with a relevant share being focussed on the West Essex population.

Prior to receipt of the allocation and letter confirming requirements on 18th November 2022, the ICB and LAs at the Joint Strategic Partnership Board agreed the following key principles of:

- Joint working to produce a single jointly owned plan.
- A focus on discharge capacity (DTA beds and homecare) and workforce retention.
- A focus on schemes which deliver within the timescales (such as resilience of Post Hospital Review and Integrated Discharge Teams; additional funding to cover essential home adaptations and utilising our Voluntary Sector prevention and discharge services).
- To include schemes that support discharges from Mental Health beds; and
- Consideration be given to mitigate any inadvertent impact on the rest of the system.

The Task and Finish Group undertook a joint process to review and prioritise schemes for both Hertfordshire and Essex. The schemes were agreed and submitted to the NHSE on the mandatory ASCDF template, along with a second HSE ICB Discharge Funding template agreeing the pooling of funds, on the 16th December 2022.

Due to timescales and the specific nature of the funding allocation, schemes and investments were signed off at the HWE Urgent and Emergency Care Board on the 13th December 2022 before being subsequently agreed at the Hertfordshire and Essex Health and Wellbeing Boards.

The approval to utilise the funds was signed off by the ICB CEO, the two LA CEOs and both Hertfordshire and Essex Health and Wellbeing Boards in December 2022. This paper acts as a formal noting of this decision by the ICB Board.

Note on the Better Care Fund:

- The BCF programme supports local systems to successfully deliver the integration of health and social care to achieve person-centred care, sustainability and better outcomes for people and carers.
- The BCF encourages integration by requiring ICBs and LAs to enter pooled budget arrangements and agree an integrated spending plan.
- The Health and Wellbeing Board maintains responsibility for the BCF, as per the policy framework published on 19th July. The BCF Plan was submitted on the 26th of September 2022, and approval was received by NHSE in January 2023.

4. Agreed priority schemes – Hertfordshire

The following 47 schemes for Hertfordshire (further detail at Appendix One) have been funded through the ASCDF to bolster social care workforce and increase capacity for packages of care to support more discharges from hospital and to prioritise activity most effective in freeing up hospital beds and reducing bed days lost, including from Mental Health Inpatient settings.

4.1 Social Care Spend Area Funded Schemes

The following 10 schemes have been funded through the ASCDF, including the full amount of the Local Authority allocation:

1) **Workforce support payments to providers -** Supporting additional pay and retention for existing staff, tying in with wider ACS winter retention plans and ensuring mental health and social care providers have equitable support. The allocation will support the following services: Support at home (mainstream homecare), Reablement care, Residential and Nursing Care Providers, Flexicare (ECH) and Supported Living.
2) **Discharge to Assess Beds -** Discharge to Assess Beds for Winter Pressure
3) **Staffing support for additional Bed capacity -** Additional staffing hours (overtime) to support discharges to Discharge to Assess Beds for Winter Pressure
4) **Discharge to Assess Beds -** Additional Discharge to Assess Beds for Winter Pressure (BUPA)
5) **Additional Assessment capability -** Post Hospital Review Team capacity to review and support assessments in the community from increased hospital discharges
6) **Staffing resilience in the Integrated Discharge Teams -** Increasing staff resilience in the Integrated Discharge Teams
7) **Equipment and Adaptations support -** Hertfordshire Home Improvement Agency funding to support increased discharges
8) **Voluntary Sector discharge support -** Voluntary Community Sector support for vulnerable residents, provision of Herts Independent Living Service hot meals and Reach Out support for people discharged on Pathway Zero
9) **Reablement at Home -** Care workforce additional capacity (Reablement or Support at Home) through Sponsorship Licenses
10) **Targeted Rural Homecare capacity -** Targeted Rural Homecare Capacity - 4 new Rural Double Up Rounds across East and West, Ring fence live in carers and provide a driver and dedicated car for each shift.

4.2 Acute Spend Area Funded Schemes

The following 8 schemes have been funded through the ASCDF:

1) **Acute Discharge Runners -** Additional hours to support acute discharge flow
2) **Additional Case Management -** Internal Case Management to reduce Not Meeting Criteria To Reside
3) **Extending support in Single Point of Contact to manage discharge flow -** SPOC extension of hours to manage discharge flow
4) **Additional Discharge Coordinator -** Employ additional Discharge Coordinator to reduce Not Meeting Criteria to Reside (NMTCRs)
5) **Phlebotomy Discharge support workforce -** Increased staffing to support quicker process for bloods to enable discharge
6) **Therapy Patient Flow Co-ordinator -** Increase Discharges with additional therapy patient flow coordinator
7) **Discharge Lead Nurse / team to work with IDT ENHT -** Increase discharges supporting the Integrated Discharge Team
8) **Additional support to discharges in hospital -** Other bolstered staffing to support discharges, including Ward Clerk, Porter Support and Pharmacy Support.

4.3 Community Health Spend Area Funded Schemes

The following 18 schemes have been funded through the ASCDF:

1) **Voluntary Sector discharge support -** Cost of Living infrastructure to manage discharges with the Voluntary and Community Sector
2) **Bridging Service -** A service to bridge care and support from Hospital
3) **Discharge to Assess Therapy provision -** Additional therapy support for DTA beds
4) **Extended Bridging Service -** An extended service to bridge care and support from Hospital
5) **Intermediate Care Beds -** Additional Intermediate Care Community Beds to support discharge from hospital
6) **Non-Weight Bearing Community Beds -** Additional NWB Community Beds to support discharge from hospital
7) **Care home placement and domiciliary care package -** Increased discharges for self-funders
8) **Early Supported Discharge (Sciensus) /Discharge capacity -** Increased early supported discharge capacity
9) **Community Beds extended medical cover weekend -** Supporting additional cover to Community Beds over the weekend
10) **Additional Community Beds Hospice -** Additional Community beds at three Hospices in South and West Herts
11) **Physiotherapy wraparound to DTA beds -** Physiotherapy post to support the 9 DTA beds at Heath Lodge
12) **Transfer Of Care Hub 7days per week (NHS C&P) -** Enabling backfill of redeployed TOCH workforce to improve flow
13) **TOCH digital solution (NHS C&P) -** Digital solution for TOCH provision & single PTL

14) **VCS Alliance (NHS C&P) -** Voluntary Sector Alliance and Single point of access for VCS organisations (whole sector ambition in 12 months)
15) **Discharge support – Transport (NHS C&P) -** Additional PTS to support hospital discharges
16) **Discharge support - HIU's (NHS C&P) -** Focussed work with VCS, District and neighbourhood teams to support HIUs post discharge
17) **Additional Capacity (NHS C&P) -** Care home / Home Care incentive complex cases
18) **Workforce (NHS C&P) -** Training, education and support for retention and recruitment of staff in care.

4.4 Mental Health Spend Area Funded Schemes

The following 10 schemes have been funded through the ASCDF:

1) **Mental Health Beds -** Additional MH beds to support discharge from hospital
2) **Discharge lounge at Kingfisher Court -** Operating discharge lounge to assist with flow, patients can be expected to be discharged during the early part of the day (9-12am) to release the bed and wait at the discharge lounge for TTAs / transport. Hence actual beds are available to allocate during the day. Staff with B4 x 2 Mon-Sun 10am-10pm
3) **Wraparound for Intensive Enablement Beds and Crisis DTA Beds -** Expansion of the Social Care support into Intensive Enablement beds + D2A and Crisis Beds, extend and wrap round these beds specific workers to enhance the opportunity to move into independent living
4) **Delayed discharge due to housing difficulties / appliances -** Accessing hotel / B&B accommodation or ability to purchase / fix appliances to accelerate discharge & create capacity in the system (part social care)
5) **Acute admissions physical health response -** Associate Nurse Practitioner / Discharge Nurse working in Mental Health Inpatient Wards providing highly skilled physical health support for service users; accelerating discharge in partnership with HCT/CLCH.
6) **Oversight of out of area beds -** Employ Senior post to oversee the Out of Area Mental Health beds
7) **Increasing community care supply - enablement at home -** Block commission homecare/ enablement at home from a provider in each quadrant of Herts. Increase to an existing scheme to increase the impact and incentivise providers to pick this up.
8) **Increasing community care supply - residential respite -** Block booking residential / nursing care, to mobilise this with Provider who manage some higher risk and most challenging SU's
9) **Intensive Dementia Support -** Dementia support for Carers/Patient post discharge
10) **Mental Health Discharge support -** Buddies scheme - Supporting MH discharge.

4.5 Primary Care Spend Area Funded Schemes

The following scheme has been funded through the ASCDF:

1) **GP Wraparound for DTA beds -** Provision to support the additional DTA bed capacity for Winter Pressures.

5. Agreed priority schemes – West Essex

5.1 From the £4.93m allocated directly to Essex County Council:

1) **Investment in care workforce (£4.4m)** to support providers to recruit and retain workers and pay/reward workers during the winter period. Payments will be made in two tranches (December and January) to all regulated providers contracted by ECC to boost their ability to retain and recruit staff. The payments will be based on the size of their workforce as recorded on the national trackers. To give an indication of scale, as at 1 November 2022 there were approximately 22,500 eligible staff, so payments would have been £195 per worker. Actual payments will be based on workforce numbers as at 1 December 2022 and 1 January 2023.
2) **One-off incentive payments (from packages referred between Friday 9 December 2022 up to and including Sunday 5 February 2023) to care providers to support hospital discharges and address capacity challenges in 'hard-to-source' areas (£490,000).**

5.2 From the monies allocated to integrated care boards, and pooled within the Better Care Fund, ECC will work with partners to commission:

1) **Boosting capacity to support people with mental health challenges to be supported and discharged from hospital (£350,000).** This will include:
   a. Additional Approved Mental Health Practitioner capacity over the winter months with a specific focus on triage and signposting to divert the request for a Mental Health Act assessment.
   b. Commission additional beds from an existing residential provider for 3 to 4 months with the specific purpose of providing time-limited (no more than four weeks) support, helping people to progress out of hospital and then progress home.
2) **Temporary increase in Alternative Reablement Capacity (ARC)** – time-limited increase of 10% hours for 12 weeks for our existing contracted provision, (or via alternative suppliers should ARC contract holders be unable to deliver the additional hours). This will help support people out of hospital and provide an additional 400 hours per week. Cost of **£121,000** to 31 March 2023.
3) **Bearing Point work to ensure equity in D2A offer in West** £200,000
4) **Ward led enablement / in reach reablement capacity** £49,000

5.3 The ICB will act as lead commissioner on schemes in West Essex including the following:

1) **Facilitating effective discharge via the Transfer of Care Hub function within the Care Co-ordination Centre (CCC) – recruit 4x Community Support Workers for the 4 months of winter (£72,500)**
2) **CCC access to Nerve Centre** - £15,500 for 23 licenses
3) **Discharge Support fund (PHB)** to allow a one-off patient for patients to purchase, services or equipment to support discharge from hospital (£40,000)
4) **Improving Discharge to Assess (D2A) offer in West Essex** – includes the commissioning of services by cohorting beds and providing a D2A Wrap Around service
5) **Night service extension of Integrated Care Team (ICT) to support Discharges** (£97,000)

5. Monitoring

The additional capacity schemes outlined will be monitored by the Joint Strategic Partnership Board and reported in summary to the ICS UEC Board. Each scheme has a designated lead and mechanism of regularly reporting on mobilisation, emerging issues, impact and expenditure.

Monitoring processes consist of fortnightly activity reports, setting out what activities have been delivered in line with commitments in the spending plan, and must be submitted to NHSE. The current BCF governance will oversee the spend and existing BCF financial management will maintain financial controls. A final spending report will be provided to the Board alongside the wider end of year BCF reports, by 2 May 2023. Fund reporting commenced on 6th January 2023, with the first report submitted to time.

Any schemes not delivering the anticipated outcomes or struggling to mobilise in line with agreed timescales will be reviewed with a view to diverting funding to schemes that are able to mobilise quickly and deliver the outcomes required for Hertfordshire. These recommendations will be managed through the ICS UEC Board as part of the overall investment strategy for winter capacity.

6. Recommendations

The Board is asked to note the processes and additional ASCDF schemes being put in place to support in Hertfordshire and West Essex until the end of March 2023. Future ASCDF is anticipated to be received in 2023/24 and 2024/25 will be advised, along with the process for agreeing priority schemes and the conditions to be met.

Appendix One

Adult Social Care Discharge Fund Schemes – Hertfordshire

Scheme ID	Scheme Name	Scheme Type	Sub Types	Estimated number of packages/beneficiaries	Spend Area	Commissioner	Source of Funding	Planned Expenditure (£)
1	Workforce support payments to providers	Improve retention of existing workforce	Retention bonuses for existing care staff	n/a	Social Care	Hertfordshire	Local authority grant	£3,445,346
2	Voluntary Sector discharge support	Local recruitment initiatives		Over 3 months, 750 people supported by Citizens Advice, 162 supported by Money Advice Unit, 12500 supported through HertsHelp and 100 receiving Winter Welfare Checks	Community Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£500,000
3	Discharge to Assess Beds	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	76 people supported for 3 months (based on 25 beds and current average LOS)	Social Care	Hertfordshire	ICB allocation	£687,000
4	Staffing support for additional Bed capacity	Increase hours worked by existing workforce	Overtime for existing staff.	144 people over 3 months	Social Care	Hertfordshire	ICB allocation	£75,000
5	Bridging Service	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	40 over 4 months (based on an 'Average No. beds per day over month' of 10 days)	Community Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£188,000
6	Discharge to Assess Therapy provision	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	20 over 4 months (based on an 'Average No. beds per day over month' of 5 days)	Community Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£174,000
7	Extended Bridging Service	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	40 over 4 months (based on an 'Average No. beds per day over month' of 10 days)	Community Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£100,000
8	GP Wraparound for DTA beds	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	Additional GP cover for 25 DTA beds as per scheme 3	Primary Care	NHS Hertfordshire and West Essex ICB	ICB allocation	£77,000

9	Mental Health Beds	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	40 over 4 months (based on an 'Average No. beds per day over month' of 10 days)	Mental Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£682,000
10	Intermediate Care Beds	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	4 over 4 months (based on an 'Average No. beds per day over month' of 1 day)	Community Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£238,000
11	Non-Weight Bearing Community Beds	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	60 over 4 months (based on an 'Average No. beds per day over month' of 15 days)	Community Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£290,000
12	Acute Discharge Runners	Local recruitment initiatives		30 over 3 months (based on an 'Average No. beds per day over month' of 10 days)	<Please Select>	NHS Hertfordshire and West Essex ICB	ICB allocation	£60,000
13	Additional Case Management	Local recruitment initiatives		28 over 4 months (based on an 'Average No. beds per day over month' of 7 days)	<Please Select>	NHS Hertfordshire and West Essex ICB	ICB allocation	£75,000
14	Extending support in Single Point of Contact to manage discharge flow	Increase hours worked by existing workforce	Overtime for existing staff.	Supports up to 15 discharges per day (up to 450 a month)	<Please Select>	NHS Hertfordshire and West Essex ICB	ICB allocation	£180,000
15	Discharge to Assess Beds	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	30 people supported for 3 months (based on 20 beds and current average LOS)	Social Care	Hertfordshire	ICB allocation	£379,000
16	Additional Assessment capability	Local recruitment initiatives		240 people over 3 months. This fund will be topped up if full recruitment achievable.	Social Care	Hertfordshire	ICB allocation	£219,000
17	Staffing resilience in the Integrated Discharge Teams	Local recruitment initiatives		360 people over 3 months (split across Community and Acute Hospitals supporting HWE ICB Patients). This fund will be topped up if full recruitment achievable.	Social Care	Hertfordshire	ICB allocation	£219,000

18	Equipment and Adaptations support	Assistive Technologies and Equipment	Community based equipment	c30 DTA cases and upwards of 400 people during winter	Social Care	Hertfordshire	ICB allocation	£438,000
19	Voluntary Sector discharge support	Local recruitment initiatives		800 people supported via Herts Community Navigator Service hospital discharge support, 1200 to support pathway 0 referrals for vulnerable residents over 3 months	Social Care	Hertfordshire	ICB allocation	£175,000
20	Reablement at Home	Reablement in a Person's Own Home	Reablement to support to discharge – step down	3 additional rounds with 9 additional carers. Supports a minimum of 18 people over 3 months but if a proportion of users require reablement (4-6 week pathway) or short-term mainstream care, the total is likely to be higher.	Social Care	Hertfordshire	ICB allocation	£39,000
21	Targeted Rural Homecase capacity	Home Care or Domiciliary Care	Domiciliary care packages	Supports a minimum of 12 people over 3 months but if a proportion of users require reablement (4-6 week pathway) or short-term mainstream care, the total is likely to be higher.	Social Care	Hertfordshire	ICB allocation	£113,000
22	Discharge lounge at Kingfisher Court	Local recruitment initiatives		50% of those discharged from the ward into the lounge are done so by 12 noon / Improved flow	Mental Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£123,000
23	Wraparound for Intensive Enablement Beds and Crisis DTA Beds	Local recruitment initiatives		Supports 10 over 4 months	Mental Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£39,000
24	Delayed discharge due to housing difficulties / appliances	Assistive Technologies and Equipment	Other	Supports 63 packages over 4 months	Mental Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£35,000
25	Acute admissions physical health response	Local recruitment initiatives		Avoids 6 admissions into acute hospitals over 3 months	Mental Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£28,000

26	Oversight of out of area beds	Local recruitment initiatives		Supports reduction in out of area beds	Mental Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£26,000
27	Increasing community care supply - enablement at home	Increase hours worked by existing workforce	Overtime for existing staff.	Supports 16 people over 3 months	Mental Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£28,000
28	Increasing community care supply - residential respite	Increase hours worked by existing workforce	Overtime for existing staff.	Supports 12 (average number of beds available per month) over 3 months	Mental Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£81,000
29	Care home placement and domiciliary care package	Home Care or Domiciliary Care	Domiciliary care packages	Supports 20 packages per month over 4 months	Community Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£132,000
30	Early Supported Discharge (Sciensus) /Discharge capacity	Reablement in a Person's Own Home	Reablement to support to discharge – step down	Supports 20 packages per month over 4 months	Community Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£391,000
31	Additional Discharge Coordinator	Local recruitment initiatives		Supports 10 packages per month (35 over Dec-Mar period)	<Please Select>	NHS Hertfordshire and West Essex ICB	ICB allocation	£11,000
32	Phlebotomy Discharge support workforce	Increase hours worked by existing workforce		Supports 8 packages per month (28 over Dec-Mar period)	<Please Select>	NHS Hertfordshire and West Essex ICB	ICB allocation	£25,000
33	Therapy Patient Flow Co-ordinator	Local recruitment initiatives		Supports 10 packages per month (35 over Dec-Mar period)	<Please Select>	NHS Hertfordshire and West Essex ICB	ICB allocation	£31,000
34	Community Beds extended medical cover weekend	Increase hours worked by existing workforce	Overtime for existing staff.	Supports 6 packages per month (21 over Dec-Mar period)	Community Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£46,000

35	Additional Community Beds Hospice	Bed Based Intermediate Care Services	Other	Supports 28 over 3 months	Community Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£147,700
36	Discharge Lead Nurse / team to work with IDT ENHT	Local recruitment initiatives		Supports 120 over 3 months	<Please Select>	NHS Hertfordshire and West Essex ICB	ICB allocation	£36,000
37	Additional support to discharges in hospital	Increase hours worked by existing workforce	Overtime for existing staff.	Non-nursing / medical support for 22 beds over 3 months	<Please Select>	NHS Hertfordshire and West Essex ICB	ICB allocation	£70,000
38	Physiotherpay wraparound to DTA beds	Local recruitment initiatives		2 day reduction in length of stay	Community Health	NHS Hertfordshire and West Essex ICB	ICB allocation	£36,000
39	Intensive Dementia Support	Reablement in a Person's Own Home	Other		Mental Health	NHS Cambridgeshire and Peterborough ICB	ICB allocation	£2,640
40	Mental Health Discharge support	Reablement in a Person's Own Home	Other		Mental Health	NHS Cambridgeshire and Peterborough ICB	ICB allocation	£2,880
41	TOCH 7days per week	Additional or redeployed capacity from current care workers	Local staff banks		Community Health	NHS Cambridgeshire and Peterborough ICB	ICB allocation	£13,200
42	TOCH digital solution	Other			Community Health	NHS Cambridgeshire and Peterborough ICB	ICB allocation	£15,600
43	VCS Alliance	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	20	Community Health	NHS Cambridgeshire and Peterborough ICB	ICB allocation	£26,481

44	Discharge support - Transport	Home Care or Domiciliary Care	Other	12	Community Health	NHS Cambridgeshire and Peterborough ICB	ICB allocation	£7,488
45	Discharge support - HIU's	Other			Community Health	NHS Cambridgeshire and Peterborough ICB	ICB allocation	£6,000
46	Additional Capacity	Improve retention of existing workforce	Incentive payments		Community Health	NHS Cambridgeshire and Peterborough ICB	ICB allocation	£2,400
47	Workforce	Improve retention of existing workforce	Wellbeing measures		Community Health	NHS Cambridgeshire and Peterborough ICB	ICB allocation	£4,800

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**27/01/2023**	
Report Title:	**Governance Report**				**Agenda Item:**	**17**	
Report Author(s):	Simone Surgenor – Associated Director of Integrated Governance & Organisational Alignment Iram Khan – Corporate Governance Manager Leon Adeleye – Corporate Governance Manager Jas Dosanjh – Corporate Governance Manager Gay Alford – Governance & Senior Business Support Officer Anna Cason – Corporate Governance and Risk Manager						
Report Signed off by:	Michael Watson, Chief of Staff						
Purpose:	**Approval**	☒	**Decision**	☒	**Discussion**	☒	**Information** ☒
Report History:	The paper will take the Board through a sequence of governance related items, clearly referencing what actions are being sought from NHS Hertfordshire and West Essex Integrated Care Board.						
Executive Summary:	**1.1** This is the third meeting of NHS Hertfordshire and West Essex Integrated Care Board. **1.2** The Board will be asked to consider the following: a) Strategic Framework – for noting. b) ICB Constitution update – approval by NHS England on 4 January 2023 for the addition of a new Board member and amendments to the ICBs Constitution. The November Board approved these changes subject to final approval by NHS England. Therefore, this update is for noting only. c) ICB Governance Handbook – updates to sub-committee Terms of Reference: • Quality Committee d) Risk register – includes updates to risk management.						

Recommendations:	**For approval –** • ICB Governance Handbook: to approve the amendments referenced at section 2 of this paper. **For noting -** • Strategic Framework • HWE ICB Constitution. • Risk register – includes updates to risk management.			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A			

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	The work forms part of an overarching transition Equality Act compliance, with impact assessments connected to the specific pieces of work.
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☒
	Successfully complete and embed the transition of staff and functions from the	☒

	three clinical commissioning groups into the Integrated Care Board	
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☒

1. Executive summary

1.1 This is the fifth meeting of NHS Hertfordshire and West Essex Integrated Care Board.

1.2 The Board will be asked to consider the following:

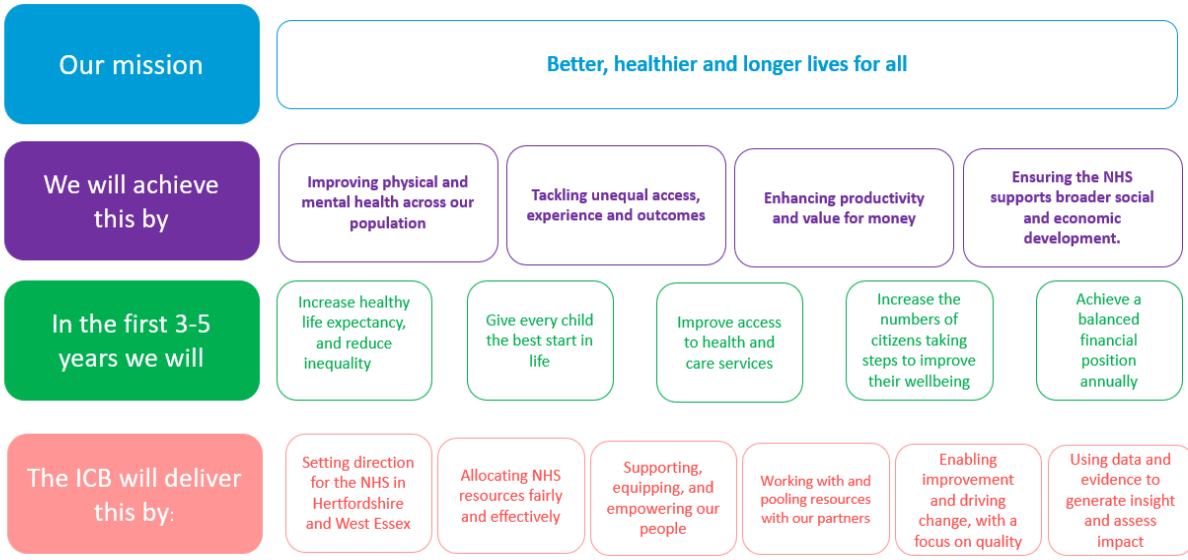
a) ICB Strategic Framework
b) ICB Constitution update – the NHS England addition of a new Board member with subsequent updates to the Constitution
c) ICB Governance Handbook – updates to identified ICB sub-committee Terms of Reference.
d) Risk Register including updates to process.

1.3 The points referenced above will be addressed in turn.

2. Items for Consideration

2.1 The Integrated Care Board agreed its strategic framework for 2022-2027 at its meeting on November 18th.

Herts & West Essex Strategic Framework- 2022-2027



Hertfordshire and West Essex Integrated Care System

2.1.2 The Strategic Framework was agreed following recommendations from the ICB Executive Team, which in itself was based on a board development day focused on developing the strategic objectives of the organisation.

2.1.3 This framework has continued to be shared ICB sub-committees and will form an ongoing agenda item for updates as part of this Board.

2.2 NHS Hertfordshire and West Essex ICB Constitution update – for an additional member to be appointed to the Board representing the VCFSE sector – for noting

2.2.1 Further to November Board where approval was sought for the following:

- To increase its membership by one – with the appointment of a formal VCFSE member to the Board. The role since 1st July 2022 had been noted as a regular participant at paragraph 2.3.2 in the ICB's Constitution.
- Subject to NHS England accepting the above, submission to NHS England for an amendment to its Constitution at paragraphs 2.2.2(b), 2.2.3, 2.3.2 and 3.12, and subsequent adoption of these amendments.

2.2.2 The Board is asked to note that on 4 January 2023, NHS England approved the above with version 3.0 of this ICBs Constitution being subsequently published in compliance with the regulator's directions.

2.3 ICB Governance Handbook – approval of proposed updates

2.3.1 The current NHS Hertfordshire and West Essex Governance Handbook, was adopted on 1st July. This adoption was on the understanding that further changes would be sought as the ICB bedded down, sub-committees started to meet and the governance supporting this new organisation evolved.

2.3.2 In support of this development the following material changes are sought for approval:

Quality Committee:

- **Paragraph 4.6 (b**) – noting a change of reference from deputy to vice chair.
- **Paragraph 4.7** – noting the addition of two Hertfordshire County Council colleagues to the membership: Director for Children and Families, and Director of Practice and Quality.

Population Outcome and Improvement Committee:

- **Paragraph 4.1** – updates to membership at 4.1 including identifying a Vice Chair, plus addition of 4.1.1.
- **Paragraph 5.5** - for noting the 6 members will include at least two Partner members *or non-executive members*….

Remaining ICB sub-committees:

- Any further updates are now scheduled for the March Board.

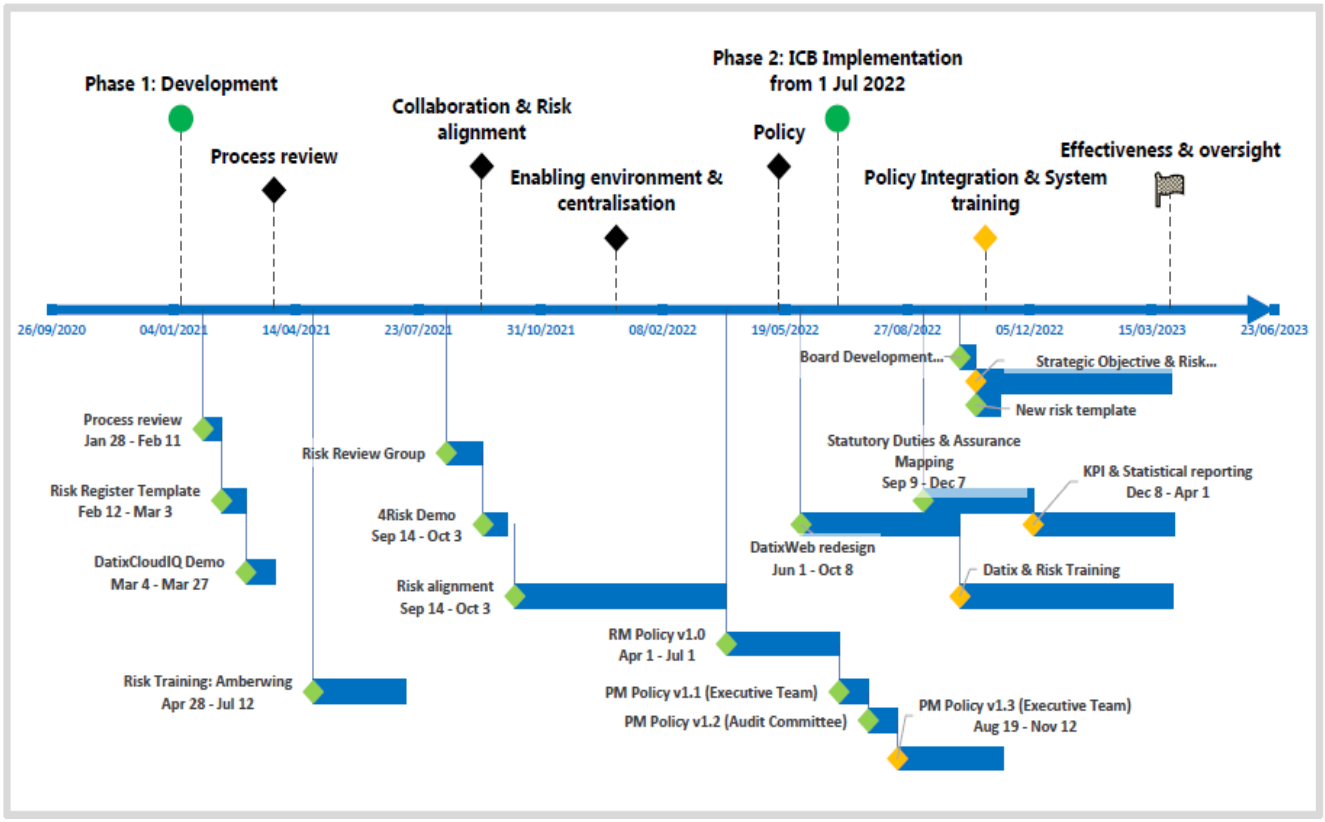
2.4 Risk Report and updates- for noting and comment

2.4.1 Further to updates noted at Board sub-committees including Audit and Risk, the Board is asked to note the following:

The ICB brings together hospitals, primary care services, and community-based organisations, therefore, it manages its risks including its ecosystem and how they affect its objectives. Over two phases illustrated figure 1, we aligned the ICB's risk management process with ISO 31000:2018 principles, including:

- Understanding that risk is inherent in all activities meant that risk management is an intrinsic element of all decision-making, and we established representatives across ICB who will be accountable for risk management within each directorate.
- To record, update, and monitor risks, we gave representatives access to Datix Risk Register. The risk lead and risk owner manage workflow. Risk reporting and mitigation are ensured by this approach.
- Our risk management process is dynamic and responsive using risk management software which means the ICB maintains a standardised approach, store risk information centrally, and access information in real-time from anywhere on its network.
- The ICB's risk management implementation plan for 2022/23 shared with the Board and Audit and Risk Committee highlighted in phases various initiatives established to enable effective risk management across the ICB.

Figure 1: HWE ICBS Risk Management Development and Implementation – timeline 2022/23



2.4.2 **Risk management and system of control**

Risk management is an inherent part of any organization, including the ICB for successful delivery of its objectives. Therefore, this section outlines the potential risks that impacts on the ICB's strategic objectives, as well as the measures in place to manage them. Currently, there are 179 risks reported on Datix Risk Register, 55 of which are corporate risks (12+). Of those, we have discussed the 11 principal risk scored 16+ for the Board to scrutinise. January 2023.

2.4.2 **(a) Overall performance of risks by ICB Directorates**

Table 2 provides the number of corporate risks from each directorate and indicates their individual overall performance using a RAG key.

Table 2 Number of risks by ICB Directorates

ICB Directorates risks		55	Overall performance
1	Chief of Staff (inc. Communications and Governance)	3	A
2	Finance	8	R
3	Nursing and Quality	11	A
4	Medical including PMOT	6	A
5	Primary care	9	A
6	Performance (inc. Business intelligence and Digital Transformation)	0	R
7	Strategy (Inc. people and workforce)	5	R
8	Operations (inc. Place and ICT)	13	A

KEY: Overall Assurance Profile

G	*Effective controls in place and the ICB (Board) is satisfied that appropriate assurances are available*
A	*Effective controls thought to be in place, but assurances are uncertain and / or possibly insufficient*
R	*Effective controls may not be in place and / or appropriate assurances are not available to the Board*

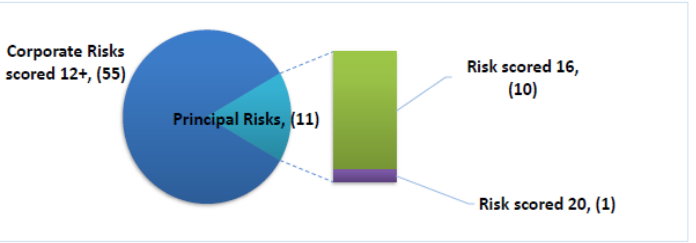
Appendix A provides the risk profile of those risks scored 16+, which the following section discuss in detail, focusing on the strength of controls in place. It should be noted that with the meetings of ICB sub-committees such as Quality Committee – the scores referenced below may have changed since the drafting of this paper:

APPENDIX A: Corporate Risks (16+)

DIRECTORATE	All Directorates	OWNER	All ICB Executive leads	Date	09/01/2023

SO IDs	STRATEGIC OBJECTIVES (ICS PRIMARY PURPOSES)	IMPACTED
1	Improving outcomes in population health and healthcare	Yes
2	Tackling inequalities in outcomes, experience and access	Yes
3	Enhancing productivity and value for money	Yes
4	Helping the NHS support broader social and economic development	

Analysis



RAG rating of overall perfomance: **Amber**

Progress: →

TRIGGER ZONES FOR MANGEMENT ACTION PLANS

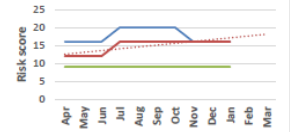
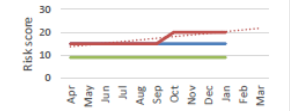
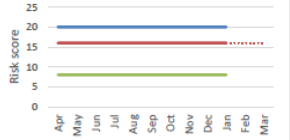
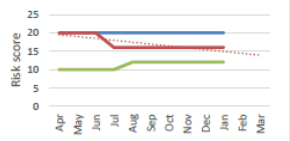
Risk Matrix

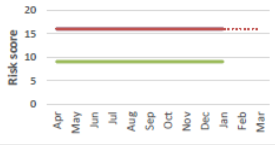
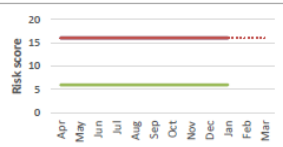
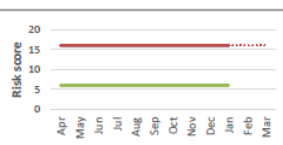
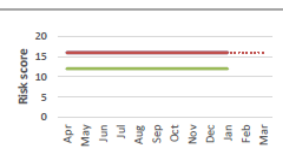
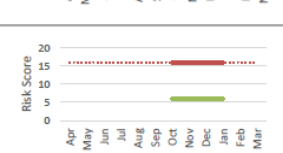
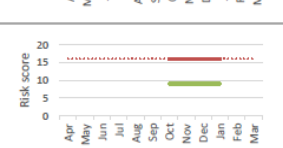
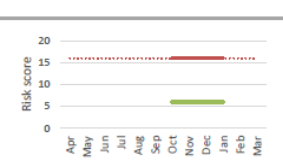
Likelihood (L)	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain				1 risk	
4. Highly Likely				10 risks	
3. Possibly					
2. Unlikely					
1. Rare					

Brief comments on the adequacy of assurance

Of the 55 corporate risks currently reported on the risk register, 10 risks are scored 16 (Risk IDs 123, 346, 351, 455, 485, 486, 498, 526, 530, & 534), and one risk scored 20 (Risk ID 307), illustrated in the pie chart. The risk matrix table on the left shows that all 11 risks are highly likely or almost certain to have a major impact on objectives 1, 2, and 3.

As part of the risk management implementation plan, risks are being reviewed, and risk leads are being supported with risk/datix training to update their risks. The list below provides further intelligence on each risk.

RISK ID	SO ID	RISK LEAD		RISK DESCRIPTION	CURRENT SCORE	Current risk score directional movement		ASSURANCE LEVEL		
15 records		Initials	Directorates		L x C = RS	Initial — Current — Target		1st line	2nd line	3rd line
123	1	AR, SG	Medical	If GPs or doctors within the Trust prescribe high doses of opioid analgesics for chronic pain (especially above 120mg oral morphine equivalent) which are not regularly reviewed in line with up-to-date national guidance (also due to long waiting times for referral to specialist services), then there is a risk that patients would continue to be prescribed very high doses of opioid analgesics, sometimes inappropriately which do not provide any additional clinical benefit and can increase patient harm and mortality resulting in potentially serious harm to patients including dependency, reduction of quality of life and reputational damage to the ICB.	16		↔	Substantial	Substantial	Substantial
307	2	HF, JS	Finance & Contract	If there is not a new provider in place when the anti-coag service ends at Buntingford and Puckeridge in December 2021, there is a risk that there will be no service in place resulting in an impact on patients care.	20			Limited	Reasonable	*None*
346	1	ME, DW, CH	Nursing and Quality	If the ICB is ineffective in supporting our acutes to progress from RI to Good, and the Trusts fail to adequately address current and emerging quality issues. Then- there is a risk relating to the quality and safety of care provided. Resulting in- harm to patients(N&Q).	16		↔	Substantial	Substantial	Reasonable
351	1	JB, MH, GS, AY	Operations	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)	16		↔	Substantial	Substantial	Substantial

RISK ID	SO ID	RISK LEAD	RISK DESCRIPTION		CURRENT SCORE	Current risk score directional movement		ASSURANCE LEVEL		
15 records		Initials	Directorates		L x C = RS	Initial Current Target		1st line	2nd line	3rd line
455	3	CH, AS	Nursing and Quality	IF there is a lack of information from NHSE&I regarding delegation of functions to the ICB including timescales and expectations, THEN there is a risk that relevant Teams will have inadequate time to prepare for the delegation of primary care quality oversight and improvement, primary care complaints, additional safeguarding and IPC requirements etc, RESULTING IN a lack of robust processes being in place to maintain oversight of quality and safety, and provide a responsive services. Transition Workstream Risk Register Ref: R029	16		↔	Limited	Reasonable	Limited
485	2	SG, RA, AK	Medical	If HWE ICB publish updated summary guidance based on national recommendations for managing patients with gender dysphoria (GD), on the assumption GPs would prescribe and monitor medicines outside of license with limited support from specialist teams then there could be renewed concern expressed by GPs that there is still no support for them to prescribe and monitor medicines outside of license in a very vulnerable group of people resulting in patient safety risk and patients not receiving the support they need.	16		↔	None	None	None
486	1	AR, SG, AK	Medical	If HWE ICB do not publish a decision on continuous glucose monitoring (CGM) following the publication of NICE guidelines NG 17, NG 18 and NG 28 published 01/04/22 then healthcare professionals will continue to receive patient enquiries on when can they access the technology and the ICB will continue to receive PALS complaints from patients and their MPs resulting in reputational damage including MP letters, patient complaints, FOI requests and Patha Kar, NHSE Diabetes Lead tweets damaging messages about organisations which are slow in the uptake of diabetes technologies.	16		↔	Reasonable	None	None
498	1	ME	Strategy	If the Integrated Care System does not address the workforce supply issues within key hot-spot areas as well as broader entry/support roles performance issues will continue to be effected.	16		↔	None	None	None
526	1	MP, RF, KC	Nursing and Quality	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.	16		⇆	Reasonable	Reasonable	Reasonable
530	1	DW, KC, RC	Nursing and Quality	If a number of organsiations across the HWE ICB are issued with CQC notices and/or are rated as Requires Improvement, Inadequate and/or are placed in Special Measures then those organsiations are not achieving the levels of quality and safety expected. As a result patient experience, patient outcomes and patient safety will be negatively impacted with the number of complaints and serious incidents increasing and poorer outcomes reported. Organisational reputation may also be affected which could impact attracting a skilled and experienced workforce.	16		⇆	Reasonable	Reasonable	Limted
534		JS	Finance & Contract	If the ICB does not have a formal contract in place with the controlling organisation of Jacob and Gardens, it may not be possible to hold the provider to account on the serious patient safety and quality concerns flagged by HCC.	16		⇆	Limted	None	None

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care Board

Quality Committee

Terms of Reference_v3

1. Constitution

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

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

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

2. Purpose of the Committee

2.1 The Quality Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the NHS England-National Quality Board Shared Commitment to Quality nqb-refreshed-shared-commitment-to-quality.pdf (england.nhs.uk) and enshrined in the Health and Care Act 2022.

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

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

3. Delegated Authority

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

https://www.healthierfuture.org.uk/sites/default/files/nhshwe-icb-constitution010722finalpending-approval-by-nhs-england.pdf

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

4. Membership and Attendance

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than four members of the Committee including two who are Non-Executive Members of the Board. Other attendees of the Committee need not be members of the Board, but they may be.

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

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

4.5 Chair and Vice Chair

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

4.5.2 If a Chair has a conflict of interest, then the co-chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

4.6 Members

(a) ICB Non-Executive Director (Chair)
(b) ICB Partner Member from Primary Medical Services (Deputy Chair)
(c) ICB Director of Nursing
(d) ICB Medical Director
(e) Other representatives:
(f) 1 x acute provider representative
(g) 1 x community representative
(h) 1 x mental health representative
(i) 1 x primary care representative
(j) 1 x local authority lead from each local authority
(k) 1 x Healthwatch (alternate between Essex and Hertfordshire)
(l) 2 x Patient Safety Partners
(m) Safeguarding Lead for Children and Families

4.7 Attendees

a) ICB Quality Improvement and Patient Safety lead
b) ICB Nursing & Quality lead
c) Independent Chair for Safeguarding Board
d) ICB Continuing Healthcare lead
e) ICB Primary Care Quality lead

f) Voluntary, Community, Faith and Social Enterprise (VCSFE) representative)
g) ICB Quality committee governance lead
h) ICB Quality committee secretarial
j) Clinical Quality Director, NHS England

5. Meetings Quoracy and Decisions

5.1 The Committee will meet every other month. Additional meetings may be convened on an exceptional basis and at the discretion of the Committee Chair.

5.2 Arrangements and notice for calling meetings are set out in the Standing Orders. https://www.healthierfuture.org.uk/sites/default/files/nhshwe-icb-constitution010722finalpending-approval-by-nhs-england.pdf

5.3 The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever: publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

5.4 There will be a minimum of the Chair or Vice Chair, plus at least the Director of Nursing or Medical Director, one provider representative and one Local Authority representative.

5.5 Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

6. Decision Making and Voting

6.1 Decisions will be taken in according with the Standing Orders. https://www.healthierfuture.org.uk/sites/default/files/nhshwe-icb-constitution010722finalpending-approval-by-nhs-england.pdf

The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.2 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

6.3 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

6.4 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

7. Responsibilities of the Committee

7.1 The responsibilities of the Quality Committee will be authorised by the ICB Board. It is expected that the Quality Committee will:

a) Be assured that there are robust processes in place for the effective management of quality
b) Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern

c) Agree and submit to ICB put forward the key quality priorities that are included within the ICB strategy/ annual plan
d) Oversee and monitor delivery of the ICB key statutory requirements (e.g., Continuing Health Care) as applicable to quality
e) Review and monitor those risks on the Strategic and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner
f) Oversee and scrutinise the ICB's response to all relevant (**as applicable to quality**) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health and Social Care (DHSC), NHS England & Improvement (NHSEI) and other regulatory bodies / external agencies (e.g. Care Quality Committee (CQC), National Institute for Health and Care Excellence (NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained
g) Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation as applicable to quality and assure the ICB that these are disseminated and implemented across all sites
h) Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes
i) Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place
j) Receive assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded
k) Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and Prevention of Future Death (PFD) report)
l) To be assured that service users are systematically and effectively involved as equal partners in quality activities
m) Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children
n) Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control
o) Clinical or Quality related policies should come through the Quality committee for oversight, scrutiny and comment prior to approval and adoption by the ICB. Policy approval will be met through compliance with the ICBs Scheme of Reservation and Delegation.
p) Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety
q) Have oversight of the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g. System Quality Groups, Infection Prevention and Control, Safeguarding Boards / Hubs etc).

8. Behaviours

8.1 ICB Values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

8.2 Equality and Diversity

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

9. Accountability and Reporting

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

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

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

10. Declarations of Interest

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

11. Secretariat and Administration

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

a) The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
b) Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
c) Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
d) Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
e) The Chair is supported to prepare and deliver reports to the Board;
f) The Committee is updated on pertinent issues/ areas of interest/ policy developments;
g) Action points are taken forward between meetings and progress against those actions is monitored.

12. Review

12.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

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

12.3 The Committee will utilise a continuous improvement approach in its delegation and all members will

be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: Friday 01 July 2022

Updated version approval: Friday 18 November 2022

Date of review: *within six months' time*

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

Population Outcomes and Improvement Committee

Terms of Reference_v3

1. Constitution

1.1 The Population Outcomes & Improvement Committee (Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

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

1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

2.1 The Committee is authorised by the Board to:

- Provide assurance and oversight to the Integrated Care Board; and
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation but may not delegate any decisions to such groups.

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

3. Objectives

3.1 The Committees Objectives:

a) Having oversight, assurance and providing constructive challenge to ensure that NHS Herts & West Essex ICB and partner organisations are delivering on its strategic commitments to:
   - Deliver better and equal outcomes for the population
   - Support personalisation in all aspects of care
   - Develop a prevention focused approach to improving health inequalities & outcomes
   - Develop the partnership with the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector to support delivery
   - Ensure that the ICB with its partners will shape and make recommendations to leverage socioeconomic growth, in ~~all~~ its communities and workforce.

- Provide oversight to the development of anchor institutions. This committee sees anchor institutions as being large organisations who are unlikely to relocate, having a significant stake in HWE ICB's geographical area. Further, these organisations long-term sustainability is tied to the wellbeing of the populations they serve.
- Promote and facilitate the use of research and evidence generated by research.

3.2 These objectives will be achieved by:

a) Promoting the adoption of Population Health Management across the ICS

b) Understanding the health and care needs of the population, including variation and inequalities to support the identification and clarification of strategic priority areas

c) Make recommendations on how we transition from a service response to a population response and identifying where there is the biggest opportunity for improvements in service outcomes.

d) Build research and governance capabilities.

4. Membership and Attendance

4.1 Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Committee will appoint no fewer than two members of the Committee including two independent members of the Board. Other members include:

- Two Non-Executive Members (one to act as Chair)
- Three Partner Members representing from across the sectors, to include the:
    - Primary Medical Service Partner member with a portfolio for estates.
    - Mental Health Trust Partner Member
    - Local Government Partner Member (both to be invited but can alternate in attendance)
- HWE ICB Director of Strategy (Vice Chair)
- HWE ICB Medical Director
- ICP Representation
- Voluntary and Community, Faith and Social Enterprise representative(s)
- Three place-based representatives
- ICB Population Health Lead(s)
- County Council Public Health from both County Councils

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

4.1.1 Attendees:

- HWE ICB Chair

- Governance Lead
- Executive Administrator

4.2 Chair and Vice Chair

In accordance with the constitution, the Committee will be chaired by an independent non-executive member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

Committee members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

4.4 Attendees

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote.

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

5. Meetings Quoracy and Decisions

5.1 The Committee will meet at least six times each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

5.2 The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.3 The Committee will meet every other month. A programme of meeting dates is set annually and advised to all members.

5.4 The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever: publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

5.5 Quorum

For a meeting to be quorate a minimum of six members including at least two Partner Members or Non-Executive Members are required, including the Chair or Vice Chair.

If any member of the Committee has been disqualified from participating on item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.4 Making Decisions and Voting

Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

6. Behaviours and Conduct

6.1 Benchmarking and guidance

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

6.2 ICB values

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

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

6.3 Equality diversity and inclusion

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

7. Accountability and Reporting

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

7.2 The minutes of the meetings shall be formally recorded by the secretary, with a summary being submitted to the Board.

7.3 The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

8. Secretariat and Administration

8.1 The Committee shall be supported with a secretariat function. Which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings.

9. Review

9.1 The Committee will review its effectiveness at least annually.

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

Date of approval: Friday 01 July 2022

Updated version approval: Friday 18 November 2022

Date of review: *within six months' time*

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**27/01/2023**	
Report Title:	**Committee Summary Reports**				**Agenda Item:**	**18**	
Report Author(s):	Governance Leads, ICB						
Report Signed off by:	Simone Surgenor, Associate Director of Integrated Governance and Organisational Alignment						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☒	**Information** ☒
Report History:	Not applicable						
Executive Summary:	Each ICB Sub-Committee has produced a summary document providing an update from the last meeting. Quality Committee – Thelma Stober Performance Committee – Thelma Stober Primary Care Board – Nicolas Small Finance and Investment Committee – Owen Mapley People Board – Ruth Bailey Commissioning Committee – Gurch Randhawa Audit and Risk Committee – Catherine Dugmore						
Recommendations:	The ICB Board are asked to **discuss and note** the content of the committee summary reports						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			
	Not applicable						

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☒
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☒
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☒

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

ICB Committee Summary Document

Quality Committee – 12 January 2023	
Key items discussed: ***(From agenda)***	• Quality Committee Governance update including terms of reference and ICB policies implementation and Equality Impact Assessments update • ICB Nursing & Quality Risk Register • ICS Quality Strategy • ICB Quality Dashboard • ICB Quality Escalation report by exception • Deep Dive - Mental Health (in acute settings and system support) • Essex Mental Health Services • National Patient Safety Strategy • ICB Quality Committee workplan • New risks and escalations from Committee
Key points made / Decisions taken:	• Two Patient Safety partners have been recruited to the membership of the committee. • The updated Quality Committee Terms of Reference was agreed and recommended for ICB Board approval. • The committee noted the ICB policy implementation plan and progress of completion of Equality Impact Assessments. The committee requested some Equality training due to the diverse membership of the committee and varying experience surrounding equality within the public sector. • Risk Register – recommendation of nine risks to be closed. Following discussions, one of the risks relating to Children and Young People mental health crisis Tier 4 bed waits will remain open. Three new risks were acknowledged.
Committees to note: **As example of information sought:** ***(Positive progress on numbers waiting for specialist CAMHS in-patient care (for MHLDA collab to note, for cross-ref by performance committee)***	The following reports came to the committee and were discussed in detail: • Continuing Healthcare, Annual Care Home report 2021-22, Safeguarding Adults Board Annual Reports (Herts and West Essex), Safeguarding Children's Partnership Annual Reports (Herts and West Essex • Minutes were noted from committee sub-groups: P*atient Safety Specialist network, System Quality Group, Infection Prevention and Control System Group, Safeguarding Adult Board Essex, Medicines Optimisation Group* • A System Risk Development workshop is to be planned for February 2023.
Board to note: ***(Highlight quality oversight and identify where further work is required)***	• The Committee will be considering how committees are sited on other areas and the process for this; an example is the Special Educational Needs (SEND) agenda. There are gaps in commissioned pathways that will be shared with the Commissioning Committee. • Reflecting on its responsibilities under the Terms of Reference, the committee agreed that it is essential the patient's voice is heard across the system. This is a key element to ensure we fulfill our duty to provide assurance to the ICB, that the patients' perspective is represented and taken into account to support the delivery of high-quality care.

Forward plan:	Additional items to be included on the agenda for next meeting, 2nd March 2023: • Deep Dive – Maternity • Session around Equality Impact Assessments to be presented by the ICB Equality & Diversity Lead • Patient Safety Incident Response Framework - governance processes for approval of provider's individual plans to be brought before committee.
Date of next meeting	2nd March 2023

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document

NHS Hertfordshire and West Essex Integrated Care Board

Performance Committee - Wednesday 9 November 2022	

Key items discussed / Decisions taken:	• Terms of Reference - The quoracy set out in the Terms of Reference will remain as two non-executive members for the time being but can be amended in due course to state 50% member attendance.
	• January meeting - It was agreed to push back the 11th January Performance Committee meeting by 2 weeks to ensure sufficient time for report information to be collated following the Christmas/New Year period.
	• Winter planning deep dive –
	  • There have been 8 core objectives set out by NHSE for operational resilience during the Winter period and 11 action plans which have been agreed for implementation at place. 6 priority metrics are covered within the presentation. Out of the 43 strategic actions that are detailed within the UEC action plan, 20 of these have already been submitted to NHSE as fully implemented, 11 have been partially implemented and 12 are planned for the coming months.
	  • Winter next steps were reviewed and actions include better support for people in the community, maximising virtual wards and physical bed capacity, improved ambulance handover and response times, and access 24/7 to mental health professionals in emergency operation centres and on-scene.
	• The next deep dive on the work plan is Elective Care and will be held at the next meeting in January.
	• The Committee agreed the recommendation for risks on UEC and Mental Health to be flagged to Board. These surrounded:
	  • Performance in UEC has continued to fall below standard for a number of months and key areas include ambulance response times and ambulance handovers.
	  • The continued pressure on Mental health services. Trajectories are in place for improvement which will be closely monitored.

Committees to note:	• The Committee is to note the discussions and decisions above.
Board to note: ***(Highlight quality oversight and identify where further work is required)***	• The Board is to note the discussions and decisions above. • The Committees revised Terms of Reference remain under review. • The Committees Workplan remains under review for 2023/24.
Forward plan issues:	• No forward plan issues identified.
Date of next meeting:	• 26 January 2023

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document

NHS Hertfordshire and West Essex Integrated Care Board

Primary Care Board – Thursday 24 November 2022	
Key items discussed: *(From agenda)*	• Primary Care subgroup terms of references, minutes and reports • Directorate report • Risk Register • Update from Healthwatch • East of England Partnership strategy for community pharmacy • ICS Digital Strategy • Development of primary care strategy • Voluntary Community Faith and Social Enterprise VCFSE Health Creation Strategy • Progress update on access
Key points made / Decisions taken:	• The directorate report provided updates on digital, transformation and workforce noting the appointment of GP clinical leads per locality across each place and three primary service providers appointed to the HWE board. • Delegated responsibility for community pharmacy, optometry and dentistry commissioning would be taken on from 1 April 2023. Hosting arrangements were being finalised with support from NSHE; HWE would provide the host function for all ICBs in the East of England. • PCB approved proposed changes to the risks that have been reviewed and the new risks proposed noting the inclusion of risks associated with delegated funds for dentistry/optometry and community pharmacy. • Noted the findings of the Healthwatch feedback report with a focus on parents, carers, children and young people across Herts and West Essex. Key themes included, accessing GP surgery, poor communication, barriers to access, lack of choice and lack of trust within minority communities. • PCB approved the East of England Partnership strategy for community pharmacy. • PCB noted the ICS Digital Strategy, the development of the primary care strategy and the Voluntary, Community, Faith and Social Enterprise Health Creation Strategy.
Committees/Board to note:	• As above.
Forward plan issues:	• Primary Care Workforce Report Deep Dive – Jan 2023 • Primary Care Transformation Report
Date of next meeting	Thursday 26 January 2023

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document

NHS Hertfordshire and West Essex Integrated Care Board

People Board - 08 December 2022

Key items discussed / Decisions taken:

- **Workforce Transformation Report** - introduced the report highlighting the following points:
  - People Strategy approved by ICB Board in November
  - Partner organisations working to align consistent rates
  - Coordination across the system in relation to strike action
  - Here for You funding to be ceased by regional/national teams. Business case being prepared to support continued delivery.
  - Cost of living coordinated approach as part of retention pathfinder
  - Regional clinical education strategy has been launched
  - HWE System has achieved henpicked menopause accreditation
  - LD & Autism workforce data collection and preparations/discussions relating to the roll out of Oliver McGowan training
  - Good growth in GP workforce, high social care vacancy rates, high turnover in secondary care
  - Social care provider and staff survey provides insight into recruitment and retention issues. For staff perceptions of development, recruitment/attraction.
  - Risks relating to Capacity to deliver workforce strategy, Financial sustainability and New ways of working have remained the same. Progamme team capacity risk has reduced.
  - Terms of Reference - The quoracy set out in the Terms of Reference will remain as two non-executive members for the time being but can be amended in due course to state 50% member attendance.
- **Social Care update**: LA and broader stakeholders working with HEE and ADASS to establish 3 year targets and plan to weave into people plan refresh. Non-directly employed workforce strategy would be going to the next Adult social care board and brought back to the next People Board.

- **Urgent and Emergency Care/Discharge**
  People Board then undertook a dedicated workshop to review support and development options for workforce within urgent and emergency care and supporting broader discharge across the system.

  People Board listened to deep dive presentations into the workforce challenges with social care and urgent emergency care

  The Board was asked to consider the challenges and issues posed by operational colleagues and develop proposals and concepts for consideration aligned to the People Strategy. Members were then asked to prioritise key activities and begin to identify a working plan going forwards.

	The Board identified six key areas of development for progression including promotion of urgent and emergency care as an area for skills audit and career development and identifying new ways of working across the system including improved collaborative work within the community, job profiles and job planning as well as improving youth engagement and the supply with under-25s. Feedback on the workshop was overwhelming positive with participants feeling they had engaged in some meaningful developmental work at a system level. People Board will look to alternate between assurance style meetings and workshops going forward. • **Integration update** received and noted.
Committees to note:	• The Committee is to note the discussions and decisions above.
Board to note: ***(Highlight quality oversight and identify where further work is required)***	• The Board is to note the discussions and decisions above. • The Committees revised Terms of Reference remain under review. • The Committees Workplan remains under review for 2023/24.
Forward plan issues:	• No forward plan issues identified.
Date of next meeting:	• 23 February 2023

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document

NHS Hertfordshire and West Essex Integrated Care Board

Commissioning Committee - Thursday 12 January 2023	
Key items discussed / Decisions taken:	• Committee role in 2023/24 planning round: - Proposal to be presented at the next meeting regarding the areas of focus for the Committee into 2023/24 (Guidance from NHS England to be reviewed *23/24 priorities and operational planning guidance*, and *Guidance on developing the joint forward plan*). - Noted that reporting from Place should be planned consistently, where possible, for the 2023/24 Workplan. • Terms of Reference: - Proposals to the Committee to be discussed and agreed before the next meeting, including - appointment of a Vice Chair, distinguishing between members and attendee, and the inclusion of new members from Hertfordshire CC. • Proposal for the extension of the Enhanced Early Intervention Vehicle Service: - Noted how the South and West Hertfordshire allocation of Ageing Well monies for 2022/23 is being aligned, to deliver national priorities, and approved this. • Virtual Ward Business Case 2023/24: - Approval of the: ○ continued mobilisation of each Place Based Partnership virtual ward model to deliver the national ambition of 40 virtual beds per 100,000 population and embed the cultural shift needed. - Noting: ○ the evaluation of each Place Based Partnership virtual ward model and to apply improvement cycle principles to the model over the next 6 months to enhance outcomes and effectiveness, • Voluntary Sector update: - Noted that the Committee will receive a further substantive paper in Autumn 2023 on the VCFSE Health Creation Strategy and related commissioning developments, • Hertfordshire and West Essex Area Prescribing Committee report: - Approval of the: ○ recommendations of HWE APC on mandatory NICE Technology Appraisal (TA) treatments and highlighted cost impact/pressures, ○ recommendations of HWE APC for treatments not included in the NICE work programme and highlighted cost impact/pressures/savings, ○ Urgent update to HWE ICS Guidelines for the management of infection in primary care and uncertain cost impact. - Noting of the:

	○ Information and agreed actions for drug safety updates, ○ Publication of NICE TAs that are the commissioning responsibility of NHS England, ○ Guideline Updates, Pathways, and other Information as specified. • Workplan 2022/23: - Noted that the internal auditors have carried out a mapping exercise regarding Committee Terms of Reference and associated workplans across the ICB, actions identified from this will be addressed.
Committees to note:	• The Committee is to note the discussions and decisions above.
Board to note: ***(Highlight quality oversight and identify where further work is required)***	• The Board is to note the discussions and decisions above. • The Committees revised Terms of Reference remain under review. • The Committees Workplan remains under review for 2023/24.
Forward plan issues:	• No forward plan issues identified.
Date of next meeting:	Thursday 09 March 2023

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document

NHS Hertfordshire and West Essex Integrated Care Board

Audit and Risk Committee – Tuesday 15 November 2022 and Tuesday 17 January 2023	

Key items discussed / Decisions taken:	**November 2022 Committee:**
	• Terms of Reference - The revised governance handbook including the recommendation for the increase in NEMs for Audit Committee will go to Board on 18th November.
	
	• Senior Information Officer (SIRO) report – received for comment and noting. The Chair thanked RB for the report and the work involved.
	  • As the DSP Toolkit has changed to Category 1 this remained as an agenda item.
	
	• Assurance Report –
	  • The report was received using a new template showing assurance across the 8 directorates of the ICB, and following a Board development session held in October 2022.
	  • It includes assurance that was obtained across the three lines of defence.
	
	• CCG 3 month 22/23 Accounts & NHS Pensions Agency update –
	  • The west Essex audit of accounts has now started. This was delayed due to the handover from KPMG to BDO.
	  • HV and ENH audits were started as planned on 17th October.
	
	• Whistleblowing:
	  • The review of Whistleblowing is on the workplan for March..
	  • Whistleblowing to be included in the Governance Report.
	
	• Internal Audit and Counter Fraud updates received and noted.
	
	• Continuing Healthcare progress update – update presentation received from the Nursing and Quality Team.
	  • The committee are asked to reflect on how this has the appropriate reach into other committees such as Commissioning Committee. Also, on how to avoid the team being asked to reproduce the same paper.
	
	January 2023 Committee:
	• The Committee met on 17th January 2023. Due to the timing of this summary a brief overview is provided for noting in that:

	• The Committee received the current iteration of the comprehensive risk report which is still being developed, and in addition an update on Quality and Nursing risks presented by the Director of Nursing and her team. • Over an above normal agenda items received including Internal Audits and Counter Fraud, the Committee also received an update on Cyber Security. • Due to sickness BDO were unable to present an Audit Plan for the ICB for the 9 months ended 31 March 2023, and in addition little progress has been made in the audit of the 3m CCG accounts. The Committee expressed its concern over this position. It was agreed the CFO and his team will urgently work with BDO to determine the year end audit timetable and requirements. The Committee offered to convene an Extraordinary ARAC to discuss this further ahead of its next scheduled meeting.
Committees to note:	• The Committee is to note the discussions and decisions above.
Board to note: ***(Highlight quality oversight and identify where further work is required)***	• The Board is to note the discussions and decisions above. • The Committees revised Terms of Reference remain under review. • The Committees Workplan remains under review for 2023/24.
Forward plan issues:	• No forward plan issues identified.
Date of next meeting:	• 21st March 2023