Meeting Book 1 - NHS Hertfordshire and West Essex ICB Board

HWE ICB Board Meeting Held in Public - 26 September 2025 at Latton Bush Centre, Harlow

1100	**1. Welcome, apologies and housekeeping** Chair	
	2. Declarations of Interest Chair	
1105	**3. Minutes of last meeting held on Friday 27 June 2025** Chair	Approval
	4. Action Tracker Chair	Approval
1110	**5. Chairman's Report** Chair	Information
1120	**6. Chief Executive Officer's Report** Jane Halpin	Information
	SYSTEM LEADERSHIP AND STRATEGY	
1130	**7. Lampard Inquiry Board Update** Beverley Flowers	Assurance/Discussion
1140	**8. Mental Health Intensive & Assertive Outreach Progress** Beverley Flowers	Assurance/Discussion
	ICB BUSINESS	
1150	**9. Frailty Emergency Admissions and Substitute Effect** Dr Sam Williamson	
1205	**10. Winter Assurance Plans** Frances Shattock/Jo Burlingham	Approval
1220	**11. Governance Report** Michael Watson/Simone Surgenor	Assurance/Discussion
1225	**12. Integrated Report for Finance, Performance, Quality and Workforce** Jonathan Wilson, Frances Shattock, Natalie Hammond, Tania Marcus	Assurance/Discussion
1235	**13. Committee Summary Reports** Committee Chairs	
	Committee Summary Front Sheet	
	Strategic Transformation and Quality Improvement Committee - held on 10 September	

Strategic Finance and Commissioning Committee - held on 11 September

East and North Herts HCP Board held on 5 September

West Essex HCP Board - held on 18 September

South West Herts HCP Board - held on 13 September

Mental Health, Learning Disability and Neurodiversity HCP Board - held on 11 September

Patient Engagement Forum - held on 9 September

1300

14. Questions from the Patient Engagement Forum and Members of the Public

CLOSING ITEMS

1305

15. Any other business
Chair

1310

16. What would service users, patients, carers and staff take away from our discussions today?
Chair

1315

17. Close of meeting
Chair

Date of Next Meeting: Friday 28 November 2025 – Venue TBC

SUPPORTING DOCUMENTS - for information only
Full reports can be found in meeting book 2

Quality Report

Performance Report

Finance Report

Item 11 - Governance Paper - Appendices

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 Date:**	**26 September 2025**	
Report Title:	**Committee Register of Interests**	**Agenda Item:**	**2**	
Report Author(s):	Gay Alford, IG and Governance Officer Jas Dosanjh, Governance Manager - Conflicts and Policies			
Report Presented by:	Governance Lead			
Report Signed off by:	Michael Watson, Chief of Staff			

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

Which Strategic Objectives are relevant to this report:	■ Relevance to all five ICB Strategic Objectives
Key questions for the ICB Board / Committee:	■ Please see the 'Recommendations' section
Report History:	■ The full ICB Declarations of Interest Register is routinely reported to the Audit & Risk Committee in line with the Committee Workplan and Terms of Reference
Executive Summary:	■ The Board Sub-Committees' Register of Interests are maintained in compliance with the HWE Standards of Business Conduct and Conflicts of Interest Policy and the ICBs statutory duties. ■ All members, and those in attendance must declare any actual or potential (previously known as direct or perceived) conflicts of interest which will be recorded in the minutes. Where a conflict is identified, at the Chair's discretion, the person may be asked to leave the meeting while a particular topic is being discussed. ■ The ICB commenced the annual Declaration of Interest refresh for 2025/26, at the point of drafting this report, the status of committee members/regular attendees declarations for 2025/26 have been noted as follows (as included in **Appendix 1**): (i) 2025/26 declaration received and processed (white background), (ii) 2025/26 declaration received but currently being processed, the entry on the register is as per 2024/25 declaration (green background), (iii) 2025/26 not received, the entry on the register is as per 2024/25 declaration (yellow background).

	The Executive Team have been provided with the names of those with outstanding declarations and disseminated within their directorates, requesting returns to hweicbwe.declarations@nhs.net. Outstanding Board and external declarations are followed up directly by the Governance Team and via escalation to the relevant Committee meetings where individuals hold a role.
Recommendations:	The Committee is asked to: ■ Remind members/attendees with outstanding declarations (identified in **Appendix 1**) to complete a return for 2025/26 using the declaration of interest form included with this paper (**Appendix 2**), ■ Note the returned declarations and whether these reflect the current membership/regular attendees for this Committee, ■ Review any potential conflicts of interest that need to be managed at the meeting in accordance with the agenda, ■ Remind members and regular attendees that - whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests (e.g., where an individual takes on a new role outside the ICB or enters into a new business or relationship), a further declaration should be made to reflect the change in circumstances as soon as possible, and in any event within 28 days. The revised declaration should be countersigned by their Line Manager or lead, and then forwarded to hweicbwe.declarations@nhs.net for logging.

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

Implications / Impact:		
Patient Safety:	N/A	
Risk:	N/A	
Financial Implications:	N/A	
Impact Assessments:	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A

Key:	White background indicates 2025/26 delcaration received
	2024/25 declaration - awaiting 2025/26 declaration
	2024/25 declaration - processing 2025/26 declaration
	Full Grey Line indicates staff no longer employed by ICB - declaration to remain on the register for 1 year
	Part grey line indicates the interest has ended.
	Full dark grey line indicates HCP Board non-ICB members only - ICB Governance support ceased. WE/SWH 1-May-25. ENH/MHLDA 1-Jul-25

Hertfordshire and West Essex Integrated Care System

Hertfordshire and West Essex ICB
Board Register of Interests 2025-26

NHS Hertfordshire and West Essex Integrated Care Board

Name:		Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Type of Interest					Date of Interest		Action taken to mitigate risk
Surname	Forename			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct interest	Indirect interest	From	To	
Bailey	Ruth	Non-Executive Member, NHS HWE ICB	Undertake HR consultancy within the UK and internationally. None of the projects are healthcare related.	√					Jan-25	Present	
			Spouse is Director in UK Health Protection Agency.					√	2016	Present	
			Executive Director of People and Organisational Effectiveness for the Nursing and Midwifery Council (job share)	√					2022	Ended Jan-25	
			Non-Executive member of South West London ICB.		√				2022	Ended Aug-24	
Burstow	Rt. Hon. Paul	Non-Executive Member, NHS HWE ICB Chair NHS HWE ICB	As Managing Director of Indy Associates Limited. The company is jointly owned by myself and my spouse and undertakes consultancy, advisory and public policy work. • On 27th May 2025 – I will be acting as a presenter and facilitator at a non-promotional event for the IRIS Group which is a group of clinicians with an interest in the impact of greenhouse gas regulations and the phasing out of PFAS from propellants in inhalers with a view to mitigating risks to patient health. IRIS is supported by LEK Consulting who are funded by AstraZeneca to provide the secretariate.	√		-	-		May-15	Present	The company does not tender for work from NHS organisations. Should a discussion or paper relate to: • AstraZeneca • Boehringer Ingelheim • MHP Group • OVID Health • L.E.K. Consulting I will declare an interest either in advance of the meeting or at the point a direct or perceived conflict is identified. I play no part in any tendering, marketing, or lobbying work on behalf of clients of MHP Group or OVID Health. If any NHS organisation within the ICS were to engage MHP Communications or any of the other organisations listed I would declare the interest and would take no part in the delivery of the work
			I am chair of the trading charity, St Andrew's Healthcare. The charity provides a range of secure mental health services, primarily in the Midlands, and several community-based specialist services	√		-	-		Oct-20	Present	I play no part in the charity's tendering processes nor do I play a role in selecting contractors within the ICS. As of 31.05.25 – declared that St Andrews Healthcare had been granted core participant status in the Lampard Inquiry. Should a discussion or paper relate to this provider, I will declare an interest either in advance of the meeting or at the point a direct or perceived conflict is identified.

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			I am chair of the trading charity, the Social Care Institute for Excellence. The charity undertakes consultancy and improvement support in social care and beyond.	√					Jul-17	Present	I play no part in the charity's tendering processes, nor do I play a role in selecting contractors within the ICS. Should a discussion or paper relate to this provider, I will declare an interest either in advance of the meeting or at the point a direct or perceived conflict is identified.
			I am the chair of the CIC, Technology Enabled Care Services Association. The CIC mission is the product agnostic and non-proprietorial promotion of TEC and the setting and auditing of industry standards. The CIC also offers consultancy services to local government, housing associations, NHS etc	√		-	-		May-20	Ended Jul-24	I play no part in the CIC's tendering processes nor do I play a role in selecting contractors within the ICS. Should a discussion or paper relate to this provider, I will declare an interest either in advance of the meeting or at the point a direct or perceived conflict is identified.
Clothier	Helen	Volunteer member of the HWE ICB's Patient Engagement Forum: Patient Representative, Paediatric Audiology Oversight.	Nil								
Coles	Toni	Place Director - West Essex	Nil	-	-	-	-	-	-	-	-
Crudgington	Scott	ICB & ICB Strategy Committee Member by position (Interim Chief Executive of Hertfordshire County Council) Partner member, Local Authority, HCC	As Interim Chief Executive of Hertfordshire County Council, a number of my services including Public Health, Children and Adult Services will commission or be commissioned by the ICS to deliver services or programmes.	√					Apr-24	Mar-25	Where a decision on funding is required that involves HCC I will declare an interest and either leave the room or not vote.
Disney	Elizabeth	Director of Operations, HWE ICB	Close relative is employed by the ICB. Role sits in a different directorate, no line management overlap.	-	-	-	-	√	Jan-23	Ongoing	No involvement in recruitment process or decision to employ
Dugmore	Catherine	Non -Executive Member, NHS HWE ICB	Cambridgeshire Community Services NHS Trust, Non Executive Director	√					Apr-22	Present	Declare as required.
			Natural England, Board Member	√					Mar-18	Present	Declare as required.
			Housing 21, Board Member	√					Sep-21	Ended May-24	Declare as required.
			Aldwickbury School Trust, Governor			√			Nov-18	Present	Declare as required.
			Royal Society for the Protection of Birds (RSPB), Trustee			√			Oct-24	Present	Declare as required.
			Institute of Chartered Accountants for England and Wales (ICAEW), Member		√				1992	Present	Declare as required.
Elton	Sharn	ENH Place Based Director	Parish Councillor, Sutton Parish Council, Central Bedfordshire	-	-	√	-	-	May-23	Mar-27	-
Fernandes	Trevor (Dr)	GP Partner Member, ICB Board	Salaried GP at Parkwood Surgery, Hemel Hempstead GP Trainer, GP Appraiser, Joint Injections	-	-	-	√	-	2020	Ended Aug-2024	Interest has ended
			Registered with GP in Hertfordshire			√			1990	To date	To be declared as appropriate.
			My spouse works at: Michael Sobell Hospice, Northwood, Middlesex	-	-		-	√	Various	Ended Dec-24	Interest has ended
			My spouse works at: Fonthill Nursing Home, St Albans, Herts St Elizabeth's Centre, Perry Green, Herts					√	Various	To date	To be declared as appropriate.
			My spouse is a patient at Watford Hospital					√	Mar-25	To date	To be declared as appropriate.
			NHS Complaints Reviewer Birmingham and Solihill ICB Mid and South Essex ICB	√					Dec-22	To date	To be declared as appropriate.

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			Outpatient at Royal Marsden Hospital London			√			Jan-23	To date	To be declared as appropriate.
			GP appraiser East of England	√					2024	Ongoing	To be declared as appropriate.
			Locum GP Hertfordshire	√					Aug-24	Ongoing	To be declared as appropriate.
			I do attend educational sessions run by private providers: Spire Hospital Harpenden, OSD Healthcare, Hemel Hempstead, Oxana Healthcare		√				Jan-23	To date	
			Community Medical Examiner employed by WHTHT.	√					Feb-22	To date	To be declared as appropriate.
Flowers	Beverley	Deputy Chief Executive and Director of Strategy , HWE ICB	Non remunerated Director role with Herts at Home Ltd a company established and fully owned by Hertfordshire County Council to provide care and support within the County. Herts at Home Ltd. Company number 11360947. Registered office address County Hall, Pegs Lane, Hertford, United Kingdom, SG13 8DE.)	-	√	-	-	√	Jan-19	Ongoing	Declare at meetings where relevant. Exclude self from decision making process in meetings if necessary.
Halpin	Jane	Chief Executive Officer, NHS HWE ICB	Nil								-
Hammond	Natalie	Director of Nursing & Quality, HWE ICB	Spouse - company - Aqua Kare, leak detection.	√						Ongoing	Does not commission/tender for work.
Hanna	Mark	VCFSE Alliance Chair	CEO of Age UK Hertfordshire						2021	Present	N/A
Howard -Jones	Elliott	Chief Executive, Hertfordshire Community NHS Trust Partner Member - Community Provider Representative	Advisor to Doccla	√		-	-	-	Jun-24	Ongoing	
Joyce	Rachel (Dr)	Medical Director	Married to an NHS consultant who works for East and North Herts Trust.	-	-	-	-	√	Jun-01	Current	To be logged on ICB DoI registers and declared if relevant in meetings/ work
			From 2018 I was a Director for Ranine Ltd - a company that provides private medical services by one consultant (spouse as above) to local independent hospitals. From 1st April 2022, I resigned my role as Director and now act as secretary who also holds shares in the company. The company does not however provide, or intend to provide, services to the NHS, social care, or NHS patients.		-	-	-	√	2018	Current	To be logged on ICB DoI registers and declared if relevant in meetings/ work
			Director of Castellan Homes Ltd, a family company for which I am a director.	√					2024	Current	It does not have and has never had a contract with the health or social sector - operating completely out of that environment.
Khan	Iram	Corporate Governance Manager - Board & Committees	Nil	-	-	-	-	-	-	-	-
Lafferty	Thom	Chief Executive Princess Alexandra Hospital NHS Trust	Director & Owner; TWL Associates Ltd (dormant)	√					Jun-14	N/A	
			CEO The Princess Alexandra Hospital NHS Trust		√				Nov-24	Present	
			Place Lead West Essex HCP		√				Nov-25	Present	
Lavington	Adam	Director of Digital Transformation	Nil	-	-	-	-	-	-	-	-
Marcus	Tania	Chief People Office	Trustee Norwood (charity supporting neurodiverse children, adults and their families).			√			Feb-25	Present	None felt necessary However, declaring as there are some links with NHS and social care

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Marovitch	Joanna	Chair VCSFE Alliance VCFSE Alliance board member Regular Attendee ICB Primary Care Transformation Committee	CEO of Hertfordshire Mind Network	√					2021	Current	
Martin	Chris	Local Authority representative, Essex County Council	Commissioning Director – Children's services, Essex County Council						Feb-23	Present	
Moberly	Nick	Non-Executive Member HWE ICB	CEO MS Society UK (including Director of MS Society Nominees Ltd and MSS (Trading) Ltd)	√					Jan-19	Present	
			Non-Executive Director, NHS Property Services	√					May-21	Present	
			Board Adviser/Chair, Dr Morton's Ltd (with small shareholding) – business has now ceased trading	√					Jan-21	Ended Dec-24	Mitigating steps to be taken surrounding Board or committee papers/agenda items.
			Director/Chair, DKWHS Ltd (new business which has acquired the business and assets of Dr Morton's on a going concern basis). Minority shareholder	√					Jan-25	Present	Mitigating steps to be taken surrounding Board or committee papers/agenda items.
			Trustee - Christian Aid			√			Dec-18	Ended Oct-24	
			Board member, MS International Federation			√			Jun-19	Ended Oct-24	
			Trustee, Medical Aid for Palestinians			√			Mar-24	Ended Oct-24	
Moodley	Pragasen	Partner Member, Primary Care - ICB Board	GP Executive Partner at Stanmore Medical Group 5 Stanmore Road, Stevenage, SG1 3QA	√	-	-		-	2004	Continuing	
			Director of AVM Medical. Suite 3 Middlesex House, Rutherford Close, Stevenage, Hertfordshire, United Kingdom, SG1 2EF. Company number 10507387	√	-	-		-	2016	Continuing	
			CD Stevenage North PCN	√					2022	Continuing	
			Director North Stevenage PCN Ltd (15421171)	√	-	-		-	2024	Continuing	
			Director Bedford Road Practice Ltd. Company number (15848852)	√					Jul-24	Continuing	
			GP Partner at Larksfield Medical Practice	√	-	-		-	2018	Continuing	
			My partner is a GP at King George surgery	-	-		-	√	2016	Continuing	
			Director Ayurveda Medical Ltd (16623904)	√					Aug-25	Continuing	
Perry	Dr Ian	GP Partner Member, ICB Board	GP Partner in Maynard Court Surgery	√	-	-		-	2013	To date	Verbal declaration to be made at the beginning of any meeting
			Epping Forest North PCN GP Partner	√					2019	To date	
			Stellar Healthcare Shareholder		-	-		-	2014	To date	

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Pond	Alan	Chief Finance Officer, HWE ICB	I am the public sector appointed Director of Assemble Community Partnership Ltd (Company Number 06471276) and associated companies Assemble Fundco 2 Ltd (Company Number 08309498) Assemble Holdco 2 Ltd (Company Number 08309495) Wolverton Holdings (Company Number 08307564) Wolverton Fundco 1 Ltd (Company Number 08306830 Assemble Fundco 1 Ltd (Company Number 06471659) Assemble Holdco 1 Ltd (Company Number 06471233) Assemble (MKHQ) HoldCo Ltd (Company Number 06710941) Assemble (MKHQ) Ltd (Company Number 06711023) All of 128 Buckingham Palace Road, London, SW1W 9SA.			√			Jul-08	Current	My role on the Board of the LIFT Company Group is to represent the interests of the local public sector, provide insight, but also to oversee the financial and governance arrangements of the companies. The Group of Companies was created to provide benefits to the NHS locally and a conflict is highly unlikely to occur. Should any conflict of interest arise, I would excuse myself from both parties for the relevant matter and should an ongoing conflict arise I would resign my director position with the Group of Companies.
			My Partner is a GP Partner of a Practice associated with HWE ICB (at Haverfield Surgery, Kings Langley) and is engaged as a clinical lead by the HWE ICB.	-	-	-	-	√	Aug-10	Current	On matters relating to primary care generally, I would always declare my relationship to my partner so anyone could question me on my motives. For matters relating specifically to Haverfield Surgery only, I will excuse myself from any discussion and take no part in any decision making. I will keep confidential any information I receive that could be of benefit to Haverfield Surgery and/or my partner.
Randhawa	Professor Gurch	Non Executive member, NHS HWE ICB Chair - ICB Strategy Committee Vice Chair - ICB Strategic Finance & Commissioning Committee	Professor of Diversity in Public Health & Director, Institute for Health Research University of Bedfordshire. Honorary Academic Contract, UK Health Security Honorary Academic Contract, Office for Health Improvement & Disparities Expert Advisor, NICE Centre for Guidelines, UK Facilitator, faculty of Public Health accredited Practioner Program, UK Faculty of Public Health Non-Executive Director, Forestry England. Adjunct Professor, Ton Due Thang University, Vietnam, Trustee, Race Equality Foundation, UK National Member, National Black and Minority Ethnic Transplant Alliance, UK Member, British Medical Association Ethics Committee, UK Member, Donation Ethnicity Liberty Inclusion Pontifical Academy for Life (PAL) – Vatican State-led Engagement of Religious communities (DELIVER) Project Member, Quality and safety of organs for transplantation - European Directorate for the Quality of Medicines and HealthCare (EDQM) Group of Experts, Council of Europe National Member, Mental Health Working Group, NHS Race & Health Observatory, UK National Member, Independent Stakeholder Advisory Board, National Institute for Health Research		√					Current	All interests declared with all parties.
			Deputy Lieutenant, Bedfordshire Patron of the Bedfordshire Rural Communities Charity Ambassador, Keech Hospice Care Volunteer, Luton Sikh Soup Kitchen Junior Cricket Coach, Harpenden Cricket club		√					Current	All interests declared with all parties.
			Patient, Davenport House surgery, Harpenden			√				Current	All interests declared with all parties.
			Extended family works at local Primary Care Network					√		Current	All interests declared with all parties.
Ridgwell	Angie	CEO Hertfordshire County Counci LA Partner Member to the HWE ICB Board	There may be occasions when ICB are making strategic commissioning or policy decisions that will have an impact on HCC services, creating cost, demand or delivery changes.		√				Sep-24	Current	If a conflict of interest arises this will be discussed with the chair, ICB notified and possible reclusion from the decision.
Sewell-Jones	Adam	Member HWE ICB Board	Chief Executive at East & North Hertfordshire Teaching NHS Trust					√	Apr-24	Present	

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Shah	Avni	Director of Primary Care HWE ICS	Spouse works for a Pharmaceutical Industry – Scope, who distribute a number of medicines across the UK.					√	Nov-20	Current	As Director of Primary Care Transformation I am not directly involved in the local decision making process of new drugs being agreed across HWE and when reports come to PCCC or Commissioning Committee if any product from that particular industry I will outline at the meeting to managing conflict.
			Spouse provides supervision and support via CPPE to foundation year community pharmacist who required support. This is commissioned through HEE and covered London and South East Area					√	Apr-23	Current	This is commissioned directly from NHSE to CPPE hence NO involvement in commissioning and contracting of this support to local community pharmacists who can access this national support.
			Spouse is Superintendent for the group of community pharmacies - Channa Chemist based in London					√	Apr-25	Current	It not impacting across EoE as Channa does not have branches in this area.
Shattock	Frances	Director of Performance	Nil	-	-	-	-	-	-	-	-
Stober	Thelma	Non-Executive Member, NHS HWE ICB	Patient , Surgery Berkhamsted	-	-	√	-	-	2018	Current	1. HWE Conflict of interest Policy . 2. NHS England » Managing conflicts of interest in the NHS and 3. Best practice in corporate governance
			Patient, RNOH Stanmore			√			2005	Current	
			Patient, Stoke Mandeville Hospital			√			2010	Current	
			Employee of Local Government Association (11177145) (LGA)		-	√	-	-	2013	Current	
			Company Secretary for the LGA						05.12.2024	Current	
			Company Secretary for Improvement and Development Agency for Local Government (IDeA) (0367557) a subsidiary of the LGA						28.02.2025	Current	
			Secretary of Land Data Community Interest Company (05417694)						14.01.2025	Current	
			Secretary of Public Sector Audit Appointments Limited (09178094) (a subsidiary of the IDeA)						15.08.2021	Current	
			Director/Trustee of London Emergencies Trust			√			2017	Current	
			Trustee of the National Emergencies Trust			√			2020	Current	
			Peabody Trust - Communities Committee			√			2021	Ended Dec-24	
			Deputy Lieutenant Greater London			√			Apr-22	Current	
Surgenor	Simone	Deputy Chief of Staff - Governance & Policies, NHS Herts & West Essex ICB	Director of Select Project Management Ltd	√	-	-	-		2011	Ongoing	Family company. No contracts held in the health and care sector
			Community Governor – Colne Engaine C of E Primary School (school run by the Vine Schools Trust).			√			TBC		Declaration will be flagged if relevant prior or during meetings. School sits outside of the ICB geographical area.
Taylor	Janet	Volunteer member of the ICB's Patient Engagement Forum	Chief Executive and employee of HPFT	√					Dec-21	Current	Declare interest
			Board Trustee - NHS Providers		√				Jul-23	Current until Jul-26	
			East of England Provider Collaborative Lead CEO 2024		√				Jul-24	Current	
Turnock	Philip	Managing Director of HBL ICT Shared Services	Nil	-	-	-	-	-	-	-	-
Watson	Michael	Chief of Staff, NHS HWE ICB	Nil	-	-	-	-	-	-	-	-
Webb	Matthew	ICB Place Director - S&W Hets	Partner is employed as an Associate Director with ArdenGem Commissioning Support Unit	-	-		-	√	Apr-24	Ended Dec-24	To be declared when appropriate
			Close relative is employed in the Talking therapies service at CNWL NHS Trust					√	Apr-24	Ended Oct-24	To be declared when appropriate

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Surname	Forename			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct interest	Indirect interest	From	To	
Wilson	Jonathan	Chief Finance Officer, HWE ICB	Nil								

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DECLARATIONS OF INTEREST FORM

Name:	
Position within, or relationship with, the ICB (or NHS England in the event of joint committees):	

Detail of interests held (complete all that are applicable):

Type of Interest*	Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)	Date interest relates		Actions to be taken to mitigate risk (to be agreed with line manager or a senior ICB manager)
		From	To	

Please note:

1. The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisation's policies. This information will be held in electronic form in accordance with GDPR/Data Protection Act 2018. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the ICB holds.

2. By completing and submitting this form you:

   - Confirm that the information provided above is complete and correct.
   - Acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable and no later than 28 days after the interest arises.
   - Are aware that civil, criminal or internal disciplinary action may result from a failure to make full, accurate or timely declarations.

3. If you do declare interests, we are required to publish the information on the ICB website and/or make arrangements to ensure that members of the public have access to the registers on request.

4. In exceptional circumstances, an individual's name and/or other information can be redacted from any publicly available registers where the public disclosure of information could give rise to a real risk of harm or is prohibited by law. Application of this exemption will be subject to Chief of Staff approval. Please provide further information below if you feel this exemption applies to any part of this declaration.

5. Please note that ICB staff need this form to be signed by their line manager before submitting.

Signed: **Date**:

Signed (Manager): **Date:** **Position:**

PLEASE RETURN THIS FORM TO: hweicbwe.declarations@nhs.net

***Types of Interest**

Types of Interest	Description
Financial Interests	Where an individual may get direct financial benefits (a benefit may arise from the making of gain or avoiding a loss) from the consequences of a decision their organisation makes. This could include: • a director (including a non-executive director) or senior employee in another organisation which is doing or is likely to do business with an organisation in receipt of NHS funding • a shareholder, partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding • someone in outside employment • someone in receipt of secondary income • someone in receipt of a grant • someone in receipt of other payments (e.g. honoraria, day allowances, travel or subsistence) • someone in receipt of research sponsorship
Non-Financial Professional Interests	Where an individual may obtain a non-financial professional benefit (a benefit may arise from the making of gain or avoiding a loss) from the consequences of a decision their organisation makes, such an increasing their professional reputation or status or promoting their professional career. This could include situations where the individual is: • an advocate for a particular group of patients • a clinician with a special interest • an active member of a particular specialist body • undertaking a research role, particularly sponsored research • an advisor for the Care Quality Commission or National Institute of Health and Care Excellence
Non-Financial Personal Interests	This is where an individual may benefit (a benefit may arise from the making of gain or avoiding a loss) personally from a decision their organisation makes in ways which are not directly linked to their professional career and do not give risk to a direct financial benefit. This could include, for example, where the individual is: • a member of a voluntary sector board or has a position of authority within a voluntary sector organisation • a member of a lobbying or pressure group with an interest in health and care
Indirect Interests	This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit (a benefit may arise from the making of gain or avoiding a loss) from a decision they are involved in making. This would include: • close family member and relatives • close friends and associates • business partners

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 27 June 2025			
Time:	12.30 - 3.00 pm			
Venue:	The Forum, Hemel Hempstead and remotely via MS Teams			

MINUTES

Name	Title	Organisation
Members present:		
Trevor Fernandes (TF)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Beverley Flowers (BF)	Director of Strategy	Herts and West Essex ICB
Jane Halpin (JH)	Chief Executive Officer	Herts and West Essex ICB
Rachel Joyce (RJ)	Medical Director	Herts and West Essex ICB
Chris Martin (CM)	Commissioning Director	Essex County Council
Nick Moberly (NM)	Non-executive Member	Herts and West Essex ICB
Prag Moodley (PM)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Ian Perry (IP)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Alan Pond (AP)	Chief Finance Officer	Herts and West Essex ICB
Gurch Randhawa (GR)	Non-Executive Member (Chair)	Herts and West Essex ICB
Angie Ridgewell (AR)	Chief Executive Officer, Hertfordshire County Council	Hertfordshire County Council
Adam Sewell-Jones (ASJ)	Joint SRO ENH Health Care Partnership	ENH Health Care Partnership
Thelma Stober (TS)	Non-Executive Member	Herts and West Essex ICB
Toni Coles (TC)	Place Director, West Essex	Herts and West Essex ICB
Mark Hanna (MH)	VCFS Alliance Board Member	
Tania Marcus (TM)	Chief People Officer	Herts and West Essex ICB
Avni Shah (AS)	Director of Primary Care	Herts and West Essex ICB
Frances Shattock (FS)	Director of Performance	Herts and West Essex ICB
Michael Watson (MW)	Chief of Staff	Herts and West Essex ICB
Matt Webb (MW)	Place Director, South and West Herts	Herts and West Essex ICB
Via Microsoft Teams:		
Alan Bellinger (AB)	Patient Engagement Forum chair	
Matthew Coats (MC)	SRO South West Herts Health Care Partnership	South West Herts HCP

In attendance:		
James Benson (JB)	CEO, CHCH (attending on behalf of Elliot Howard-Jones)	East North Herts HCP
Rosie Connolly (RC)	Associate Director, Quality Improvement (attending on behalf of Natalie Hammond)	Herts and West Essex ICB
Ed Knowles (EK) (via Teams)	Development Director ((attending on behalf of Karen Taylor)	
Michael Meredith (MM)	Chief Strategy Officer (PAH) attending on behalf of Thom Lafferty	West Herts HCP
Tracey Norris	Meeting clerk	Herts for Learning Limited
Babatunde Sokoya (BS)	Associate Community Pharmacy Lead	Herts and West Essex ICB
Simone Surgenor (SS)	Deputy Chief of Staff – Governance	Herts and West Essex ICB

ICB/25/25	Welcome, apologies and housekeeping
25.1	In the absence of Paul Burstow (annual leave) Gurch Randhawa chaired the meeting, he welcomed all, in particular the Mayor of Dacorum. He confirmed that this was not a public meeting but a meeting being held in public (members of the public were welcome to attend to observe the meeting) there was an opportunity for members of the public to submit questions in advance to agenda item 12.2.
25.2	Apologies for absence had been received from: ■ Paul Burstow ■ Ruth Bailey ■ Natalie Hammond (represented by Rosie Connolly) ■ Sharn Elton ■ Elliott Howard Jones (represented by James Benson) ■ Thom Lafferty (represented by Michael Meredith) ■ Karen Taylor (represented by Ed Knowles) The following attendees were joining the meeting via MS Teams: ■ Matthew Coats ■ Ed Knowles ■ Alan Belinger
25.3	The Chair noted that this would be Alan Pond's last meeting as Chief Financial Officer, he thanked Alan for his outstanding contribution in this role and wished him well in his future pursuits. Jonathan Wilson had been appointed as Alan's successor.
ICB/26/25	Declarations of interest
26.1	The Chair invited members to update any declarations relating to matters on the agenda and reminded them of their responsibility to update their declarations, for example when they had ceased an association with an organisation. All members declarations were accurate and up to date with the register available on the website: Declaration of interests – Hertfordshire and West Essex NHS ICB
ICB/27/25	Minutes of the previous meeting
27.1	The minutes of the previous meeting held on Friday 28 March 2025 were approved as an accurate record, subject to the correction of the spelling of some members' names.
ICB/28/25	Action Tracker
28.1	Action updates were noted: ■ 82.4/24 Mental Health Intensive and Assertive Outreach Review: item closed, see report at agenda ICB/30/25. ■ 12.2/25: Lead a session on digital and AI: not yet progressed.
28.2	The Board noted the updates to the action tracker.
ICB/29/25	Integrated Delivery Plans: Health and Care Partnerships
29.1	East and North Herts: Adam Sewell-Jones (ASJ) ASJ referred to the presentation at pages 24-54 of the document pack and summarised the main points: ■ HCPs were a delivery vehicle for ICB strategic priorities whilst at the same time reflecting local population need; local resident feedback was collected via Health Watch and other channels. ■ ICB priorities were summarised on page 26 of the report. ■ Challenges were listed on page 27, most notably; paediatric audiology, community paediatrics and frailty (increasing size of cohort) and the financial envelope.

	■ Successes included: o Hospital at home o Integrated services in heart failure o Integrated neighbourhood teams; now embedded. o Working at place rather than acute; excellent community collaborations. o Voluntary sector (NB hospice provision): key and expanding. ■ ENH had been approved at Partner Level across the system to take over leadership of Health Care Partnerships and by 1 November 2025, ENH expected to have caught up with other HCPs in the region in terms of delegated agreements/10-year plan. ■ Improvements to place based performance report would be progressed; data should be tracked if it had meaning/was useful. Limitations to primary care information access was a barrier to success.
29.2	The Board approved the Integrated Delivery Plan for East North Herts HCP
29.3	West Essex – Toni Coles (TC) TC referred to the presentation at pages 77-87 of the document pack, drawing the board's attention to the following: ■ Overarching principles: o Care closer to home. o Delivery in the locality. o Management of pathways to ensure equity of access. o Population health management. ■ Target: Material improvements to be made before winter. ■ Governance of HCP: This had been approved by the partnership board (which sits under the PAH board) and there was joint leadership/resources and reporting; governance was effective. A GP member had been elected to the executive board on a rolling basis to represent primary care. ■ Priorities included: o Build on past successes. o Focus on health inequalities in Harlow. o Prevention agenda for young people with mental health issues. o Deployment of resources and investment decision to support focus area (Harlow) eg Better Care Fund. o Development of Integrated Neighbourhood Teams. o Frailty: proactive care model. o Elective recovery: consolidation of plans. o Workshops planned for July on care closer to home strategy for children and young people. o Reduction of non-elective admissions. o Reduce agency costs at PAH. o Review of community hospital bed utilization.
29.4	The Board approved the Integrated Delivery Plan for the West Essex HCP
29.5	South West Herts – Matthew Coats (MC) MC referred to the presentation at pages 68-76 of the document pack, drawing the board's attention to the following: ■ The HCP was maturing well with good support and engagement from all parties and board links. ■ INT: each one is led by a GP, supported by a secondary care consultant and a community service lead and integrated manager. ■ Host provider for adult community services. ■ Social funding partnership with MacMillan was working well. ■ Priorities included: o Primary care access and vaccination take up. o Move forward with the health campus development.

	○ Frailty. ○ Reducing inequalities (focus on Hertsmere). ○ Designing success measures that are smart and measurable. ■ Prioirties were aligned to the medium-term plan and the 2025/26 operational plan of the ICB but also reflected local priorities (see page 71 for more detail). ■ Successes in last three months included: delegation of community contracts (seven) to HCP – the strong governance and matrix of executive team was well placed to support this innovative approach.
29.6	The Board approved the Integrated Delivery Plan for South West Herts HCP
29.7	Mental Health, Learning Disability and Neurodiversity – Ed Knowles (EK) EK referred to the presentation at pages 68-76 of the document pack, drawing the board's attention to the following: ■ The IDP was based on the joint commissioning arrangements between the NHS and local authorities (MTP and Joint Forward Plan). ■ Priorities: ○ Crisis support. ○ Reduce out of area beds. ○ Role of MHLDN in integrated neighbourhood team model. ○ Developing ICB-wide strategies for dementia, suicide prevention and autism. ○ Addressing inequality of access for services and support.
29.8	The Board approved the Integrated Delivery Plan for the Mental Health, Learning Disability and Neurodiversity HCP
29.9	Questions and comments were invited: ■ Board members noted the collaborative work across all three localities, despite each starting at different levels of development. ■ The focus on frailty and care closer to home felt appropriate; complex patients wanted to be treated at home. ■ The volume of work arising from case management and long-term conditions was raised; the need for strong and resilient general practice was noted. ■ It was noted that not all citizens were frail or slotted neatly into a cohort. ■ The HCPs' plans aligned with the national direction of travel; going forward cluster arrangements needed to be embedded/promoted although it was noted that the HWE ICB was further forward than other ICBs in the region in this regard. ■ The strong links to place and population health management were celebrated and the flexibility in the system to allow for clear strategic priorities to be interpreted differently depending on local context. ■ Four meaningful plans had been developed and approved in a short space of time; evidence of cross system collaboration. Thanks were extended to all colleagues who had contributed to this process. ■ The role of the board in terms of accountability/scrutiny of IDPs was discussed, the following was raised: ○ ICB would expect to understand the progress of each IDP through the lens of outputs and levers. ○ The role of the board and its committees was to ensure its strategic blueprint was successfully translated into practice. ○ The understanding of strategic commissioning may evolve in the future. ○ A holistic view of service delivery needed to be monitored alongside more prescriptive metrics (eg attendances at ED).
29.10	The Board noted and approved the Integrated Delivery Plans

ICB/30/25	Mental Health Intensive and Assertive Outreach Review
30.1	Beverley Flowers presented this agenda item (see report at pages 88-98 of the document pack) highlighting the following: ■ The ICB was not yet fully compliant with national guidelines (this was a similar position to many other ICBs across England). ■ Next steps: identify gaps and which ones can be addressed within the constraints of no additional resources. ■ There were different systems of monitoring and review within Herts and Essex; a change to the oversight in Hertfordshire would be agreed w/c 30 June and reported to the Quality Group. ■ Different time scales were involved as Herts and Essex were not at the same developmental stage (different starting points). ■ All low cost/no-cost actions would be undertaken. The financial gap (to achieve compliance with national requirements) was in the region of £3m. ■ Advice was being sought from the national team as this work stream had not been included in the financial plan priorities for 2025/26. ■ Discharge processes were robust. ■ Transfer processes were robust. ■ Areas to develop: ○ Crisis care coordinator roles. ○ Raising awareness of pathways.
30.2	Questions and comments were invited: ■ The board discussed the need for focus and momentum to be maintained. Greater clarity on the costings of each element of the action plan and a ranking of what actions would have the greatest impact was needed. ■ Clarity on the level of risk this represented to the ICB was sought; a large area of risk was in terms of patient/public safety if service users were discharged for non-compliance with community services and became "missing". There needed to be good inter-agency working and robust policies and procedures in place to ensure service users were identified and supported. Differences in application of definitions between EPUT and HPCT needed to be explored. ■ The prevention of future deaths report was highlighted and the following challenges noted: ○ Tensions between health care professionals and police in responding to service users in crisis. ○ The impact of changes to the Mental Health Act vis the need for consent. ○ Stretched resources in mental health services, reducing the number of attempts made to contact patients resulting in referral back to primary care. ■ Action: Prioritisation list to be drawn up with costs.
30.3	The Board noted the Mental Health Intensive and Assertive Outreach Review
30.4	Action: Prioritisation list to be drawn up with costs for September Board meeting
ICB/31/25	Chair's update report
31.1	The Chair's report (see pages 99-105 of the document pack) was noted. There were no questions arising.
31.2	The Board noted the Chair's update
ICB/32/25	Chief Executive Officer's report
32.1	Jane Halpin (JH) referred to her report (see pages 106-109 of the document pack) drawing the board's attention to the following items to celebrate: ■ The work undertaken to create health care partnership delivery plans. ■ The progress being made with operating models and INTs.

	■ Work on developing two new clusters, with representation from both Herts and West Essex Challenges within the ICB were acknowledged: ■ Anxiety regarding job security/organisational change and the impact this had on operational function/service delivery improvements.
32.2	There were no questions/comments arising.
32.3	The Board noted the CEO's report
ICB/33/25	Governance Report
33.1	Michael Watson (MW) presented the governance report (see pages 110-116 of the document pack) and highlighted the following two items: ■ Changes to the ICB constitution: paragraph 2.1 - allowing the CEO to hold an executive role in another organisation in preparation of future cluster creation/activity. Approved. ■ Board assurance framework (BAF): Changes had been made to the corporate risk register and subsequent changes to the BAF would be brought to the next meeting for approval. These had been discussed at the Audit Committee, having been first identified at the Transition Sub-committee.
33.2	The Board approved the updates to the ICB constitution and noted the BAF
ICB/34/25	Updates from Sub-Committees
34.1	Committee chairs were invited to highlight the risks/challenges to escalate to board level (see committee summarised at pages 117 -145 of the document pack).
34.2	East and North Herts HCP Board: Adam Sewell-Jones ■ Operating model clarification. ■ Creation of subcommittee for the ENH Teaching Trust; due to be approved at the Board on Monday 30 June. Prior to board approval, the committee would operate as a committee in common. ■ Reports from four INTs.
34.3	West Essex HCP Board: Toni Coles ■ Nothing to escalate.
34.4	MHLDA HCP: Ed Knowles ■ Discussion on the potential impact of changes to the benefits system being discussed at Parliament; huge increase in anxiety in patients reported by clinicians. ■ Multi-agency approach to change to the Mental Health Act would be needed.
34.5	Audit and risk committee: Thelma Stober ■ No new risks to escalate to the board. ■ Changes to terms of reference (to include reference to cyber security responsibilities) had been approved by committee chairs. ■ Good discussion on BAF and the risks relating to transition. ■ Completion and submission of annual report and accounts, thanks to all staff involved in this process.
34.6	Strategic Finance and Commissioning Committee: Nick Moberly ■ Financial balance achieved in 2024/25. ■ Balanced plan proposed for 2025/26; transition tasks underway to achieve this. ■ Despite the challenging circumstances facing all providers/system users, the system was performing well.
34.7	People Committee: Tania Marcus ■ Assurance against the operational plan. ■ No change in priorities and focus. ■ Staff feedback results shared.

	■ Workforce transition programme. ■ Review of terms of reference in light of the forthcoming transition process.
34.8	System Transformation and Quality Improvement Committee: Rosie Connolly • No change to the usual challenges and risks; paediatric audiology, *c-diff* and antimicrobial stewardship and never events. • Good progress made by the wheelchair service. • Mental health deep dive to support work on MTP.
34.9	Patient Engagement Forum: Alan Bellinger *1. We held our quarterly face to face meeting on June 10 and caught up on all projects on which we are working* *2. We continue to be engaged on the Medium Term Plan and in particular:* *2.1 Supporting the hypertension campaign - we have 5 fully trained members of the PEF with thanks to Kevin Hallahan* *2.2 We Engaged in Elective Care meetings and representing the interests of patients on the waiting list; and* *2.3 Engaged in the transformation of Urgent & Emergency Care* *3. Finally - we have established a Task & Finish Group to consider how best we can demonstrate the impact of the work that the PEF does.*
34.10	The Board noted the Committee updates
ICB/35/25	Integrated report for finance, performance, quality and workforce
35.1	MW introduced this agenda item (see pages 146-163 of the document pack) and invited questions/comments: ■ The positive performance report was noted; there were no high risk categories. ■ Community waits for children remained high; work was ongoing to address this including: o Learning lessons from other services/areas. o Identification of fragmentation of service as barrier to improvement/delivery. o Overlap with HCC SEND improvement work. o Complexities in paediatric audiology despite early identification in gap in service. ■ Interim report on the ADHD task force had been received w/c 23 June, suggestion that the service should follow 10:20:70 approach as seen in diabetic service and that less complex neuro diverse children should be managed closer to home. ■ Early identification of ADHD/autism was essential. ■ ENH was now fully staffed for paediatric audiology; work was ongoing to improve/develop estate; aim – become centre for excellence. ■ New model for ADHD/neurodiversity pathways; these needed to be separate to community paediatrics. ■ Stabilisation but no reduction in the number of ADHD/autism referrals being made; funding had been made available to reduce waiting list. ■ Structural issues were acknowledged but impact on children from delay to services was not acceptable; ICB should make choices/trade-offs to ensure this received funding/priority. ■ Learnings from West Essex service model to be shared.
35.2	The Board noted the integrated reports for finance, workforce, quality and performance
35.3	Action: Update on children's services at next meeting
ICB/36/25	Questions from the public
36.1	None received.

ICB/37/25	What would service users, patients, carers and staff take away from our discussion today?
37.1	■ IDP discussions gave assurances that detailed plans had been drawn up providing localities with a good framework to support future changes/challenges. ■ Not enough excitement/celebration of outstanding work being carried out across the system. Future meetings should highlight on successes, for example: ○ 60% of general practice had signed up to share data on the integrated data platform. ○ Reduction in emergency admissions for frailty. ○ Good outcomes/output from digital meeting.
Date of next meeting: Friday 26 September at Latton Bush, Harlow	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Herts and West Essex Integrated Care Board Board Meeting Action Tracker Last updated on 15 September 2025								
Private / Public	**Action Tracker Ref No**	**Date of Meeting**	**Subject**	**Action**	**Responsible Lead**	**Deadline Date**	**Comments and Updates**	**Status**
Public	12.2	31/01/2025	What would service user take away	**Lead a session on Digital and AI**	ASJ and MC			**Open**
Public	30.4	27/06/2025	Mental Health Intensive Assertive Outr	**Further work on prioritisation requested.**	BF	**26/09/2025**	**Agenda item for September Board**	
Public	35.3	27/06/2025	Integrated Report	**Childrens Services Update requested for next Board**	BF	**26/09/2025**	**Agenda item for September Board**	

RAG Rating Key:	
Red	**Open (overdue)**
Amber	**Open (on-going)**
Green	**Completed / Action Closed**

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Meeting:	*Meeting in public*	☐	*Meeting in private (confidential)*	☐
	HW ICB Board		**Meeting Date:**	**26 September**
Report Title:	**Chairman's Report**		**Agenda Item:**	**5**
Report Author(s):	Rt. Hon. Paul Burstow, ICB Chair			
Report Presented by:	Rt. Hon. Paul Burstow, ICB Chair			
Report Signed off by:				

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

Which Strategic Objectives are relevant to this report **[Please list]**	• Increase healthy life expectancy and reduce inequality • Give every child the best start in life • Improve access to health and care services • Achieve a balanced financial position annually
Key questions for the ICB Board / Committee:	N/A
Report History:	N/A
Executive Summary:	This report is being presented to the ICB Board meeting on 26th September 2025. Board will note specific reference to: • Neighbourhood health updates • ICB alignment with national strategy • Planning Framework for the NHS in England • Transition and integration • Financial position and changing regime

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			☐
	No conflicts have been identified for the purpose of discussion at this session.			
Implications / Impact:				
Patient Safety:	N/A			
Risk: *Link to Risk Register*	N/A			
Financial Implications:	N/A			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***		An impact assessment has not been undertaken for this paper. It provides a high-level update.	
	Quality Impact Assessment:		Please see above.	
	Data Protection Impact Assessment:		Please see above.	

Chair's Report – September 2025

Introduction

As we enter the second quarter of 2025/26, our system continues to deliver for local people while navigating significant national reform. Our mission remains to improve health outcomes, reduce inequalities, and provide joined-up, person-centred care across Hertfordshire and West Essex.

This report reflects on achievements since the Board last met in June, highlights national developments shaping our direction, sets out the implications of transition to new Integrated Care Board (ICB) footprints from April 2026, and explains how the changing financial regime will affect us locally.

Recent achievements and system delivery

Over recent months we have seen strong delivery and innovation across our system:

- Patient access and satisfaction improved across general practice, NHS dental and community pharmacy services, supported by better telephony, expanded online access, the NHS App and Pharmacy First.
- Vaccination and prevention activity intensified, with catch-up campaigns for measles and other childhood immunisations, promotion of the forthcoming combined MMRV vaccine, and preparations for winter flu and COVID programmes.
- Blood pressure checks in community and faith settings, supported by trained volunteers through the community champions initiative, are improving early detection and tackling health inequalities.
- Health inequalities work in Dacorum was recognised in Parliament in July, highlighting the role of local leadership in addressing barriers to access.
- Primary care capacity has expanded, with new GP facilities planned in Hatfield and consultation under way on a proposed health campus in Hemel Hempstead to bring services together.
- Seasonal health preparedness was strengthened through heat-health alerts and family health campaigns.

Neighbourhood health

Integrated Neighbourhood Teams are now established across Hertfordshire and West Essex, serving populations of around 30,000–50,000. Shared caseloads, targeted support for frailty, and population health data are helping people stay well at home and reducing avoidable admissions.

- Neighbourhood health has also underpinned prevention and inequalities work, with recent community-based blood pressure checks and volunteer training demonstrating how local partnerships can improve trust and reach.

- West Essex has secured a place in Wave 1 of the National Neighbourhood Health Programme. Participation in the first cohort provides targeted national support, peer learning with exemplar sites and a structured evaluation framework to accelerate improvement. This will also help us prepare for transition into the new Essex ICB from April 2026 by aligning neighbourhood models, outcomes and data tools across Mid and South Essex and North East Essex.

The programme gives West Essex a practical test bed to develop shared pathways and measures that can be adopted across the future Essex footprint, supporting a smooth transfer of commissioning arrangements and continuity of care for residents. The success of these initiatives will hinge on the involvement of local government, the wider public sector and VCFSE in the design and delivery of this important change.

National Strategy Alignment

NHS 10-Year Health Plan

In July, Government published the 10-Year Health Plan for England, setting out three system-wide shifts for the decade ahead: from hospital to community; from analogue to digital; and from sickness to prevention. The plan also commits to innovation, workforce reform and financial discipline. We are reviewing our medium-term strategy to ensure alignment with these priorities.

Planning Framework for the NHS in England

In September, NHS England issued the Planning Framework for the NHS in England, requiring systems to develop integrated five-year plans covering 2026/27–2030/31. The framework sets expectations for outcome-focused planning across finance, workforce, quality, activity and service transformation, alongside meaningful engagement with people and communities.

Transition and integration

New ICB footprints from April 2026

On 9 September, a Written Parliamentary Statement confirmed that new ICB footprints will be established from 1 April 2026. Hertfordshire will join Bedfordshire, Luton & Milton Keynes and Cambridgeshire & Peterborough in the new Central East ICB, while West Essex will join Mid & South Essex and North East Essex in the new Essex ICB. This means Hertfordshire and West Essex will transition into two separate organisations, requiring careful alignment across both future footprints.

Implications

Medium-term plans must be flexible enough to support both new ICBs. Transitional governance with neighbouring systems will be vital to sustain delivery and statutory functions. Provider relationships, commissioning responsibilities, workforce plans and financial flows are being mapped to avoid duplication or gaps, while engagement is tailored to the needs of each future ICB area.

Leadership and workforce transition

We are awaiting the announcement of Chief Executives for the new ICBs. Following consultation, expressions of interest and interviews, the appointment of Executive Directors across the region is close to completion, with outcomes expected shortly. There remains ambiguity around funding and phasing of restructuring and redundancies for Agenda for Change ICB staff. This uncertainty weighs heavily on colleagues, and I want to thank our staff for their continued dedication and professionalism despite the personal challenges they face. Their commitment is ensuring safe and resilient discharge of functions during transition.

Financial position and changing regime

Where we are in 2025/26

NHS organisations in Hertfordshire and West Essex have planned to break even by the end of this year. This has required significant in-year savings, close cost control and reliance on some national non-recurrent support. Each local NHS organisation has set out recovery actions to help close the gap, and if delivered alongside national support we expect to reach balance in 2025/26.

How the national financial regime is changing

The NHS financial framework is being re-shaped to move away from one-off bailouts and system-wide control totals, towards clear organisational accountability and sustainable balance.

- Deficit support is conditional and time-limited. In 2025/26, support is linked to plan compliance, with repayment or carry-forward rules and potential capital consequences where conditions are not met.
- The use of blanket block payments is reducing. More elective and planned activity is now paid through national prices, linking income more closely to services delivered.
- From 2026/27, deficit support will be withdrawn. Each ICB and trust will be expected to live within its allocation on a recurrent basis.
- System control totals are ending. Financial accountability will sit clearly with each statutory organisation within an ICB footprint.
- Oversight will be sharper. Organisations in deficit or in receipt of exceptional support will face additional scrutiny and cannot be rated in the top oversight segments.

Implications for Hertfordshire and West Essex

For our system this means:

- Delivering balance without reliance on exceptional support by closing recurrent gaps and reducing temporary staffing.
- Aligning plans to the new ICB footprints from April 2026 so that accountability and funding flows clearly to the new organisations.
- Increasing productivity by standardising pathways, digitising processes, and embedding clinically-led efficiency initiatives.
- Ensuring payments are linked to services delivered, with a stronger focus on outcomes and access for patients.
- Managing risks carefully, as slippage against plan will have direct financial and oversight consequences.

Functions and statutory developments

National guidance has clarified expectations for key ICB functions:

- Medicines optimisation: strengthen system pharmacy leadership, use data-driven commissioning, and deliver efficiencies while enabling safe uptake of innovation.
- SEND: retain strategic commissioning responsibilities until at least 2027, with a focus on quality assurance, inspection readiness and integration with neighbourhood models.
- Safeguarding: maintain strategic safeguarding leadership and designated professionals within ICBs, with scope to delegate some tactical functions to providers under clear governance.

- Continuing healthcare: maintain accountability for eligibility decisions while securing efficiencies through scaled administration and digital case management.

We are reviewing our arrangements in these areas to ensure resilience and readiness through transition.

Workforce and people

Our People priorities remain focused on recruitment, retention and wellbeing. Over the summer we launched campaigns encouraging students to consider NHS careers, supported by apprenticeships and the Health and Care Academy. Multi-professional skill-mix is being developed in neighbourhood and primary care teams, and new workforce analytics using Qlik Cloud is providing improved insight into deployment and skills.

Digital and analytics

Digital capability is increasingly underpinning our transformation agenda. Progress includes:

- Deployment of Qlik Cloud to enhance workforce planning.
- Expanded use of the NHS App to support patient access to appointments, prescriptions and health records.
- Launch of the Healthier Together website, giving families trusted advice and reducing avoidable demand on urgent and emergency care.

Public and community engagement

We are strengthening public involvement through the new Insight Bank, launched in September, enabling communities to shape planning and decision-making. Consultation is under way on the Hemel Hempstead health campus, and seasonal campaigns such as Healthier Together, vaccination promotion and heat-health alerts have been widely accessed.

Safety and quality

A new patient safety campaign was launched in September to raise awareness, promote vigilance and embed learning from incidents across commissioning and provider partners. This complements national safeguarding guidance and strengthens our focus on safety during organisational change.

Conclusion

The 10-Year Health Plan and the Planning Framework set a clear direction: care closer to home, digitally enabled, prevention-led and outcome-driven.

For Hertfordshire and West Essex, transitioning into two new ICBs adds complexity but also an opportunity to shape strong, future-ready organisations. By strengthening our financial discipline, deepening neighbourhood delivery, aligning with national expectations and working closely with partners and communities, we are well placed to navigate change and continue delivering for our population.

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:	26 September 2025	
Report Title:	Chief Executive's Report				Agenda Item:		
Report Author(s):	With contributions from the ICB Executive Team and Partner Members						
Report Presented by:	Dr Jane Halpin, Chief Executive Officer						
Report Signed off by:	Dr Jane Halpin, Chief Executive Officer						
Purpose:	Approval / Decision	☐	Assurance	☒	Discussion	☐	Information ☐
Which Strategic Objectives are relevant to this report	■ Increase healthy life expectancy and reduce inequality ■ Give every child the best start in life ■ Improve access to health and care services ■ Increase the number if citizens taking steps to improve their wellbeing ■ Achieve a balanced financial position annually						
Key questions for the ICB Board / Committee:	N/A						
Report History:	N/A						
Executive Summary:	This report is being presented to the HWE ICB Board for its meeting on the 26 September 2025. Board will note specific reference to the: ■ ICB Change Process ■ Financial plan delivery ■ Provider Capability Assessment Approach ■ Medium Term plan and HCP Updates						
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	☒
	No conflicts of interest have been identified for the purpose of discussion at this session.	
Implications / Impact:		
Patient Safety:	*N/A*	
Risk: *Link to Risk Register*	*N/A*	
Financial Implications:	*N/A*	
Impact Assessments: *(Completed and attached)*	*Equality Impact Assessment:*	A separate impact assessment has not been undertaken for this paper, as it provides a high-level update.
	Quality Impact Assessment:	Please see above.
	Data Protection Impact Assessment:	Please see above.

ICB Change Process

Since the Board last met, NHS England has confirmed the arrangements regarding designate Chairs for the region's future reorganised integrated care boards. At the time of writing, formal announcements for CEOs are still awaited, and full details of governance arrangements for the second half of this year, during which the six current ICBs will increasingly work together so that the three new larger ICBs are ready to become statutory organisations from April 2026, will be shared as they are agreed.

The three future ICBs will have the following structures in place:

- Mid and South Essex ICB will work with North East Essex and West Essex.
- The combined footprints of Bedfordshire, Luton and Milton Keynes ICB, Cambridgeshire and Peterborough ICB, and Hertfordshire will work together.
- Norfolk and Waveney ICB will work together with Suffolk.

There will be a focus in this Board meeting on the progress made through system working locally. This includes our work to develop and commence delivery of our Medium Term Plan, and a new operating model which has seen the start of delegation of the delivery and planning of services to our Health Care Partnerships (anticipating elements of the recent 10 year plan).

We have made progress on core priorities and the establishment of vital transformation programmes, including the launch of new models of care, the mobilisation of integrated neighbourhood teams, and the establishment of innovative approaches to prevention, whilst also achieving successful delivery of our financial plans. This has been underpinned by extensive development of population health management approaches, including our data platform, DELPPHI.

Delivering our Financial Plan

As colleagues will have seen elsewhere in today's papers, we remained on track to deliver our 25/26 financial plan at M4. At this time last year we had deviated from plan - although as the board will know, we successfully managed to achieve our plan last year.

Delivering the remainder of the plan, and in particular the system transformation elements of it, will be a whole system challenge in which all organisations will have a critical role to play. We should also acknowledge that this need to focus on delivery of the plan will also take place alongside significant organisation change and uncertainty.

Provider Capability Assessment Approach

The new NHS Oversight Framework 2025/26 (NOF), which has now been published, describes a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement. It has been developed with engagement and contributions from the NHS leadership and staff, representative bodies and think tanks, including through two public consultations.

As part of this approach, NHS England will assess the ICB's delivery, reflected through NOF segmentation, but also its capability. The provider capability rating will help inform NHSE's response

to NOF segmentation and may also inform any decisions about entry into the National Provider Improvement Program (NPIP), and consideration for new Foundation Trust status.

This approach aims to give NHS England a holistic view of providers, extending beyond delivery of national programmes to also capture wider information relevant to organisational governance and grip. It is also intended to be a development tool to support Boards to reflect on their competencies, strengthen internal assurance and drive continuous improvement.

It is intended that in the future, capability ratings will be published alongside quarterly NOF segmentations.

The self-assessment template and accompanying guidance will be issued later this month, with provider Boards given two months to complete and return their assessments.

National Neighbourhood Health Implementation Programme (NNHIP)

Earlier this year, Places across the Hertfordshire and west Essex geography submitted applications to join the first wave of the National Neighbourhood Health Implementation Programme (NNHIP).

Neighbourhood Health is central to the Government's ambition to shift care from hospitals to community, analogue to digital and delivering sustainable health and care services, moving from sickness to prevention. It is hoped that the NNHIP will build on existing work and support new approaches to transform the health and care of neighbourhoods. The aim of this new national programme is to accelerate workstreams, by supporting shared learning and solutions, tackling challenges and delivering improvement.

I am pleased to report that both West Essex and South and West Hertfordshire were successful in their applications and have been accepted to join the first wave of the programme. As a result of becoming a wave one NNHIP site, these Places will be able to access the following national offer from the programme:

- A national coach to work with Place and neighbourhood teams
- Access to subject experts
- 3 face-to-face regional learning workshops
- Online support (practical tools, case studies and real-time learning)
- A knowledge hub with themed areas for peer-to-peer learning
- Data and evaluation workshops to support baseline development and outcome tracking
- A knowledge management centre to share and access insights from across the country
- Capability-building training for your local coach and team members
- Opportunity to help shape enablers (such as funding flows)

Further updates on activities and progress will be shared as the programme is rolled out during the coming months.

Dr Jane Halpin
Chief Executive
Hertfordshire and West Essex ICB

1: Formal Joint working

Special Educational Needs and Disabilities, Children and Young People

Ensuring every child has the best start in life:

The ICB has been working in partnership with Hertfordshire County Council to deliver the Special Educational Needs and Disabilities (SEND) priority improvement and action plan. A stocktake with Department for Education (DfE) and NHS England (NHSE) was held on 19 June 2025 and the following outcomes have been formally noted, a summary is as below:

- Area for Priority Action 1: Improving data to provide a shared, accurate understanding of the provision for SEND in Hertfordshire. The stocktake meeting confirmed that good progress made in this area.

- Area for Priority Action 2: Increase collaboration across all SEND provision, and with a particularly urgent focus on addressing the areas leaders have identified in their strategy for SEND.

- Collaborative working is improved and stronger governance arrangements provide greater oversight and challenge to help drive the pace of improvements. Efforts to improve SEND service quality are progressing, including the use of a quality improvement tool, pre-checks for new providers, and early-stage development of quality assurance visits.

- Areas for Improvement 1: Take action to address the variability in children and young people's access to health services, so that all those with SEND in Hertfordshire have an equal opportunity to access appropriate provision and support that meets their needs.

- Area for Improvement 4: Further address the gaps and delays in service provision to meet the full range of needs of children and young people with SEND.

- There has been improved access to speech and language services with more children being assessed within the 6-week target, with a reduction in those waiting more than 13 weeks for a speech and language report for an education health and care plan from 590 in October 2023 to 10 in May 2025.

ICS Pathology Services Transfer to a New Shared Network in 2025

HWE ICS pathology staff and services have been successfully transferred to Health Services Laboratories (HSL) from 1 March 2025 following a 9-month mobilisation period. The 15-year contract secures significant investment to modernise pathology services across HWE and provide a sustainable service for our patients. HSL will be responsible for delivering over 20 million tests per year for our population.

HSL are currently developing a new central hub laboratory at Croxley Park, Watford which is planned to be operational in summer 2026. Most routine pathology testing, including pathology services for GPs and community providers will be processed at the new Croxley Park hub lab, whilst more urgent results will be delivered on each of the three trusts' acute rapid response hot laboratories which are in the process of being refurbished in line with the transformation plan.

Frailty and End of Life Programme

Improve UEC through more anticipatory/SDEC care:

As can be seen in the later paper on Frailty, the work carried out over the last two years has led to significant (>50%) reductions in rates of admissions related to frailty, and further work is continuing. The agreed model for Early Alternatives to admissions (one of the frailty 7 interventions) has been approved and signed off. This is now with place teams to implement. Assurance reporting and metrics are still being finalised.

Early discussions have commenced regarding Unscheduled Care Coordination Hub (UCCH) and better support for end of life patients.

A new falls pathway launched in July for ENH and WE, for those who take prescribed anticoagulants. Ongoing work is taking place to raise the profile of the pathway and increase utilisation.

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

- Frailty - The Culture change work has included the launch of a public toolkit – to increase awareness of frailty and the actions people can take to reduce its impact. A comprehensive implementation guide is currently with stakeholders for comment. Training and videos are being created and will be included within the implementation guide.
- Personalised Care Week commences 22nd September. Awareness is being raised across HWE and there is a public communications campaign being drafted and plans across providers which will be shared.
- Falls - Place teams are working with all partners to improve awareness of falls prevention classes for those who are at low risk of falls, aiming to improve our falls prevention outcomes.
- End of Life - work is underway to ensure consistency of training, messaging and learning outcomes being delivered across HWE. Aiming to raise awareness of end of life and advance care planning discussions across our frontline workforce and helping our 'generalists' understand their role in end of life care.
- Frailty and digital innovation - 86% of all CQC registered adult social care providers in HWE are now using electronic records. Reported benefits include safer medication management as well as staff reporting they are saving on average at least 4 hours per week through more efficient digitised processes.
- Within polypharmacy an 'only order what you need' campaign has been approved and is due to commence in September. Ongoing promotion of the 'Its ok to ask' campaign and Benefits, Risks, Alternatives and Nothing (BRAN) resources are taking place to encourage the public to understand more about their own medications.

2. Delivering our Medium Term plan via local Health & Care Partnerships

Improving hypertension detection:

A hypertension detection communications campaign is now live across all of Hertfordshire and west Essex.

Integrated hypertension diagnostic pathways have been developed across the ICS, incorporating general practice and community pharmacy pathways into a cohesive, integrated pathway promoting hypertension detection across the HWE ICS.

A hypertension dashboard has been created with BI to track progress against local and national targets. Furthermore, a GP Fellow has been appointed to support with hypertension projects.

Work is in progress with the ICB Communications team to deliver BP monitors to libraries. BP monitors were delivered to all Essex libraries on 9th Sept 25.

In June 2024, NHSE awarded the ICB just over £100K funding to pilot hypertension detection in six dental surgeries and four optometry settings. Over the one-year period from 1st September 2024, the pilot has delivered 1,991 BP checks to patients.

An evaluation of the pilot is being undertaken by Hertfordshire University and Health Innovation South West. The final evaluation report will be available in October 2025. The findings from the evaluation will inform local future commissioning decisions.

East and North Herts (ENH) Health and Care Partnership (HCP)

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

The CVD Delivery Group has agreed a plan for an integrated heart failure model, to improve outcomes and experience, for people affected by cardiovascular disease and heart failure. The plan promotes a proactive model of care (aligned with the ICS *Care Closer to Home* approach), so that existing secondary and community services are more effectively coordinated to deliver integrated heart failure services. The new PHM risk stratification tool will enhance support for GP practices by identifying individuals at risk of cardiovascular disease who are living in areas of high deprivation.

Children's care backlog recovery:

Improvements continue to be made in reducing waiting times for Children's Audiology services in ENH, through approaches that includes mutual aid and regional load-sharing. Recruitment of additional audiologists has been successful, and waiting lists are being closely monitored. Operational measures being deployed include running additional clinics and accelerating access for children.

Ensuring every child has the best start in life:

The level of recurrent funding to providers of community paediatrics and neurodiversity assessments across HWE has been increased, including East and North Hertfordshire Hospital Teaching Trust (ENHTT) and Hertfordshire Community Trust (HCT). Funding will support the delivery of Community Paediatric services and the neurodiversity pathway transformation for children across Hertfordshire and west Essex.

South and West Hertfordshire (SWH) Health and Care Partnership (HCP)

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

Targeted support to practices with low detection and/or management is leading to improvements. One practice, Bennetts End, exceeded PCN and ICB targets post-visit, in CVD detection and will be used as "best practice" across the Place to support other practices to improve.

Other areas of work include:

- Hypertension champions are being identified to support with increasing the numbers of blood pressure checks.
- Community Service Specification reviews have been completed for Cardiac Rehabilitation and Heart Failure.
- First Lipid Optimisation training continues with 7 PCN training sessions booked into late 2025.
- HCPs are leading on taking forward the Integrated Heart Failure model of care. Updates are provided through the ICB's CVD Strategic Advisory Group (SAG).

Improving hypertension detection:

An outreach event was held in Broxbourne community church in July in partnership with One Vision to reach people from a Black and south Asian background. Additional blood pressure (BP) monitors were also delivered to HCT and Community Action Dacorum to expand detection in places of faith and local sports halls.

Improve UEC through more anticipatory/SDEC care:

Work has taken place to audit those ambulance calls triaged to community services but later returned to the ambulance systems. The aim of this is to decrease the number of calls returned following triage.

In relation to continuing to decrease emergency admissions relating to frailty, scoping work is to be carried out on developing a true 'Single Point of Access' for admission avoidance.

Better care for those in mental health crisis:

SWH has carried out a "Compassionate Communities." Project, which aimed to support patients to improve their physical and mental wellbeing, with a particular emphasis in dealing with death, grief, and loss. This project has been undertaken jointly by Attenborough PCN and North Watford PCN, in partnership with Rennie Grove Peace Hospice.

The ICB continues to support and facilitate a group looking at Delayed Transfers of Care with HPFT beds to identify any gaps and support to help service users move through the system.

Increasing healthy life expectancy and reduce inequality:

Communities First and local general practice held a 'one stop shop' for mildly frail patients in Borehamwood in May. The patients involved received targeted intervention from nurse, Pharmacist, and a Social Prescriber review. This helped patients better understand services available to support them locally. Similar events are being developed to reach more patients, particularly those living in more deprived communities.

In Watford, the Integrated Neighbourhood Team is taking shape. A machine learning approach has been taken to identify patients at high risk of being admitted to hospital as an emergency. This has identified 300 patients for the Team to begin to work with. Outcomes to measure the effectiveness of this work are in development.

An audit has taken place amongst acute, community and primary care providers to understand how services support access for those with sensory needs. Next steps are to identify gaps in knowledge or practice and provide relevant training and information.

Discussions with Royal National Institute of Blind People (RNIB) are ongoing regarding the funding of Eye Care Liaison officers across HWE. These posts will be based in acute settings and will support take up of health and care services for those with sight loss.

Improve access to health and care services:

- St Albans Locality

  A Digital Health Empowerment project has been running (led by HaLo PCN in partnership with Communities 1st). The primary goal has been to enhance access to technology-based solutions, particularly healthcare apps like the NHS app and Patient Access, to prevent digital exclusion among vulnerable groups within the community.

- Watford & Three Rivers

  A pilot project is being undertaken to reduce the rate of "Did not Attend" appointments at practices, thereby reducing wasted GP hours. This is being led by patient representatives with support from the ICB. The patient reps are working with one Surgery (Gade practice) initially with an aim of rolling out more widely.

  Scoping work has begun to develop a true Single Point of access for Urgent and Emergency care in SW Herts.

  In Watford, The Town Hall Quarter Programme is an initiative of the Council to regenerate the area at the top of Watford High Street and the Town Hall. This work includes a new health facility – to be located on the existing council car park. Discussions are ongoing around the size of the build and what health and care services can be located in the building.

- SWH Integrated Respiratory Service

  The new Integrated Respiratory Service provided by Central London Community Healthcare NHS Trust (CLCH) and West Hertfordshire Teaching Hospitals NHS Trust (WHHT) commenced on the 1st April 2025. Value for money of the approach will be kept under close review, particularly to ensure sleep studies work is affordable.

- South & West Hertfordshire Integrated Community Musculoskeletal, Rheumatology and Pain Service (iMSK)

  The service is currently receiving more referrals than the budget will support. Work is taking place to explore how other funding allocated but not fully used for similar services locally might be redeployed in a manner that helps offset current pressures.

  Meetings with WHTH Radiology, Rheumatology and Pain teams have been undertaken to evaluate pathways and ensure collaborative working with the services and clinical teams.

- Other MSK service updates:

  - Improvement in average call waits to 3 mins and email turn around within 24 hours.
  - Monthly newsletter circulated to Primary care.
  - A new patient appointment and cancellation booking app went live in June 2025.

- Monthly review of current waiting list in the service and service wait times.
- All estates are operational.

- Ophthalmology Single Point of Access (SPoA)

  Commissioners have appointed EyeV limited to deliver Ophthalmology referral management for the SWH population. This service was previously provided as part of the community ophthalmology service. The new SPoA went live in April 2025. The service provides community optometrists with a platform to send routine, urgent and macular degeneration referrals.

  Patients are offered an independent choice of providers within a 14-mile radius of their postcode for all routine referrals. All urgent referrals are triaged to Hospital Eye Services (HES).

  This service ensures that:

  - The ICB is following the NHSE guidance on patient choice
  - Any perceived conflict of interest is removed
  - GP burden is reduced by ensuring that Optical practices can refer through the SPOA rather than sending a referral letter to general practice.

<u>Increase the number of residents taking steps to improve their wellbeing:</u>

- A Type 2 diabetes project (WellnessStride) was carried out in the Dacorum locality, motivating individuals to adopt healthier lifestyles.

  The Wellness hub project aims to tailor services for ethnically diverse communities in St Albans.

<u>Achieve financial sustainability:</u>

- South West Herts System Resilience Group now has clear oversight of UEC capacity funds. This senior group will monitor spend against plan and monitor activity delivered to ensure value for money.

West Essex (WE) Health and Care Partnership (HCP)

<u>Reduce inequality with a focus on outcomes for CVD and hypertension:</u>

- A further 230 blood pressure machines have been delivered across WE GP practices for patient use.
- A blood pressure monitor loan scheme has been funded by ECC public health in partnership with ECC libraries service.

<u>Improve UEC through more anticipatory/SDEC care:</u>

- Princess Alexandra Hospital Trust (PAHT) have opened an Emergency Department SDEC to improve patient experience in ED.
- A bid has been submitted to NHSE for monies to support Stroke community rehab care.

- A proactive care model for residents at risk of admission has been implemented across all 6 INTs in WE, with an enhanced approach in Harlow to support increased caseloads.

Elective care recovery:

- The HCP has been successfully awarded 2 years of funding for training to develop a GP with an extended role in Gastroenterology - in conjunction with the PAH Gastroenterology team.
- Community tele-dermatology pathway is continuing to save 250 referrals at PAHT and patient experience is rated 100% Excellent/Good.
- The breathlessness pathway has gone live, comprising a symptom-based referral from primary care after appropriate respiratory & cardiology diagnostic tests, secondary triage and MDT approach.
- Hydroxychloroquin screening in place with patient choice for referral. PAHT have 50 patients that are being referred.

Childrens care backlog recovery:

- Frameworks have been generated for Quality Improvement for Paediatric Diabetes and Asthma in line with the care closer to home ambition.
- The Fair Education Alliance asked the West Essex CYP partnership Board if they could film an interview with the Chair in follow-up to a recent case study on our experiences of applying a Common Outcomes approach. The case study and film will be used as online content alongside the Fair Education Alliance "Report Card" aligned to the coalition's joint policy priorities, which will launch in September.

Ensuring every child has the best start in life:

- Frameworks have been generated for Quality Improvement for Paediatric Diabetes and Asthma in line with the care closer to home ambition

- Representatives from education, local government, WE HCP & PAH Maternity met on 20 August to discuss progress on a joint initiative to provide better information, help and support for parents during a child's all-important early years of life in the format of a Padlet called My Life, My Future: Bump to Five. This is currently being user tested and is due to be launched in October. Now planning similar work on the subsequent 'seasons' of life from primary education through to employment.

Increasing healthy life expectancy and reduce inequality:

- The Health Determinants Research Collaboration meeting identified HCP involvement opportunities for the Healthy Home research project.
- The Neighbourhood Fund Board has been launched in Harlow. The Local Authority is leading on the submission of the 10 year investment plan working with the ICB and other system partners to agree focus areas.

- The Stepping Stone Homes Project has been approved to support those being discharged from hospital who cannot return home and require a short term stay to increase their independence before going onto adult social care or self-caring – Landlord identified in Harlow and lease discussions being finalised.

Improve access to health and care services:

- Work is taking place with primary care and acute providers to improve the number of referrals of stroke patients to community stroke service. Refreshed communications are in place.
- A CDC walk-about created better understanding of the GP diagnostic referral pathway, which can be refreshed to make further efficiencies
- There has been sign up from all system partners for application to the National Neighbourhood Health Improvement Programme

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

- Research and data has been collated and circulated on loneliness and isolation for neuro-divergent people.

Hertfordshire Mental Health, Learning Disability and Neurodiversity (MHLDN) Health and Care Partnership (HCP)

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

The MHLDN HCP is piloting Enhanced Physical Health checks for people with serious mental illness (SMI). The aim of the pilot is to establish how we can best provide a holistic approach to both meet the national target for the number of people receiving their health check but also make sure that these checks are making a difference. The pilot is looking at how to best integrate with public health services as well as working with primary care colleagues to consider how the health check process can be standardised across different practices so that GPs are aware of what other services and support are available to help act on the Physical Health Checks findings.

Better care for those in mental health crisis:

The MHLDN HCP has overseen the successful procurement process for the provision of a “Crisis House” based in Buntingford. This service will provide short term (7-14 days) support for people in mental health crisis with a focus upon recovery, daily living skills and empowerment in a non-restrictive setting. The successful provider, Way Through, will deliver the services in partnership with HPFT and other local partners. The service is currently scheduled to go-live from December 2025. It was agreed that this project will be monitored and supported as part of the MHLDN HCP Crisis Care Partnership Board’s work programme.

Hertfordshire Constabulary colleagues presented a stocktake report to the MHLDN HCP Crisis Care Partnership Board related to the implementation of Right Care Right Person (RCRP). The presentation detailed the progress made against phase 1 and 2 (Concern for Welfare and AWOLS from hospital) and the work still required in relation to phase 3 (Transport). In relation to Phase 4 (section 136) the stocktake report noted that further work was still required to reduce the delays in handover but also acknowledged the development of mature and effective multi-agency partnership working which was helping to manage flow and improve service user experience in the context of rising demand and limited capacity.

Childrens care backlog recovery:

Following a competitive procurement process the provider of the Children and Young People's Neurodiversity Support Hub has been confirmed as Add-vance. Add-vance were the existing provider of this service. The three-year contract will allow the Hub to make longer term staffing and resource decisions, which is expected to help with recruitment and retention of staff.

A key element of the new Children and Young People's Neurodiversity pathway is the single point of referral for GPs and other referral agencies – based on the premise that schools, other health professionals and other practitioners should be able to refer into the pathway to relieve pressure on GP services and to ensure that the professional who knows the child best could make the referral without delay.

In preparation for this new referral process and to improve referral and demand monitoring, HCT and ENHT have undertaken a joint referral logging project that will bring all referrals into a single team for recording before being redistributed to the relevant Trust for processing. Referrals would still only be accepted from GPs through this new process, with a view to expand the referral agencies agreed later as the rest of the Pathway comes online. The referral logging processes will commence in September 2025 with a new admin team to manage the process. The service will not be fully digitalised at this point, but nonetheless it will still bring considerable benefits to the system including better demand monitoring and data collection, improved and more efficient processes for GPs, less confusion or frustration for parents and carers, and easier transition as the rest of the Pathway develops.

Increasing healthy life expectancy and reduce inequality:

The MHLDN HCP and HCC's Public Health team has worked to develop myth busting information related to co-occurring mental health and substance use to help build awareness of this issue and dispel some of the myths about access to treatment and support:

- Myth busting poster: Busting Myths about CMHSU GPs
- Myth busting detail: COMHSU Myth Busting - this document contains more detail about the facts and contains references to national papers/guidance.

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

Having been approved as a Centre of Excellence for Music in Dementia Care, the Music in Herts Dementia Care Champion programme has launched by welcoming cohorts of staff from residential and nursing home providers and training them in how music can connect, comfort and uplift those living with Dementia and how to incorporate it into the lives of residents with Dementia on a daily basis.

System-Wide Improvement Collaborative Launch

Better care for those in mental health crisis:

As part of our ICB Quality Improvement Delivery Plan we committed to running one system-wide improvement collaborative over a 12-month period linked to a shared priority. As well as supporting improvements in a priority area, the collaborative also supports our workforce across the system to develop their improvement skills with training and coaching provided.

The priority agreed was to focus on high intensity users of urgent and emergency care services including those with underlying mental health conditions, with an aim to better support the individuals concerned and reduce ED attendances and admissions.

Following significant planning and engagement at provider, Health and Care Partnership, and system level, including colleagues from health, social care, Voluntary, Community, Faith, and Social Enterprise (VCFSE) sectors and members of our population, our system collaborative was launched on 29th July 2025.

The launch included a powerful patient story to help us understand how best we can make improvements, and agreement of our collective core aims. These are to reduce urgent care attendances, improve care closer to home, and to increase signposting to alternative support offers. The details, drivers and improvement ideas will be developed and tested over the coming months.

We look forward to the ongoing engagement and progress made via the system improvement collaborative that will improve the care and experiences for members of our population.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

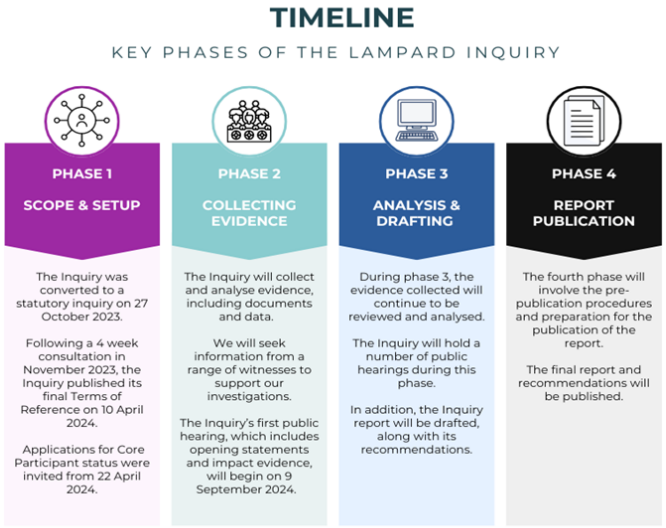
Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWEICB Public Board meeting				Meeting Date:	26/09/2025	
Report Title:	Lampard Inquiry Board Update				Agenda Item:	7.	
Report Author(s):	David Wallace – Deputy Director Nursing & Quality HWEICB Phil Read, Associate Director – Central PMO (MSEICB)						
Report Presented by:	Beverley Flowers Deputy Chief Executive & Director of Strategy HWEICB						
Report Signed off by:	Beverley Flowers Deputy Chief Executive & Director of Strategy HWEICB						
Purpose:	Approval / Decision	☐	Assurance	☒	Discussion	☐	Information ☒
Which Strategic Objectives are relevant to this report [Please list]	improve access to health and care services increase healthy life expectancy and reduce inequality						
Key questions for the ICB Board / Committee:	Is the Board assured as to the actions in place across the 3 ICBs to respond to the live Inquiry?						
Report History:	Report is also being presented to the Boards of MSE and SNEE ICBs						
Executive Summary:	To update the Board on the establishment of the Lampard Inquiry and the development of the cross Essex ICBs response. Scope of the Inquiry Following review, the Scope of the Inquiry was updated earlier during 2025 to clarify the Inquiry's definition of inpatient death, as well as inclusion of Learning Disability and Drug and Alcohol units. The scope on mental health assessments was also updated to clarify the Inquiry's focus on assessments in Accident and Emergency, assessments by gatekeeping teams, and Mental Health Act assessments. There have been no further amendments to the Inquiry's Scope although other cases may be included at the Chair's discretion. Disclosures						

	The Lampard Inquiry publishes 'Disclosure Updates' confirming the number of requests for information under either Rule 9 of the Inquiry Rules 2006 (a formal request for submission/response) or Section 21 of the Inquiries Act 2005 (notices issued by the Chair on the Inquiry to compel the submission of evidence). The latest published position is as reported to the Board in May 2025. Based on March 2025 figures: • 58 requests to organisations which are core participants. • 72 requests to organisations which are not core participants. • 162 requests to individuals and families. The ICBs have received no further Rule 9 or Section 21 requests. Two Rule 9 requests have been received to date (July 24 and Feb 25), both of which were responded to within the required time limits. Public Hearings Two public hearings have taken place in recent months. • Monday 28 April to Thursday 15 May 2025 - The ICBs submitted written evidence as part of this hearing (in response to the Rule 9 requests) but were not asked to give any evidence in person. • Monday 7 July to Monday 14 July 2025 –The ICBs were not asked to submit any information relating to this public hearing. There have been no further inquiry requests for information from the ICBs. Sample Case review The NHS commissioning cycle and associated processes is included within the scope of the Inquiry and has been identified as a future area of interest. In June 25 meetings were held between key members of ICB staff and legal representatives to discuss current and historical commissioning, contracting and quality monitoring arrangements covering the 23-year period of this Inquiry. As a result, the ICBs in partnership with legal teams, have commenced a review of 6 cases spanning 2015 to 2023 (note: records prior to 2015 are not held by the ICBs and therefore excluded from this review). Sample cases were chosen in liaison with legal teams taking into consideration the circumstances of the patient's death, the location, changes in the commissioning landscape and the scope of the Inquiry. The intended output of this undertaking is to submit a statement to the Inquiry prior to the next hearing (October 2025) to provide a detailed evidence-based assessment of: 1. The commissioning landscape at this time of these cases. 2. Identification of contracts in place and how they were monitored. 3. The quality monitoring arrangements at the time of these incidents, and 4. Any specific sample case knowledge and/or actions taken by the ICB, relating to these cases.

	Following discussion between ICB legal representatives and the Lampard Inquiry legal teams this proactive ICB case review (may) become a formal Inquiry Rule 9 request for information, in accordance with the Inquiry's Scope. The three ICB SROs will oversee this case review.			
Recommendations:	The Board is asked to note the report and take assurance on the progress in developing the pan Essex ICBs approach to responding to the Inquiry and to the requests of the Inquiry to date.			
Potential Conflicts of Interest:	*Indirect*	☐	*Non-Financial Professional*	☒
	Financial	☐	*Non-Financial Personal*	☐
	None identified			☐
	Director of Nursing & Quality previously employed by EPUT.			
Implications / Impact:				
Patient Safety:	*Yes – Through ensuring there are systems and processes in place to prepare for and learn from the work of the inquiry overtime, and as it pertains to the quality and safety of mental health services commissioned and provided for the population of Essex*			
Risk: *Link to Risk Register*	*680*			
Financial Implications:	*N/A*			
Impact Assessments: *(Completed and attached)*	*Equality Impact Assessment:*	N/A		
	Quality Impact Assessment:	N/A		
	Data Protection Impact Assessment:	N/A		

1. Executive Summary

1.1 In June 2023 it was announced that the Essex Mental Health Independent Inquiry (established in 2021) would be granted statutory status (Public Inquiry) under the Inquiries Act 2005. In April 2024 final Terms of Reference were published and the first public hearings began on 9 September 2024. The purpose of the Inquiry is to investigate the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trust(s) in Essex ("the Trust(s)") between 1st January 2000 and 31st December 2023.
The Inquiry will continue into 2026/27. A schematic of the phases of the Inquiry is shown below.



1.2 The ICBs' Approach
The three Essex Integrated Care Boards; Mid and South Essex (MSE), Hertfordshire and West Essex (HWE) and Suffolk and North East Essex (SNEE) continue to work collaboratively to be able to respond collectively and effectively to the requirements of the Inquiry.
Each of the ICBs has been designated a 'core participant' to the Inquiry. A core participant is an individual, organisation or institution that has a specific interest in the work of the Inquiry. Core participants have a formal role and special rights in the Inquiry process.

A shared programme office has been established comprising.

- Programme Director (part time)
- Senior Project Manager (1 wte)
- Administrative Support (1wte)

Mills & Reeve LLP have been appointed as Legal advisors and a KC (Kings Counsel) appointed as legal representation to the Lampard Inquiry representing the three ICBs.
Programme and legal costs are being apportioned 1/7 to SNEE and Herts & West Essex ICBs, 5/7 Mid & South Essex ICB. Legal costs are monitored and reported through each of the ICBs and remains within budget.

The three Senior Responsible Officers (SROs) are;

- Dr Matthew Sweeting, Executive Medical Director, MSE
- Lisa Nobes, Chief Nurse, SNEE
- Beverley Flowers, Deputy Chief Executive, HWE

They are supported by ICB Lampard leads;

- Phil Read, Programme Director and MSE lead
- Tom McColgan, Governance & Compliance Manager, SNEE
- David Wallace, Deputy Director of Nursing and Quality, HWE

This paper updates the Board following the report submitted in May 2025. It includes;

- Inquiry Updates
- Public Hearings
- Requests to the ICBs for information
- The Joint ICBs Programme

2.0 Main content of Report

2.1. Inquiry Updates

Scope of the Inquiry

Following review, earlier in 2025 the Inquiry's Scope was updated to clarify the Inquiry's definition of inpatient death, as well as inclusion of Learning Disability and Drug and Alcohol units. The scope on mental health assessments was also updated to clarify the Inquiry's focus on assessments in Accident and Emergency, assessments by gatekeeping teams, and Mental Health Act assessments.

There have been no further amendments to the Inquiry's Scope although other cases may be included at the Chair's discretion.

Disclosure

The Lampard Inquiry publishes 'Disclosure Updates' confirming the number of requests for information under either Rule 9 of the Inquiry Rules 2006 (a formal request for submission/response) or Section 21 of the Inquiries Act 2005 (notices issued by the Chair on the Inquiry to compel the submission of evidence).

The latest published position is as reported to the Board in May 2025. Based on March 2025 figures:

- 58 requests to organisations which are core participants.
- 72 requests to organisations which are not core participants.
- 162 requests to individuals and families.

The ICBs have received no further Rule 9 or Section 21 requests. Two Rule 9 requests have been received to date (July 24 and Feb 25), both of which were responded to within the required time limits.

2.2 Public Hearings

Two public hearings have taken place in recent months.

Monday 28 April to Thursday 15 May 2025 - The Inquiry heard contextual evidence relating to the provision of mental health inpatient care in Essex, and evidence relating to some systemic issues around the provision of care. The ICBs submitted written evidence as part of this hearing (in response to the Rule 9 requests) but were not asked to give any evidence in person.

Monday 7 July to Monday 14 July 2025 – The inquiry heard witness statements from bereaved family members. The ICBs were not asked to submit any information relating to this public hearing.

Future public hearing dates are below, agendas and supporting information will be confirmed in due course.

- 13th October – 30th October 2025
- 2nd February – 19th February 2026
- 20th April – 7th May 2026
- 6th July – 23rd July 2026
- October 2026: closing statements.
-

Hearing recordings are available online: The Lampard Inquiry - investigating mental health deaths in Essex

2.3 Inquiry Requests to the ICBs

There have been no further inquiry requests for information.

2.4 Joint Essex ICBs Programme

The ICBs commissioning, finance, quality and contracting teams remain in place to respond positively and promptly to any requests for information. Navigating the complexities of the commissioning landscape from 2000, retrieving historical data or information from former commissioning organisations across this period and reliance on corporate memory of individuals for pre-ICB processes remains the most challenging aspect of responding to the Inquiry.

The programme was formally established in autumn 2024 with the cross ICB Joint Project Working Group meeting monthly from December 24. As reported to Board in May 2025 the programme is supported by several groups with targeted areas of work, which include:

Safeguarding – Mid and South Essex ICB leads the Safeguarding process for the three Essex ICBs and has a Memorandum of Understanding (MoU) with the Inquiry. The ICBs have agreed a process for any Inquiry 'Safeguarding Alerts / Non-Alerts', including receiving responses from EPUT, and have a weekly scheduled meeting to discuss anything outstanding.

The first 'referral', now referred to as an alert, was received in May 2024. Since then, we have received the following:

- Alerts Received: 24 (HWE: 1 / SNEE: 3 / MSE: 17 / Other: 3)
- Non-Alert Received: 4 (Issues outside the scope of the Inquiry)

Communications – Maintaining a dedicated Inquiry space on the respective ICB's intranet, explaining further details about the Inquiry, where to find support, and who to contact; as well as relevant updates aligned with the Inquiry's public hearings from 2024 until 2026. There is also information available on the ICS website

Human Resources (HR) – The Project Team and HR group meet monthly to review support needed for staff affected by the Inquiry, specifically focusing on legal support (provided by Mills and Reeve), practical support (provided by the Project Team), and wellbeing support, available to all staff.

Information Governance (IG) and Historic Records – The Information Governance Team support with primary oversight of historic records, as well as IT service support and Cyber Security for any records from former organisations held within ICB servers and databases, and completion of the privacy impact assessment. We have developed and issued new procedures for records destruction to ensure the ICBs meet the additional requirements of the Inquiry e.g. further retention of documents beyond ordinary timescales. A 'Stop' notice is in force to prevent the destruction of any Inquiry related records or information.

Senior Responsible Officers (SROs)
The Senior Responsible Officers for the ICBs meet fortnightly with the Programme Director and Legal Advisors as necessary (weekly if needed for example when a Rule 9 is in operation). This allows the SROs to receive assurance on progress against requests, development of the programme approach and to support mitigation to risks and issues identified. It also provides an executive director level mechanism to sign off requests within the requisite timescales.

2.4.1 Sample Case Review September Statement
The NHS commissioning cycle and associated processes is included within the scope of the Inquiry and has been identified as a future area of interest. In June 25 meetings were held between key members of ICB staff and legal representatives to discuss current and historical commissioning, contracting and quality monitoring arrangements covering the 23-year period of this Inquiry. The ICB had previously identified a risk associated with NHS commissioning reorganisation and concerns raised and acknowledged through these meetings regarding the potential loss of organisational memory and key members of staff, that may be called upon, to respond to any future Rule 9 requests.

As a result, the ICBs in partnership with legal teams, have commenced a review of 6 cases spanning 2015 to 2023 (note: records prior to 2015 are not held by the ICBs and therefore excluded from this review). Sample cases were chosen in liaison with legal teams taking into consideration the circumstances of the patient's death, the location, changes in the commissioning landscape and the scope of the Inquiry.
The intended output of this undertaking is to submit a statement to the Inquiry prior to the next hearing (October 2025) to provide a detailed evidence-based assessment of:

1. The commissioning landscape at this time of these cases.
2. Identification of contracts in place and how they were monitored.
3. The quality monitoring arrangements at the time of these incidents, and
4. Any specific sample case knowledge and/or actions taken by the ICB, relating to these cases.

Following discussion between ICB legal representatives and the Lampard Inquiry legal teams this proactive ICB case review (may) become a formal Inquiry Rule 9 request for information, in accordance with the Inquiry's Scope.
The three ICB SROs will oversee this case review.

Findings/Conclusion

The Essex ICBs continue to work together through a joint programme approach to the Inquiry and are ready to respond positively to any future Rule 9 and supplementary requests.

No further formal requests for information have been received to that which has already been reported to Board.

The sample case review is intended to provide the ICBs, ICB legal representatives and the Lampard Inquiry with sufficient detail regarding the commissioning and quality monitoring arrangements in place at key times of interest to the Inquiry.

The review also seeks to address any loss of organisational memory and mitigate against organisational change risks.

Recommendation

The Board is asked to note the report and take assurance on the continued oversight and coordination of the pan Essex ICBs approach to responding to the Inquiry.

Appendices
None.

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	NHS Hertfordshire & West Essex Integrated Care Board Meeting				Meeting Date:	26/09/25	
Report Title:	Mental Health Intensive & Assertive Outreach Progress update				Agenda Item:	8.	
Report Author(s):	David Wallace- Deputy Director of Nursing HWEICB						
Report Presented by:	Beverley Flowers – Deputy Chief Executive & Director of Strategy						
Report Signed off by:	Beverley Flowers – Deputy Chief Executive & Director of Strategy						
Purpose:	Approval / Decision	☐	Assurance	☒	Discussion	☒	Information ☒
Which Strategic Objectives are relevant to this report [Please list]	■ Reduce health inequalities. ■ Have a more anticipatory, community-based model of care. ■ Deliver true integration of our services. ■ Support patients to engage in self-management and collaborative care planning						
Key questions for the ICB Board / Committee:	• Board to receive an update on the progress of the Mental Health Intensive and Assertive Outreach Review to date.						
Report History:	• N/A						
Executive Summary:	• Following the publication of Guidance on Intensive and Assertive Community Mental Health Treatment and the initial ICB-led reviews which have been reported to the Board previously. In June 2025, the National Team launched a further national review to assess progress against local system action plans. • This has required ICBs to complete a system self-assessment using a standardised template and were asked to complete and submit their returns to their regional teams by 3 September 2025. The HWE review was carried out in partnership with HPFT and in Essex with EPUT. The purpose of these reviews to o Reflect on progress over the past 6–12 months o Identify ongoing challenges o Outline next steps and support needs • The self-assessment asked for review against 9 Domains. • Overall ratings for the Hertfordshire system and Essex – although we have started to make progress in improving our intensive and assertive						

<table>
<tr><td></td><td colspan="4">community care, we are not yet able to provide full assurance that we can fully meet the need of this population group. Within that however there is much good work which has taken place, and our system partners are to be commended for their good work.

Overall RAG rating against the 9 domains nuanced and HWE is not an outlier in comparison to other ICBS when discussing progress against the system reviews at regional forums.

• Further work is ongoing with system partners to develop a clearer understanding of the risks associated with non-fidelity to the Assertive outreach model, and the associated actions which the ICB may need build into future planning this work continues and will be reported in more detail to future Board meetings.

• Key to note that at this point, there are significant resourcing implications in order to meet full fidelity, however there is as yet no national steer regarding any additional financial support for systems to deliver.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">• The board is asked to note progress on the review and the contents of the report and accompanying presentation.</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">The review and subsequent actions will steer system improvements to improve patient safety for this cohort.</td></tr>
<tr><td>Risk: Link to Risk Register</td><td colspan="4">-</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">-</td></tr>
<tr><td rowspan="3">Impact Assessments:
(Completed and attached)</td><td colspan="2">Equality Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Quality Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Data Protection Impact Assessment:</td><td colspan="2">N/A</td></tr>
</table>

1. Executive summary

Following the publication of the Intensive and Assertive Community Mental Health Treatment Guidance and the initial ICB-led reviews which have been reported to the board previously. In June of this year, the National NHS England Team launched a further national review to assess progress against local system action plans.

This has required ICBs to complete a system self-assessment using a standardised template for completion and submission to their regional teams by the 3rd of September 2025.

The purpose of these reviews are to:

- Reflect on progress over the past 6–12 months
- Identify ongoing challenges
- Outline next steps and support needs

It should be noted that it was agreed with the NHSE Regional Team that rather than an assessment being completed for HWE and the two Mental Health Trusts, a single assessment should be completed for Hertfordshire and a separate assessment for Essex would be carried out as a single process with oversight and input from the 3 ICBs (HWE, MSE and SNEE) to begin aligning towards the Greater Essex footprint as the direction of travel for Essex.

The self-assessment asked for a review of progress against 9 Domains:

- Partnership Working
- Workforce
- Community Based Care – Access and oversight
- Key working arrangements and caseload management
- Out of hours provision
- Care delivery
- Information sharing
- Family and carer involvement
- Demonstrating Impact

Against each domain ICBs were asked to provide a high level and summary RAG rating of status with reflections on the previous 6 months as well as consideration to the next 6 months priorities and actions. Additionally, ICBs were asked to reflect on 2 overarching summary questions:

1. *Reflecting on progress made, are you assured that the services in your area are able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up?*

2. *Are you on track to present, or have you already presented, your updated action plans at both Trust and ICB public board meetings by the 30 June 2025 deadline, as requested in the February 2025 letter from Claire Murdoch and Adrian James?* – Action Complete

2. Key points from the Hertfordshire and West Essex review

The reviews were carried out in partnership with our Mental Health Providers HPFT and EPUT.

Our overall rating for both the Hertfordshire and Essex systems found that, although progress is being made, both systems are not yet able to provide full assurance of meeting the needs of the target population group, particularly regarding the prescribed caseload sizes and therefore intensity required.

However, there is much good work which has taken place, and system partners are to be commended on this work and the pace of assessment of population need, including identification and risk assessment of the target population.

The overall RAG rating against the 9 domains are nuanced due to the complexities inherent with identifying and supporting this cohort of our population, but HWE does not appear to be an outlier in comparison to other ICB's when discussing progress against the system reviews at regional forums and the challenges identified.

There are also distinct differences between the two self-assessments, with the Essex assessment covering more partners, commissioners and service contexts.

The full self-assessments (Appendices 1 & 2) are appended to this report for further reading and contextualising of the RAG ratings. In summary the ratings are as follows:

Hertfordshire:

Domain	Rating	Descriptor
Partnership Working	Amber	Some elements of partnership and governance are in place, but they are inconsistent, informal or still developing.
Workforce	Amber	Some systems are in place, but they are incomplete, inconsistently applied, or under development.
Community Based Care – Access & oversight	Green	Comprehensive, embedded, and routinely monitored policies and governance arrangements are in place to ensure access, support, and safe transitions for individuals in this patient group.
Key working arrangements & caseload management	Amber	There is some oversight in place, but we are not able to fully monitor key worker allocation or caseload appropriateness
Out of Hours Provision	Amber	Some arrangements exist, but they are inconsistently applied, informal, or lack full system engagement
Care Delivery	Amber	Some oversight mechanisms exist, but they are inconsistently applied or not fully embedded across services
Information sharing	Green	Clear, formalised, and consistently applied information sharing protocols are in place across all relevant partner organisations.
Family & carer involvement	Amber	Some arrangements exist, but they are inconsistently applied, informal, or lack clear governance
Demonstrating Impact	Red	There are no formal processes to measure or monitor the effectiveness of local services

Essex:

Domain	Rating	Descriptor
Partnership Working	Amber	Some elements of partnership and governance are in place, but they are inconsistent, informal or still developing.
Workforce	Red	There are significant gaps in assurance processes relating to staffing for this.
Community Based Care – Access & oversight	Amber	Some policies and governance arrangements exist, but they are inconsistently applied, under development, or lack full alignment with best practice.
Key working arrangements & caseload management	Red	We have no oversight or monitoring mechanisms in place to ensure key worker allocation or to monitor caseload appropriateness
Out of Hours Provision	Red	There are no formal arrangements in place for multi-agency coordination outside of core hours
Care Delivery	Red	There is no consistent oversight to ensure that individuals in this cohort have care plans or that their needs are comprehensively assessed.
Information sharing	Amber	Some protocols or agreements exist, but they are inconsistently applied or not embedded across all partners.
Family & carer involvement	Red	There are no formal mechanisms in place to gather, monitor, or respond to family and carer feedback
Demonstrating Impact	Red	There are no formal processes to measure or monitor the effectiveness of local services.

Self-assessment in both Essex and Hertfordshire have identified there are resourcing implications to meet full fidelity, particularly in increasing capacity to enable the smaller caseloads identified in the model to achieve the intensity of input required. As yet, there is no national steer as to additional support to systems to deliver and meet this level of intensity and read across to the Personalised Care Framework regarding caseload sizes or standardisation of KPI's linked to fidelity indicators.

3. Next Steps

Further work is ongoing with system partners to develop a clearer understanding of the risks associated with non-fidelity to the Assertive outreach model, and the associated actions which the ICB may need build into future planning as this work continues and will be reported in more detail to future Board meetings.

Item 8 - Appendix 1 - IAO NHSE submission Hertfordshire HWEICB 29-08-2025

Intensive and assertive Community Mental Health treatment: ICB review outcome template

NHS England

Review details - to be completed	
ICB Name	
Region	
Please list the providers in your area, which the review covers	
Name of SRO overseeing review	
Operational lead responsible for completing review	
Please provide the email address for the operational lead responsible for completing the review	

Scope and purpose

The purpose of these local reviews is to ensure that appropriate, intensive, and assertive mental health care is available to meet the needs and support the wellbeing of people with severe mental illness who may struggle to engage with traditional services. The group under consideration includes individuals who:
- Are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
- May not respond to, want or may struggle to access and use 'routine' monitoring, support and treatment that would minimise harms
- Are vulnerable to relapse and/or deterioration with serious related harms associated (esp. but not limited to violence & aggression)
- Have multiple social needs (housing, finance, self-neglect, isolation etc)
- Likely present with co-occurring problems (e.g. drug and alcohol use/dependence)
- May have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems)
- Concerns may have been raised by family / carers

National guidance is clear that this care does not necessarily need to be delivered through a standalone team. Instead, all community mental health teams should be equipped to provide intensive and assertive support to this group, wherever they present.

Key Features of the Intensive and Assertive Community Treatment Model
This model is a multidisciplinary, community-based approach designed to deliver flexible and person-centred care. Its core components include:
- Multidisciplinary, Skilled Workforce: Care should be delivered through an MDT. Each service user should have a named key worker within the team who provides personalised support, monitors early signs of relapse, and initiates appropriate interventions. Staff must be trained in engagement techniques, trauma-informed care, risk assessment, and the management of co-occurring conditions such as substance misuse.
- Community-Based, Person-Centred Care: Care is provided in the individual's environment – at home or community or the least restrictive setting. This enhances accessibility, supports recovery, and promotes continuity of care, including during periods of hospitalisation.
- Intensive Support with Low Caseloads: Key workers should maintain a small caseload, enabling intensive, personalised, and frequent contact. Daily or near-daily engagement is often required to maintain therapeutic relationships and proactively address emerging needs.
- 24/7 Continuity and Out-of-Hours Support: While full 24/7 services are not mandated, robust out-of-hours support is essential to ensure safety and responsiveness, especially during crises or transitions.
- Comprehensive, Integrated Care: Wraparound support needs to be available to meet the individual's mental and physical health, housing, and social care needs. Care plans must be co-produced whenever possible, reviewed at least every six months, and include detailed guidance for escalation.
- Collaborative, Multi-Agency Approach: Effective care involves coordinated working between multiple partner organisations including housing services, social care, primary care, and criminal justice agencies. Information-sharing protocols must support holistic decision-making and reduce duplication of effort across services.
- Active Involvement of Families and Carers: Where appropriate, families and carers must be engaged in care planning, treatment, risk/safety management, and care transitions, even where direct information sharing is limited. Their insight is key to sustaining recovery and managing risk collaboratively.
- Strong Governance and Safety Management: Governance structures at both ICB and provider level must support oversight of quality, safety, and risk. Proactive identification and management of risk is essential, underpinned by multi-agency partnership approach and shared governance structures.
- Demonstrable Impact: Services must monitor appropriate outcomes and use data to inform continuous improvement.

All ICBs are expected to complete the review by 3 September 2025 and submit the completed template to their regional team.

Intensive and assertive Community Mental Health treatment: ICB review outcome template

NHS England

About this review

As set out in the 2024/25 Planning Guidance, NHS England directed all Integrated Care Boards (ICBs) to review their policies and practices across community mental health services. The objective was to ensure that local systems are equipped to meet the needs of individuals with Severe Mental Illness (SMI) who may struggle to engage with traditional services and require more intensive and assertive community-based support.

ICBs were specifically asked to work with local partners to evaluate existing provision, assess whether it meets the needs of this population, and identify areas for improvement. This national requirement was reinforced through guidance and a structured reporting template issued in July 2024, which asked systems to identify involved providers, examine key policies and practices, highlight service gaps, and set out improvement actions.

All 42 ICBs completed this initial review by September 2024. Submissions highlighted examples of good practice, opportunities to strengthen care pathways, and common challenges—particularly related to workforce capacity. Since then, systems have been working to implement action plans and enhance whole-system responses to ensure timely, coordinated, and effective care for this vulnerable group.

Following Claire Murdoch's February 2025 letter marking the publication of the Independent Mental Health Homicide Review, and as part of ongoing assurance, ICBs are required to review and update their action plans at both six and twelve months. This updated template has been developed to support the June 2025 review and is intended to assist ICBs in evaluating their progress in delivering improved assertive and intensive community treatment.

This work is also critical in supporting broader improvements to ensure that fewer people require this level of intervention. A key part of this includes the development of a new Personalised Care Framework, designed to ensure that all individuals with serious mental illness receive consistent, person-centred, and well-coordinated support across teams and settings. Due to be published in Summer 2025, the framework will offer further guidance to ICBs and mental health providers on how to improve the quality and continuity of care for this population group.

The review is designed to be light-touch and should be completed as a self-assessment in collaboration with local partners. The template uses a RAG (Red-Amber-Green) rating approach to help systems assess their current position, identify ongoing challenges, and outline next steps.

All ICBs are expected to complete the review by 3 September 2025 and submit the completed template to their regional team. These returns will help inform national policy development. NHS England will also publish a national summary report drawing on both the July 2024 and June 2025 reviews, including key findings and recommendations for system improvement.

Update on progress since summer 2024

Reflecting on your initial review and the development of local action plans, it would be helpful to understand the progress made across the ICB since that point

Reflecting on progress made, are you assured that the services in your area are able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up?	No – we have started to make progress in improving our intensive and assertive community care, however are still unable to provide full assurance that we can fully meet the need of this population group.
Are you on track to present, or have you already presented, your updated action plans at both Trust and ICB public board meetings by the 30 June 2025 deadline, as requested in the February 2025 letter from Claire Murdoch and Adrian James?	*Yes – This has already been completed or is scheduled to take place by 30 June 2025.*

Item 8 - Appendix 1 - IAO NHSE submission Hertfordshire HWEICB 29-08-2025

Understanding the specific provision in place in line with the model of care

The following questions are designed to gather information on the provision currently in place across your ICB footprint. We recognise that progress may vary across different areas; this exercise is intended to develop a national overview of where systems are concentrating their improvement efforts and to identify any gaps where additional national support may be required.

Partnership working

	RAG key	ICB self-assessment
To what extent has your ICB taken action to strengthen partnership working and governance arrangements to support this patient group? Consider: • Whether dedicated forums or local partnership arrangements exist to oversee safety, quality, and outcomes. • Clear governance structures, with defined responsibilities and accountability for this population are in place. • Evidence of collaborative action taken with system partners to improve support and outcomes for the group.	**Red - There is no clear partnership working or governance structure in place for this patient group** •No dedicated forums or partnership arrangements currently exist. •Roles and responsibilities across the system are unclear or undefined. •Little to no evidence of collaborative activity to support this group. •The ICB has not yet initiated any focused work in this area. **Amber - Some elements of partnership and governance are in place, but they are inconsistent, informal or still developing** •There may be ad hoc or emerging forums for collaboration. •Governance structures are partially defined but not widely understood or embedded. •Some joint actions have been taken with system partners, but gaps remain in coordination and oversight. •Plans are in place to strengthen arrangements, but impact is not yet clear. **Green - Strong and embedded partnership and governance arrangements are in place to support this patient group** •Dedicated forums or formal partnership structures exist and are regularly used to monitor safety, quality, and outcomes. •Governance responsibilities are clearly defined, understood, and integrated across relevant organisations. •There is robust evidence of collaborative planning and delivery with measurable improvements for the target population.	Amber - Some elements of partnership and governance are in place, but they are inconsistent, informal or still developing.
Reflecting on the Past Six Months: What progress has been made in strengthening your approach to partnership working? Please highlight any key achievements, as well as any ongoing challenges or barriers you have encountered.	Development of HCP MHLDN Primary and Community Mental Health Partnership Board work plan including IAO work IAO workshops held with VCSFE, probation, housing HWE Primary and Community Assurance Board discussing approaches across both HWE trusts Existing HPFT pilot primary/specialist MH MDT meeting continuing in Stort Valley Villages (action 22) Update 24.7.25 plans for rolling out MH MDT in other localities including addressing co-occurring MH Drug/alcohol. Balance between meeting high levels of demand and resource capacity will be challenging.	
Looking Ahead: What are your plans over the next six months to strengthen and improve partnership working? Please outline any planned initiatives, priorities, or changes in approach.	*Development of HCP MHLDN Primary and Community Mental Health Partnership Board work plan including IAO work* *IAO workshops held with VCSFE, probation, housing* *HWE Primary and Community Assurance Board discussing approaches across both HWE trusts* Determining at what level to offer MH MDTs - neighbourhood, PCN or individual GP practices (or combination of all) Communicating with partners on when to escalate and how to escalate re patients which they have concerns about. Physical health test and learn models focussing on people with SMI 1) with primary care (Watford - SW Herts) 2) with VCSFE (Hitchin - EN Herts) Engagement with, for the purpose of aligning work (in the near term) in MH space with Neighbourhood Health Implementation Programme at Place. Longer term there will need to be a collaborative approach to shift cultural and behavioural ways of working at neighbourhood level.	

Workforce

	RAG key	ICB self-assessment
To what extent does your ICB have effective systems in place to provide assurance of safe staffing for the care and treatment of this patient group? Consider: • Whether workforce plans account for the specific needs of this population. • Availability and uptake of appropriate training and competency development. • Recruitment and retention strategies relevant to staff working with this group. • Robust mechanisms for the ongoing monitoring and assurance of safe staffing levels, skills, and competencies.	**Red - There are significant gaps in assurance processes relating to staffing for this patient group** • No clear workforce planning specific to the needs of this population. • Training and competency frameworks are absent or not aligned with service needs. • Recruitment and retention challenges are unaddressed. • No routine mechanisms to monitor or assure safe staffing levels or skills. **Amber - Some systems are in place, but they are incomplete, inconsistently applied, or under development** •Workforce planning partially considers this population but lacks detail or implementation. •Relevant training is available but not consistently accessed or mandated. •Some recruitment or retention activity is underway, but gaps remain. •Assurance processes exist but lack robustness or regular review. **Green - Robust systems are in place and embedded to ensure safe and competent staffing for this patient group** •Workforce plans clearly address the specific care needs of this population. •Staff receive appropriate training and demonstrate required competencies. •Effective recruitment and retention strategies are in place and monitored. •Safe staffing is regularly reviewed through established assurance processes.	Amber - Some systems are in place, but they are incomplete, inconsistently applied, or under development.
Reflecting on the Past Six Months: What progress has been made in supporting the workforce that provides care and treatment for this patient group? Please include an overview of your workforce plans, efforts to recruit peer support workers, and any challenges or barriers you are currently experiencing.	Trust has oversight of high-risk teams / locations. This is managed through core management and QRM and escalated at PRM. Workforce remodelling is part of the Transformation Programme. National guidance from NHS England on MH Community based staffing levels – awaited (action 16) Oliver McGowan eLearning launched in July 2023 and increased to 95% in M10, exceeding the 92% target. (action 21) Lived Experience roles, sit operationally but are professionally led, need to assess assurance / compliance (action 8) Staffing levels and caseloads are managed and monitored at a local level. Further training in Person Centred Care and Support Planning for all staff to support coproduction of care plans with all service users irrespective of their method of engagement. (action 12) Mental Health wards have completed the Phase I data collection of the Mental Health Optimal Staffing Tool (MHOST), and the Phase II will be completed in Q4. The update on the MHOST implementation will be provided to IGC in the Month 12 report. (action 17) Specific work related to tightening psychosis pathways for this cohort. Complemented by training and risk management for this cohort. Staffing review within ACMHS and FACT Community teams to effectively support this cohort (core standard review to provide consistency of approach - review of frequency of contact, medication, identification on EPR etc) . No workforce plan in place to deliver a standalone IAO team or additional peer support provision within existing funded envelope.	
Looking Ahead: What actions are planned over the next six months to strengthen the skills, training, and competencies of staff supporting this patient group? Please outline any specific initiatives, development programmes, or strategic priorities.	Fundamentally we are not forecasting to be able to meet the caseload requirement of 15 service users per worker unless either new resource is available, or resources are moved from another service area, and there are currently no worked up proposals for either. However there is potential to work up proposals for consideration in the context of 10 year plan asks and review of local population health priorities. The workforce currently in place in Community Mental Health Teams are able to support the cohort using a 9-5 mondel with additional support provided through the Flexible & Assertive Community Treatment model that provides support at weekends and through the Crisis Resolution and Hoime Treatment Teams and the Enhanced Rehabilitaiton Service, although the scope of these service also supports other populations. Strategic Priorities include working with current workforce and community providers to strengthen shared care records and data governance to ensure that joint partnership working can be more effective in the Integrated Neighbourhood space. Working with services to share the assertive outreach approaches across teams and providers	

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Key working arrangements and caseload management		
	RAG key	**ICB self-assessment**
To what extent are local governance structures in place to provide assurance that all individuals in this cohort have an allocated key worker, and that caseloads are appropriate to provide the level support needed for individuals requiring intensive and assertive engagement? Consider: • Whether there are systems in place to monitor and ensure key worker allocation for every individual in scope. • Whether local governance structures provide oversight of caseload size and complexity. • The extent to which caseloads enable key workers to deliver proactive, personalised, and sustained engagement.	**Red – We have no oversight or monitoring mechanisms in place to ensure key worker allocation or to monitor caseload appropriateness** • Many individuals in the cohort may not have an identified key worker. • Caseloads are unmanaged or exceed safe levels, limiting the ability to provide intensive support. **Amber – There is some oversight in place, but we are not able to fully monitor key worker allocation or caseload appropriateness** • Most individuals have a key worker, but allocation is not routinely tracked or assured. • Caseload sizes are monitored in some areas, but data is incomplete or actions are not always taken. **Green - Robust and embedded oversight and monitoring systems are in place, providing clear oversight and assurance of key worker allocation and caseload management** • All individuals in the cohort have a named key worker. • Caseloads are regularly reviewed to ensure they are manageable and allow for assertive, personalised engagement.	Amber – There is some oversight in place, but we are not able to fully monitor key worker allocation or caseload appropriateness
Reflecting on the Past Six Months: Please describe how you monitor and maintain oversight of key worker allocation and caseload management. Include any challenges or barriers you have encountered in ensuring appropriate staffing and workload balance.	Staffing levels and caseloads are managed and monitored at a local level. Trust has oversight of high-risk teams / locations. This is managed through core management and QRM and escalated at PRM. (action 16) Weekly data performance review is in place to monitor activity wioth the cohort. Model of care being implemented for wrap around support includes consideration of the future models for FACT/ACMHS and PATH.	
Looking Ahead: What actions are planned over the next six months to improve oversight of key worker assignment and caseload management for this cohort? Please include any planned changes to processes, use of data or digital tools, or workforce development initiatives aimed at ensuring effective and equitable support.	The key working and care-coordination model in the trust is being considered in relation to changes to CPA, i.e. separation of care coordination from delivery of interventions. Revisions have been made to the Delivery of Care Policy (not yet ratified through all governance steps) This brings in the introduction of a named professional for those requiring a single intervention & A CARE COORDINATOR for those with more complex mental health needs. It is anticipated that there may be further changes once Personalised Care Framework is finalised by national team. Case load discrepancies across the geodraphy will be addressed - linked to workforce and resources mentioned above Investment into caseload management tool has been considered in HPFT Further exploration re ability to monitor this cohort via digital/reporting structures	

Out of hours provision		
	RAG key	**ICB self-assessment**
To what extent are local arrangements in place to support effective multi-agency coordination outside of core hours for individuals in this cohort? Consider: • Whether there are established pathways or protocols for coordination between key agencies (e.g. police, crisis services, social care, ambulance services) outside of 9–5 working hours. • The clarity of roles, responsibilities, and escalation routes during evenings, weekends, and public holidays. • The extent to which these arrangements are used in practice to support timely, safe, and appropriate responses.	**Red - There are no formal arrangements in place for multi-agency coordination outside of core hours** • Agencies operate in isolation during evenings, weekends, and public holidays. • There are no agreed pathways, protocols, or escalation procedures in place. • Responses are reactive and inconsistent, and there is no specific out-of-hours provision in place for this group. **Amber - Some arrangements exist, but they are inconsistently applied, informal, or lack full system engagement** • Certain agencies coordinate out-of-hours, but this is reliant on individual relationships or ad hoc solutions. • Pathways and escalation routes are partially defined but not consistently used. • There is access to a crisis line for individuals who require out-of-hours provision. **Green - Clear, formalised, and embedded arrangements are in place to enable effective multi-agency coordination outside of core hours** • All relevant partners (e.g. police, crisis services, social care, ambulance) are engaged in agreed protocols • Roles, responsibilities, and escalation procedures are clearly defined and routinely used • There is a full 24 hour access to support for individuals who require out-of-hours provision	Amber - Some arrangements exist, but they are inconsistently applied, informal, or lack full system engagement
Reflecting on the Past Six Months: Please provide an overview of the out-of-hours provision currently in place for this cohort. Include any challenges or barriers you have encountered in delivering consistent and effective support outside of core service hours.	Put in an update on any crisis pathway developments and current process - including - community duty teams - Nightlight and VCSFE cafes etc - SPA and crisis teams - MHRV/ Street triage - mental health urgent care centre - NHS 11, A&E liaison roles HPFT is clear in terms of 24/7 provision and offer which includes the above support services.	
Looking Ahead: What specific actions are planned over the next six months to strengthen out-of-hours support for individuals within this patient group? Please include any proposed service developments, workforce initiatives, or partnership approaches aimed at improving access and continuity of care outside standard operating hours.	Anticipating that this will link into the 24/7 MH neighbourhood models - the implimentation of which will be considered within the system following 5 August webinar re 24/7 MH neighbourhood model	

Care delivery		
	RAG key	**ICB self-assessment**
To what extent is there appropriate oversight in place to ensure that individuals in this cohort have a care plan, and that their clinical, social, and psychological needs are effectively assessed and addressed? Consider: • The extent to which care plans are co-produced, person-centred, and regularly reviewed. • Whether oversight mechanisms ensure that care planning includes a comprehensive assessment of clinical, social, and psychological needs. • Evidence of multidisciplinary involvement and coordinated action to meet identified needs. • There is joint discharge planning arrangements in place between inpatient and community teams to support transitions in care.	**Red - There is no consistent oversight to ensure that individuals in this cohort have care plans or that their needs are comprehensively assessed** • Care plans are often missing, incomplete, or outdated. • Assessments of clinical, social, and psychological needs are not routinely undertaken. • No formal governance structures or quality assurance mechanisms are in place to monitor care planning or needs assessment. • Joint discharge planning arrangements are not in place between inpatient and community teams following a period of hospital admission. **Amber - Some oversight mechanisms exist, but they are inconsistently applied or not fully embedded across services** • Most individuals have care plans, but quality and consistency vary. • Holistic needs assessments are undertaken in some cases but not systematically or across all domains. • Oversight processes are present but lack regular review or do not drive improvement. • There is some evidence of joint discharge planning arrangements between inpatient and community teams but these are not formalised or regularly monitored. **Green - Robust and embedded oversight arrangements are in place to ensure care plans are in place and holistic needs are assessed and addressed** • All individuals in the cohort have co-produced, care plans that are regularly reviewed. • Clinical, social, and psychological needs are systematically assessed and reflected in care planning. • Strong governance mechanisms ensure quality assurance and continuous improvement across the system. • There is clear joint discharge planning arrangements in place between inpatient and community teams following a period of hospital admission.	Amber - Some oversight mechanisms exist, but they are inconsistently applied or not fully embedded across services
Reflecting on the Past Six Months: Please provide details on how you maintain oversight of care plans and assessments for individuals within this patient group. In particular, describe how concerns or red flags are identified, how responsive actions are coordinated across services, and any barriers you have encountered in ensuring timely and effective intervention.	Delivery of Care Policy in draft, to go through Divisional, then Trust governance routes (Action 9) Safety dashboard provides real time oversight on compliance with risk assessment. Risk Assessment Metrics are reported to the Trust Board via the performance Report. Suicide Prevention Training which includes Risk formulation training Quality and compliance identified via Audit Enhanced Risk Assessment Team in place Risk Assessment CQI Project Suicide Prevention (Hertfordshire Suicide Prevention Board) includes risk formulation. Enhanced Risk Assessment (ERA) Team PACE audits evidence mixed results on quality of risk assessments. (action 11) Development of EPR and dashboard reporting Quality metrics are being developed Governance is managed through Quality, Safety, Effectiveness Committees and Exec Boards HPFT have delegated Social care responsibility for adults with MH needs - which supports a holistic, personalised care approach to need including discharge planning. HPFT to consider ASCENT Business case.	
Looking Ahead: What specific actions are planned over the next six months to enhance oversight of the care provided to individuals within this patient cohort? Please include any initiatives aimed at improving monitoring, quality assurance, or inter-service coordination.	Quality of risk assessment and management poricess to be audited Taking forward the EPR and dashboard reporting elements Sharing ASCENT BC	

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Information sharing	RAG key	ICB self-assessment
To what extent are clear and effective information sharing protocols in place between relevant partner organisations and agencies to support safe, coordinated care for this cohort? Consider: • Whether formal information sharing agreements or protocols exist and are aligned with legal and professional standards. • The consistency and timeliness of information sharing across health, social care, police, education, and voluntary sector partners. • Whether staff are aware of and trained in appropriate information governance practices. • Evidence of information sharing supporting joint decision-making, risk management, and continuity of care.	**Red - There are no formal information sharing protocols in place, or existing protocols are not used in practice** • Significant barriers to information flow between agencies. • Staff are unclear on when and how to share information appropriately. • Lack of information sharing impacts coordination, safety, and continuity of care. **Amber - Some protocols or agreements exist, but they are inconsistently applied or not embedded across all partners** • Information is shared in some cases, but processes may be informal, fragmented, or delayed. • Staff awareness and training on information governance is variable. • Systems do not reliably support timely or secure information exchange across sectors. **Green - Clear, formalised, and consistently applied information sharing protocols are in place across all relevant partner organisations** • Information sharing arrangements are aligned with legal and professional standards. • Staff are trained and confident in using them appropriately. • Systems support timely, secure, and purposeful information flow to enable coordinated care, joint risk management, and continuity across services.	Green - Clear, formalised, and consistently applied information sharing protocols are in place across all relevant partner organisations.
Reflecting on the past six months: Please outline the progress you have made in developing information sharing protocols and agreements, and/or describe any barriers you have encountered in implementing them.	The Trust participates in My Care Record information sharing agreements and the Hertfordshire and West Essex Shared Care Record (SCR) managed by the HWE ICB. Trust CIO and CCIO have discussed relevant information to be shared via ICS Shared Care Record (SCR) with primary care digital leads as well as the ICB Mental Health Liaison Group. Once the identified dataset go through technical feasibility assessments internally and with the SCR team, these will be developed on the Trust's Clinical Data Repository with an aim to share the additional data into the SCR. (Action 4) Attends complex needs meetings - shares relevant information (not necessarily PID). Shared care record in place. Work with Drug/alcohol service re patients with co-occuring presentations HPFT well embedded into MAPPA and safeguarding meetings Primary care MDT forums MADE events, CTR processes, Right Care right person. Good liaison with Police and representation on Criminal justice board.	
Looking ahead: What specific actions are planned over the next six months to enhance multi-agency information sharing and collaboration?	Continuing to share learning and good practice with relevant forums.	

Family and carer involvement	RAG key	ICB self-assessment
To what extent are there governance arrangements and processes in place to monitor, respond to, and act on feedback from families and carers of individuals in this cohort? Consider: • Whether the ICB is aware of, and has oversight of, local mechanisms for collecting and monitoring family and carer feedback. • Whether there are clear processes in place at provider and/or system level to respond to feedback and make improvements. • How feedback from families and carers informs service development, quality assurance, and personalised care planning. • Evidence of regular engagement with families and carers in shaping services.	**Red - There are no formal mechanisms in place to gather, monitor, or respond to family and carer feedback** • The ICB has limited or no awareness of local processes for involving families or carers. • Feedback is not routinely collected or used to inform care or service improvement. • Families and carers report feeling excluded or unheard. **Amber - Some arrangements exist, but they are inconsistently applied, informal, or lack clear governance** • The ICB is aware of some local processes but does not have consistent oversight. • Feedback mechanisms are present but may be limited in reach or impact. • Responses to feedback are variable, and changes made are not always communicated or evidenced. **Green - Clear, embedded arrangements and processes are in place to routinely capture and respond to family and carer feedback** • The ICB has full oversight of local processes and ensures feedback is used to inform service development and care planning. • Families and carers are regularly engaged, and their input is valued and acted upon. • There is evidence of feedback driving measurable service improvement, with clear communication back to families and carers.	Amber - Some arrangements exist, but they are inconsistently applied, informal, or lack clear governance
Reflecting on the last six months: Please outline the progress made in improving your approach to involving families and carers in the care of this patient group. Your response should include how staff respond to concerns raised by families, the mechanisms in place to support meaningful engagement, and any current barriers to effective involvement.	Family involvement in individual care planning identified via PACE audits (action 27) Carer and family involvement corporately reported at Experience Group (action 3) Carers working group with actions Carers and family involvement in equality work Completion of identification of carers and family involvement on EPR Carer involvement training patient safety partners help to shape services (e.g. service model development, audit and evaluation) HPFT social care responsibilities for carers assessments under Social Care Act	
Looking ahead: What specific actions are planned over the next six months to strengthen the involvement of families and carers in care planning, service reviews, and service design?	PACE audits evidence mixed results on family involvement in Ward Rounds and Discharge Planning meetings. Need a process to continuously and accurately gain assurance (performance) around family involvement. Further work on Carers in relation to the Personalised Care Framework Engaging with carers over the next 6 months across a number of specific areas following review of actions above Clearer communication to carers on how carers can escalate concerns they have for the people they look after Further work required to build on co-production/co-design for service improvement.	

Demonstrating impact	RAG key	ICB self-assessment
To what extent are processes in place to measure, monitor, and demonstrate the effectiveness and impact of local services supporting this cohort? Consider: • Whether the ICB is aware of and has oversight of performance indicators, outcome measures, and quality metrics for relevant services. • The extent to which data is regularly collected, analysed, and used to inform service improvements. • How impact measurement incorporates patient outcomes, experience, and system-wide benefits. • How lived experience helps inform service design and delivery. • Whether there is transparency and accountability in reporting service effectiveness.	**Red - There are no formal processes to measure or monitor the effectiveness of local services** • The ICB lacks awareness of any outcome measures or performance data. • Data collection is absent or inconsistent, with no systematic analysis. • Service design and delivery is not co-produced with people with lived experience. • Service impact is not evaluated, limiting opportunities for improvement or accountability. **Amber - Some processes exist but are inconsistent, incomplete, or lack full integration across services** • The ICB has partial oversight of some performance indicators or outcome measures. • Data is collected irregularly or not routinely analysed to inform decisions. • There is limited input from people with lived experience to support the design and delivery of services. • Impact measurement focuses on limited aspects and does not fully incorporate patient outcomes or experience. **Green - Comprehensive and embedded processes are in place to systematically measure, monitor, and demonstrate service effectiveness** • The ICB has full oversight of relevant metrics, including PROMs and family specific outcome measures. • Data is regularly collected, analysed, and used to drive continuous service improvement. • Services are co-designed with people with lived experience. • Reporting is transparent, and findings inform commissioning and accountability frameworks.	Red - There are no formal processes to measure or monitor the effectiveness of local services.
Reflecting on the last six months: Please describe the improvements made in monitoring service quality and tracking outcomes for this patient group, including any challenges or barriers faced.	Evidence Based pathway delivery group continues to review progress of all Evidence Based Pathways and Interventions Psychosis Pathway updates provided to Transformation Board and Effectiveness Group. (Action 20) PSIRF reporting to IGC Divisional Incident Safety reports to Safety Group Patient Safety Incident Panel Month 12 review now due of PSIRF – good governance review. PSIRF RSM audit under way (Action 2) Trust escalation framework in place. Risk and oversight of risk governed through the Safety Group up to QRMC. (Action 6) Waiting times measured as part of the Performance Reports presented at Trust Board. (Action 14)	
Looking ahead: What actions are planned to evaluate and gain deeper insight into the impact of services on this patient group?	Data is collected but not systematically for this cohort- HPFT have identified numbers of people involved as using Cluster 16/17 as a starting point and then refined through discussion within MDTs to generate a list of appropriate cases Dashboard development underway to support ongoing monitoring of this cohort without the need to routine data analysis. EPR data development to be able to review PROMS/CROMs and improve accessibility to support the way people are able to work with this cohort. Lived experience feedback (including carers) loop to be developed - need to scope out range of actions needed and prioritise which need to be done in following period	

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Closing questions	
Thank you for taking the time to support this review. Please return the completed template to your regional NHSE team.	
Are there any particular are of best practice you can share?	*Achievements against the delivery of Community based care - access and oversight*
What additional support is required from NHSE to meet the needs of the individuals in scope?	*Interface with other priorities/asks in 10 year plan.* *Historically there were guidelines for specific intensive assertive outreach cohort - is there an expectation that this is a new direction of travel* *Provide clear steer if there is an expectation for areas to re-allocate resources to meet the max 15 people on caseload* *Share any learning where teams are made up of partners outside of the statutory services where they are commissioned to provide services*

Intensive and assertive Community Mental Health treatment: ICB review outcome template

NHS England

About this review

As set out in the 2024/25 Planning Guidance, NHS England directed all Integrated Care Boards (ICBs) to review their policies and practices across community mental health services. The objective was to ensure that local systems are equipped to meet the needs of individuals with Severe Mental Illness (SMI) who may struggle to engage with traditional services and require more intensive and assertive community-based support.

ICBs were specifically asked to work with local partners to evaluate existing provision, assess whether it meets the needs of this population, and identify areas for improvement. This national requirement was reinforced through guidance and a structured reporting template issued in July 2024, which asked systems to identify involved providers, examine key policies and practices, highlight service gaps, and set out improvement actions.

All 42 ICBs completed this initial review by September 2024. Submissions highlighted examples of good practice, opportunities to strengthen care pathways, and common challenges—particularly related to workforce capacity. Since then, systems have been working to implement action plans and enhance whole-system responses to ensure timely, coordinated, and effective care for this vulnerable group.

Following Claire Murdoch's February 2025 letter marking the publication of the Independent Mental Health Homicide Review, and as part of ongoing assurance, ICBs are required to review and update their action plans at both six and twelve months. This updated template has been developed to support the June 2025 review and is intended to assist ICBs in evaluating their progress in delivering improved assertive and intensive community treatment.

This work is also critical in supporting broader improvements to ensure that fewer people require this level of intervention. A key part of this includes the development of a new Personalised Care Framework, designed to ensure that all individuals with serious mental illness receive consistent, person-centred, and well-coordinated support across teams and settings. Due to be published in Summer 2025, the framework will offer further guidance to ICBs and mental health providers on how to improve the quality and continuity of care for this population group.

The review is designed to be light-touch and should be completed as a self-assessment in collaboration with local partners. The template uses a RAG (Red-Amber-Green) rating approach to help systems assess their current position, identify ongoing challenges, and outline next steps.

All ICBs are expected to complete the review by 3 September 2025 and submit the completed template to their regional team. These returns will help inform national policy development. NHS England will also publish a national summary report drawing on both the July 2024 and June 2025 reviews, including key findings and recommendations for system improvement.

Update on progress since summer 2024

Reflecting on your initial review and the development of local action plans, it would be helpful to understand the progress made across the ICB since that point

Reflecting on progress made, are you assured that the services in your area are able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up?	No – we have started to make progress in improving our intensive and assertive community care, however are still unable to provide full assurance that we can fully meet the need of this population group.
Are you on track to present, or have you already presented, your updated action plans at both Trust and ICB public board meetings by the 30 June 2025 deadline, as requested in the February 2025 letter from Claire Murdoch and Adrian James?	*Yes – This has already been completed or is scheduled to take place by 30 June 2025.*

Understanding the specific provision in place in line with the model of care

The following questions are designed to gather information on the provision currently in place across your ICB footprint. We recognise that progress may vary across different areas; this exercise is intended to develop a national overview of where systems are concentrating their improvement efforts and to identify any gaps where additional national support may be required.

Partnership working

ss may vary across different areas; this exercise is intended to develop a national o	RAG key	ICB self-assessment
To what extent has your ICB taken action to strengthen partnership working and governance arrangements to support this patient group? Consider: • Whether dedicated forums or local partnership arrangements exist to oversee safety, quality, and outcomes. • Clear governance structures, with defined responsibilities and accountability for this population are in place. • Evidence of collaborative action taken with system partners to improve support and outcomes for the group.	**Red - There is no clear partnership working or governance structure in place for this patient group** •No dedicated forums or partnership arrangements currently exist. •Roles and responsibilities across the system are unclear or undefined. •Little to no evidence of collaborative activity to support this group. •The ICB has not yet initiated any focused work in this area. **Amber - Some elements of partnership and governance are in place, but they are inconsistent, informal or still developing** •There may be ad hoc or emerging forums for collaboration. •Governance structures are partially defined but not widely understood or embedded. •Some joint actions have been taken with system partners, but gaps remain in coordination and oversight. •Plans are in place to strengthen arrangements, but impact is not yet clear. **Green - Strong and embedded partnership and governance arrangements are in place to support this patient group** •Dedicated forums or formal partnership structures exist and are regularly used to monitor safety, quality, and outcomes. •Governance responsibilities are clearly defined, understood, and integrated across relevant organisations. •There is robust evidence of collaborative planning and delivery with measurable improvements for the target population.	Amber - Some elements of partnership and governance are in place, but they are inconsistent, informal or still developing.
Reflecting on the Past Six Months: What progress has been made in strengthening your approach to partnership working? Please highlight any key achievements, as well as any ongoing challenges or barriers you have encountered.	*The 3 ICBs in Essex have a good strong partnership working and some governance with EPUT which in the last 6 months which has focused on the Assertive Outreach (AO) cohort. There are various governance and structures in place that oversee quality, safety and outcomes of this cohort. Overall there is joint actions with some system partners, but gaps remain in coordination and oversight.* *Local nuances* *SNEE: Development of partnership working with local charity Summit to improve engagement with the identified cohort as a development of work they already do to engage communities with health inequalities and deprivation. Overseen and supervised by EPUT. BCF and health inequalities monies used.* *Mid & South Essex (MSE): Through its local implementation group (AO -Action Plan Review group, aims to foster and establish continued working with EPUT driven by operational leads to ensure collaboration and partnership. Whilst this group is fully established, some key challenges have been denoted around consistency and frequency of the meetings with some cancellations due to current change process within organisations. As part of the MTP, AO has been anchored within this work which is identified as a key priority with system focus and embedding within the wider programme governance. initial engagement through clinical lead of identified engagement with Thurrock LA around identified work done for complex individuals to be considered as dovetailing within this cohort as positive practice.* *West Essex (WE): No formal governance in this area because there is no AO provision. There is CMHT provision and the governance that has oversight to this cohort will be the same provision CMHT recovering and wellbeing services. All services users that are in this cohort are identified and managed withing the CMHT protocols.* *Provider (EPUT) .Some examples of good partnership include:* *- The High intensity user group (HIUG) in each locality across Essex this is a mutli-agency forum using frequent flyers of emergency services.* *- There are formal system meetings such as MARAC/MAPPA, and EPUT has received positive feedback from these forums regarding positive engagement.* *- EPUT has a shared care record that allows some other organisations to access patient information.*	
Looking Ahead: What are your plans over the next six months to strengthen and improve partnership working? Please outline any planned initiatives, priorities, or changes in approach.	*EPUT are currently putting together a Costed Options Appraisal and will be presented to trust Board in due course flowed by presentation ICBs for consideration. This paper will focus on the lack of provision across the three ICBs and assess the risk of not achieving fidelity to the AOT model. A particular focus of the paper will be to improve governance in areas where it is currently lacking. Strengthening governance and quality assurance will be key to the group's work over the next six months to ensure ongoing reporting via the key governance workstreams of the three ICBs, as is current until it morphs into an Essex footprint.*	

Workforce

	RAG key	ICB self-assessment
To what extent does your ICB have effective systems in place to provide assurance of safe staffing for the care and treatment of this patient group? Consider: • Whether workforce plans account for the specific needs of this population. • Availability and uptake of appropriate training and competency development. • Recruitment and retention strategies relevant to staff working with this group. • Robust mechanisms for the ongoing monitoring and assurance of safe staffing levels, skills, and competencies.	"Red - There are significant gaps in assurance processes relating to staffing for this patient group • No clear workforce planning specific to the needs of this population. • Training and competency frameworks are absent or not aligned with service needs. • Recruitment and retention challenges are unaddressed. • No routine mechanisms to monitor or assure safe staffing levels or skills. Amber - Some systems are in place, but they are incomplete, inconsistently applied, or under development •Workforce planning partially considers this population but lacks detail or implementation. •Relevant training is available but not consistently accessed or mandated. •Some recruitment or retention activity is underway, but gaps remain. •Assurance processes exist but lack robustness or regular review. Green - Robust systems are in place and embedded to ensure safe and competent staffing for this patient group •Workforce plans clearly address the specific care needs of this population. •Staff receive appropriate training and demonstrate required competencies. •Effective recruitment and retention strategies are in place and monitored. •Safe staffing is regularly reviewed through established assurance processes."	Red - There are significant gaps in assurance processes relating to staffing for this patient group.
Reflecting on the Past Six Months: What progress has been made in supporting the workforce that provides care and treatment for this patient group? Please include an overview of your workforce plans, efforts to recruit peer support workers, and any challenges or barriers you are currently experiencing.	The Trust currently lacks effective systems to ensure safe staffing for this patient group due to the resourcing required for small caseloads. A significant challenge is the gap between national requirements for Assertive Outreach Services and the absence of specific funding in the 2025/26 operational plan. This funding shortfall presents a major barrier to establishing consistent, robust systems. As a result, there is no clear workforce planning tailored to this cohort, and the necessary training and competency frameworks are either absent or not aligned with the specialised care required.	
Looking Ahead: What actions are planned over the next six months to strengthen the skills, training, and competencies of staff supporting this patient group? Please outline any specific initiatives, development programmes, or strategic priorities.	Essex System partners are currently conducting a thorough review of our existing staff's competence and capacity against the fidelity requirements of evidence-based models. At present we understand that current staffing numbers are insufficient to meet the demand and intensity of care required by the cohort. Our review will detail the risks of operating at the current staffing level with no additional resources. The goal is to provide a clear and compelling case for the need for additional resources to ensure we can deliver a safe, sustainable, and effective service. This will address in the costed options appraisal.	

Community based care - access and oversight

	RAG key	ICB self-assessment
To what extent are local policies and governance arrangements in place to ensure equitable access and oversight of community-based care for individuals identified as needing intensive and assertive community treatment? Consider: • Whether local policies explicitly state that "Did Not Attend" (DNA) should not be used as a reason to discharge individuals. • The existence of governance arrangements that provide oversight and assurance of; referral pathways into services, effective identification of patients requiring intensive and assertive treatment, and transition processes between services.	**Red - There are no formal local policies or governance arrangements in place to support access to community services for individuals in this patient group** • DNAs may still result in discharge without consideration of vulnerability. • Referral pathways, systems to effectively identify patients in this cohort, and transitions are unclear or inconsistently applied. • No oversight or assurance mechanisms in place to monitor these processes. **Amber - Some policies and governance arrangements exist, but they are inconsistently applied, under development, or lack full alignment with best practice** • Policies discourage discharge after DNAs but are not fully embedded or monitored. • Pathways exist but may vary between services or lack transparency. • There are limited systems in place to effectively identify patients in this cohort. • Transition processes are present but lack consistency or clear accountability. • Limited or ad hoc governance arrangements exist to oversee these areas. **Green - Comprehensive, embedded, and routinely monitored policies and governance arrangements are in place to ensure access, support, and safe transitions for individuals in this patient group** • Clear policy prohibits DNA-based discharge for this group, with staff training and oversight in place. • Referral pathways are standardised, transparent, and equitable. • There are clear systems in place to effectively identify individuals who require intensive and assertive treatment. • Transition processes are well-defined and supported by joint working. • Governance structures provide effective oversight, assurance, and continuous improvement.	Amber - Some policies and governance arrangements exist, but they are inconsistently applied, under development, or lack full alignment with best practice.

Reflecting on the Past Six Months: What progress has been made in identifying individuals within this patient group, ensuring they have appropriate access to services, and maintaining oversight of their care? In addition, please describe how you monitor and assure that relevant policies are being effectively translated into practice for this cohort, including any barriers or challenges you are currently facing.	Initial identification of the cohort was completed manually in early this year. There is limited AO provision in Essex, with a small, separate service in Thurrock. EPUT has a policy that explicitly prohibits the use of DNA as a reason to discharge. The current policy states that after 2 DNAs the team must review the case and discuss with MDT and this applies to all patients including cohort. Local nuances: SNEE: Current DNA policy have been reviewed and assurance has been provided. Wider policy suite to be completed and reviewed. MSE: Initial work in identifying the current provision across Mid & South supported by the 4 locality operational leads conducted to clearly delineate the current provision and the numbers within scope of the identified patient group and service provision which identified limitation and sparsity within the ICB. Continued engagement and understanding of the implementation around the providers policy and its application WE: Discussions are in early stages to review current policies, these are reflective of practice across other areas in Essex and NHSE guidance. Identification of the cohort has been completed. Governance pathway in west Essex for assurance of review of services is via the MH Expert Oversight Group and mandated on agenda for discussion and agreement.
Looking Ahead: What steps do you plan to take over the next six months to improve the identification of individuals in this cohort, strengthen oversight of their care, and enhance their access to appropriate services?	There are no automated systems to identify this cohort, which introduces a risk if we continue to operate manually. We will be looking at whether our Electronic Patient Record (EPR) systems can support this function.

Key working arrangements and caseload management		
	RAG key	**ICB self-assessment**
To what extent are local governance structures in place to provide assurance that all individuals in this cohort have an allocated key worker, and that caseloads are appropriate to provide the level support needed for individuals requiring intensive and assertive engagement? Consider: • Whether there are systems in place to monitor and ensure key worker allocation for every individual in scope. • Whether local governance structures provide oversight of caseload size and complexity. • The extent to which caseloads enable key workers to deliver proactive, personalised, and sustained engagement.	**Red – We have no oversight or monitoring mechanisms in place to ensure key worker allocation or to monitor caseload appropriateness** • Many individuals in the cohort may not have an identified key worker. • Caseloads are unmanaged or exceed safe levels, limiting the ability to provide intensive support. **Amber – There is some oversight in place, but we are not able to fully monitor key worker allocation or caseload appropriateness** • Most individuals have a key worker, but allocation is not routinely tracked or assured. • Caseload sizes are monitored in some areas, but data is incomplete or actions are not always taken. **Green - Robust and embedded oversight and monitoring systems are in place, providing clear oversight and assurance of key worker allocation and caseload management** • All individuals in the cohort have a named key worker. • Caseloads are regularly reviewed to ensure they are manageable and allow for assertive, personalised engagement.	Red – We have no oversight or monitoring mechanisms in place to ensure key worker allocation or to monitor caseload appropriateness
Reflecting on the Past Six Months: Please describe how you monitor and maintain oversight of key worker allocation and caseload management. Include any challenges or barriers you have encountered in ensuring appropriate staffing and workload balance.	The Trust identified over 600 people in this cohort across Mid Essex, WE & SNEE. There are quality assurance groups in place that monitor key worker allocation for this cohort. However we are unable to assure the extent to which caseloads enable key workers to deliver proactive, personalised, and sustained engagement. The average caseload size is 30, which is double the NHSE recommendation and triple the fidelity size, significantly hindering the ability of key workers to deliver proactive, personalised, and sustained engagement to individuals requiring intensive support. The ICB are aware that changes to Essex County Council contract with EPUT (Sec75) may potentially impact on staff model and potentially increase demand on staffing model.	
Looking Ahead: What actions are planned over the next six months to improve oversight of key worker assignment and caseload management for this cohort? Please include any planned changes to processes, use of data or digital tools, or workforce development initiatives aimed at ensuring effective and equitable support.	We have recognised the need to improve our capacity for monitoring and allocation processes. To address this, the Trust are compiling an options appraisal paper that will tackle the lack of provision across the three ICBs and provide insight to the boards regarding the risks of not operating according to evidence-based models. Organisational oversight will be provided through the community first governance, which reports to our boards, ICBs and executive to ensure appropriate oversight	

Out of hours provision		
	RAG key	**ICB self-assessment**
To what extent are local arrangements in place to support effective multi-agency coordination outside of core hours for individuals in this cohort? Consider: • Whether there are established pathways or protocols for coordination between key agencies (e.g. police, crisis services, social care, ambulance services) outside of 9–5 working hours. • The clarity of roles, responsibilities, and escalation routes during evenings, weekends, and public holidays. • The extent to which these arrangements are used in practice to support timely, safe, and appropriate responses.	**Red - There are no formal arrangements in place for multi-agency coordination outside of core hours** • Agencies operate in isolation during evenings, weekends, and public holidays. • There are no agreed pathways, protocols, or escalation procedures in place. • Responses are reactive and inconsistent, and there is no specific out-of-hours provision in place for this group. **Amber - Some arrangements exist, but they are inconsistently applied, informal, or lack full system engagement** • Certain agencies coordinate out-of-hours, but this is reliant on individual relationships or ad hoc solutions. • Pathways and escalation routes are partially defined but not consistently used. • There is access to a crisis line for individuals who require out-of-hours provision. **Green - Clear, formalised, and embedded arrangements are in place to enable effective multi-agency coordination outside of core hours** • All relevant partners (e.g. police, crisis services, social care, ambulance) are engaged in agreed protocols • Roles, responsibilities, and escalation procedures are clearly defined and routinely used • There is a full 24 hour access to support for individuals who require out-of-hours provision	Red - There are no formal arrangements in place for multi-agency coordination outside of core hours
Reflecting on the Past Six Months: Please provide an overview of the out-of-hours provision currently in place for this cohort. Include any challenges or barriers you have encountered in delivering consistent and effective support outside of core service hours.	The existing local arrangements can manage general patient deterioration but are not equipped for the intensive needs of this specific cohort. Currently, there are no services operating in isolation for this group during evenings, weekends, and public holidays. In addition, we lack agreed-upon pathways, protocols, or escalation procedures. This often leads to the inappropriate use of other services, such as the Home Treatment Team or hospital admissions. There is also a lack of enhanced support from a patient's existing care team, particularly during out-of-hours and weekends. We recognise that due to system pressures, this cohort is not prioritised because they are less likely to present at emergency care touchpoints.	
Looking Ahead: What specific actions are planned over the next six months to strengthen out-of-hours support for individuals within this patient group? Please include any proposed service developments, workforce initiatives, or partnership approaches aimed at improving access and continuity of care outside standard operating hours.	This current issue cannot be mitigated without additional resource. This is not the only high-risk cohort being supported by MH services.	

Care delivery		
	RAG key	**ICB self-assessment**
To what extent is there appropriate oversight in place to ensure that individuals in this cohort have a care plan, and that their clinical, social, and psychological needs are effectively assessed and addressed? Consider: • The extent to which care plans are co-produced, person-centred, and regularly reviewed. • Whether oversight mechanisms ensure that care planning includes a comprehensive assessment of clinical, social, and psychological needs. • Evidence of multidisciplinary involvement and coordinated action to meet identified needs. • There is joint discharge planning arrangements in place between inpatient and community teams to support transitions in care.	**Red - There is no consistent oversight to ensure that individuals in this cohort have care plans or that their needs are comprehensively assessed** • Care plans are often missing, incomplete, or outdated. • Assessments of clinical, social, and psychological needs are not routinely undertaken. • No formal governance structures or quality assurance mechanisms are in place to monitor care planning or needs assessment. • Joint discharge planning arrangements are not in place between inpatient and community teams following a period of hospital admission. **Amber - Some oversight mechanisms exist, but they are inconsistently applied or not fully embedded across services** • Most individuals have care plans, but quality and consistency vary. • Holistic needs assessments are undertaken in some cases but not systematically or across all domains. • Oversight processes are present but lack regular review or do not drive improvement. • There is some evidence of joint discharge planning arrangements between inpatient and community teams but these are not formalised or regularly monitored. **Green - Robust and embedded oversight arrangements are in place to ensure care plans are in place and holistic needs are assessed and addressed** • All individuals in the cohort have co-produced, care plans that are regularly reviewed. • Clinical, social, and psychological needs are systematically assessed and reflected in care planning. • Strong governance mechanisms ensure quality assurance and continuous improvement across the system. • There is clear joint discharge planning arrangements in place between inpatient and community teams following a period of hospital admission.	Red - There is no consistent oversight to ensure that individuals in this cohort have care plans or that their needs are comprehensively assessed
Reflecting on the Past Six Months: Please provide details on how you maintain oversight of care plans and assessments for individuals within this patient group. In particular, describe how concerns or red flags are identified, how responsive actions are coordinated across services, and any barriers you have encountered in ensuring timely and effective intervention.	We ensured that all individuals identified in this cohort had risk plans and care plans in place. However, we were unable to confirm that all of their needs are being met. Local nuances: NEE: There is appropriate oversight in place to ensure individuals in the AOT cohort have care plans that are regularly reviewed and reflect their clinical, social, and psychological needs. In general terms care plans are co-produced with service users and developed through multidisciplinary input, supporting person-centred and coordinated care, however this is not possible for the AOT cohort given current case-load sizes. The ICB recognises that further assurance is needed however this is in the context of the outstanding options paper and the lack of resource to achieve fidelity to the model.	
Looking Ahead: What specific actions are planned over the next six months to enhance oversight of the care provided to individuals within this patient cohort? Please include any initiatives aimed at improving monitoring, quality assurance, or inter-service coordination.	We will develop a framework with flexibility to meet the needs of this cohort, however the lack of resources limit this development.	

Information sharing		
	RAG key	**ICB self-assessment**
To what extent are clear and effective information sharing protocols in place between relevant partner organisations and agencies to support safe, coordinated care for this cohort? Consider: • Whether formal information sharing agreements or protocols exist and are aligned with legal and professional standards. • The consistency and timeliness of information sharing across health, social care, police, education, and voluntary sector partners. • Whether staff are aware of and trained in appropriate information governance practices. • Evidence of information sharing supporting joint decision-making, risk management, and continuity of care.	**Red - There are no formal information sharing protocols in place, or existing protocols are not used in practice** • Significant barriers to information flow between agencies. • Staff are unclear on when and how to share information appropriately. • Lack of information sharing impacts coordination, safety, and continuity of care. **Amber - Some protocols or agreements exist, but they are inconsistently applied or not embedded across all partners** • Information is shared in some cases, but processes may be informal, fragmented, or delayed. • Staff awareness and training on information governance is variable. • Systems do not reliably support timely or secure information exchange across sectors. **Green - Clear, formalised, and consistently applied information sharing protocols are in place across all relevant partner organisations** • Information sharing arrangements are aligned with legal and professional standards. • Staff are trained and confident in using them appropriately. • Systems support timely, secure, and purposeful information flow to enable coordinated care, joint risk management, and continuity across services.	Amber - Some protocols or agreements exist, but they are inconsistently applied or not embedded across all partners.
Reflecting on the past six months: Please outline the progress you have made in developing information sharing protocols and agreements, and/or describe any barriers you have encountered in implementing them.	There is a well-established formal information sharing protocols through MAPPA and MARAC. However there are known gaps with GPs and other organisations specific to this cohort.	
Looking ahead: What specific actions are planned over the next six months to enhance multi-agency information sharing and collaboration?	Without the resource to support information sharing process we are limited to review on a by case basis.	

Family and carer involvement		
	RAG key	**ICB self-assessment**

To what extent are there governance arrangements and processes in place to monitor, respond to, and act on feedback from families and carers of individuals in this cohort? Consider: • Whether the ICB is aware of, and has oversight of, local mechanisms for collecting and monitoring family and carer feedback. • Whether there are clear processes in place at provider and/or system level to respond to feedback and make improvements. • How feedback from families and carers informs service development, quality assurance, and personalised care planning. • Evidence of regular engagement with families and carers in shaping services.	**Red - There are no formal mechanisms in place to gather, monitor, or respond to family and carer feedback** • The ICB has limited or no awareness of local processes for involving families or carers. • Feedback is not routinely collected or used to inform care or service improvement. • Families and carers report feeling excluded or unheard. **Amber - Some arrangements exist, but they are inconsistently applied, informal, or lack clear governance** • The ICB is aware of some local processes but does not have consistent oversight. • Feedback mechanisms are present but may be limited in reach or impact. • Responses to feedback are variable, and changes made are not always communicated or evidenced. **Green - Clear, embedded arrangements and processes are in place to routinely capture and respond to family and carer feedback** • The ICB has full oversight of local processes and ensures feedback is used to inform service development and care planning. • Families and carers are regularly engaged, and their input is valued and acted upon. • There is evidence of feedback driving measurable service improvement, with clear communication back to families and carers.	Red - There are no formal mechanisms in place to gather, monitor, or respond to family and carer feedback
Reflecting on the last six months: Please outline the progress made in improving your approach to involving families and carers in the care of this patient group. Your response should include how staff respond to concerns raised by families, the mechanisms in place to support meaningful engagement, and any current barriers to effective involvement.	There no formal procedures to monitor contact with family/carers in this identified cohort, however in general EPUT has established procedures and platforms to gather feedback. This includes the use of the Patient Advice and Liaison Service (PALS) and a dedicated patient feedback platform like iWantGreatCare. We also actively seek the perspectives of families and caregivers at various opportunities to gain a more complete understanding of an individual's needs and experiences. SNEE & MSE : There is no specific mechanisms for collecting feedback for those under the AO cohort, although there are mechanisms that currently provide feedback from patients. While these mechanisms inform service development, quality assurance, and personalised care planning, there is a recognised gap in targeted feedback for AO, which will need to be addressed through co-production. WE: Service leads and ICB meet monthly to discuss and review current service, including service measures and integration with community services	
Looking ahead: What specific actions are planned over the next six months to strengthen the involvement of families and carers in care planning, service reviews, and service design?	To address gaps in the current service position, EPUT and ICB leads have agreed to compile an options appraisal paper. This paper will focus on the lack of provision across the three ICBs and assess the implications of not adhering to evidence-based models. In addition, with the high caseloads clinician hold they are unable to deliver at fidelity without resource.	

Demonstrating impact

	RAG key	ICB self-assessment
To what extent are processes in place to measure, monitor, and demonstrate the effectiveness and impact of local services supporting this cohort? Consider: • Whether the ICB is aware of and has oversight of performance indicators, outcome measures, and quality metrics for relevant services. • The extent to which data is regularly collected, analysed, and used to inform service improvements. • How impact measurement incorporates patient outcomes, experience, and system-wide benefits. • How lived experience helps inform service design and delivery. • Whether there is transparency and accountability in reporting service effectiveness.	**Red - There are no formal processes to measure or monitor the effectiveness of local services** • The ICB lacks awareness of any outcome measures or performance data. • Data collection is absent or inconsistent, with no systematic analysis. • Service design and delivery is not co-produced with people with lived experience. • Service impact is not evaluated, limiting opportunities for improvement or accountability. **Amber - Some processes exist but are inconsistent, incomplete, or lack full integration across services** • The ICB has partial oversight of some performance indicators or outcome measures. • Data is collected irregularly or not routinely analysed to inform decisions. • There is limited input from people with lived experience to support the design and delivery of services. • Impact measurement focuses on limited aspects and does not fully incorporate patient outcomes or experience. **Green - Comprehensive and embedded processes are in place to systematically measure, monitor, and demonstrate service effectiveness** • The ICB has full oversight of relevant metrics, including PROMs and family specific outcome measures. • Data is regularly collected, analysed, and used to drive continuous service improvement. • Services are co-designed with people with lived experience. • Reporting is transparent, and findings inform commissioning and accountability frameworks.	Red - There are no formal processes to measure or monitor the effectiveness of local services
Reflecting on the last six months: Please describe the improvements made in monitoring service quality and tracking outcomes for this patient group, including any challenges or barriers faced.	There is no performance data specific to this cohort and ICBs are limited to wider CMHT performance data. There are no agreed impact metrics specific to this group other than the metrics within the current contract which does include patient experience, safety data and other quality metrics. There are measured relating to AO fidelity which can be applied however in the absence of fidelity, this cannot be achieved currently.	
Looking ahead: What actions are planned to evaluate and gain deeper insight into the impact of services on this patient group?	We aim to develop formal key metric to measure key indicators but this will be determined once the system agree on operating model, subject to the options appraisal. The lived experience charter principals will guide us and support the service redesign and delivery.	

Closing questions

Thank you for taking the time to support this review. Please return the completed template to your regional NHSE team.

Are there any particular are of best practice you can share?	*The use of BCF and Health Inequalities monies in NEE to commission an EPUT adjacent outreach service (not AOT) shows promise as a potential way to augment a fidelitous Trust model. EPUT have provided an open and committed approach to the achievement of an AOT model, in the context of lack of resource.*
What additional support is required from NHSE to meet the needs of the individuals in scope?	*The Personalised Care Framework doe not reference caseload sies for this cohort or fidelity to a model; we would welcome alignment and clarity. KPIs should be standardised nationally and linked to fidelity markers in order to reduce variation. We would welcome examples of how the model has been delivered in the absence of additional monies. Workforce training is likely to represent significant investment; we would welcome examples of how this has been achieved elsewhere. We would welcome early commitment to resources to achieve the aim of improving public safety and improved care for this cohort and their families. ICB oversight represents an additional layer of bureaucracy for Trusts in the development process and given pending changes, we would welcome a review of governance.*

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Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	ICB Board				Meeting Date:	26/09/2025	
Report Title:	Frailty Emergency Admissions and Substitution Effect				Agenda Item:	9.	
Report Author(s):	Dr Sam Williamson, Associate Medical Director, HWE ICB Charlotte Mullins, Associate Director, HWE ICB Del Ford, Senior Head of PHM, HWE ICB Dr Bashak Onal, PHM Programme Manager, HWE ICB						
Report Presented by:	Dr Sam Williamson						
Report Signed off by:	Dr Jane Halpin						
Purpose:	Approval / Decision	☐	Assurance	☐	Discussion	☒	Information ☐
Which Strategic Objectives are relevant to this report [Please list]	■ Improve UEC through anticipatory and same day emergency care						
Key questions for the ICB Board / Committee:	■ The Board is kindly requested to ○ discuss and agree next steps for managing substitution through dedicated system wide transformation programme ○ identify analysts in provider organisations who can work with ICB to further identify target groups						
Report History:	■ Early oversight by Dr Jane Halpin						
Executive Summary:	The ICS has taken a whole system approach to frailty management to support the Medium-Term Priority ambition: "Improve UEC through anticipatory and same day emergency care". The attached paper provides additional analysis on frailty emergency admissions and substitution effect along with recommendations.						

Recommendations:	■ Recommended actions to reduce growth in non-frail admissions should include targeted activities including proactive care, urgent community response and hospital-based interventions. ■ These offer significant opportunity to improve outcomes for patients as well as pressures on acute hospitals and system finances and should be implemented by providers, adopting a similar whole systems approach.			
Potential Conflicts of Interest:	*Indirect*	☐	*Non-Financial Professional*	☐
	Financial	☐	*Non-Financial Personal*	☐
	None identified			☒
	N/A			
Implications / Impact:				
Patient Safety:				
Risk: *Link to Risk Register*				
Financial Implications:				
Impact Assessments: *(Completed and attached)*	*Equality Impact Assessment:*	N/A		
	Quality Impact Assessment:	N/A		
	Data Protection Impact Assessment:	N/A		

Frailty Emergency Admissions and Substitution Effect

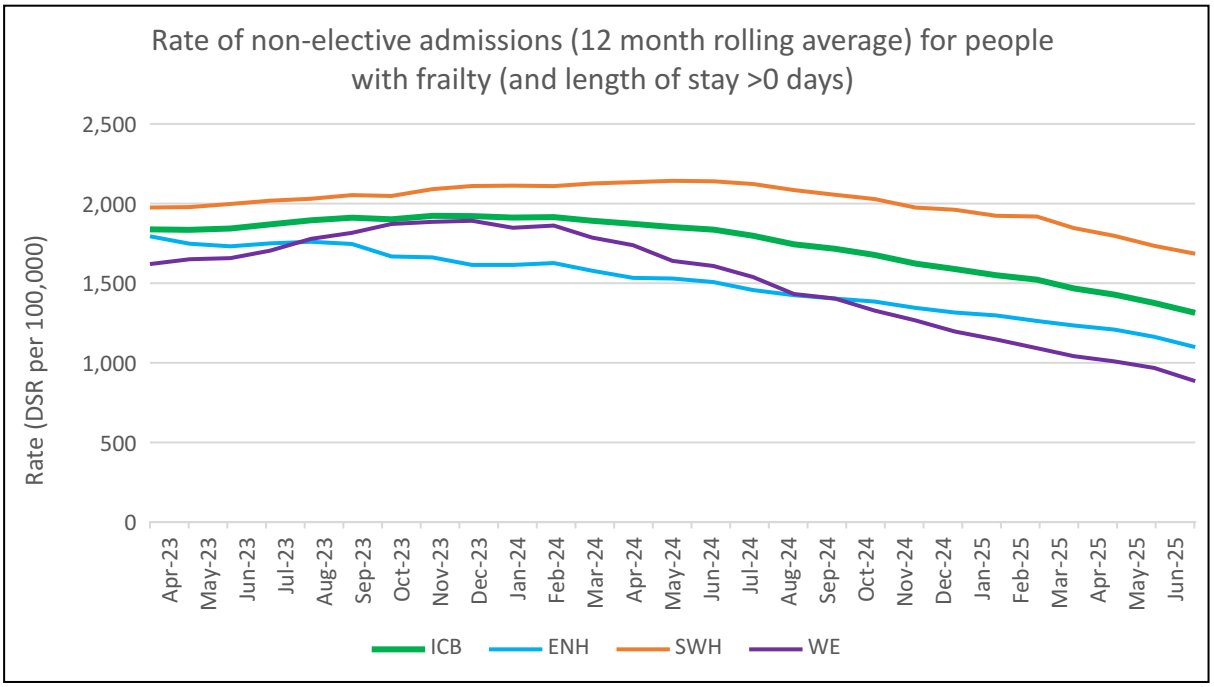
Report author	Sam Williamson, Charlotte Mullins, Del Ford, Bashak Onal
Date	15/09/2025

Key messages

- This report provides additional analysis on frailty emergency admissions and substitution effect.
- The observed trend in frailty admissions continues, with the rate of emergency admissions in people with a diagnosis of frailty currently down one third compared to 2023 and expected to continue declining.
- Despite this improvement, system pressures remain high, with inpatient capacity being used for admissions in non-frail patients, including long term conditions that are potentially amenable to proactive care or community based urgent response.
- Recommended actions to reduce growth in non-frail admissions should be implemented by providers, adopting a similar whole systems approach.

Emergency admissions for people with Frailty

Additional data to July ’25, with increased practice coverage, show continued reduction in the rate and total number of emergency admissions for people with frailty. The rate (directly standardised rate per 100,000, 12-month rolling average) has reduced by 32% between the peak in November 2023 (1,922) and June 2025 (1,314).



Note: A 12-month rolling average reflects combined activity over the last year and therefore does not represent the rate in the most recent month.

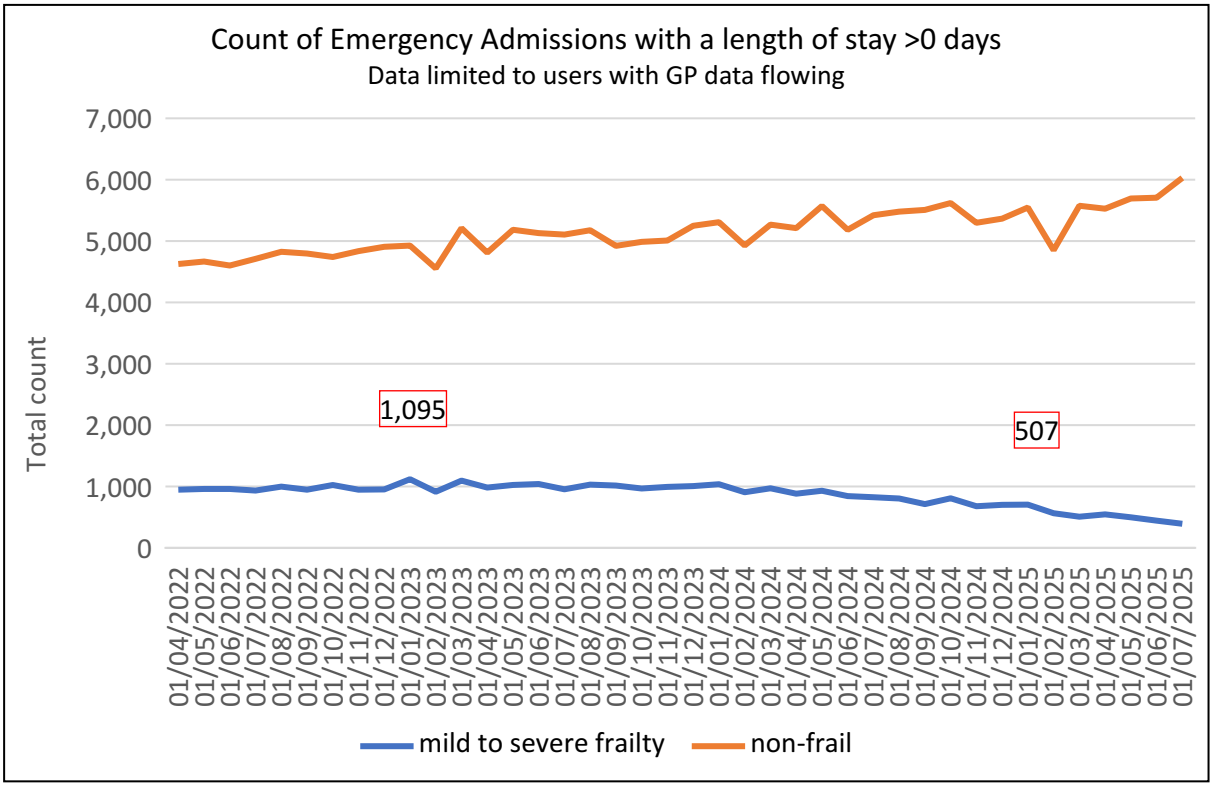
The total monthly emergency admissions in people with frailty has reduced by 57%, compared to the same month in ’23. In June 2025 there were 443 emergency admissions in people with frailty, compared to 1040 in June 2023. The trend is observed across all geographic Places, and all frailty cohorts. The greatest reduction has been observed in WE (78%) and in the severe frailty cohort (64%). ICB analysis has been corroborated through collaborative working with Trust teams and triangulation with the national team.

Conclusions and recommendations

- The ICS whole system approach is demonstrating significant impact on the Medium-Term Plan priority to reduce demand for non-elective inpatient care amongst our frail population. This is through improved diagnosis, proactive care and maximising alternative community responses to urgent needs.
- The ICB should continue to fund practices, through the Enhanced Commissioning Framework, to accurately identify and stage frailty and end of life, as well as deliver core care processes in general practice.
- Neighbourhood teams should continue to focus on proactive identification of complex cases for care coordination, using ICB resources such as the INT Implementation Guide, Population Health Management risk stratification tools, and the frailty interventions dashboard (restricted access). This structural shift will be supported by involvement in the National Neighbourhood Implementation Programme.

Substitution effect

The net impact on inpatient activity is so far negligible, as reductions in emergency admissions for people with frailty are being substituted by admissions in non-frail adults. SHREWD reporting shows that system pressures remain high with bed occupancy over 90%; OPEL status consistently at 3 or more across acute sites; surge capacity being used through summer months; and 463 hours of ambulance crews lost to handover delays last month.



Local data show a 22% increase in total emergency admissions in non-frail adults where the length of stay is >0 days in the first four months of 25/26 compared to 22/23. This is confirmed by the national team, with benchmarking analysis showing an 8% growth in admission in people aged 65 years and over (significantly below the national average), whilst there has been a 22% increase among people aged under 65 years. This is a pattern consistent with the substitution effect.

Using population segmentation, growth in non-frail activity in adults is primarily driven by people in segments 3 (Lower Complexity) and 4 (Advanced Disease & Complexity). Whilst patients in these segments have urgent care needs, prior to frailty admissions reducing patients, cases were being managed in the community and increases in admissions cannot be fully attributed to demographic and disease prevalence growth alone. This substituted activity represents care that was either not previously requiring inpatient admission; a result of operational practices and cultural norms that favour admission, utilising available capacity in hospitals; or because of fragmentation within the system that makes referral and transfer to alternative providers the harder option for clinical teams.

Therefore, this represents an opportunity to maximise proactive care and make best use of urgent community pathways. Thematic analysis of this substituted activity in non-frail adults shows significant growth in the following areas:

- Circulatory disease: coronary heart disease, heart failure, arrythmias, stroke, hypotension
- Digestive system: appendicitis, pancreatitis, gall bladder disease, melaena
- Genitourinary: renal failure, CKD stage 5, kidney stones
- MSK and injuries: osteomyelitis, pain in joints, soft tissue disorders, fractured femur
- Diabetes & endocrine: hyper- and hypokalaemia, diabetes mellitus.
- Additional areas in non-frail adults aged 65+: constipation, peripheral vascular disease

Whilst many of these admissions are potentially avoidable through proactive care and urgent community care alternatives to admission (e.g. CHD, heart failure, renal failure), there are conditions that continue to require urgent inpatient treatment (e.g. pancreatitis, fractured neck of femur).

Conclusions and recommendations

- Growth in substituted admissions in non-frail adults include a range of conditions that are preventable through proactive management or can be managed in the community through virtual hospitals and urgent community response.
- Actions to manage non-frail admissions by providers should be managed by the ICB as a dedicated system wide transformation programme.
- Acute Trusts should implement operational processes to manage non-frail patients being considered for admission to identify patients suitable for community based care
    - Early clinical review in the emergency department
    - Operational review of patients with a Decision to Admit.
- Acute hospitals should work with providers of community services including VH to complete an audit of non-frail admissions. This audit should assess non-frail patients who were admitted and identify cases where there was potential opportunity for community-based management as an alternative to inpatient care. Learning from this audit should be used to support initiatives to identify and refer relevant patients to community pathways.
- Improve awareness of clinical capabilities and capacity of virtual hospital and community-based services ensuring secondary care teams can identify appropriate cases for referral.
- Virtual hospitals (VH) and community care services should embed staff in the Emergency department to actively identify patients and transfer care to community settings.
- Urgent Community Care Hubs/Care Coordination Centre and ambulance teams should identify people with urgent care needs who can be suitably transferred to virtual hospital and community providers for ongoing management. E.g. stack, call before convey etc.
- Improve and develop proactive models of care:
    - The ICB should continue to fund practices, through the Enhanced Commissioning Framework, to accurately identify and stage key long term conditions (including COPD, hypertension, heart failure, chronic kidney disease and diabetes) as well as deliver core care processes in general practice.
    - Integrated community services should continue to proactively identify and manage complex patients with long term conditions to optimise treatment and reduce risk of emergency admission to support delivery of the Care Closer to Home strategy. For example, integrated respiratory service, integrated heart failure service, integrated diabetes service.

With thanks to the Population Health Management and Business Intelligence team in the ICB as well as analysts in acute providers who supported with analysis and investigations.

Meeting:	*Meeting in public*	☐	*Meeting in private (confidential)*	X☐
	HWE ICB Board	Meeting Date:	26th September 2026	
Report Title:	HWE ICS Winter Plan	Agenda Item:	10.	
Report Author(s):	Jo Burlingham Deputy Director of Operations, HWE ICB			
Report Presented by:	Jo Burlingham Deputy Director of Operations, HWE ICB			
Report Signed off by:	Frances Shattock, Director of Performance, HWE ICB			
Purpose:	Approval / Decision ☐	Assurance ☐	Discussion ☐	Information X☐
Which Strategic Objectives are relevant to this report	• Increase healthy life expectancy and reduce inequality. • Improve access to health and care services.			
Key questions for the ICB Board / Committee:	• Is the Herts and West Essex (HWE) Integrated Care Board (ICB) assured of the system plans being put into place over winter? • Is the HWE Board assured that the HWE ICS (Integrated Care System) Winter Plan has been stress-tested by the system and actions from the exercise have been embedded into the plan?			
Report History:	• Not presented before			
Executive Summary:	The presentation outlines: • NHSE Expectations for Winter • HWE ICB's approach to planning and managing Winter 2025/26 • Learning from last Winter and Critical Incidents and the scale of the Challenge • Actions being actions taken by the ICB and wider system partners to mitigate system pressures for winter 2025/26 • Operational Responses and Escalation Measures to be Deployed During Peak Periods of Demand • System Coordination Centre Functions Supporting Winter 2025-26 • ICS Transformation Programmes for Winter 2025/26 • Health and Care Partnership and Provider Plans to support Winter 2025/26 • Stress Testing of the HWE ICS Winter Plan • HWE ICB Board Assurance Statement and NHSE Winter Plan Checklist 2025/26			

Recommendations:	• To note the actions being put into place across the system for Winter 2025/26 • To approve the HWE ICS Winter Plan for 2025/26 • To note that the HWE ICS Winter Plan 2025/26 has been stress-tested by the system and actions from Exercise Aegis have been embedded into the plan • To note and approve the HWE ICB Board Assurance Statement (slide 78) • To note and approve the HWE ICS assurance against the requirements in the NHSE Winter Plan Checklist 2025/26 (slide 79)			
Potential Conflicts of Interest:	*Indirect*	☐	*Non-Financial Professional*	☐
	Financial	☐	*Non-Financial Personal*	☐
	None identified			☐
	None			
Implications / Impact:				
Patient Safety:	These proposals support improvement in patient safety and mitigate risks to patient safety throughout the Winter Period (1st November 2025 to 31st March 2026).			
Risk: *Link to Risk Register*	Links to all open risks in the Operations tab of Datix relating to SCC and EPRR			
Financial Implications:	NIL			
Patient or public engagement or consultation:	N/A			
Impact Assessments: *(Completed and attached)* *Please detail key impacts the Board/Committee should note:*	*Equality Impact Assessment:*	Yes – available on request as large file. Key Impacts: Mitigated		
	Quality Impact Assessment:	Yes – available on request as large file.		
	Data Protection Impact Assessment:	NO Key Impacts:		

Hertfordshire and West Essex Integrated Care System

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HWE ICS
FINAL **Winter Plan 2025/26**
v1.6

Working together
for a healthier future

Slides	HWE Winter Plan Contents
3- 19	• Introduction to Planning and Managing Winter 2025/26 for the Herts and West Essex (HWE) Integrated Care System (ICS) • NHSE Expectations for Winter – UEC Plan 25/26 • Winter Planning 2025/26 – HWE ICS Timeline • Understanding Urgent and Emergency Care Need in our System for Winter • Implementation of our HWE UEC Strategy over Winter • Winter Performance 2022/23 Vs Present – Scale of the Challenge • Learning from last Winter and Critical Incidents
21 - 29	• HWE ICS In-Winter Operational Responses and Escalation Measures to be Deployed During Peak Periods of Demand • System Coordination Centre Functions Supporting Winter 2025-26
30 - 44	• ICS Transformation Programmes for Winter: Integrated UEC, Frailty and Community services 24/25 • Demand Management - Alternatives to Hospital Attendance/ Admission • Unscheduled Care Coordination Hub and Roadmap • Focus on 25% Reduction in Hospital Admissions for Frail Older People • Proactive Care and Care Closer to Home (CCTH) • High-impact interventions for Children and Young People this Winter • Focused Infection Prevention and Control Support for HWE Winter 2025/26 • Approved ICS UEC Priority Allocations for Winter 2025/26 • Winter Communications and System Wide Vaccination Programme for Winter 2025/26
45 - 48	• South West Herts Health and Care Partnership (Place) Winter Plan 2025/26
49 - 51	• West Herts Health and Care Partnership (Place) Winter Plan 2025/26
52 - 53	• East and North Herts Health and Care Partnership (Place) Winter Plan 2025/26
54 - 73	• High Level Provider Plans to support Winter 2025/26
74 - 76	• Stress Testing of HWE ICS Winter Plan -Exercise Aegis 4th September 2025
77 - 80	• HWE ICB Board Assurance Statement and NHSE Winter Plan Checklist 2025/26

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Introduction to Planning and Managing Winter 2025/26 for the Herts and West Essex (HWE) Integrated Care System (ICS)

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NHSE UEC Plan 2025/26

Staff Wellbeing

- ✓ Improve vaccination rates.
- ✓ Improve flu vaccinate uptake via a designated plan (by the end of Q1).

System Partnership

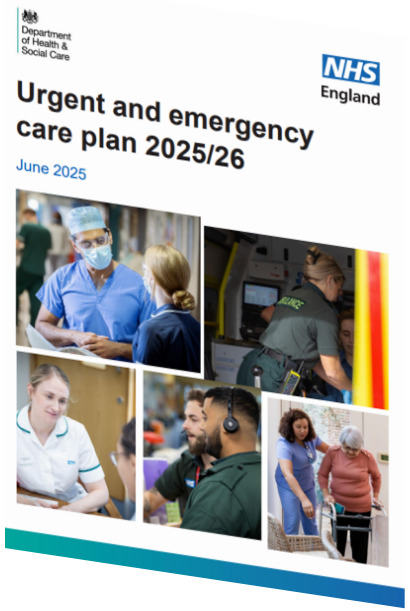
- ✓ Increase the number of patients receiving care in primary, community and mental health settings.
- ✓ Meet the 45-minute maximum handover standard

Leadership

- ✓ Maximise visible Leadership and location of leaders.

Digital

- ✓ Access summary care records by the end of 2025/2026.
- ✓ Use NHS federated data platform (rolled out 86% of Acute Trusts by end of 2026).



Supporting Patient Flow

- ✓ Improve flow through hospital with a particular focus on patients waiting over 12 hours and eliminate corridor care.
- ✓ Direct less urgent cases to Same Day Emergency Care (SDEC).
- ✓ Optimise the use of urgent treatment centres.
- ✓ Utilise alternative care pathways such as neighbourhood multidisciplinary teams.
- ✓ Utilise Call before you Convey (CB4YC) schemes.
- ✓ Improve access to mental health teams.

Hertfordshire and West Essex Integrated Care System

Winter Planning 2025/26 – HWE ICS Timeline

Present proposal at the HWE ICS Operational Planning Group for Seasonal Pressures

SCC to collate review responses and develop a draft winter plan

Submission of draft plan to HWE ICB UEC Board

Final plan for board sign off, including WINTER PLAN - BOARD ASSURANCE STATEMENTS

June 2025 | 4th July | 18th July | 5th August 2025 | 12th August | 4th September 2025 | 31st September 2025 | 7th October 2025 | 1st November 2025 – March 2026

Winter Template sent to system partners to complete by 18th July

Submission of draft plan to NHSE

Test and exercise plan at the local system winter workshop

NHSE Check and Challenge Session

GO LIVE

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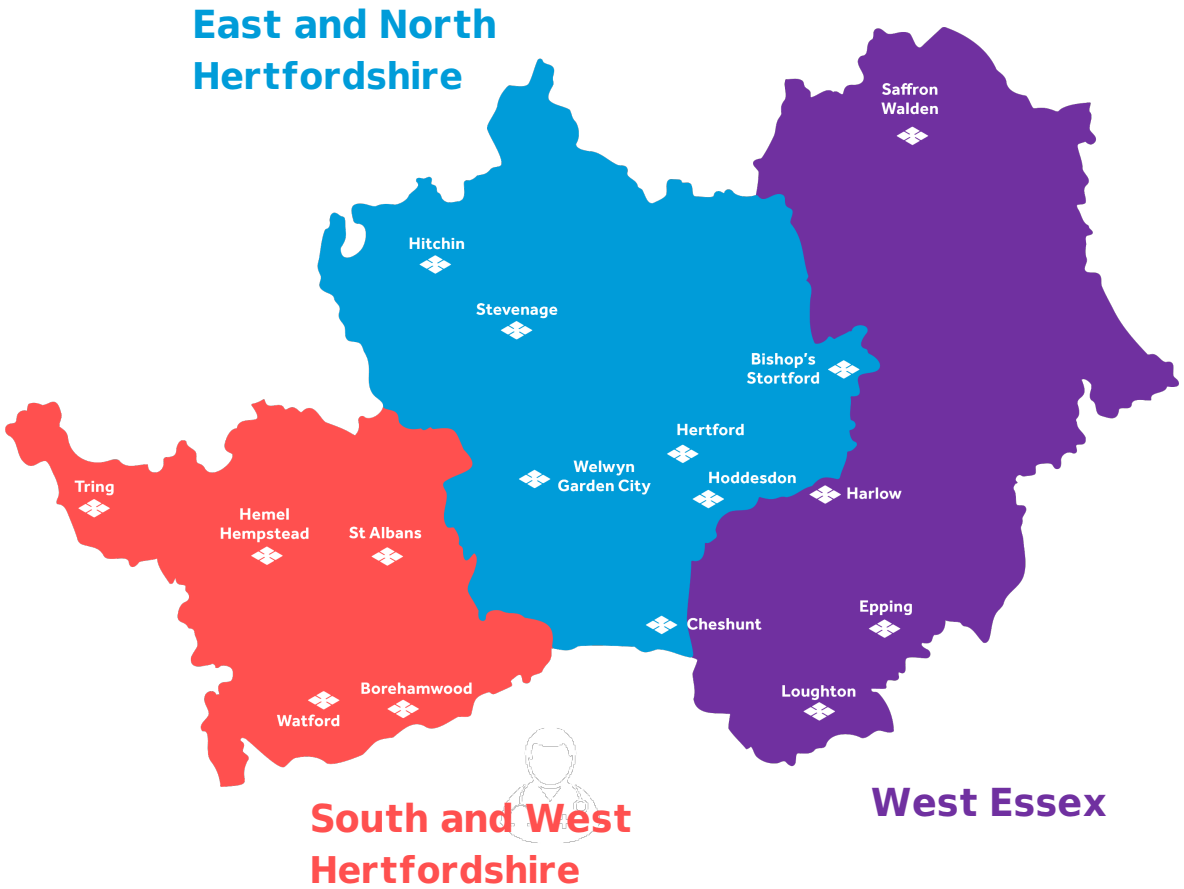

1.6 million people

1 Integrated Care Board
1 Integrated Care Partnership
4 Health and Care Partnerships
Including a Mental Health, Learning Disability and Neurodiversity HCP

1 Voluntary, Community, Faith & Social Enterprise Alliance, representing thousands of local organisations

2 county councils and 13 district/borough councils

4 mental health and community providers

3 acute hospital providers

130 GP practices in 35 Primary Care Networks

276 community pharmacies

225 opticians

243 dental practices

Hertfordshire and West Essex Integrated Care System

Understanding our Populations' Urgent and Emergency Care Needs over the Coming Winter

- Ageing population and increasing multi-morbidity, over 100,000 people are living with frailty.
- People aged over 65 years are at greatest risk of living with frailty and requiring urgent and emergency care.
- Frail older people are most likely to suffer risks of an acute hospital admission – decompensation, delirium, and other harms.

- Children and young people account for over a quarter of ED attendances*
- Children are the most likely age group to attend EDs when they could be managed more effectively in alternative settings

- Many of the longest waiting ED patients have mental health problems.
- Higher proportion of mental health attendances at Watford General Hospital than national average.
- Mental health clinical deep dives demonstrated fragmentation of the system (lack of join up between psychiatry, drug and alcohol teams, social services and primary care.

*with higher than national year-on-year growth in CYP ED attendances at Lister and Watford General.

Clear cohorts to focus on over Winter 2025/26

Focus on children and young people, mental health crisis response, and frailty and end-of-life care.

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Implementation of our HWE UEC Strategy over Winter 2025/26

- Coordination of the system to utilise all available capacity both flexibly and responsively
- Foster a positive culture with an understanding of clinical risk across providers with dynamic, collective decision-making to mitigate this.
- Prevention and targeted proactive, personalised care to specific populations backed by population health management
- Move care away from emergency admissions, crisis response, exacerbations, and ill-health.
- Ensure a coherent, streamlined, accessible and convenient same day urgent care system so people can easily and rapidly access the right care, in the right place, first time.
- Continued improvement of effectiveness and efficiency of our emergency care pathways to meet patients' needs as close to home as possible, where safe and appropriate.
- Sharp focus on children and young people, those who require a mental health crisis response, and those living with frailty and near the end-of-life.

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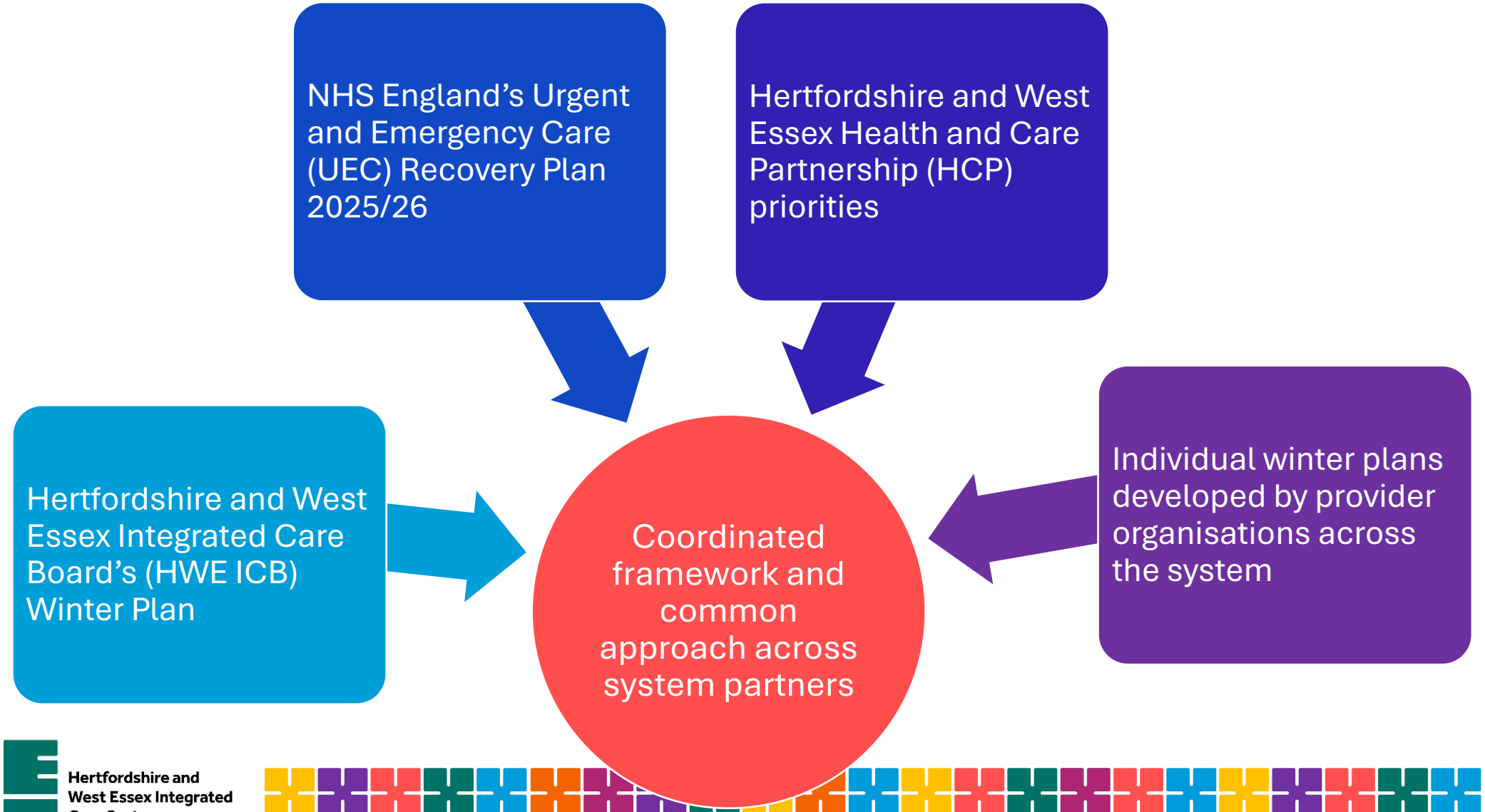
Planning and Managing Winter 2025/26 for the Herts and West Essex Integrated Care System



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UEC demand winter[1] FY2324 vs winter FY2425 vs winter FY2526 plan

	Winter FY2324 (actuals)	Winter FY2425 (actuals)	Winter FY2526 (plan)
GP attendances per day	23,419	24,683 (+5.4%)	26,050 (+5.5%)
111 calls offered per day	1,526	1,444 (-5.4%)	1,564[2] (+8.32%)
Ambulance incidents per day	497	528 (+6.2%)	534[3] (+1.1%)
Conveyances per day[4]	219	219	214 (-2.3%)
ED attendances per day[5]	1514	1547 (+2.2%)	1576 (-1.9%)

1. For the purposes of this analysis, winter is defined as the period from October to March
2. From *draft* Indicative Activity Plan
3. From EEAST internal plans
4. This analysis shows conveyances to the three acute Trusts in HWE, rather than conveyances of HWE patients
5. This analysis shows ED attendances at the three acute Trusts and two minor injuries units in HWE. The FY2526 plan figures have been uplifted as the planning submission included acute trusts only

Hertfordshire and West Essex Integrated Care System

Winter vs summer ED demand trends in Hertfordshire and West Essex

Patient age	% of summer[1] ED attendances	% of winter[1] ED attendances
Under 18	26.25%	28.75%
18 to 64	51.77%	49.70%
65+	21.98%	21.55%

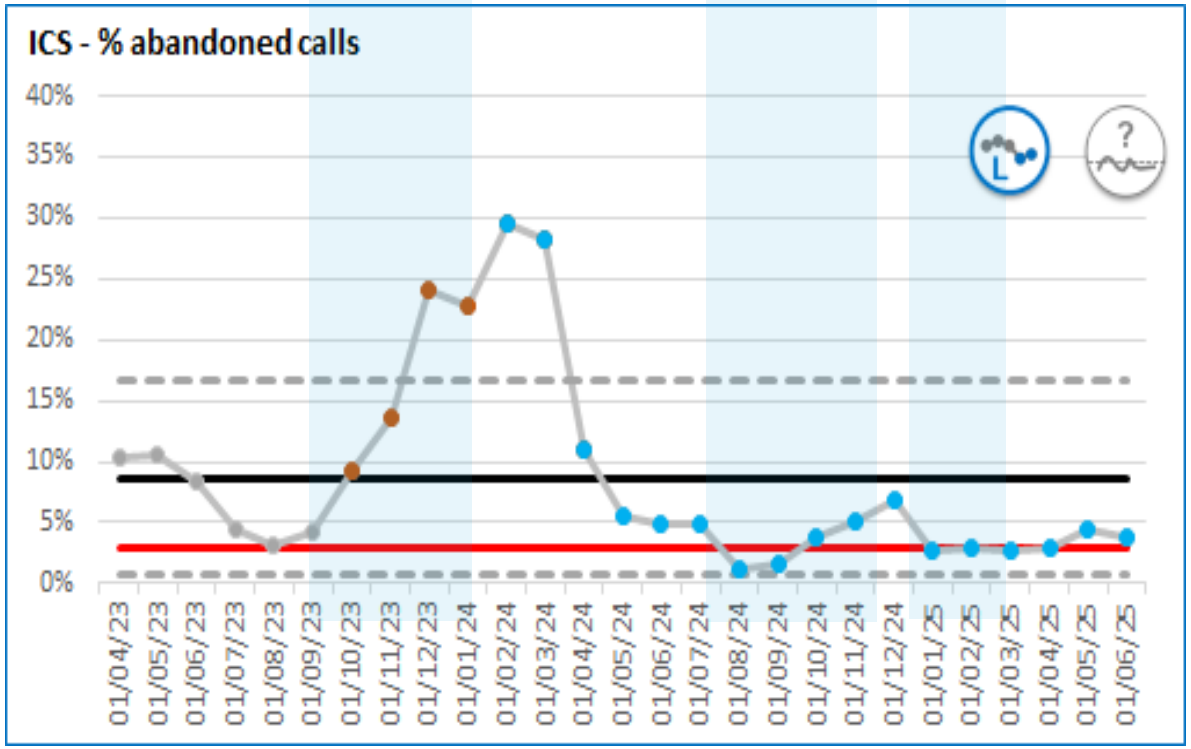
Presenting complaint	% of summer ED attendances	% of winter ED attendances
Medical	74.53%	78.60%
Trauma / injury	25.47%	21.40%

1. For the purposes of this analysis, winter is defined as the period from October to March and summer is the period from April to September. Analysis in the table above is based on data from April 2022 to March 2025

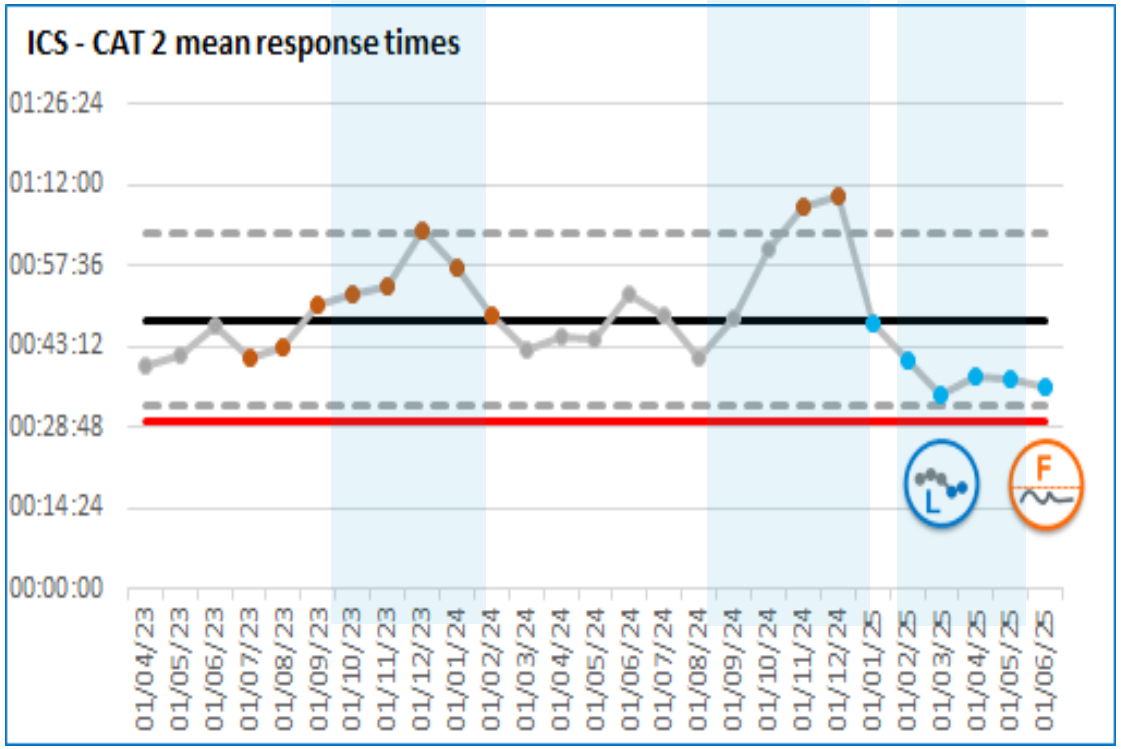
Hertfordshire and West Essex Integrated Care System

Winter 2023/24 vs Winter 2024/25 vs Present Performance – 111 and 999

Winter FY2324	Winter FY2425	M1-3 FY2526
21.5%	5.1% ↓	3.8% ↓



Winter FY2324	Winter FY2425	M1-3 FY2526
00:53:01	00:53:30 ↑	00:37:04 ↓



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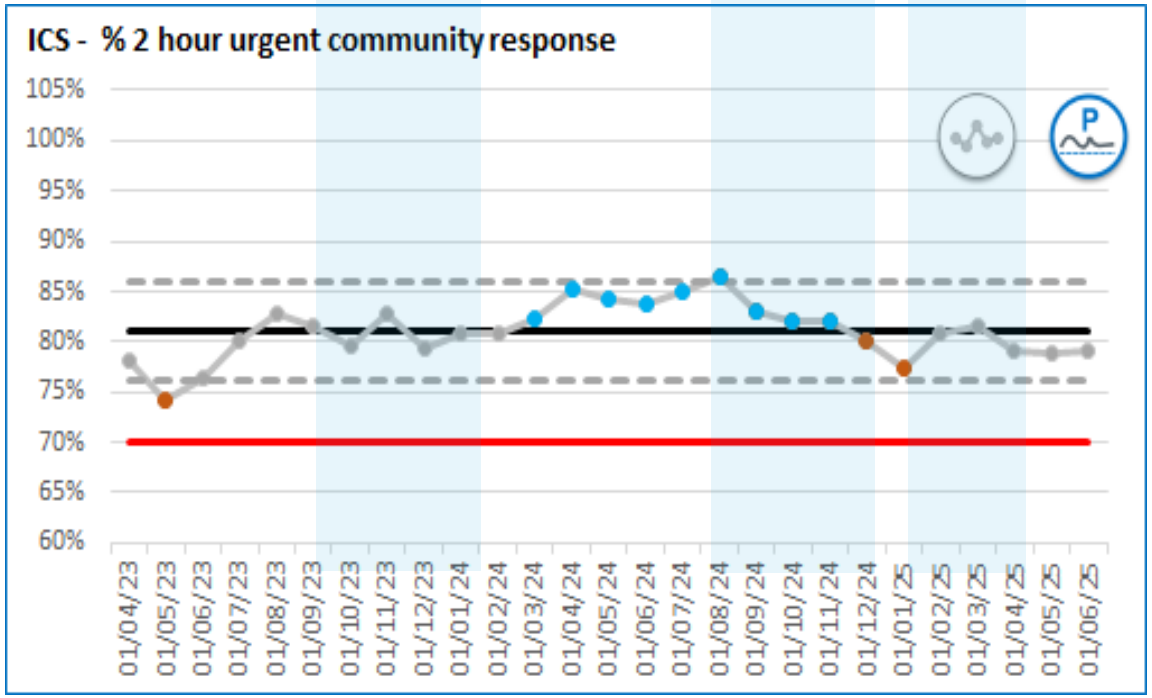
Winter 2023/24 vs Winter 2024/25 vs Present Performance – Community Responses and Pathways

Winter FY2324
81%

Winter FY2425
80.6%

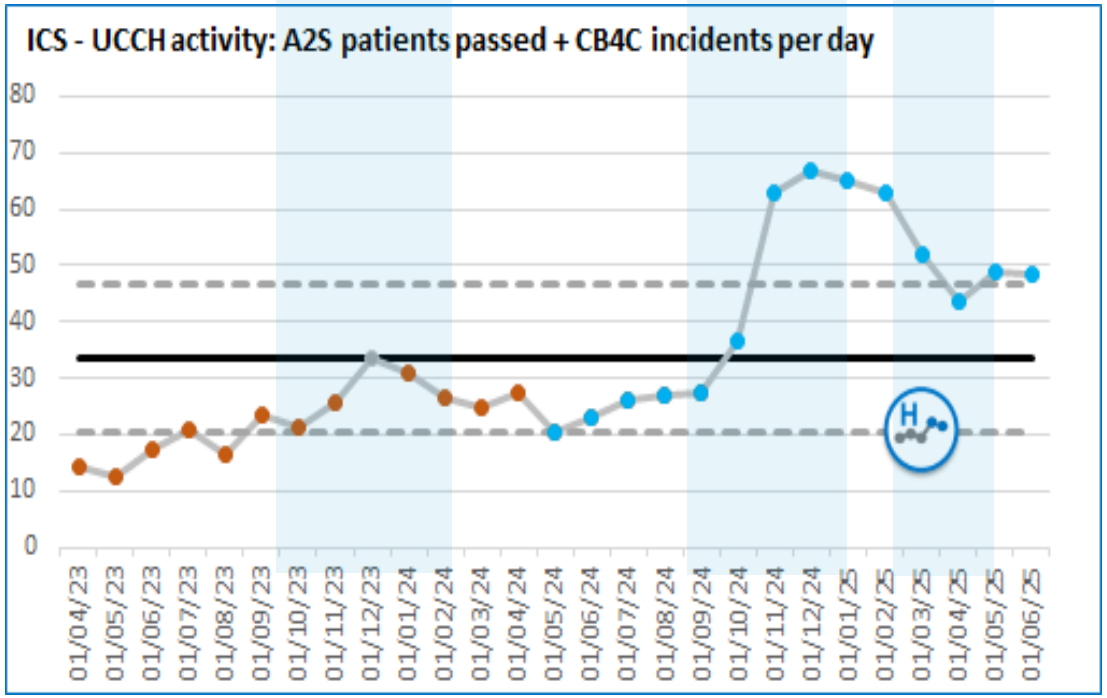
M1-3 FY2526
79.0%



Winter FY2324
27.1

Winter FY2425
57.6

M1-3 FY2526
47



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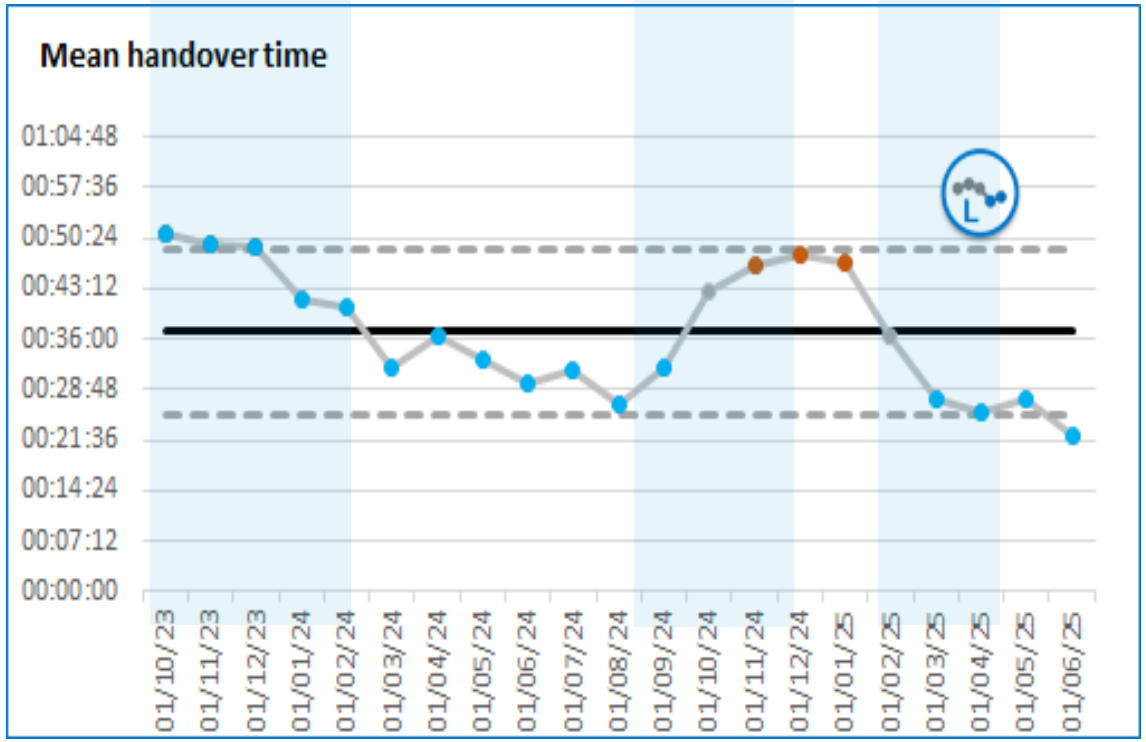
Winter 2024/25 vs Present Performance – Ambulance Handovers and ED

Winter FY2324
00:43:59

Winter FY2425
00:41:28

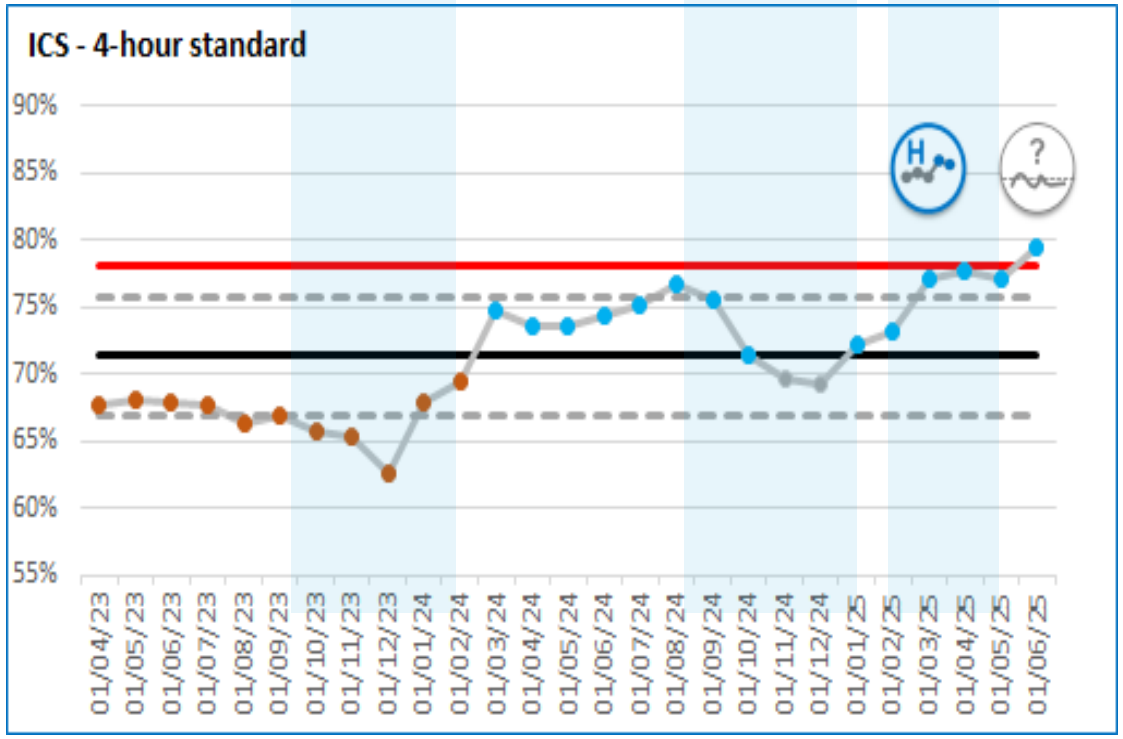
M1-3 FY2526
00:25:15



Winter FY2324
67.7%

Winter FY2425
72.2%

M1-3 FY2526
78.1%



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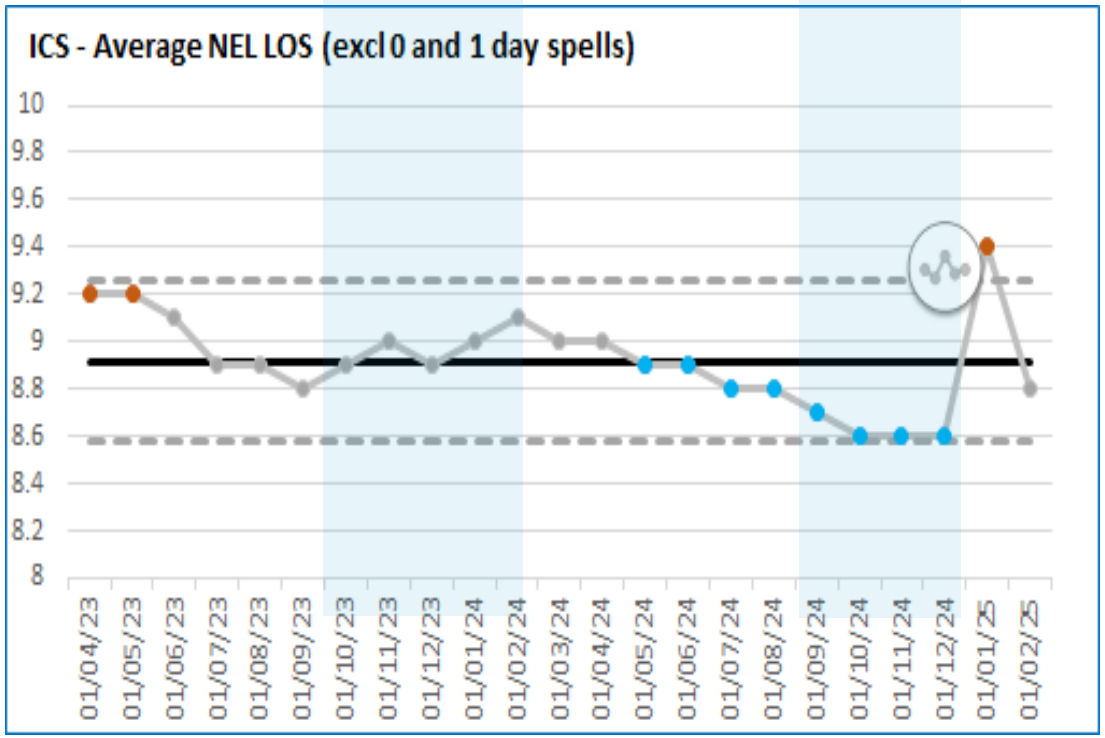
Winter 2023/24 vs Winter 2024/25 vs Present Performance – Non-elective LOS and Patients No-Longer Meeting the Criteria to Reside

Winter FY2324
9.0 days

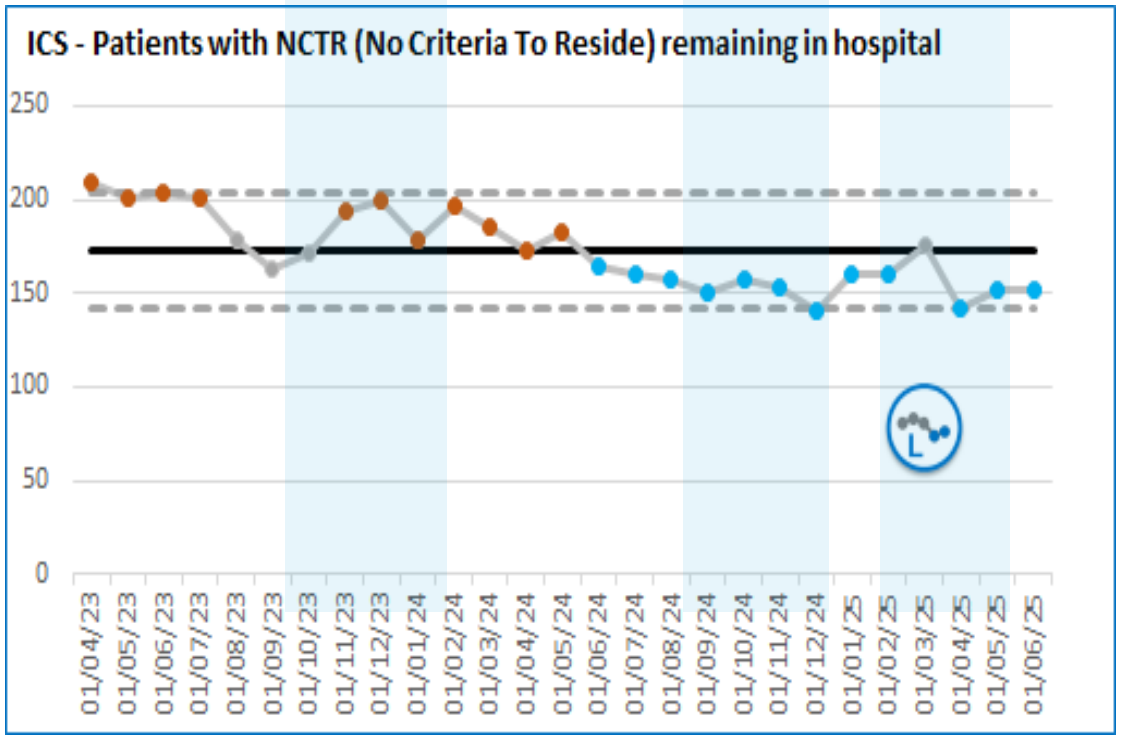
Winter FY2425
8.8 days



Winter FY2324
187.5 pts per day

Winter FY2425
157.8 pts per day

M1-3 FY2526
148.7 pts per day



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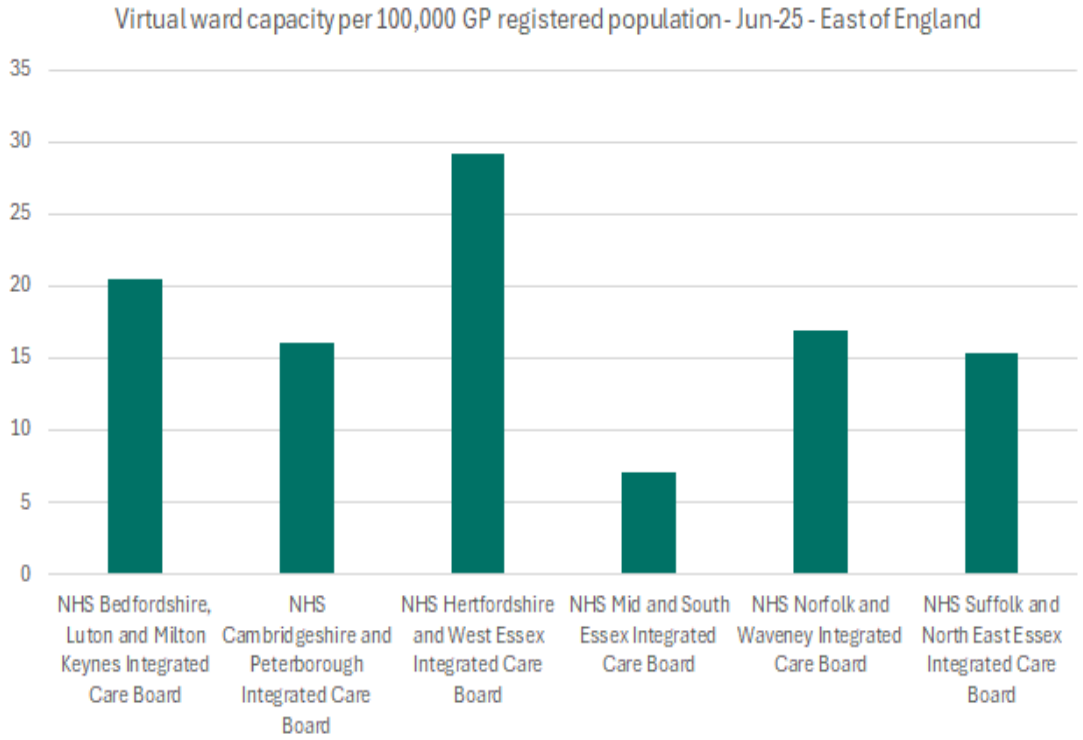
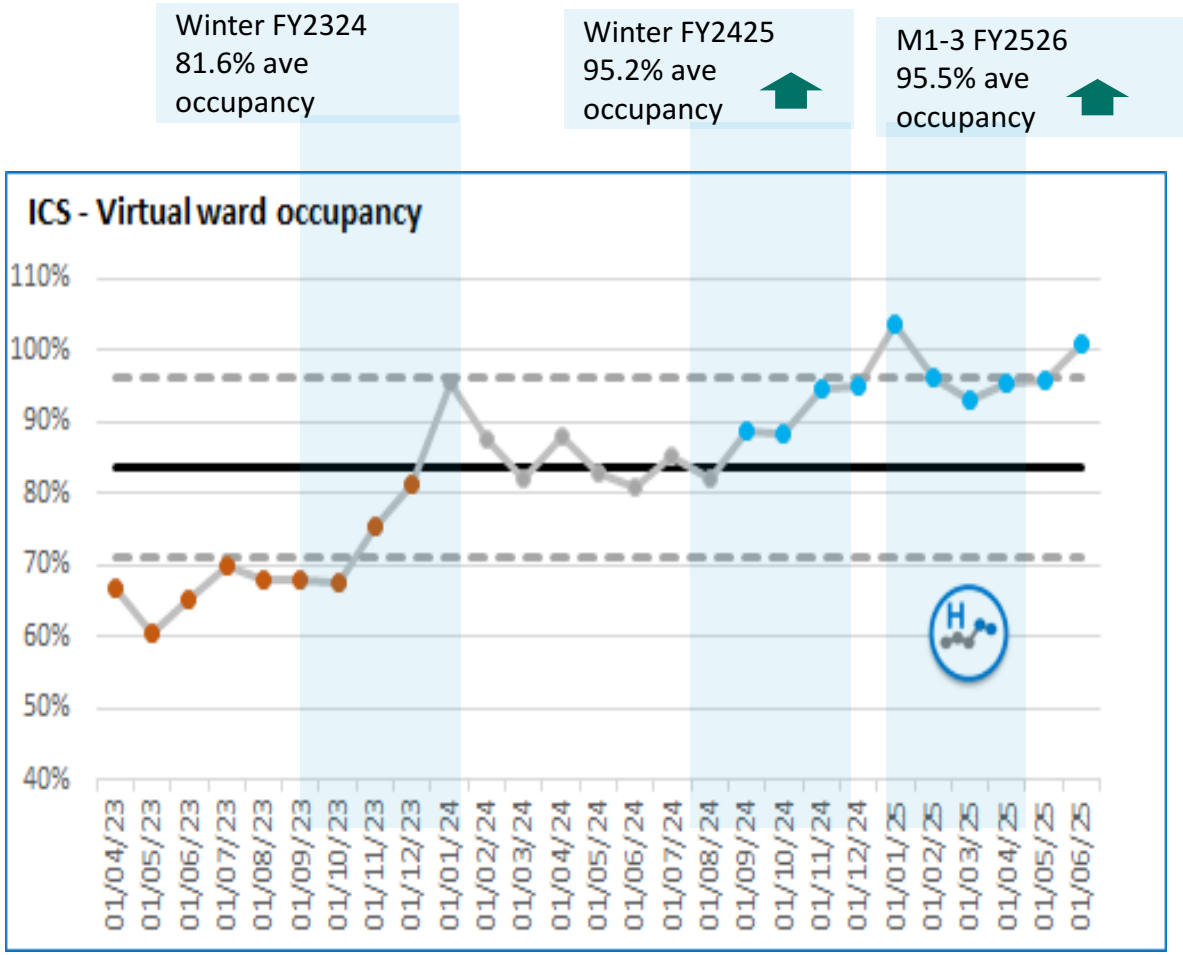
Winter Performance 2023/24 vs 2024/25 vs Present Performance – Virtual Ward





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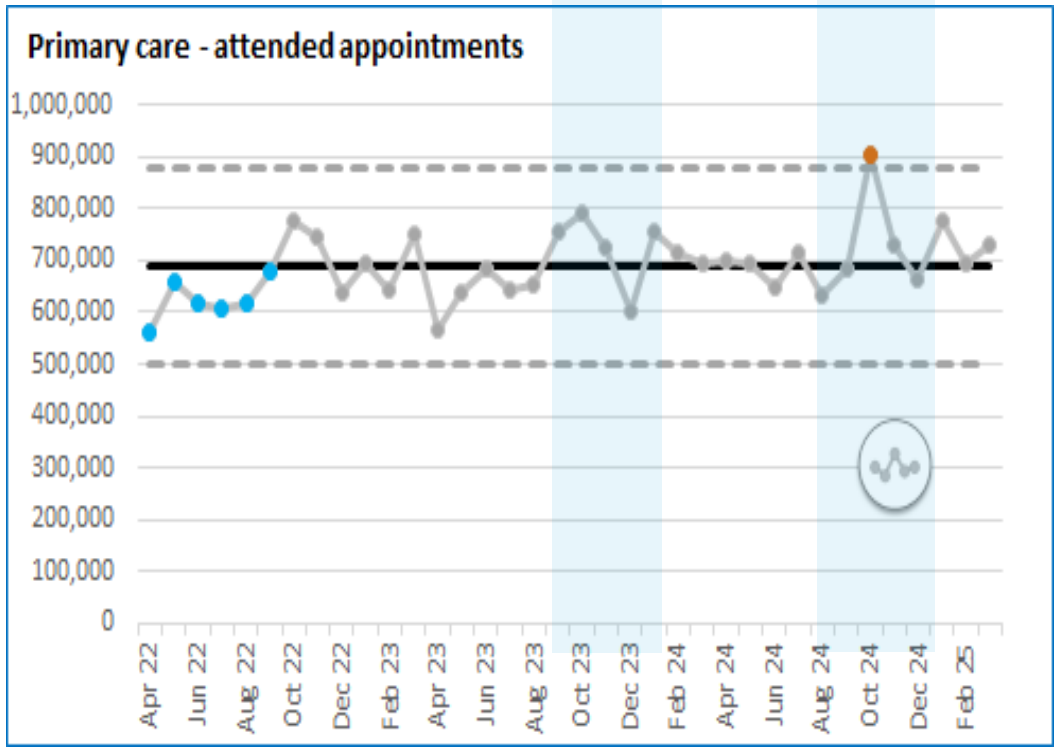
Winter Performance 2023/24 vs 2024/25 vs Present Performance – Primary Care Access and Capacity

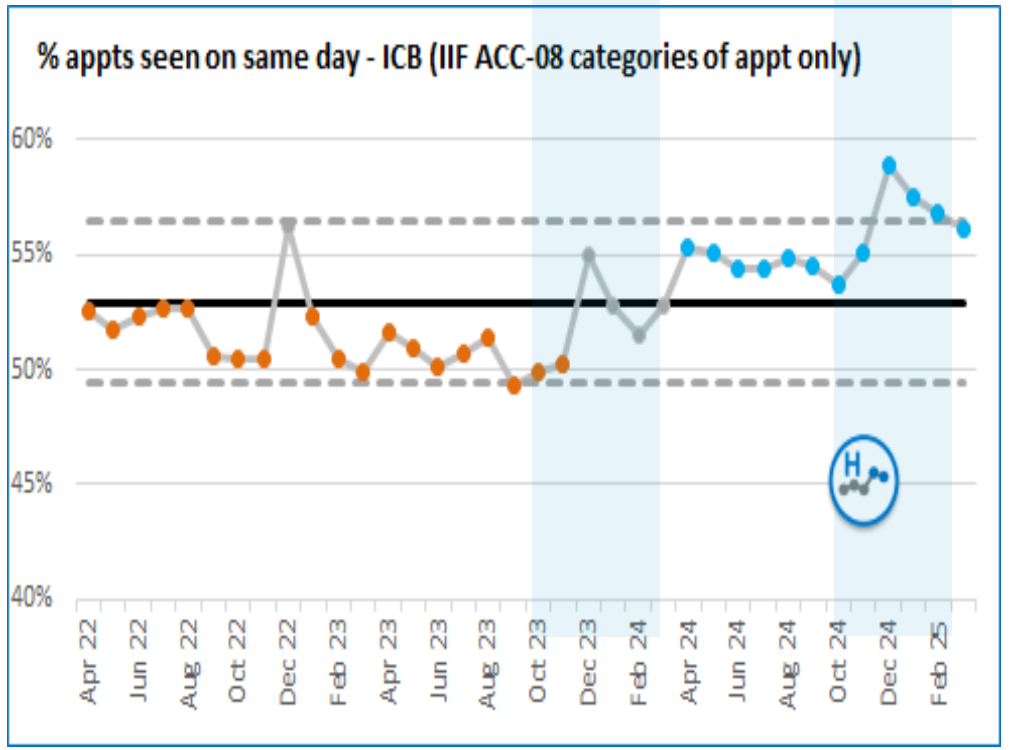
Winter FY2324
23419 per day

Winter FY2425
24683 per day



Winter FY2324
52% same day attendances

Winter FY2425
56.3% same day attendances



* This uses the IIF ACC-08 categories of appointment only which should only include appointments where the patient is looking to get the next available appointment – i.e. should exclude appointments such as flu vaccine appointments

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In Summary

111 demand is expected to increase by 8.3% this winter	
C2 ambulance response times remain challenged.	
ED attendances forecast to reduce but expecting an increase in paediatric attendances and medical complaints	 
Community responses within 2 hours and UCCH activity will continue to increase	
Mean ambulance handover times have improved but demand will average 219 conveyances per day	 
Average non-elective LOS has decreased	
Patients who remained in hospital when they had no criteria to reside have reduced.	
Average occupancy and capacity of virtual wards has increased	
GP attendances and those seen on the same day forecast to increase by 5.5% in winter FY25/26	

Learning from Winter 2024/25 and NHSE Regional Level 3 Critical Incident

Locality Operations Oversight Cell (LOOC) function worked well.	SCC Clinical Lead Role to be enhanced and Action Card to be updated with clinical actions required when a Regional incident is declared	Assess the effectiveness of trial CHC funding process for overnight and weekend requests during extremis	SCC Extremis Action Card to be updated with learning from this incident, e.g. Battlefield Triage Sub-Acute Co-horting Options	Winter Plan should only include actions which are additional to BAU functions or plans already in place.
Embedded 1	Completed 2	Embedded 3	In progress 4	In progress 5
Established processes meant providers were already well rehearsed in working together	Presence of clinical decision makers – Maintain tempo into weekend	IPC Lead given clear roles and responsibilities within the SCC to support system escalations	Clinical review of patients awaiting patient handover - must be undertaken - Third party cohorting to be explored, to avoid EEAST co-horting	SCC Incident action card to be updated with actions required when a Regional incident is declared, including the process for opening additional capacity
Enhanced 6	Embedded 7	Embedded 8	Embedded 9	Completed 10

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HWE ICS In-Winter Operational Responses and Escalation Measures to be Deployed During Peak Periods of Demand

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System Coordination Centre Functions Supporting Winter 2025-26

The SCC will support winter demand through a structured, system-wide approach to coordination, oversight, and escalation.

SCC Safety Oversight and Impact Group (SSOIG):

Provides strategic oversight and management of system risks. Proactively identifies potential risks and puts mitigations in place. Enhanced meeting cadence throughout winter to review emerging pressures and ensure timely actions are taken to maintain patient safety and system resilience.

Operational Winter Planning Group & Winter Workshop:

Leads end-to-end seasonal planning, including winter preparedness. Winter Workshop scheduled for 18th September to bring system partners together to review and implement learning from previous winters and the Level 3 incident last year, and align operational plans across the system.

24/7 SCC Rota and Resourcing:

Fully operational 24/7 rota with all critical roles (on-call staff, clinical leads, tactical and strategic leads and support officers) providing continuous support to providers and commissioners, ensuring coordinated decision-making and a rapid response to any system pressure or escalation.

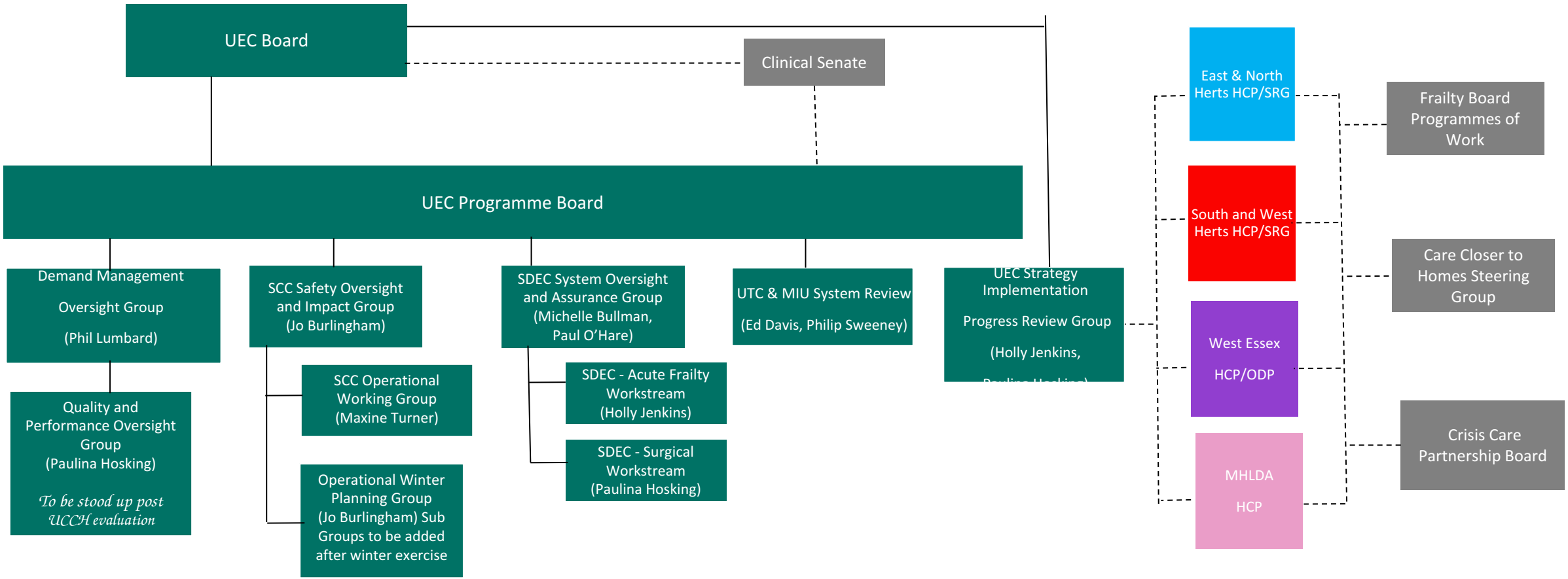
Alignment with SCC SOP and Frameworks:

SCC's winter response is underpinned by a Standard Operating Procedure (SOP) and Single Surge and Escalation Framework, ensuring a consistent and structured approach to incident management, escalation, and communication.

Integration with System-Wide Plans and Policies:

SCC operations are aligned to this Winter Plan, the OPEL (Operational Pressures Escalation Levels) Framework, and local provider-level winter plans ensuring consistent, collaborative decision-making.

ICS UEC Governance framework



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System Coordination Centre Key Functions for Winter 2025-26

Clinical Leadership: Clinicians support the SCC 24/7 and have either an NMC, LMC or HCPA registration to proactively support the SCC with patient safety risk mitigation.

Monitoring Demand and Capacity: Monitors real-time data on patient admissions, bed availability, staff capacity, across all services.

Coordinating Responses to Pressures: Facilitates communication and coordination between hospitals, ambulance services, social care, and other healthcare providers to ensure efficient use of resources. Prevent bottlenecks, such as hospital bed shortages or delayed discharges and supports repatriations and mutual aid.

Managing Escalation Procedures: When demand reaches critical levels, the SCC manages the escalation process, ensuring that additional resources are deployed quickly. This can involve redirecting patients to less pressured services.

Data-Driven Decision-Making: By analysing data trends and projections, the SCC helps to anticipate future pressures and make proactive decisions to minimise disruptions in care.

Incident Management and Communication: In the event of severe weather, outbreaks, or other incidents, the SCC acts as a hub for coordinated incident management, ensuring that all parts of the system are informed and able to respond effectively.

HWE SCC Operational Surge Plans for Winter 2025/26

		Latest winter 25/26 planned core beds open	Latest winter 25/26 planned escalation beds open	Latest winter 25/26 planned total beds open	Winter 25/26 additional surge capacity if required	Current variance to operating plan (actual open beds minus plan, source = daily sitrep on 3rd August)
ENHT	Adult G&A	551	0	551	0	-5
ENHT	Paediatric G&A	26	0	26	4	0
ENHT	Adult critical care	18	0	18	2	0
WHHT	Adult G&A	580	29	609	0	4
WHHT	Paediatric G&A	47	0	47	0	0
WHHT	Adult critical care	19	0	19	0	0
PAH	Adult G&A	396	0	396	0	+4
PAH	Paediatric G&A	16	0	16	3	0
PAH	Adult critical care	10	0	10	2	0
HCT	Community beds	73	0	77	4	0
CLCH	Community beds	97	0	97	0	0
EPUT	Community beds	87	0	87	0	0
ENH	Virtual ward beds	210	0	210	40	0
SWH	Virtual ward beds	164	0	164	0	0
WE	Virtual ward beds	106	0	106	0	0

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Live Action Cards Implemented – Continually evolving

Action Cards						
Number	Title	Status	Version	Date of Upload	Department	Owner
A01	Senior Manager On-Call	Live	V3.5	13.05.2025	SCC	Ben Hallam
A02	Director On-Call	Live	V4.2	29.01.2025	SCC	Ben Hallam
A03	SCC Support Officer	Live	V4.3	13.09.2024	SCC	Norvi Buami
A04	Evacuee - Incident Manager	Live	V0.3	26.02.2025	EPRR	Rob Brice
A05	Reinforced Autoclaved Aerated Concrete (RAAC) Incidents	Stood Down	V1.0	12.05.2024	EPRR	Grainne Stephenson
A06	ICB Mass Casualty MASCAS	Stood Down	V1.0	12.05.2024	EPRR	Grainne Stephenson
A07	SCC Tactical Lead	Live	V2.3	29.05.2025	SCC	Maxine Turner
A08	SCC Strategic Lead	Live	V2.0	13.09.2024	SCC	Maxine Turner
A09	EEAST Locality Operational Cell (LOC)	Stood Down	V3.3	25.11.2024	EEAST	Glenn Young
A10	SCC EPRR Lead	Live	V2.3	29.05.2025	EPRR	Wes Routledge
A11	SCC Primary Care Lead	Live (Under Further Review)	V1.1	30.05.2024	Primary Care	Philip Sweeney
A12	ICB Comms Lead	Live	V1.3	15.11.2024	Comms	Gemma McKelvey
A13	HWE Clinical Safety Reviews of Ambulance Delays EEAST ICB	Live	V1.0	31.05.2024	EEAST	Glenn Young
A14	SCC Clinical Lead	Live (Under Further Review)	V1.2	29.05.2025	Medical	Mark Lim

All Live Action and Procedure Cards are Stored within the SCC MST Group Repository Here:
01. Action and Procedure Cards

Live Procedure Cards Implemented – Continually evolving

Procedure Cards						
Number	Title	Status	Version	Date of Upload	Department	Owner
PR01	On-Call Log	Live	V3.1	23.05.2024	EPRR	Rob Brice
PR02	Mainstream	Live	V2.5	16.05.2025	SCC	Norvi Buami
PR03	10.30 ICB weekday and weekend SHREWD Report	Live (Under Further Review)	V3.1	03.07.2024	SCC	Ben Hallam
PR04	10.45hrs SCC Regional Escalation Slide Submission	Live	V2.2	20.12.2024	SCC	Ben Hallam
PR05	10.45 SCC Regional Sitrep Slide	Stood Down	-	-		-
PR06	Repatriation Escalations	Live	V1.3	11.12.2024	SCC	Maxine Turner
PR07	SCC Collations	Live	V3.0	10.09.2024	SCC	Norvi Buami
PR10	NEPTS Actions and Escalation Process	Live	V3.1	29.05.2025	SCC	Maxine Turner
PR11	ICB Communications Cascade	Live	V3.1	22.11.2024	EPRR	Wes Routledge
PR12	SCC Remote Mailbox Access	Live	V3.2	24.05.2024	SCC	Ben Hallam
PR14	Incident Notification Checklist	Live	V1.2	22.11.2024	EPRR	Wes Routledge
PR15	Hospital Evacuation & Mass Casualty Response Incidents	Live	V1.0	20.09.2024	EPRR	Grainne Stephenson
PR16	OPEL Extremis Actions	Live (Under Further Review)	V1.1	20.09.2024	SCC/Clinical	Jo Burlingham / Mark Lim
PR17	Standing up HETCG Checklist	Live	V1.2	22.11.2024	EPRR	Wes Routledge
PR18	Handover 45 SOP (Release to Respond)	Live (Under Further Review)	V1.0	23.12.2024	SCC	Jo Burlingham / Paulina Hosking
PR19	HWE SCC Mental Health Escalation Protocol	Live	V1.3	08.05.2025	Ops	Ed Davies / Maxine Turner
PR20	IPC - High Consequence Infectious Disease Case Reported	Live	V2.7	19.05.2025	IPC	Jennifer Day / Lynn Stewart
PR21	IPC - Infectious Disease Incident or Outbreak Reported	Live	V1.2	19.05.2025	IPC	Jennifer Day / Lynn Stewart
PR22	EEAST Locality Operational Cell (LOC)	Live	V3.5	28.02.2025	EEAST	Sandra Treacher/Paulina Hosking
Guidance Live and Available Via ICB Intranet	ICB Local Site Shelter and Evacuation Guidance (The Forum, Charter House and Kao Park)	Live	S&W: V1.3 ENH: 1.2 WE: V1.1	September 2024	Corporate Support	Kelly Taylor

All Live Action and Procedure Cards are Stored within the SCC MST Group Repository Here:
01. Action and Procedure Cards

Care System

SCC Cards Under Development – Continually evolving

Cards In-Development						
Number	Title	Status	Version	Planned Launch Date	Department	Owner
PR09	Use of Internal and external SCC Chat	In-Development	TBC	Spring 2025	SCC	Maxine Turner
New	PTS Requests and Escalations	In-Development	TBC	Spring 2025	Contracts	Sarah-Jane Evans
New	PTS Escalations	In-Development	TBC	Spring 2025	SCC	Maxine Turner
New	HWE Community Escalations (OOA POC and DTA referrals)	In-Development	TBC	Spring 2025	UEC	Place UEC Leads
New	HWE ICB IPC Role Action Card	In-Development	TBC	Spring 2025	IPC	Jennifer Day / Lynn Stewart
New	EEAST HALO Action Card	In-Development	TBC	Spring 2025	IPC	Paulina Hosking/Ben Hallam

Summary of HWE ICS Risk / Issue Scores (Timestamp August 2025)

Issue	Issue Description	Unmitigated Score	Mitigated Score	Risk Direction
2.	Increased ambulance C2 response times presents a risk to patients awaiting an ambulance response within the community (Including Rapid Release)	33	28	↔
7.	IF patients with specific MH needs are held in ED due to MH system delays, with or without police, THEN patient experience and safety may be compromised. In addition, staff safety could be compromised RESULTING in long ED waits, lack of access to appropriate facilities (ligature risks), lack of supervision and risk of absconding. For ED staff this could result in exposure to physical of non physical harm.	22	20	↑
11.	Clinical risk to patients cared for in non-standard ward environments: bedded in ED, corridor care, additional beds in bays, SDEC, outlier wards including IPAC risks.	28	18	↓
1.	Ambulance handover delays present clinical risks to patients awaiting handover at Acute ED	28	16	↓
9.	A combination of increasing patient demand coupled with high hospital bed occupancy has resulted in delayed admission from ED. If these patients are not assessed and treated, admitted and/or discharged out of the ED within a reasonable timeframe, then the department will become overcrowded. (Release to respond has now increased risk – Potential it may be GP IA, ask acutes for demand profile).	27	18	↔
4.	Clinical risks to patients delayed within EDs (12hrs from arrival)	25	11	↓
10.	Paediatric demand v capacity - IF demand for paediatric admission outstrips capacity (caused by an increase in infectious diseases, respiratory or otherwise) THEN patients will not be able to be admitted to ward/HDU areas and will remain in ED RESULTING in potential clinical harm and potential for mutual aid and/or diverts to other acutes	23	19	↔
3.	Critical care capacity exceeded due to seasonal high acuity and demand	22	18	↔

Summary of HWE ICS Risk / Issue Scores (Timestamp August 2025)

Issue No.	Issue Description	Unmitigated Score	Mitigated Score	Risk Direction
5.	Clinical risk to inpatients (physical beds) who no longer meet C2R having prolonged admissions and/or are moved incorporate placements while waiting discharge support. These are patients who are not receiving the appropriate interventions or rehabilitative support. RESULTING in potential deconditioning. Increase in complexity of long term care required and delays to long term placements	20	17	
8.	PTS Capacity - IF demand for capacity for the Non-Emergency Patient Transport Service is not met THEN patient journeys may be delayed or aborted RESULTING IN delays in access to ongoing care or discharges from the patients setting which will in turn impact on patient's care, patient flow across the system and lengths of inpatient stay.	21	16	
12.	Clinical risk to patients in the primary care not able to access same day access resulting in high walk in attendances – seek intelligence	19	13	
6.	Impact of high numbers of covid, flu and winter respiratory illness on demand, capacity and flow.	11	10	

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ICS Transformation Programmes for Winter: Integrated UEC, Frailty and Community services 2025/2026

Working together
for a healthier future

ICS Transformation Programmes for Winter: Integrated UEC, Frailty and Community services 25/26

Reducing admissions for frail elderly

Aim to reduce frailty non-elective admissions by 25%

Integrated UEC – managed at UEC Programme Board, reported at UEC Board

1. Demand management innovation:111/CAS/UCCH (A2S and CB4C) new model
2. SDEC for acute frailty
3. UTC and MIU system review

Frailty and EoL priorities – managed at Frailty/EoL Board, reported at UEC Board

1. Deprescribing including reduction in anticholinergic medicines
2. Falls prevention – mapping pathways e.g. long lie and overall review of commissioned services
3. Digital Advanced Care Plan implementation

Care Closer To Home (Community Services Review) priorities – managed by CCTH Steering Group, reported at UEC Board

1. At scale implementation of Integrated Neighbourhood Teams within PCNs
2. UEC pathways – UCR and VW/H@H
3. Care Coordination Centres
4. Intermediate Care – early supported discharge, D2A, reablement focus

2025/26 UCCH ROADMAP

1 TRUE CARE COORDINATION

- Visability of UCCH and CCC rotas
- Mapping and alignment of triage processes + end-to-end reporting
- Alternative technologies
- Trusted Assessor Model (MVP)
- Equality of access across the system

2 REDUCING ED CONVEYANCES

- Qualitative data collection to understand underutilisation of CB4C
- Communications to promote CB4C
- Report impact of CB4C on conveyances
- Role of AP in UCCH
- UCCH GPs CAD training

3 SERVICE GAPS

- Explore Mental Health, Social Care and Frailty pathways
- Standardise templates for deep-dives: to include rejections, cases follow up and to support development of clinical pathways
- Underutilisation of SDEC: conduct interviews with staff to explore blockages and opportunities

4 PRIMARY CARE

- Improved PC referrals/pathways
- Startegic engagement and agreement on PC role in demand management

5 UCCH SOP

- To include confirmation of the HWE UCCH model
- To include all EoE SPoCs phone numbers
- Clarity of SDEC pathways to encourage referrals

6 OPPORTUNITIES

- Contractual clarity on emergency prescribing
- Improve collaboration between UCCH and CCCs: role swaps, shadowing, etc
- Comprehensive guide and educational opportunities for UCCH GPs to understand available community services
- Second phase of evaluation: longer term impacts

Hertfordshire and West Essex Integrated Care System

Demand Management - Alternatives to Hospital Attendance/ Admission

- **Frailty identification:** Pre-hospital (ambulance services) assessment and accurate identification of frailty in Emergency Departments using Clinical Frailty Scale (Rockwood).

- **Urgent Community Response/Falls acute response:** Strong focus on providing urgent care in the community, referrals through Unscheduled Care Coordination Centres to either Urgent Community Response (seen within 2 hours), Hospital at Home/Virtual Ward, or use of response vehicles (e.g. falls cars). Alternative pathways for falls with long-lie or head injury on anticoagulants.

- **Same Day Emergency Care (SDEC)** when needs cannot be met by primary/community services, SDEC-by-default approach
  - profile SDEC demand to ensure service meets demand, assessment tools to benchmark and address gaps
  - direct referral from primary care, NHS 111, ambulance services (standardised acceptance criteria and inclusion on DoS)
- Alternatives to Admission - Clinical Pathways (hweclinicalguidance.nhs.uk)

Top Tips to help you use the Clinical Frailty Scale

The Clinical Frailty Scale (CFS) was designed to summarise the results of a Comprehensive Geriatric Assessment. It's now commonly being used as a triage tool to make important clinical decisions, so it is imperative that it is used correctly.

#1 **It's all about the baseline**
If the person you are assessing is acutely unwell, score how they were 2 weeks ago, not how they are today.

#2 **You must take a proper history**
The CFS is an objective clinical assessment tool. Frailty must be sensed, described, and measured - not guessed.

#3 **Trust, but verify**
What the person you are assessing says is important, but should be cross-referenced with family/carers. **The CFS is a judgement-based tool**, so you must integrate what you are told, what you observe, and what your professional clinical experience tells you from dealing with older adults

#4 **Over-65s only**
The CFS is not validated in people under 65 years of age, or those with stable single-system disabilities. However, documenting how the person moves, functions, and has felt about their health may help to create an individualised frailty assessment.

#5 **Terminally ill (CFS 9)**
For people who appear very close to death, the current state (i.e. that they are dying) trumps the baseline state.

#6 **Having medical problems does not automatically increase the score to CFS 3**
A person who isn't bothered by symptoms and whose condition(s) doesn't limit their lives can be CFS 1 or 2 if they're active and independent.

#7 **Don't forget "vulnerable" (CFS 4)**
People in this category are not dependent (though they may need assistance with heavy housework), but often complain of "slowing down". They're becoming sedentary, with poor symptom control.

#8 **Dementia doesn't limit use of the CFS**
Decline in function in people living with dementia follows a pattern similar to frailty, so if you know the stage of dementia (mild, moderate, severe) you know the level of frailty (CFS 5,6,7). If you don't know the stage of dementia, follow the standard CFS scoring.

#9 **Drill down into changes in function**
When considering more complex activities of daily living (such as cooking, managing finances, and running the home) the focus is on *change* in function. A person who has always relied on someone else to perform a particular activity should not be considered dependent for that activity if they've never had to do it before and may not know how.

Kenneth Rockwood, Sherri Fay, Olga Theou & Linda Dykes
v1.0 9 April 2020

Hertfordshire and West Essex Integrated Care System

Proactive Care

- **Polypharmacy review:** General Practice deliver Structured Medication Reviews that include polypharmacy review (≥ 8 medications, in particular anticholinergic medicines) as part of the annual review of people with moderate or severe frailty. Action to deprescribe HWE Hints and tips for anticholinergic burden (ACB) medication reviews

- **Identification of falls risk in frail individuals:** Assess falls risk for patients with frailty, those with moderate falls risk should be referred for strength and balance programme & those at high-risk to a falls prevention/frailty clinic

- **Integrated Neighbourhood Team (INT) proactive identification and management of complex patients:** PCNs/localities form MDTs for case management and care coordination for complex patients with involvement from general practice, community provider, social care and specialists. Patients identified through PHM searches

- **Proactive Patient Flagging** ahead of winter for individuals who are case-managed by an INT across primary care, 111, community services and social care. to ensure these patients receive the most appropriate and timely response, particularly during periods of increased system pressure. This approach supports the overarching goal of reducing avoidable hospital attendances and admissions, while promoting coordinated, person-centred care.

- **Advance Care Planning:** all clinicians seeing patients who are severely frail or in the last year of life to:

  LOOK for Advance Care Plan (ACP)

  START the conversation about the patient's preferences and priorities for emergency care to update

  INITIATE (where not available) an ACP

  ACT in line with the patient's wishes, promote shared decision making

  https://www.hertsandwestessex.ics.nhs.uk/your-health-and-care/support/personalised-care/shared-decision-making/

  COMMUNICATE the patient's ACP to other services on discharge

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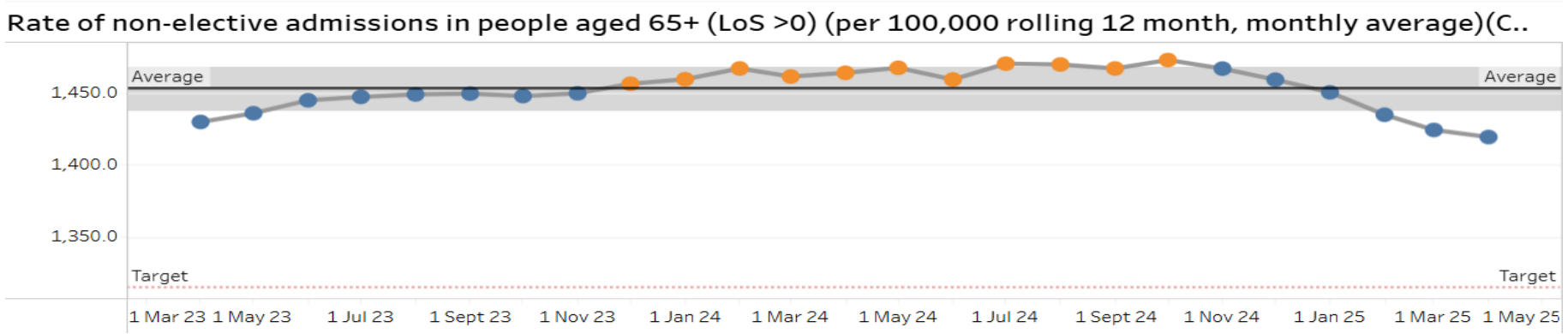
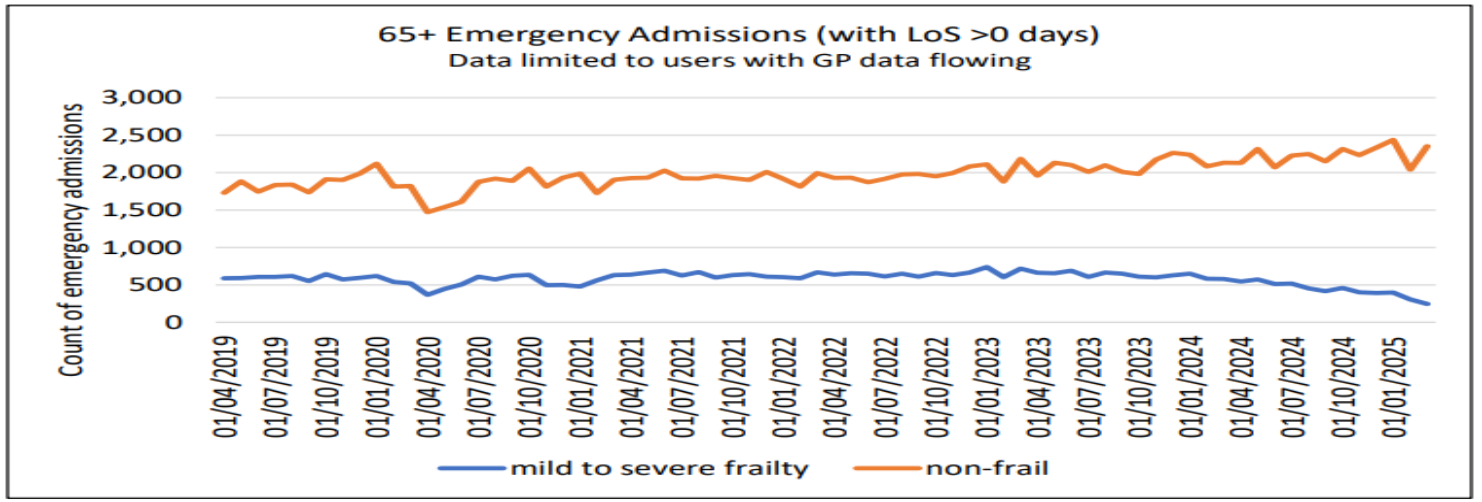
Focus on 25% Reduction in Hospital Admissions for Frail Older People





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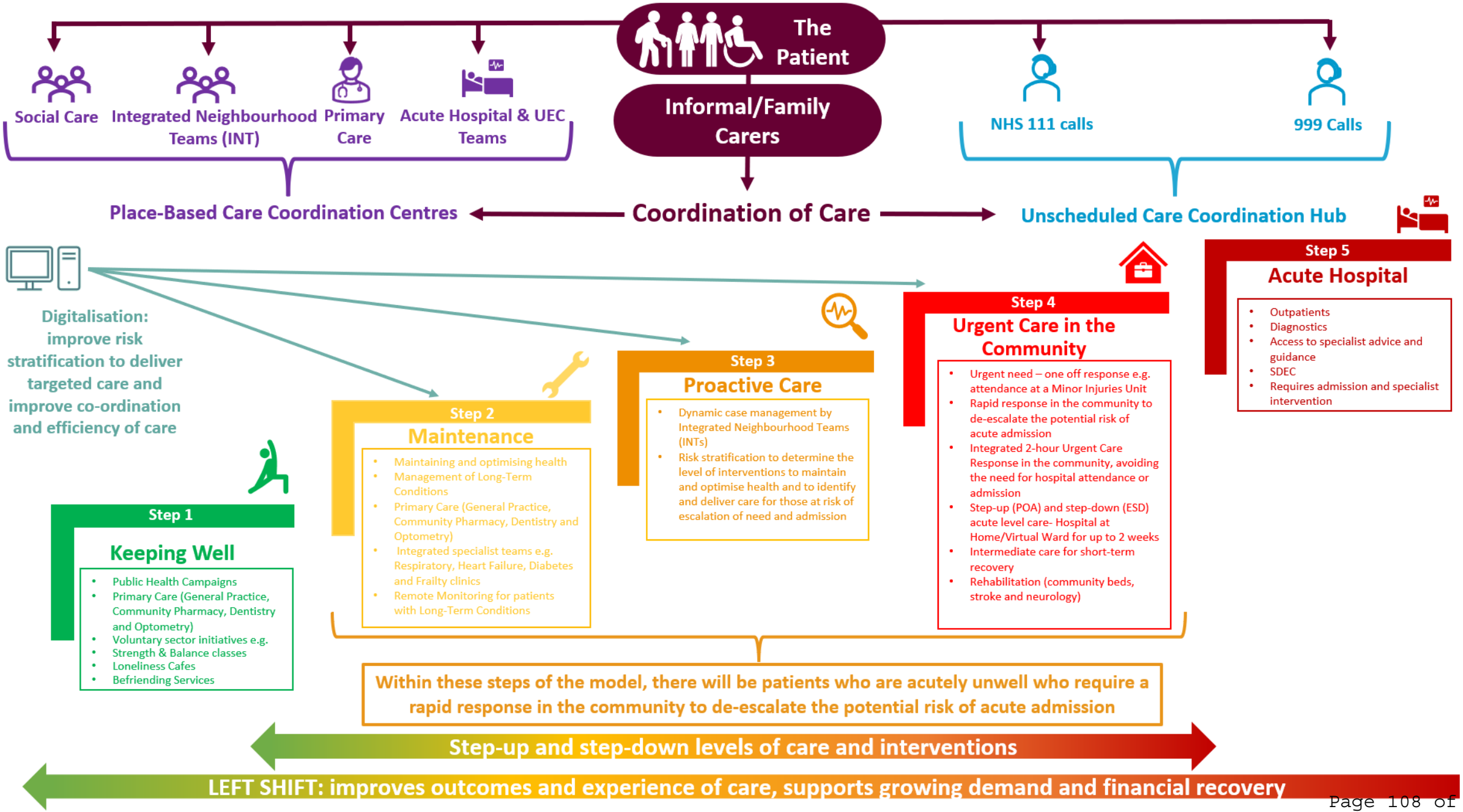
Care Closer to Home Model of Care



High-impact interventions for Children and Young People this Winter 2025/26

- Critical Care Surge plan in place for winter
- ICS mutual aid policy which details the process, timescales on how requests are managed over winter.
- Promoting Childrens flu and Covid programmes, assuring call and recall in place for all cohorts
- Expanding and promoting Healthier Together as a resource to support self-care and self-management by families and CYP, recent review of pathways for common presentations/conditions. Working with Public Health nurses to signpost to the Healthier together as part of duty offer.
- SWH Community asthma and wheeze service offering bite size refresher training to acute and community services on CYP asthma from middle of August ahead of September surge.
- Review of our Urgent Treatment Centres/Minor Injury Units capacity and delivery models to manage our populations' same day urgent care needs with recommendations for where and how efficiencies as a system can be addressed. Attendances by CYP are part of this review to ensure we have the right support for our children and young people and their families.
- Acute trusts are working to implement a digital system to identify the deteriorating child, the national Paediatric Early Warning System (PEWS).
- Maintaining 24/7 access to community crisis response and intensive home treatment as an alternative to acute inpatient admissions.
- Community nursing teams urgent care pathways in West Essex and West Hertfordshire
- Promotion of RSV maternity vaccination programme

Focused Infection Prevention and Control Support for HWE Winter 2025/26

The following support is based on current Infection Prevention and Control (IPC) resources and functions within the ICB.

- Memorandum of Understanding for Delivery of Core Health Protection Functions in Hertfordshire and West Essex, is currently being reviewed prior to winter.
- Gap analysis being undertaken against NHSE Clinical response to local incidents and outbreaks of infectious disease: Commissioning guidance for ICBs
- Collaboration with HWE System Co-ordination Centre and tracking of IPC bed closures across the system. Support to risk assess bed closures and minimise service disruption.
- Facilitation of complex discharges to care homes.
- An agreed Integrated Care System Approach to IPC Support in HWE Care Homes with County Council.
- Care Settings Infection Prevention Cell meetings held monthly and led by County Council.
- Quarterly system wide HWE IPC Strategic Group meetings at which local organisations present IPC risks and issues are presented and discussed.
- IPC risk assessments of surge/ escalation areas in acute settings.
- Review of system isolation capacity
- Support with staff vaccination programmes, including in primary care (survey being undertaken to determine and better understand challenges in primary care)
- System wide C.difficile action plan.
- HWE ICS Healthcare associated infection (HCAI) Oversight Group to better interrogate local HCAI data, undertake thematic reviews of learning and monitor impact of focussed remedial work across the system.
- Assurance regarding programmes for FFP3 fit testing and support to non trust providers.
- Monitoring of the ICB contracted service for the management of outbreaks and IPC related incidents.
- Oversight and collation of a system wide outbreak & IPC incident spreadsheet to act as an early warning system.
- Support and advice for the management of outbreaks and incidents, with participation in Incident Management Team (IMT) meetings, for high risk outbreaks i.e. death / serious harm being caused to patients or staff, significant antimicrobial resistance, impact on system resilience, protracted period of incident, further transmission despite outbreak measures, repeated outbreaks of the same organism, outbreak affecting more than one organisation / trust.
- Development of action cards for ICB senior managers on-call for the management of outbreaks and high consequence infectious diseases, including training provision.

Approved ICS UEC Priority Allocations for Winter 2025/26

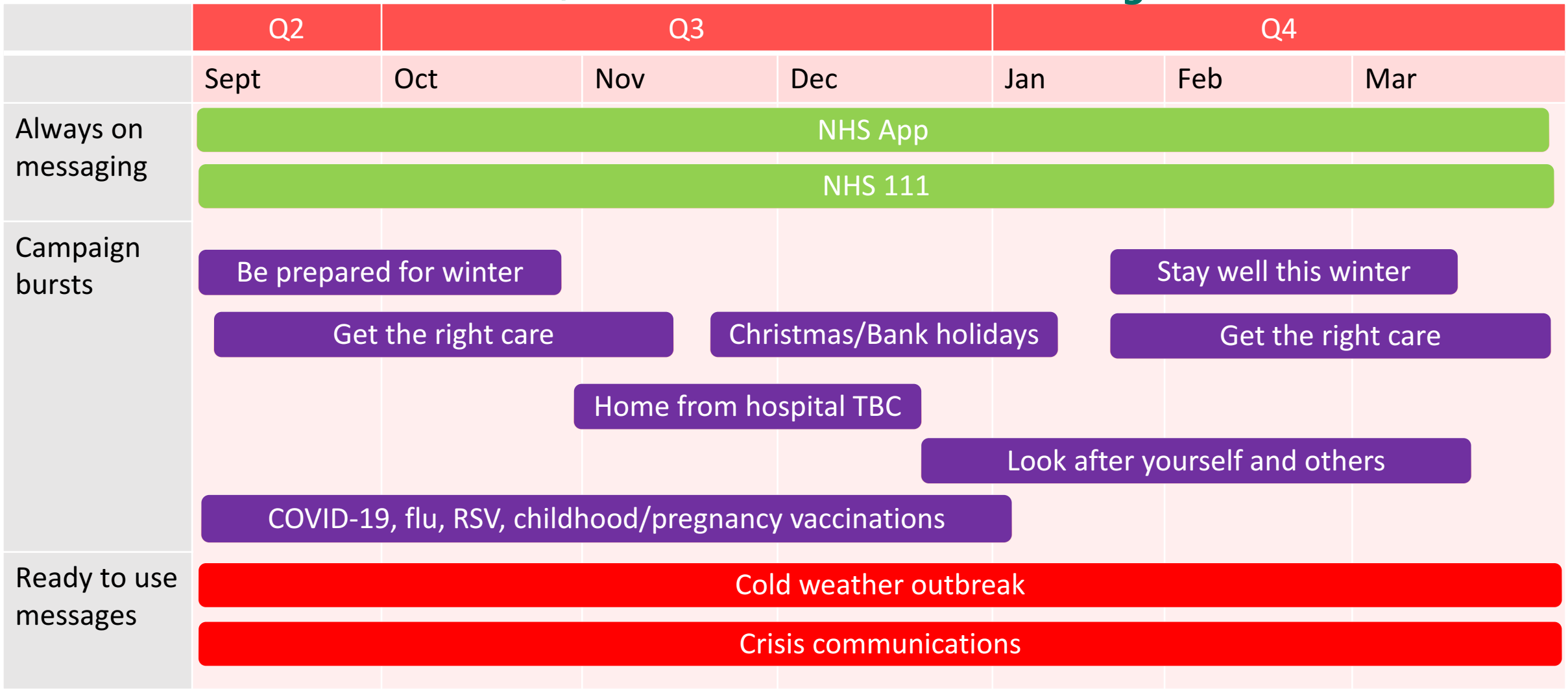
UEC Plan	2025/26 Value
Expenditure	
Early Discharge (Sciensus) - WHTH	£939,000
UCCH - Regional Funded	£498,569
UCCH - ICB funded	£565,000
Local Operations Cell (LOC) - EEAST	£235,330
Virtual Ward - WHTH	£3,977,000
Virtual Ward - EPUT	£4,178,733
Extension to VCFSE Crisis Beds 24/7 (HMN)	£460,000
PTS Support	£1,248,000
Red Cross Discharge - WHTH	£160,000
SCC Vital Hub Dashboards	£15,000
ENHT NEL beds (15)	£2,962,000
NHS111 - HUC	£1,080,000
Bounceback Support to ED	£310,000
PAH NEL Beds (17 - Nightgale)	£1,794,000
Virtual Ward - HCT	£4,558,523
Total Expenditure	**£22,981,155**
Funding	
UEC funding	(£8,571,856)
Physical and VW Funding	(£13,970,144)
NHSE SCC Digital Funding	
Regional funding for UCCH	(£546,000)
Total Funding	**(£23,088,000)**

Hertfordshire and West Essex Integrated Care System

Winter Communications 2025/26 - Operational triggers for key winter messages

Trigger	Internal messaging	External messaging
Winter BAU	• Staff vaccination campaign • Wellbeing and support • Home from hospital messaging	Be prepared for winter Know where to get help Get your winter and childhood/pregnancy vaccinations Support to get relatives out of hospital
Cold weather alerts	• Staff advice / actions	Cold weather warning advice from UKHSA
IPC alerts i.e. Norovirus	• Critically observing the basics of IPC	Support trusts with any "Please observe responsible visiting" guidelines and/or ward restrictions. Basic hygiene advice i.e., wash hand, kill it bin, it kill it. Not visiting people in hospital if unwell
Opel 3, prolonged	• Pressure awareness • Actions to take/actions taken • Wellbeing/support	Hospitals are busy, please consider alternatives (full messaging in communications strategy)
Opel 4	• Pressure awareness • Actions to take/actions taken • Wellbeing/support	Please only attend hospitals in emergency (full messaging in communications strategy)

Winter Communications 2025/26 timeline of winter messages



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Community Pharmacy Key Messages for Reducing Admissions

Community pharmacies can play a vital role in reducing emergency admissions and improving patient outcomes

Pharmacy First service

Pharmacists can treat minor ailments like coughs, colds, and skin conditions, reducing the burden on GPs and preventing unnecessary emergency visits.

Flu Vaccinations

Pharmacists can administer flu vaccinations, reducing the spread of the virus and the potential strain on healthcare systems.

Discharge Medicines Service

Community pharmacies and Trusts to work together to ensure patients receive clear and accurate instructions regarding any medication changes when they leave the hospital, minimising errors and confusion that could lead to emergency visits.

Adherence Support

Pharmacists can help patients understand their medication regimen, address any concerns, and provide tools or strategies to improve adherence. This can reduce medication-related problems and hospitalisations.

Local Immediate Access to Emergency Medicines service

This service aims to ensure that appropriate palliative care and/or emergency drugs are stocked in participating community pharmacies before the need arises, resulting in improvement of access to medicines when required and reduction of hospital admissions.

Blood Pressure Management

Community pharmacies can work with patients to monitor chronic conditions such as high blood pressure, providing support and education to prevent complications and hospitalisations.

Hertfordshire and West Essex Integrated Care System

Pharmacy First service

- The Pharmacy First service includes seven new clinical pathways. These will enable pharmacists to offer advice to patients and supply NHS medicines where clinically appropriate including some prescription-only medicines under Patient Group Directions, to treat 7 common conditions:

System Wide Vaccination Programme – Key Actions for Winter 2025/26

- Increase uptake of flu vaccination amongst workforce (across acute, community and primary care providers) by working with providers to ensure access is available via occupational health services.
- Share good practice from those alas who have good uptake
- Continue to work closely with system partners on joined up approach to improve vaccination rates inc. comms, data, MECC offer etc. This will include working with CSAIS and primary care teams to increase flu vaccinations in children
- Increase awareness of National booking system via targeted communications (to include those under 74 who are clinically at risk) as will be open until end of flu campaign for the first time
- Promote awareness of newly launched walk-in finder once available to enable easy access to community pharmacy vaccination offer
- Promote **'year round'** offer of RSV vaccination for over 75s and pregnant women (over 28 weeks gestation
- Survey currently being undertaken to understand barriers to vaccination. Results awaited – due by mid August.
- Vaccination communications plan in place as per previous slide.
- Vaccination Cell for Winter to be Implemented

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South West Herts Health and Care Partnership (Place) Winter Plan 2025/26

Working together
for a healthier future

SWH HCP UEC/ System Resilience Winter plan 2025/6	
Governance / group	ICB Winter plan – UEC Board/ HCP Board
Author	Edward Davis

UEC Recovery Plan – SWH SRG has reviewed the UEC Recovery Plan. Below are the key areas from the UEC recovery plan for SWH SRG. The full analysis can be found in appendix 1

NHS E priority actions	SWH outline Response
Improve Admission avoidance, use of UTC and SDEC	• Dedicated HCP UEC workstreams focussing on UCR capacity and scope – aim to develop 'job cycle time' for UCR team. Will also look at enhancing scope of practise. Will link in with UCCH demand management work and modelling to determine cap in capacity. • UTC - Joint Improvement plan at Watford in place • SDEC - Development of ED SDEC at weekends. GP Access to ED SDEC and in conjunction with Care Coordination Centre
Strengthening ambulance trust direct access to SDEC	• Ambulance direct pathways to ACU/ED SDEC/EAU. Use of HALO in care coordination centre and for ambulance / patient navigation.
Neighbourhood MDTS coordinating proactive care for population cohorts with complex health and social need	• Each neighbourhood to develop their own plans to proactively support a vulnerable population cohort with the intention of putting in place proactive care to prevent admission into urgent care services (detail on slide 3)
Developing SPoA/Call before convey	• There is a strategic workstream looking to totally evolve the SWH CCC • For winter 25/26, there will be an interim solution that will be developed, building on the 24/25 trial of a ED consultant embedded within the CLCH UCR CCC • SWH will continue to support and work alongside the UCCH
Ambulance handover	• HO45 in place at Watford – agreed actions with EEAST • Agreed plan is 27 mins – June average 19 mins • Ambulance handover workstream in place
Mental Health response	• A proposal to develop a MH crisis assessment centre at Watford is part of the UEC capitol allocation – this has been agreed and a business plan is being developed at pace • MH UCC utilisation from Watford – will require a plan to increase • MH JRV utilisation will be monitored through SRG
Reduce 12 hour waits in ED	• WHTHT Patient Flow Programme refreshed for 25/26 and in line with UEC Plan. • Multiple workstreams align to 12 hour improvement trajectory including discharge/admission avoidance/SDEC improvements and expansion/medical workforce expansion. • Focus on frail/elderly support.
Reduce LoS	• WHTHT Patient Flow Programme refreshed for 25/26 and in line with UEC Plan. Multiple workstreams align to 12 hour improvement trajectory including discharge/admission avoidance/SDEC improvements and expansion/medical workforce expansion • Weekly LOS meetings in place. • Focus within ToCH on super stranded (+21 days) as per UEC plan
Discharge – Stretch targets for P0/Local agreed metrics for P1-P3 Ensure BCF resource included winter surge capacity/ Demonstrate effective use of capacity	• P0 strategy targets in place at West Herts including weekend discharges • As part of ToCH development work, a new SOP has been implemented and KPIs agreed between the ToCH and West Herts. • DTA beds have a winter surge capacity built in that wil come on line in October 25. • P1 review in progress which will feed into winter work to increase P1 patient percentage
Discharge – reduce internal delays > 48 hours	• Data Pack in development to highlight internal delay reasons • Patient flow team in Medicine and in Therapies to improve internal delays • QI workstream in surgery for TTA process • Good practice/areas for development highlighted from Stronger systems, safer care, building resilience events
Use Tech to drive down delays	• OPTICA has been introduced for use in the ToCH to support more efficient discharge

SWH HCP UEC/ System Resilience Winter plan 2025/26	
Governance / group	ICB Winter plan – UEC Board/ HCP Board
Author	Edward Davis

Priority Improvement Workstreams

– It is recognised that during winter there is less time to support improvement work. SWH HCP has developed a robust improvement work plan for UEC (appendix 2). Meetings associated with these workstreams will be deemed essential and will not be stood down even in extremis. These workstreams will be in addition to individual providers own winter plans. In addition, there will continue to be BAU partnerships and enabling working groups. In addition to the priority workstream, DTA capacity and MH will be a priority for monitoring through SRG, however, may not require working groups to be set up.

Workstream	Comments	Expected impact
Care Coordination	• A strategic branch of the workstream will design a new operating and clinical model for care coordination in SWH. This will support all prevention of admission and secondary care referrals from community clinicians, including primary care, EEAST, 111, CLCH teams and the UCCH to be managed and directed to the most suitable place for that patients. There will be a hierarchy of community first. However, unlikely to be in place by winter 25/26 • A second branch will work on an interim solution for winter 25/26 which will build on the work from winter 24/25 where an ED consultant was embedded within the CLCH UCR CCC.	• More patients directed to POA services. • Where POA not suitable, more patients directed to the right specialty and service within secondary care, avoiding the need to attend ED first.
Transfer of Care	• Over the last 12 months +, a working group has been evolving the previous IDT into a fully functioning ToCH. A new SOP has been written which gives a clear on day leadership structure that spans organisation boundaries, puts the patient at the centre and allows for seamless working. By winter 25/26, there will be an agreed set of KPIS for P1-P3 patients that will allow close monitoring. • There will be a continual review of the DTA overstay position to ensure the DTA bed stock is utilised as efficiently as possible. • A second workstreams revieing the CLCH rehab bed requirement with a focus on delivering more patients returning to their usual place of residence. • A learning audit has taken place that will allow CLCH to learn from system peers regarding which patients have been accepted onto P1 pathways, with the intention of identifying and learning or gaps in practise.	• Reduce average daily number of nMCTR – target 50/day by end of March 2025 • Increase number of patients retuning to normal place of residence – target 95% • Understand demand for rehab beds and model required capacity.
UCR resource and scope	• A time and motion study has been carried out to understand the true required allocation of time per activity within the UCR team. This will be used to support the capacity modelling to ensure that all resources are being used efficiently. • This will link with work undertaken as part of the ICB wide demand management group to model unmet demand and required capacity across UCR teams originating from A2S and Cb4C. • Following an audit in ED, the EM division at West Herts have proposed several key pathways to develop the scope of the UCR team.	• Increase efficiency of UCR team and therefore increase capacity within existing resource • Increase scope of practise of team • Model for future demand state to increase resourcing of team.
Same Day Urgent Care	• A mapping exercise has been undertaken to determine what models of same day appointments are offered across GP practise/PCNs/Neighbourhoods across SWH – this will lead to an options appraisal that will look to develop a best practise model of delivery, reviewing options such as pooling resource. This will look to ensure maximum capacity within primary care • An options appraisal has been produced which will ensure that current urgent care resource is shared equitably across each neighbourhood within SWH.	• Ensure an equitable offering of urgent care services across each neighbourhood. • Ensure efficiency and best practise is applied across primary care in SWH in relation to same day demand.
Other workstreams	• The care home conveyance group will continue to focus on key action that will reduce conveyance and admissions from care homes. This will include training to support VH patients within care homes, utilisation of HAARC and monitoring the new care home dashboard and identifying any outliers for targeted interventions. • There will be a continual review of the PTS position to ensure there is no adverse effect from the new booking procedure introduced to support over capacity working.	• Reduce conveyance and NEL from Care Homes • Support the effective use and deployment of NEPTS resource to support SWEH HCP

Urgent and Emergency Care

Improve **urgent and emergency care** through more anticipatory and more same day emergency care

aligned to the urgent and emergency care national priority

ICB 7 High Impact Interventions

- Improve A&E waiting times and ambulance response times compared to 2024/25, with a minimum of 78% of patients seen within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
- Category 2 ambulance response times should average no more than 30 minutes across 2025/26

I want to know if I need emergency care that I can access timely, high quality care

Urgent and emergency care

- Care coordination
- VH expansion
- Same day urgent care
- ToCH
- UCR

Planned: HCP

Delivered: HCP - SRG

Care Co-ordination	To create a single point of care co-ordination for clinicians where patients require timely and seamless access to urgent same day supported decision making
Transfer of Care	Development of a transfer of care hub for South West Hertfordshire managing the transfer of care from acute sites to community and from community and DTA beds to onward care
UCR Resource Mapping	Focus on additional UCR resource required to deliver the contribution to the 25% reduction in non-elective activity
Virtual Hospital	Expansion of Frailty H@H
Improving same day urgent care	Work to design an equitable urgent care offering across each neighbourhood including output from UTC review

South and West Herts Health and Care Partnership

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

West Essex Health and Care Partnership (Place) Winter Plan 2025/26

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WEHCP UEC / System Resilience Winter plan 2025/26	
Governance / group	ICB Winter Plan / LDB, HCP Board, CCTH EOG
Author	Michelle Bullman

Short term tactical transformation and key actions supporting operational oversight and management

West Essex HCP recognises that no single organisation can tackle winter pressures alone. Through a collaborative approach, partners are aligning services and co-designing solutions that prioritise early intervention and prevention of admission, a home first approach to transfer of care and seamless service transitions. This includes working with EEAST to avoid unnecessary conveyance to hospital through alternative pathways, earlier discharge planning, maximising UCR and Hospital@Home capacity.

WE Place Operations team is closely aligned to the Care Co-ordination Centre, TOCH and PAHT site team proving the helicopter view of the local and wider system and supporting operational flow, managing surge and escalations across place. WEHCP is building a more resilient, responsive, and patient-centred model of care—one that not only meets winter challenges but builds on the foundation for sustainable improvements year-round.

Tactical operational focus for Winter will include:

- Daily operational oversight. System capacity is monitored live, with agreed surge protocols within the CCC, enabling response and decompression within 24 hours.
- Working with HPFT and ERPUT MH to maximise the flow of MH patients into the MH UCC on the Lister Hospital site.
- Working with INTs to establish a High Intensity Users workstream initially focusing on presentations at PAHT.
- WE system wide programme of MADE events to support patient flow, prevention of admission and timely transfer of care
- Working with EEAST to redefine the role of the HALO and strengthen the relationships between HALO and ED and site team.

Resilience, Governance and call Candence – There is an established call cadence that will support the system during winter. Utilising the OPEL framework and SHREWD platform, this will allow rapid shared situational awareness and risk sharing across the three levels of support (Operational, Tactical, Strategic). In addition, WE will continue to support the SCC daily call cadence for shared situational awareness across the ICB. With the exception of the Clinical and Quality leads meeting, the below are seen as essential to system delivery and will not be stood down even in extremis.

Call	ICB/HCP	Cadence	Purpose
SCC daily	ICB	• Daily 09:30 • 16:30 if required	• A shared situational awareness across the ICB. • Support shared decision making across providers
Place based Escalation Call	HCP	• Mon, Weds, Fri 11am • Further daily calls as required	• Shared situational awareness of any risk affecting performance or delivery in WE today • Enable shared risk based decision making
WE System Daily Huddle	HCP	• Daily at 13:30 • Further calls as required	• Manage and resolve daily place based escalations and provide shared situation awareness over tactical issues
WE Senior UEC Leaders Ops Group	HCP	• Monthly	• Provide opportunity to discuss themes and challenges within the WE system and support UEC/Winter delivery and system flow.
Quality and Performance committee (WE)	HCP	• Monthly	• Takes assurance from LDB regarding delivery of UEC and system flow • First meeting in October

Workstreams improving and supporting delivery of care over Winter– Following review of the winter letter, the UEC recovery priorities and the 10 HII, the below established workstreams will support delivery of patient care over the Winte period and contribute to the management of system pressures, improving patient flow, supporting home first ethos and care closer to home. These workstreams will be in addition to individual providers own detailed winter plans.

Workstream highlights	Comments	Expected impact
PAH UEC Improvement Programme	• UEC divisional focus on acute medicine flow, medical SDEC, initial assesment, non-admitted pathway and ambulance handover. • Medicine divisional focus on discharge lounge utilisation, standardising board & ward round (including golden patients, TOC process improvement and optimisation of capacity management in Alex Health. • Surgery divisional focus on SDEC improvement programme and criteria led discharges. • CHAWS divisional focus on internal streaming to SDEC & UTC, external streaming to HUC OOH's and pharmacy and admission avoidance. • Clinical Support Services divisional focus on improving performance radiology & pathology internal professional standards • Review of nightingale ward usage to repurpose as escalation capacity	• To contribute to achieving 78% performance by March 2026. • To support meeting percentage of 12hr+ stays in ED (type 1) of 6.5%. • To achieve 30 mins average ambulance handover times.
Integrated Prevention of Admission (IPOA) Programme	• Development of CCC Bi Dashboard to have overview of capacity and flow in the system to support triage and decision making in MDT's • Maximising the use of prevention of admission services • UCR Review in Q2 • Maximise Access to the Stack activity, improving completion rates and reduce auto-rejects	• Reduce ED attendance for those who can be cared for under the POA streams
Proactive Care – Integrated Neighbourhood Teams (INT) Programme	• Proactive care including core INT CCH model and Frailty interventions. • Proactive care for vulnerable patients – CCC working with INTs to support direct access pathways for patients under pro-active care via the CCC. • Harlow South Reduction in Readmission Project • Harlow Locality Enhanced Proactive Care Project - EPUT review /develop care plans fpr patients identified by primary care as at risk of admission ahead of Winter • LBC Care Home Hub • Care Home QI Project • St Clare Hospice, Saffron Walden Community Hospital (run by EPUT), and North Uttlesford PCN have established a partnership to deliver two specialist end of life care beds for patients at the Saffron Walden Community Hospital.	• Reduce rate of emergency admissions for falls within the community for >65's • Reduction in avoidable ED attendances from nursing & residential homes
Community Hospital Review Programme	• Community Hosptial review - whole-system review of community hospital capacity in WE examining how existing estate and service delivery models can best meet the future care needs of the West Essex population. It aims to support a modernised approach to intermediate care, step-down/step-up provision, ambulatory and sub-acute services — aligned to the Care Closer to Home model. • A system wide model in place via the Care Coordination Centre to coordinate UCR, H@H, reablement and community beds using a standard triage approach.	• An increase in the number of patients supported in the community and therefore reduced ED attendances.
Integrated Discharge Improvement Programme (IDIP) including Intermediate Care	• Discharge is planned from admission, with CCC and ToC teams to become fully integrated by Winter 25 and then progress in working towards supporting early coordination, particularly for complex cases. • Utilisation of the discharge lounge to generate earlier flow and bed capacity • Maintain OPAL as an assessment unit and review workforce to bolster weekend cover • Increase in the utilisation of H@H • Utilisation of the community bed model agreed following review • Tracking of all discharges over 48hrs supporting real time solutions, live monitoring of system capacity, discharge planning on admission supporting early coordination. • Pathway 0 Hospital Discharge Support offer form VCFSE • P1-P3 discharge pathways are aligned to the Home First model, community hospital review, D2A complex bed model and reablement access.	• Improve flow at PAHT • Minimise TTA delays • Improve TOC team capacity to increase coordinated & joint working
Mental Health	• Established MH escalation process in place working with both EPUT & HPFT for WE patients. • MH RRV – Delays to mobilisation of WE vehicle should be resolved for Winter roll out. • Ongoing works to improve the pathway for EPUT MH patients to utilise MHUCC.	• Ensure oversight of MH pathway • Reduction in MH

Transformation from a West Essex Perspective

PAH Board

Executive Management Board

Operational Board

WEHCP Board

WEHCP Quality and Transformation Committee

WEHCP Clinical and Professional Leads Committee

Care Closer to Home EOG

PAHT Urgent Care Programme Board

NHSE Tiering

Cancer Board

Outpatients Improvement Programme

Theatres Improvement Programme

Urgent Care Programme (internal PAH)

Frailty (internal PAH)

Care Closer to Home

Performance and accountability (exiting tier 1)

Unwarranted variation (pathway and process)

Case management and pathway navigation

Tumour Site Leads (job planning and leadership)

Virtual Consultations

Referral Optimisation

Patient Initiated Follow Up

842

POA (inc. ePOA)

Emergency Flow Project

Team Job Planning

Ophthalmology – Vanguard

Urology

UEC

Surgery

CHAWS

CSS

OPAL as assessment

Frailty Hot Clinics (OPAL)

Frailty Cancer pathways

UEC IDIP Programme

UEC POA Programme

Proactive Care (INTs) Programme

Culture Change Programme

Community Hospital Review Programme

Integration and partnership priorities enabling Care Closer to Home - Frailty, Children and Young People (Paediatrics) and adult emergency care

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ENH HCP UEC/ System Resilience Winter plan 2025/26	
Governance / group	ICB Winter plan/ HCP Board
Author	Phil Lumbard

High Impact Interventions – In September 2024, a review of the HII areas was carried out by ENH SRG. The below score were assigned (1-8) with comments in each area.

	Comment
Community beds	• No additional community bed capacity funded for 25/26
Inpatient flow	Delivery of ENHT UEC improvement plan 25/26
Acute Beds	32 additional acute beds funded this winter
Demand manamgment	Continued expansion of ICS UCCH in line with NHSE
VH	C.£4m invest into continued delivery for 25/26

Resilience, Governance and call Candence – There is an established resilience call cadence that will support the system during winter. Utilising the OPEL framework and SHREWD platform, this will allow rapid shared situational awareness and risk sharing across the three levels of support (Operational, Tactical, Strategic). In addition, SWH will continue to support and be involved in the SCC daily call cadence for shared situational awareness across the ICB. With the exception of the Q+P meeting, the below are seen as essential to system delivery and will not be stood down even in extremis.

	P		
SCC daily	ICB	• Daily 09:30 • 16:30 if required	• A shared situational awareness across the ICB. • Support shared decision making across providers
Daily Operational call	HCP	• Daily 10am, 1pm • Further daily calls as required	• Shared situational awareness of any risk affecting performance or delivery in SWH today • Enable shared risk based decision making
Weekly delay call	HCP	• Weekly – Wed • Further calls as required	• Take escalations from daily call and provide shared situation awareness over discharge delays
Monthly CHC/Complex pathway review	HCP	• Monthly	• Oversight CHC & CCP patients
Quality and Performance	HCP	• Monthly	• Takes assurance from SRG regarding delivery of UEC and system flow

Winter letter response – SWH SRG has reviewed the winter letter content. This has helped informed our decision making over winter improvement priority areas. A high level response to each area covered in the letter is provided below.

Letter heading	ENH outline Response
Planning and financial	• ENH will work to deliver against the agreed 25/26 planning trajectories. • Improvement workstreams will look to utilise existing workforce and will not have access to addition funds. • Capital fund for AHO expansion
Providing safe care	• The resilience and governance call cadence will ensure operational, tactical and strategic oversight of delivery against plan and seek to give assurance on day to day safety implications • SRG will ensure oversight of delivery against action plan • Delivery oversight of ICB NEL frailty reduction
Supporting people to stay well	• Vaccination strategy to be developed outside of UEC team
Maintaining patient safety and experience	• Our CCC priority workstream will seek to deliver greater prevention of admission particularly in frail patients. • CTH also identified as priority improvement area • SCC has daily clinical on call for clinical oversight

Priority Improvement Workstreams – It is recognised that during winter there is less time to support improvement work. Therefore, ENH wanted to prioritise 3 to 4 improvement workstreams to deliver against. Having reviewed the winter letter, the UEC recovery priorities and the 10 HII, SWH SRG has developed the below priority improvement workstreams to dedicate system time and resource to for winter 24/25. Meetings associated with these workstreams will be deemed essential and will not be stood down even in extremis. These workstreams will be in addition to individual providers own winter plans. In addition, there will continue to be BAU partnerships and enabling working groups. In addition to the priority workstream, DTA capacity and MH will be a priority for monitoring through SRG, however, may not require working groups to be set up.

Workstream	Comments	Expected impact
Demand management and Care Coordination	• Contimue to develop ICB UCCH offer to support winter	• An increase in the number of patients supported in the community and therefore reduced ED attendance. • Increase in patients supported directly to the right place for treatment within the acute ie. SDEC
4 hour performance	• Continued delivery of the ENHT UEC programme across 25/26	• To achieve or exceed plan
Discharge Improvement programme	• A task and finish group has been established to look further improve discharge standards within ENH. • The group will look at both integrated pathways as well as data quality and reporting	• Increase number of daily discharges • Reduce delays • Consistent reliable data

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High Level Provider Plans to Support Winter 2025/26

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Slides	High Level Provider Plans to Support Winter 2025/26
54 - 56	• EEAST Winter Actions 2025/26
57	• HUC High Level Actions to support Winter 2025/26
58	• Primary Care Actions for Winter 2025/26
59	• East and North Herts Trust - Key Actions for Winter 2025/26
60	• West Herts Hospital Trust - Key Actions for Winter 2025/26
61	• PAHT Actions to support HWE Winter 2025/26
62-63	• Community Provider Trust Actions to Support HWE Winter Plan
64	• MH Actions to support HWE Winter Plan 2025/26
65-70	• HCC and ECC Social Care Actions to Support HWE This Winter 2025/6 Including BCF Support
71	• Maximising VCSE Support for Winter 2025/26

EEAST Winter Actions 2025/26

- Review and update of our Clinical Safety Plan
  - Including the Clinical Safety Cell to provide live oversight during periods of escalation
- Local Operational Oversight Cells
  - Will be in place to support each of the 6 expect SCCs
  - To work in partnership with all local providers
  - To coordinate operational activity, performance, challenges and escalations needed
- Executive Lead in place for each ICB
- Delivery of all Operational Productivity measures in agreed trajectories
  - Including Handover to Clear, Hear & Treat and Out of Service reductions
- Maximise our Patient Facing Staff hours
  - Reductions in annual leave (50%)
  - Reductions in training
  - Use of overtime and incentive schemes
  - Sickness management
  - Support with Private Ambulance Service provision
- Active Fleet Management
  - Focus on vehicle availability against shift requirements
  - Fleet logistics Cell (being implemented over summer period in preparation)
- Local Engagement

EEAST Winter Actions – Partnership Working for Winter 2025/26

- 111 Demand Management
  - Assistance with driving down the demand on 999 and emergency services wherever possible
- UCCH Delivery
  - Consistency of daily delivery
  - Agreed capacity for alternative pathways, can this be increased?
  - KPIs for delivery– what should we expect?
- Arrival to Handover
  - UEC Plan ask for no handovers over 45 mins, will this be achieved? What are our expectations/plans?
  - Trajectories for winter handovers
- Call Before Convey
  - Consistency of delivery across areas
  - Agreed KPIs for use of and delivery of requirements
- Local Engagement

ICB HWE : System's set of requests (X5) from EEAST.

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East of England Ambulance Service
NHS Trust

East North Herts Place Area.

- Increase Community response capacity within HCT
- Support links with HUC for EIV response
- Increased volume of A2S calls completed
- Reduce the number of auto-reject calls passed

South Herts Place Area.

- Increase Community response capacity within CLCH
- Increased volume of A2S calls completed
- Reduce the number of auto-reject calls passed

West Essex Place Area .

- MHRV to go live
- Increase Community response capacity within EPUT
- Increased volume of A2S calls completed
- Reduce the number of auto-reject calls passed

ICB HWE

- A2H within 30 minutes (HO45 agreement)
- Link SDEC Frailty units with UCCH GP/Clinician/HUC/CBYC
- Auto-reject rate on A2S to reduce
- Maximise call cycle time on CBYC 20mins
- Support to establish an Interoperability Toolkit (ITK) link with the 111 providers

EEAST Commitments

- Mandate CB4C for patients over 75y. (Subject to 10-10 or clinical appropriateness) – subject to CB4UC capacity to support uplift in activity
- Maximise our own H&T.
- Annual Leave reduced by 50% over Christmas Period.
- Lead Director per ICB
- LOOC

HUC Actions to Support HWE Winter Plans 2025

- HUC 111 Management and workforce planning teams work closely with internal BI teams to accurately forecast upcoming 111 activity to meet expected seasonality demands.
- HUC's internal surge and escalation strategy works in line with the OPEL triggers.
- Recruitment to 111 remains a high priority during the winter period to meet the expected uplift in demand.
- Homeworking for eligible staff members also supports the resilience of our services and work life balance of our colleagues.
- On Call Managers on site and overseeing all services provided by HUC for visible, accessible leadership.
- Operational Delivery Managers overseeing the Contact Centres in real time 24/7 monitoring Opel thresholds and pressures.
- HUC offer targeted incentives during the busy winter season to encourage staff to work above contracted hours.
- Coaches/Clinical Floorwalkers in the contact centres, and working remotely, to support the workforce and staff in the graduation bay requiring additional support.
- GP Navigator in the CAS 111 to monitor patient safety actively move cases in the queue and provide second triage to pathways outcomes
- Refused dispositions project in place to manage the acuity of patients safely
- Refreshed failed contacts to reduce pressures in the queues
- Dedicated CAS management on site to monitor and manage cases, and productivity.

Primary Care Actions to Support HWE Winter Plans 2025/26

- Continued work to develop neighbourhood multidisciplinary teams to support those with health needs that can be proactively managed, which will avoid hospital admission.
- Support patients in their discharge journey to avoid hospital readmissions.
- Promote the use of alternatives to ED by ensuring General Practice have the most up to date information on available services.
- Encourage and promote the use of Advice and Guidance support before sending patients to acute hospital settings.
- Reviews practice website to ensure patients find them easy to navigate and provides relevant support and correct signposting options.
- Support National Vaccination Programme with local delivery
- Maximise use of alternative pathways and ED avoidance through development of a primary care pathway direct to UCCH
- Engaging with Primary Care (PC) to understanding PC role in demand management and educational opportunities for GPs involved in the hub referrals
- All practice will be using online consultations by October 2025, during core hours.
- Monitor peaks in demand and support practices to manage this.
- Use any emerging intelligence on health areas that may need a focus, such as respiratory illness outbreaks.
- Primary Care senior on-call manager in place Monday – Friday.

East and North Herts Trust - Key Actions for Winter 2025/26

Prevention

Flu vaccine will be offered to all employees, contractors, volunteers and students from 1 October 2025.

The importance, safety, effectiveness and availability of the vaccine will be promoted using the following:

- All staff email from the CEO
- Weekly Trust communications email
- Posters and fliers with QR code for booking app
- Social media posts
- Team what's app messages
- Presentations at meetings, staff networks and huddles
- Intranet page
- Roaming vaccine team

Update will be monitored through divisional performance meetings and TMG

Capacity

Review of bed base and identification using the full capacity protocol of triggers for increased capacity with specific reference to ED, SDEC, critical care, stroke, PPCI, trauma, paediatric and respiratory capacity.

Robust review of all patients with a length of stay over 21 days.

Early discharge planning and increased use of the discharge lounge and discharges before midday.

Completion of ED capital work in ambulance handover.

Monitoring of RTT and cancer performance against trajectory.

Ensuring use of hospital at home.

Maximising frailty pathways

Infection Prevention and Control

Management of PPE stock and top up is in place.

Monitoring of staff fit testing and escalation through TMG and divisional performance meetings of any areas with inadequate numbers of staff tested and passed.

IPC and site working closely on outbreak actions including bed / ward closures and cohort wards.

Leadership

Daily monitoring from October on local and national profile to indicate surge in activity.

Ensuring equal take up of leave each quarter to ensure maximum resilience to cope with surge in quarter 4.

Review of vaccination uptake and staff sickness at TMG.

System wide communication, collaboration and support for patient pathways and colleagues, early escalations of concerns and requests for support.

Consideration and Risks

Attention and monitoring of impact of surge to RTT, cancer and diagnostic capacity

Ensuing prompt step down from critical care and hyper acute stroke unit to protect capacity and accelerate patient recovery.

Risk to safely cope with surge if industrial action continues

Implementation of phase 1 of OneEPR is scheduled for February 2026. Training and go live implication on work force, activity and flow.

WHHT Priority Actions for Winter 2025	
Improve Admission avoidance, use of UTC and SDEC	• Dedicated HCP UEC workstreams focussing on UCR capacity and scope – aim to develop 'job cycle time' for UCR team. Will also look at enhancing scope of practise. Will link in with UCCH demand management work and modelling to determine cap in capacity. • UTC - Joint Improvement plan at Watford in place • SDEC - Development of ED SDEC at weekends. GP Access to ED SDEC and in conjunction with Care Coordination Centre
Strengthening ambulance trust direct access to SDEC	• Ambulance direct pathways to ACU/ED SDEC/EAU. Use of HALO in care coordination centre and for ambulance / patient navigation.
Neighbourhood MDTS coordinating proactive care for population cohorts with complex health and social need	• Each neighbourhood to develop their own plans to proactively support a vulnerable population cohort with the intention of putting in place proactive care to prevent admission into urgent care services (detail on slide 3)
Developing SPoA/Call before convey	• There is a strategic workstream looking to totally evolve the SWH CCC • For winter 25/26, there will be an interim solution that will be developed, building on the 24/25 trial of a ED consultant embedded within the CLCH UCR CCC • SWH will continue to support and work alongside the UCCH
Ambulance handover	• HO45 in place at Watford – agreed actions with EEAST • Agreed plan is 27 mins – June average 19 mins • Ambulance handover workstream in place
Mental Health response	• A proposal to develop a MH crisis assessment centre at Watford is part of the UEC capitol allocation – this has been agreed and a business plan is being developed at pace • MH UCC utilisation from Watford – will require a plan to increase • MH JRV utilisation will be monitored through SRG
Reduce 12 hour waits in ED	• WHTHT Patient Flow Programme refreshed for 25/26 and in line with UEC Plan. • Multiple workstreams align to 12 hour improvement trajectory including discharge/admission avoidance/SDEC improvements and expansion/medical workforce expansion. • Focus on frail/elderly support.
Reduce LoS	• WHTHT Patient Flow Programme refreshed for 25/26 and in line with UEC Plan. Multiple workstreams align to 12 hour improvement trajectory including discharge/admission avoidance/SDEC improvements and expansion/medical workforce expansion • Weekly LOS meetings in place. • Focus within ToCH on super stranded (+21 days) as per UEC plan
Discharge – Stretch targets for P0/Local agreed metrics for P1-P3 Ensure BCF resource included winter surge capacity/ Demonstrate effective use of capacity	• P0 strategy targets in place at West Herts including weekend discharges • As part of ToCH development work, a new SOP has been implemented and KPIs agreed between the ToCH and West Herts. • DTA beds have a winter surge capacity built in that wil come on line in October 25. • P1 review in progress which will feed into winter work to increase P1 patient percentage
Discharge – reduce internal delays > 48 hours	• Data Pack in development to highlight internal delay reasons • Patient flow team in Medicine and in Therapies to improve internal delays • QI workstream in surgery for TTA process • Good practice/areas for development highlighted from Stronger systems, safer care, building resilience events
Use Tech to drive down delays	• OPTICA has been introduced for use in the ToCH to support more efficient discharge

PAHT Actions to support HWE this Winter

Collaborative winter resilience plan to ensure the safe care of patients - agreed winter surge capacity through risk based reverse boarding, with aligned surgical bed base to ensure elective patients are not compromised.

UEC improvement Programme

Trust trajectory to achieve 78% 4hr Ed performance by March 26

- Ambulance – Successful PDSA which increased triage capacity to be embedded to support achievement of <30 mins offloads and support of HO45
- 4 hour standard – Trust wide improvement plan focused on increasing early flow through the ward areas.
- UEC improvement plan is focusing on reducing the number of breaches within Further Assessment through the early identification of medical SDEC patients who can be treated outside of the ED and the re launch of the internal professional standards
- Improve early escalation of ambulance offload delays
- Refinement of EM SDEC pathways to enable direct streaming of patients
- Continue resetting of AAU and Charnley short stay unit
- Established in reach from EPUT community H@home consultant/medic to support discharge and reduce admissions at the front door

Plans to further embed this approach across other pathways

- IUTC – improve utilisation and streaming to support decompression in ED
- Paeds transformational programme delivery – to achieve 90%+ daily

Discharge Improvement Programme (DIP)

- Medicine frailty improvement plan including reduction of LoS through and protecting assessment (not bedding) OPAL AFU
- Medical ACPs to undertake missed opportunities audit reviewing all admitted and non-admitted Acute Medicine breaches
- Standardising Board and Ward rounds (inc. Golden patients)
- Alex Health optimising Capacity Management
- Focused delivery of improved % of discharges before midday
- Improve Discharge Lounge utilisation (enabling earlier discharges and improving flow)
- Provide safe and good quality care for patients cared for in escalation spaces and ensure all risk assessments completed in line with PAHT's Full Capacity Protocol
- Optimise the use of H@H capacity
- Continue to improve joint working and practice communication between TOCH and CCC in and out of hours.

Community Provider Trust Actions to Support HWE Winter Plan (1)

- Daily board rounds are in place across all community inpatient units and discharge planning commences on the day of admission with EDD set within 24hrs . All patients have assessments completed within 24hrs of admission including an assessment for mobility.
- Weekly inpatient MDT reviews, EDD set within 24hrs, and rehab goals set.
- Flexible admission criteria to also support P1 and P2 social care delays and also provision of mutual aid to system partners to support flow.
- Direct admissions from the community to prevent acute hospital attendances.
- Expansion of slow stream rehab
- Expansion of direct access referral pathways into early intervention vehicle service and SDEC pathways to support POA services as well as the ability to respond to Falls as part of the UCRT pathway
- Continue to promote virtual hospital pathways across the system to support full utilisation of capacity
- Provision of a community first dose IV pathway
- Care Coordination Centre in place - integrated multidisciplinary team works collectively with all system partners 7 days a week and is responsible for single point of triage, admission avoidance and transfer of care.
    - Facilitates shared decision making which is person centric based on health and care needs.
    - Implements the D2A guidance supporting the “home first” principles.
    - Supports same day discharge and maximises capacity by managing transfer of care, having oversight of system demand and capacity.
    - Harnesses the deployment of admission avoidance services via UCR, falls response, virtual hospital and community hospital direct admissions.
    - Supports the system to reduce ambulance conveyances to acute trusts by enabling access to the stack/handover at home by a skilled workforce.
    - Prioritises use of system resources, as adults are navigated and receive the correct service first time.

Community Provider Trust Actions to Support HWE Winter Plan (2)

- Virtual Ward providing appropriate step up and step-down capacity is in place optimising the use of the current capacity for remote monitoring and face to face care including first dose IV antibiotics, IV diuresis and IV fluids.to increase utilisation ahead of winter by:
  - Daily in-reach to acutes, working collaboratively with medical staff to proactively identify suitable adults for the service from ED, assessment areas, UTC and wards.
  - UCR Response 8am-8pm 7 days a week
  - Implementing improved access to SDEC and onward referral to virtual ward or other admission avoidance services.
  - Proactive working with primary care and care homes to increase referrals to the virtual hospital service and improve direct assess and referral process.
- CLCH piloting a Community Treatment Clinic for additional IV capacity

Mental Health Actions for HWE this Winter

- Developing a winter resilience plan focusing on the following priorities:
  - Capacity / Demand / Surge from independent providers as needed.
  - Flow, Discharge and Clinically Ready For Discharge escalations.
  - MHLDA Inpatient Quality Programme.
  - Enhanced Crisis support
  - 24/7 CRHTT, First Response, MH Urgent Care Centre
  - 24/7 MH Liaison
  - Effective community capacity and pathway
  - Oversight, decision making and governance / Daily Rhythm / 7 day working
  - SHREWD Embedded within day-to-day operations and escalation process regarding OPEL actions developed and ready to mobilise
  - Consider Extremis actions for post OPEL 4

- Crisis Care Partnership Board, sustain UEC funding of VCFSE Crisis Alternatives, continued use of MH Joint Response Vehicles, 136 MH support at Lister, crisis comms refresh.

- Vaccination programme developed and to be delivered

- Additional S136 place of safety in development

- MH Urgent Care Centre embedded to reduce admissions, speed up flow through ED and reduce 136 use.

- Transformation plans in place for pathways across; adult acute, crisis, community & rehabilitation; older adult inpatient, crisis and community; CYP crisis, inpatient and community, developing targeted services for people with personality disorder and complex emotional needs (HPFT Ascent model), HPFT crisis house, increase adult inpatient capacity with Dove ward repurpose, Seward Lodge project

- Emergency access to housing / hotel accommodation out of hours with follow up in hours in place.

- Mental Health Discharge (10 Actions) implemented; strengthen discharge processes, escalations & enhanced bed management approach including new digital solution.

- Fully operational CYP crisis service in place.

- Continued roll out of Level 2 Oliver McGowen training programme to maximise impact of interventions for people with a LD and/or autism.

- Single Point of Access enables swift response to all mental health referrals ensuring right place right time responses.

- Continued use of wrap around care and support for people who need same day follow up but don't require ED attendance (SDEC)

- Continue close VCFSE joint working across pathways from early help to crisis and HIU work.

ECC Social Care Actions to Support HWE This Winter (1)

- Build on initiatives from 2024/25 and strengthen continuation of initiatives such as dementia discharge support and continued roll out of the Reablement Matrix which supports better use of capacity
- Use learning from previous years and agreed principles with partners that have help shape proposals and our approach:
    - Comply with guidance around funding sources and bring providers into the planning conversations where possible
    - Do not further complicate systems – build on what's already there with a focus on 'home first'
    - Work collaboratively across Health and Social Care to support design, implementations and visibility of our initiatives
    - Explore admission avoidance solutions where funding source guidance allows
    - Focus on fewer but larger interventions to support clearer evaluation of impact and build in the ability to flex
    - Ensure good data collection and systemic sharing of insight
- Expand reach of local initiatives at an alliance level to connect individuals to community-based support to reduce admission and readmission to hospital and residential care including:
- Falls prevention initiatives such as slipper swaps and information, advice and guidance on strength and balance home exercises to prevent falls, local groups to connect with, and wider social care support.
- Voluntary and Community Sector discharge support to help people re-settle at home after and admission.
- Therapy support to Additional Reablement Capacity service
- Continue to set a LAPEL level which guides us in standing up/down infrastructure for pressure response, including frequency of system calls and reporting. Senior Leaders convene at the weekly Priority Review Meeting (PRM) to set this level and review our SITREP report as well as give position statements from each locality area. This forum is key in coordinating the ECC response around winter.

ECC Social Care Actions to Support HWE This Winter (2)

Intermediate Care

Increase the numbers of people who are supported to stay at home, promote greater use of care technology and continue to reduce the need for long-term care to:

- Improve flow & efficiency across services.
- Focus on outcomes rather than hours of support.
- Be integrated and guided by a single joined-up service specification.
- Ensure protected capacity for admission avoidance.
- Focus on continuous improvement across health and care services.

We have already made significant progress through the recommissioning of our main reablement contracts with revised objectives and are working on reviewing the bridging service to improve flow and ensure we commission the right activity for admission avoidance and our home first ambitions with a focus on ensuring adults go directly into reablement services where appropriate. Through these contracts partners will coordinate and flex total capacity to meet demand and needs of adults, while reducing the need to purchase Reablement services on a spot basis. This co-ordination will result in fewer hand offs and faster pickups of reablement, supporting faster discharges.

Our intermediate care programme will also be developed through:

- Joint work on reviewing decision making points and Intermediate Care pathways and flows to build a shared understanding of responsibilities and agreed criteria in place – including Continuing Health Care.
- Implementation of new Home to Assess service to ensure reablement capacity is maximised for those appropriate for it.
- Procurement activity timed to ensure new contracts are mobilised before the winter period (H2a and RtH in North).
- Flexibility in-built to contracts to allow for surge capacity to be switched on simply
- The development of an IC Dashboard to provide more detailed insight on use across the different services and the county, demand/capacity requirements and analysis of length of stay, spot usage, IP placements, and outcomes including failed starts, restarts, readmissions, and ongoing care needs.

Better Care Funded Schemes – West Essex

- **Care Technology** continues to grow with 14,000 people benefiting to keep them independent in their own homes. We will work in partnership across the local authority and NHS to link our care technology advisers to individuals, carers and health and care staff to identify where technology can have the greatest impact on managing demand and system flows. It is expected this service will grow to support 19,500 people by March 2026.
- Our BCF plan also recognises the significant contribution **Carers** make to preventing admissions and care needs escalating. Our carers offer funded through the BCF will provide:
- A central point of Carers can contact directly for early information and guidance and can be referred on to our specialist offer or to social care. Call handlers are trained to identify people that call for other services as carers.
- **Specialist Carers Pathway Co-ordinators** are working with partners to improve identification of unpaid carers and their access to support.
- Specialist support that includes; practical solutions to address specific challenges; and solution-focused interventions such as conflict resolution, mediation and emotional wellbeing support.
- Other key schemes and initiatives are:
- Recovery to Home beds, complex beds, D2A capacity (to be updated for each ICB)
- Dementia Community Support Service
- Funding allocated for ‘spot’ reablement demand
- Additional Reablement Capacity (ARC) and ECL.
- Alongside delivery of these initiatives to help proactively manage demand, where possible we will flex existing capacity in our contracts, and if needed use spot purchasing. We are also working on maturing our TOCH teams to support effective pathway identification and utilisation, making sure people are accessing the right services at the right time.

HCC Social Care Actions to Support HWE This Winter (1)

- Processes are now in place to receive **INT** referrals into our front door (ACS Contact Centre), which will be triaged and flagged to the appropriate team (New this winter)
- Connect and Prevent – (**Reablement First**) prioritises reablement before long-term care using digital tools to enhance independence and reduce hospital admissions. (new this winter)
- Connect and Prevent – (**Carer Support**) uses digital technology to identify and support unpaid carers at risk, preventing breakdowns and emergency admissions. (new this winter)
- **Delegated Healthcare Activities (HCPA)** piloting projects in care/nursing/homecare to support the development delegated healthcare activities in care settings. (new this winter)
- **Health and HCC Early Intervention Vehicle (EIV)** provides rapid, integrated care in the community to prevent admissions and support safe discharge. (in place last winter)
- **Care Home Lifting Devices Project (HCPA**) equips 53 care homes with lifting devices to manage falls safely, reduce ambulance reliance, and prevent hospital admissions. (in place last winter)
- **Joint HCC & CHC Out of Hours Crisis Support Service** provides timely and effective care for people and their carers outside of regular Continuing Health Care service hours, enhancing service coordination and optimising resources. (new this winter)
- **Interagency Dispute Resolution Policy: NHS Framework for Continuing Healthcare** to avoid and /or resolve disputes promptly in a person-centred way. To ensure individuals are not left without appropriate support while disputes between statutory bodies about funding responsibilities are resolved. (new this winter)

HCC Social Care Actions to Support HWE This Winter (2)

- Joint Funding Policy: NHS Continuing Healthcare to support making timebound decisions, using an evidence based approach and sharing information in timely way. To aide the equitable agreement of joint health and social care packages, where funding responsibilities will be divided between the NHS and Local Authority. (new this winter)
- Post Hospital Review Team in S&WH will be providing 8 am to 8pm cover and 8am to 6pm ENH
- Annual social care provider winter preparedness webinar
- Reminders about staff resilience though winter
- Herts Sports Partnership trains primary care staff to prescribe physical activity and signpost older adults to local movement opportunities to reduce isolation and admissions.
- Slipper Swap Scheme provides anti-slip slippers and falls prevention advice to reduce injury risk and hospital admissions among older adults.
- HertsHelp connects residents and carers to timely support, helping prevent admissions and support safe discharge during winter.
- Adverse weather conference for the VCFSE
- Robust cold weather health alert cascade in place
- Collaborative winter vaccination communications with the ICB
- HCC front line staff flu vaccination is targeted to eligible staff (managers identifying front line workers) via HR and will be providing vouchers. Giving staff more flexibility so that staff could get a vaccine when and where it suited them most.
- Data Inspired Living – is an innovative assistive technology that supports independent living. The service utilizes a dashboard that collects data from various sensors placed around the home, providing a near real-time view of daily routines. This service will be providing urgent installations to support hospital discharge

Better Care Funded Schemes – Hertfordshire

- **Social Care Prevention of Admission Service** delivers early support to prevent hospitalisation and maintain independence
- **Discharge to Assess Beds** (69 Summer, 99 beds in the Winter) supports people who are clinically optimised to leave hospital and have an assessment and continue care in a care home up to 28 days. These beds have multi-agency health and social care wraparound support to work along the care home provider to enable people to reach their personalised goals.
- **CHC Advanced Practitioners** provide resilience for CHC, and are responsible for managing the demand for Social Worker assessment requests from the ICB during CHC processes
- **Designated Social Care Lead for Inpatient Mental Health Discharges** (Advanced Practitioner) supports smoother discharges from HPFT inpatient beds
- **Hertfordshire's Carers Support Services** provides support to unpaid carers and carers breaks
- **Hospital and Community Navigation Service** is a partnership of voluntary organisations working closely together to provide an integrated social prescribing service throughout Hertfordshire.
- **Social Workers in Emergency Department (ED)** at Lister and Princess Alexandra Hospital (PAH) aim to prevent unnecessary hospital admissions by assessing and supporting rapid, safe, and timely discharges 7 days a week
- Funded social care staff within the **ENH Transfer of Care Hub** and **Transfer of Care Hub** in South and West Herts (in place last winter). TOCH in S&WH is also using Opticia to support discharges
- The **Hertfordshire Home Improvement Agency (HHIA**) is continuing to support residents within the partnership with Districts (Stevenage, North Herts, St Albans, Broxbourne, East Herts and Watford) to remain independent in their own homes with Disabled Facilities Grant funding
- **Reablement** home care is a short-term service specifically commissioned to work with people who initially need some care and support to support their independence.
- **HES** Winter operational resilience plans will be in place to support equipment delivery over the winter period
- **Voluntary Sector HILS Active Ageing** provides one-to-one exercise support to people aged 65 and over living in their own home. (in place last winter)
- **Prevention and Enablement Service** (HCPA) trains care staff in exercise and falls prevention to embed mobility support and reduce winter hospital admissions. (in place last winter)
- **Acoustic Monitoring Pilot (HCPA)** uses sound detection in care homes to enable faster interventions and prevent hospital admissions, especially for residents with dementia. (new this winter)
- **Impartial Assessor Service (HCPA)** facilitates safe discharges from hospitals to care homes, reducing readmissions and improving system flow. (in place last winter)
- **Hospital and Community Navigation Service operates 7 days per week,** supporting vulnerable residents discharged from Hospital to Home. An Enhanced 14 day service assisting with practical support, urgent key safe installations, bed moves and decluttering within the same day or 24-hour response is available to the most vulnerable people to reduce the risk of re-admission. (in place last winter)
- **Health and Independent Living Support (HILS) Discharge 14-Day offer** for meals on wheels and medication prompts and wellbeing checks strengthens safe recovery at home. (in place last winter)
- **Enhanced volunteer support with Reach Out service** co-ordinates volunteers to provide companionship and practical support to older people who are medically vulnerable and at risk of hospital admission or who have recently been discharged from hospital. (in place last winter)
- **Voluntary sector wellbeing calls made to people over 65** who have been discharged on pathway 0 (with no new needs or increased needs) to check if there are any unmet needs, new needs or signposting required to prevent readmissions and to remain at home. (in place last winter)

Hertfordshire and West Essex Integrated Care System

Maximising VCSE Support for Winter 2025/26

- **Money advice** through CABx and joint work with HCC and PCN SPLWs on promoting access to Household Support etc. https://www.hertfordshire.gov.uk/about-the-council/news/cost-of-living/help-to-manage-the-cost-of-living.aspx
- **Hertfordshire VCFSE Alliance** providing voice of the sector within the ICS/ICB, with other forums including the Hertfordshire Community Leaders Forum and local CVSs across the wider system.
- Access to **warm spaces**: https://www.hertfordshire.gov.uk/services/adult-social-services/news-and-campaigns/community-spaces.aspx
- **Money Advice Unit** within the Council: https://www.hertfordshire.gov.uk/media-library/documents/adult-social-services/money-advice-factsheets/money-advice-unit-what-we-do.pdf
- **Hertfordshire Faith and Health Board** aims to connect health, care and social care services with underserved communities by working closely with faith leaders and community groups.
- **Volunteering** (good for volunteer as well as society) - £550k over three years Volunteering for Health project – more flexible and integrated use of volunteers across 'place' (passporting). Ongoing commissioning of GoVolHerts and local volunteer centres via Community Help Hertfordshire – opportunity to direct volunteer recruitment efforts to any services needing additional capacity.
- Pathway 0 ff-up calls (65+s 1 day and 5 days) – associated w 20% ↓ in 7-day reattendances at A&E etc; Ticket Home in PAH
- Waiting Well calls – 10% (depending on speciality) need social prescribing (SP); all value contact; 3% gone private
- Hospital SP (Herts) linked to 'wrap around' VCFSE support (house clearance, fridge filling, money advice and social prescribing) estimated savings to HCC of 1,081 bed nights worth approximately £324k; Ticket Home PAH
- Falls prevention/Postural Stability in VCFSE; streamlining referrals from VCFSE; part of frailty deep dive to ICB in May
- Carer nurse support in the acutes (Herts) and ensuring links to the VCFSE Carers Organisations; Ticket Home in PAH
- Mind Crisis Cafes (minimum of 20% of users would have gone to A&E if not in existence - Herts)

Hospices

- Additional surge capacity can be opened on a cost be case basis
- Mutual aid to support step down from Hospital @ Home and community services to free up capacity for higher acuity cases in H@H
- Community Day services, e.g. living well with Isobel. Breath Easy, Community Development Meet Ups etc…
- Improving the health and wellbeing of family/unpaid carers
- Educational role in working with HUC. PC and Care Homes to support EOL referrals and management of Respect forms

Hertfordshire and West Essex Integrated Care System

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Stress Testing of HWE ICS Winter Plan

Exercise Aegis 4th September 2025

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Stress Testing of ICS Winter Plan – Exercise Aegis 4th September 2025

Overall aim:

- To test ICS and Provider Plans and identify risks, issues and potential mitigations
- To ensure plans are robust, and connected in a coherent way to mitigate winter pressures

Objectives:

- Strengthening System Resilience and Strategic Response
- Escalating winter scenarios to stress-test escalation protocols, governance frameworks, and decision-making under pressure
- Identify gaps in business continuity and critical incident response.
- Enhance Operational Grip and Clinical Safety across urgent and emergency pathways.
- Drive System-Wide Learning and Winter Plan Improvement

Scenario tested three levels of escalation:

- **Baseline:** Business as usual
- **Moderate escalation:** Prioritisation, mutual aid, infrastructure resilience
- **Extreme escalation:** Governance under stress, critical decisions, whole-system coordination

Hertfordshire and West Essex Integrated Care System

Actions Agreed Post Exercise Aegis

HWE ICS Winter Vaccination Cell	• Track uptake of Flu vaccination for all frontline Health and Social Care Staff • Implement Public Health Surveillance Dashboard to monitor community uptake across all cohorts and track number of cases and capacity impacts of flu • Mutual Aid for Vaccination clinics and campion train the trainers
Enhance Communications Cell Cadence	• Improve localised proactive communication strategies, especially around Flu and RSV vaccinations in line with earlier predicted rise in cases • Develop HCP Communications to prevent Flu admissions
Demand Management Oversight	• Continual review of Surge and Escalation Incremental Actions through SHREWD • Widen front end triage capacity and consider best use of senior clinical decision makers • Maintain traction on UCCH actions • Staff MOU to redeploy staff around the system to services with critical or unsafe staffing levels
Additional Actions for Extremis for Winter 2025	• Enhanced clinical oversight to support earlier decision making for all patients and avoid perverse impacts of decisions made across the system • Lowering the clinical threshold for admission to alternative pathways and agreeing step up/step down thresholds to free up capacity across all pathways. E.g. community beds, VW • Develop standardised Respiratory Hub SOP for short notice stand up and ensure they are fit for purpose with appropriate equipment and PPE. • Develop Extremis Paediatric SOP and review UTC acuity thresholds for certain cohorts e.g. Respiratory. MH • Agree consistent thresholds for surge protocols and Temporary Escalation Spaces (TES) • Consider e-consorts to be switched off for limited period in line with other extremis actions to support additional same day access for PC
Stand up HWE IPC Cell	• Develop consistency of testing across all pathways (RSV, Flu and Covid) including use of POCT • Develop consistent thresholds for the introduction of mask-wearing and tolerance of risk for extremis actions for supply shortages • Develop mutual aid framework for fit testing • Develop supplier framework for FFP3 Providers

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HWE ICB Board Assurance Statement and NHSE Winter Plan Checklist 2025/26

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HWE ICB Board Assurance Statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the ICB Winter Plan for 2025/26.	TBC	Date booked for September Board
A robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.	Yes	Completed – Mtigations in place
The ICB's plan was developed with appropriate levels of engagement across all system partners, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	YES	Through the ICS Winter Planning Group
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	TBC	Local Exercise planned for 4th September supported by Region
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	YES	Winter Director Appointed
Plan content and delivery		
The Board is assured that the ICB's plan addresses the key actions outlined in Section B.	YES	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	YES	As tested by Local Exercise
The Board is assured there will be an appropriately skilled and resourced system control centre in place over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.	YES	Full rota and Governance in place

NHSE Winter Plan Checklist 2025/26	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
Vaccination programmes across all of the priority areas are designed to reduce complacency, build confidence, and maximise convenience. Priority programmes include childhood vaccinations, RSV vaccination for pregnant women and older adults (with all of those in the 75-79 cohort to be offered a vaccination by 31 August 2025) and the annual winter flu and covid vaccination campaigns.	YES	In Line with RVOC expectations
In addition to the above, patients under the age of 65 with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses should receive targeted care to encourage them to have their vaccinations, along with a pre-winter health check, and access to antivirals to ensure continuing care in the community.	YES	In Line with RVOC expectations
Patients at high risk of admission have plans in place to support their urgent care needs at home or in the community, whenever possible.	YES	In Line with RVOC expectations
Capacity		
The profile of likely winter-related patient demand across the system is modelled and understood, and individual organisations have plans that connect together to ensure patients' needs are met, including at times of peak pressure.	YES	Through Winter Planning Group
Seven-day discharge profiles have been shared with local authorities and social care providers, and standards agreed for P1 and P3 discharges.	YES	Through Situational Awareness Calls and Operational Planning submissions
Action has been taken in response to the Elective Care Demand Management letter, issued in May 2025, and ongoing monitoring is in place.	YES	Acute led and KLOE monitored
Leadership		
On-call arrangements are in place, including medical and nurse leaders, and have been tested.	YES	Full SCC Roster including Clinical Leads
Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	YES	Fully Operational

HWE Winter Plan 2025/26 Summary

- Strong ICB UEC Governance in place to ensure delivery of the UEC Strategy, UECRP and Winter Plan
- Place level delivery and monitoring of system plans are led by the SRGs reporting into Health and Care Partnerships.
- Mature System Coordination in place
- Locality Operations Cell and associated processes to support ambulance demand and improve operational efficiency
- National OPEL Framework operational with ongoing development of SHREWD functionality to support operational delivery and ensure incremental actions at each stage of OPEL to maintain patient safety
- Ongoing clinical and operational review of system risks at the ICB led SCC Safety, Oversight and Impact Group
- Winter Plan stress-tested and additional winter cells stood up to support delivery, oversight and governance

Hertfordshire and West Essex Integrated Care System

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board Meeting – in public				Meeting Date:	26/09/2025	
Report Title:	Governance report				Agenda Item:	11.	
Report Author(s):	• Simone Surgenor – Deputy Chief of Staff, Governance and Policies (HWE ICB) • Sharon Fox – Director of Governance (NHS Cambridge and Peterborough ICB) • Michelle Evans-Riches - Head of Corporate Governance (NHS Bedford, Luton and Milton Keynes ICB) • Board Assurance Framework: ■ Tatiana Njendu – Risk and Compliance Officer (HWE ICB) ■ Leon Adeleye – Corporate Governance Lead, Risk and Regulation (HWE ICB)						
Report Presented by:	• Michael Watson, Chief of Staff						
Report Signed off by:	• Michael Watson- Chief of Staff						
Purpose:	Approval / Decision	☒	Assurance	☐	Discussion	☐	Information ☐
Which Strategic Objectives are relevant to this report	• Increase healthy life expectancy, and reduce inequality • Give every child the best start in life • Improve access to health and care services • Increase the numbers of citizens taking steps to improve their wellbeing • Achieve a balanced financial position annually						
Key questions for the ICB Board / Committee:	Noted in the recommendations below.						
Report History:	This report forms part of a regular agenda item with the HWE Board.						
Executive Summary:	This paper is in support of transition arrangements for ICBs, cited in the NHS 10-year plan.						
Recommendations:	• The Board is asked to acknowledge NHSE'S approval of bringing together the ICBs of Bedfordshire Luton & Milton Keynes ICB (BLMK) Cambridgeshire & Peterborough ICB (C&P), and the Hertfordshire footprint of Hertfordshire and West Essex ICB (HWE) which will be formally established on 1 April 2026. • The Board is asked to endorse the proposed transitional Governance Framework outlined at Appendix A, acknowledging that this is an iteration at a point of time which will further develop and be brought to the first Cluster Board in-Common which we anticipate will take place during October 2025. • The Board is asked to endorse the proposed changes to the ICB's Constitution set out at Annex A and recommend the amendments to NHSE for approval.						

	• The Board is asked to endorse the Memorandum of Understanding including the Data Sharing Agreement set out at Annex B. • The Board is asked to acknowledge that changes are still being made as the transitional framework develops. • Recognising that there may be potential minor amendments required the Board is asked to delegate final approval of any further amendments to the ICB Chair, Chief Executive, Deputy Chair and Audit & Risk Committee Chair for approval. • Note the update provided at paragraph 5 to this paper – this ICBs Board and Assurance Framework.			
Potential Conflicts of Interest:	*Indirect*	☐	*Non-Financial Professional*	☐
	Financial	☐	*Non-Financial Personal*	☐
	None identified			☐
Implications / Impact:				
Patient Safety:	This update provides core governance framework updates, and therefore supports patient safety.			
Risk:	*[Refer to latest Risk Register when completing]*			
Financial Implications:	No additional implications to report in this paper.			
Patient or public engagement or consultation:	Nothing in addition to note, over and above the work undertaken in support of the documented services.			
Impact Assessments:	*Equality Impact Assessment:*	A separate EIA has not been completed for this paper – as the services, policies or appointments referenced would as part of their due diligence, undertaken relevant impact assessments. Guidance continues to be gained through the HWE ICB Equality Lead.		
	Quality Impact Assessment:	Please see the response provided against the EIA entry above.		
	Data Protection Impact Assessment:	Please see the response provided against the EIA entry above.		

1 Introduction

1.1 As the Board is aware, NHSE has approved the bringing together the ICBs of Bedfordshire Luton & Milton Keynes ICB (BLMK) Cambridgeshire & Peterborough ICB (C&P), and the Hertfordshire footprint of Hertfordshire and West Essex ICB (HWE). This was formally announced by the Minister for Health in parliament on Tuesday 9 September 2025. As a result, we will be moving through a period of transition to create a unified single entity with the utilisation of shared leadership and functions, whilst uniting the best of our legacy systems.

1.2 During the transition and whilst the current ICBs retain their sovereign status, BLMK and C&P ICBs will work together. HWE ICB will be participating in two separate closer working arrangements with its Chair remaining in post until the organisation is disestablished. From 1st October 2025 the HWE Chair will also become ICB Chair for Mid and South Essex ICB and Chair designate of the future Essex ICB.

1.3 Governance leads from the three ICBs have been working together in close collaboration to propose a governance framework to reflect the collaborative arrangements during the transition period, and to provide a state of readiness for the creation of a new ICB on 1 April 2026.

1.4 As the Board is aware, each ICB is governed by its Constitution and associated Governance Framework which is set out in individual ICB's Governance Handbooks. The Handbooks provide key governance tools such as our Committee Structures and Terms of Reference, Functions and Decision Map, Standing Financial Instructions, Scheme of Reservation and Delegation alongside key polices such as Standards of Business Conduct and Conflicts of Interest.

1.5 Any changes to ICB Constitutions have to be agreed by the respective ICB Board and submitted to NHSE for approval prior to implementation. Changes to each Governance Handbook can be invoked with Board approval.

1.6 This paper presents the proposed ICB Constitution changes aligned with the transitional Governance Framework set out at Appendix A. Governance Leads are currently working on the revisions required to the Governance Handbook and associated documents which will be approved through the proposed transitional arrangements. The paper also presents a Memorandum of Understanding and associated Data Sharing Agreement.

2 Background

2.1 The Governance Framework has been designed to meet the following objectives:

- To keep the three organisations safe in terms of ensuring each ICB fulfils its statutory duties until a new statutory organisation is formed and/or new statutory changes are triggered;
- Approaching future governance in two phases:
  - Pre-transition - To ensure we provide a pragmatic and streamlined approach to ensure an effective transition: and
  - Post- transition - To consider the future governance framework that we will need in place to deliver in support of the 10-year plan and 3 shifts:
    - The requirements of the ICB Model Blueprint published in May 2025 that is aligned to the clustering and formal establishment of a new ICB in either April 2026 or April 2027.

- That provides sufficient flexibility to adapt to the changing landscape whilst maintaining a simple but effective form.
- That is ambitious and supports innovation, and the provider landscape.
- Will ensure the resident and patient voice and experience comes through – linking with neighbourhood/local structures.

3. Transitional Arrangements

3.1 Board Membership

3.1.1 The ICB Model Blueprint has indicated that we need to reduce the size of ICBs going forward although it has not been clear about what this means in practice. It is clear from national governance calls that each ICB is required:

- To ensure that each Board meets the requirements of the Health and Social Care Act 2022 by having as a minimum - Chair, Chief Executive (CEO), and three Partner Members (one each from local authorities, NHS Trusts and Primary Medical Services). From the Model ICB Constitution, mandated by NHSE, we also need to have a Board Member with experience of Mental Health, Director of Finance, Chief Nursing Officer, Chief Medical Officer and 2 Non-Executive Members.
- To consider an optimum Board membership of 15 members, recognising that the transition period and size of the ICB may mean this needs to increase to a maximum of 20.

3.1.2 Going forward, we understand that there will be a requirement for Combined Authorities / Strategic Authorities to have ex-officio status on ICB Boards. In addition, we are now aware that it is proposed that Integrated Care Partnerships will be abolished, local authority and NHS partner members will not be Board members which requires legislative change. There has been no indication whether PMS partner members will continue to be members of the Board. We have been advised that we will need to maintain a Joint Forward Plan until legislation is amended.

3.1.3 These considerations have been incorporated into the proposed Board membership set out in the Framework.

3.2 Board and Committees - Approach

3.2.1 As set out above, our objective is to ensure that we streamline our Governance Structure bringing our Boards and Committees together, whilst maintaining our obligations as independent legal entities.

3.2.2 We have been advised by NHSE that we must comply with NHSE Guidance on Arrangements for the Delegation and Joint Exercise of Statutory Functions which includes a section on joint decision-making. We must maintain separate decision-making on CHC (a limitation in secondary legislation) and on functions central to the corporate governance of the ICB – the guidance states:

- Functions central to the corporate governance of individual organisations
- These functions assure the organisation's leadership that it is functioning effectively, so must be retained if the organisation is to operate in its own right; for example, the requirement on each organisation to prepare consolidated annual accounts, or to have an audit committee.

- Some of these are functions that are widely recognised as being essential to good governance and should not therefore be within the scope of s65Z5 arrangements.

- The ICB auditor panel, which may be the audit committee, must be kept independent.

3.2.3 With this in mind, our proposal is that where possible we operate Board and sub-Committees of the Board using the in-Common or Joint Committee models, with each sovereign ICBs Schemes of Reservation and Delegation providing clear lines of delegation and decision-making. For clarity:

- A committee in-Common is two or more organisations meeting in the same place at the same time, has separate agendas but the same items on them and it may reach the same conclusions. But the individual organisations remain distinct and (if the committee is decision-making) take their own decisions. It is understood, this form will have to be used for Boards or Committees triggered by statute i.e. the ICB Board, Remuneration Committee, Audit Committee.

- A Joint Committee is made up of representatives from two or more organisations, who work together to oversee, manage, or resolve specific matters. Joint Committees often have delegated authority from the host organisations to make decisions on its behalf. This could be used for non-statutory committees, and would enable e.g. Great Essex ICB participation in a relevant committee where this was necessary.

3.2.4 With a Board or Committee meeting in-Common there is no requirement to change each ICBs Constitution, as the meeting impacted do not change in their statutory or sovereign form. However, to trigger a formal joint committee formal delegation would need to be noted in each ICBs Constitution and Scheme of Reservation and Delegation.

3.2.5 The arrangements to work in-Common or via a Joint Committee arrangement are now referenced in the draft Governance Handbook proposed for the Cluster and will be approved by the Board in Common at its first meeting. The development of the working draft is being overseen by the Joint Transition Committee. We would also need to acknowledge Part 2 agendas where sovereign organisations need to consider business pertinent to their ICB alongside where items may relate to Essex.

3.2.6 Looking at current Committees of each organisation we have created revised outline terms of reference which will be operated as Committees in-Common/Joint Committees. With those statutory meetings, meeting in-Common – those changes are primary likely to be centred on membership. These are:

- Audit & Risk Committee (Statutory) – with the Committees for each sovereign ICB meeting in -Common
- Remuneration & Workforce Committee (Statutory) – with the Committees for each sovereign ICB meeting in-Common
- Finance Planning and Payer Function Committee – to operate as a Joint Committee
- Utilisation Management & Quality Improvement Committee – to operate as a Joint Committee
- Three Neighbourhood Health Delivery Committees (one for each current ICB geography)– Joint Committees

- Management Executive Committee – To operate as a joint committee whilst the ICBs remain sovereign entities, and each Executive is employed by each ICB.

3.2.7 The proposed Committee structure, outline objectives and associated membership is set out in Section 5 of the Framework.

3.2.8 There will be a need to work on transitioning the existing sub structures / feeder Groups to existing ICB Committees to ensure the appropriate level of assurance going forward. This will form the basis of the Functions and Decision Map included in the Governance Handbook and will be developed further leading up to the formal establishment of the new ICB.

Those ICBs operating under the geography of what will become the Essex ICB from April 2026, have agreed a governance format using primarily Joint Committees or meeting in-Common, where relevant.

3.3 Hertfordshire and West Essex – Transition Governance

3.3.1 To support a smooth transition and closer collaboration, a jointly appointed CEO will lead the three ICBs (BLMK, C&P, and HWE) from 1 October 2025 to 31 March 2026. These ICBs will work together across Essex to delegate responsibilities or appoint deputies as needed, ensuring clear oversight and allowing flexibility as they move into their new organisational structures.

3.3.2 Through this period of transition, those ICBs operating under the geography of what will become the Essex ICB from April 2026, have agreed a governance format using primarily Joint Committees or via meetings held in-Common, where relevant.

4. Governance Documentation

4.1 To align the Governance Framework, and reflect the position in relation to Herts and West Essex ICB, Governance Leads have worked together to produce the following:

- Proposed revisions to ICB Constitutions to reflect the changes. In summary, these include each ICB reducing the size its Board membership (whilst maintaining the mandated requirements to the NHSE Model Constitution) to reflect the jointly appointed roles, efficiently aligning this across the sovereign ICBs whilst reflecting HWE ICBs cross areas and complying with current statutory requirements.

- Aligned Draft Governance Handbook which includes proposed:
  - Terms of Reference for the proposed Statutory Committees meeting in-Common or via a Joint Committees
  - Scheme of Delegation
  - Associated key Governance policies.

  The Revised Governance Handbook will be received by the new Board post 1st October 2025 to formally approve its adoption and recognise that a period of settling will take place in October to November whilst committee Terms of Reference and membership are finalised.

- Proposed Memorandum of Understanding between those ICBs working collaboratively in support of the 10 year-plan and across the areas impacted by the revised ICB

footprints in our regions. This also includes the proposed Data Sharing Agreement annexed to the MoU referenced above. This is attached at Annex B.

4.2 Care is being taken to ensure Senior NHS Governance Leads are kept informed of these updates as part of the transition due diligence, with time being set-aside to ensure the efficient approval of key documentation to support the new working arrangements. In support of the timelines, it is proposed that with the sovereign ICB Board referenced above sitting at various points across September, support of the revised Constitution is delegated to identified members thus ensuring the new Board membership can be enacted for 1st October 2025.

5. Risk and Board Assurance Framework

In support of an update provided to this ICBs Audit and Risk Committee when it sat virtually on 19th September 2025:

5.1 Since the last submission to the Committee in June, the Board Assurance Framework (BAF) has been updated to reflect changes in the system risk profile. Risks 675 and 644 have been de-escalated from the BAF following reassessment, while three new risks (745, 722 and 698) have been added, evidencing that the framework continues to evolve in response to emerging issues.

5.2 Risk 679 (Financial Efficiency Risk) has been rescored from 20 to 12, reflecting the current control total position and associated efficiency plans and is now being monitored on the CRR.

5.3 These updates, alongside ongoing emphasis on improving the quality of risk data entries, demonstrate that the BAF remains an active tool for monitoring strategic risks and providing assurance to the Board.

5.4 The BAF report can be found at Appendix B to this paper.

6. Recommendation

6.1 The Board is asked to acknowledge NHSE'S approval of bringing together the ICBs of Bedfordshire Luton & Milton Keynes ICB (BLMK) Cambridgeshire & Peterborough ICB (C&P), and the Hertfordshire footprint of Hertfordshire and West Essex ICB (HWE) which will be formally established on 1 April 2026.

6.2 The Board is asked to endorse the proposed transitional Governance Framework outlined at Appendix A, acknowledging that this is an iteration at a point of time which will further develop and be brought to the first Cluster Board in Common which we anticipate will take place during October 2025.

6.3 The Board is asked to endorse the proposed changes to the ICB's Constitution set out at Annex A and recommend the amendments to NHSE for approval.

6.4 The Board is asked to endorse the Memorandum of Understanding including the Data Sharing Agreement set out at Annex B.

6.5 The Board is asked to acknowledge that changes are still being made as the transitional framework develops.

6.6 Recognising that there may be potential minor amendments required the Board is asked to delegate final approval of any further amendments to the ICB Chair, Chief Executive, Deputy Chair and Audit & Risk Committee Chair for approval.

6.7 In respect of the Board Assurance Framework – the Board is asked to note the progress made and governance gaps identified.

7. Attachments – to be found in the 'Supporting Documents' Meeting Pack

- Appendix A - Governance Framework:
  - Annex A - Memorandum of Understanding
  - Annex B - Data Sharing Agreement.
- Appendix B – Board Assurance Framework

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	NHS HWE ICB Board meeting held in Public		Meeting Date:	26 September 2025
Report Title:	Integrated report for finance, performance, quality and workforce		Agenda Item:	12.
Report Author(s):	Shirley Potter, Programme Manager, Executive Team Member(s)			
Report Presented by:	Jonathan Wilson, Frances Shattock, Tania Marcus, Natalie Hammond, Michael Watson			
Report Signed off by:	Jonathan Wilson, Frances Shattock, Tania Marcus, Natalie Hammond, Michael Watson			
Purpose:	Approval / Decision ☐	Assurance ☒	Discussion ☐	Information ☒
Which Strategic Objectives are relevant to this report [Please list]	■ Increase healthy life expectancy, and reduce inequality ■ Give every child the best start in life ■ Improve access to health and care services ■ Increase the numbers of citizens taking steps to improve their wellbeing ■ Achieve a balanced financial position annually			
Key questions for the ICB Board / Committee:	Areas for discussion are identified in the summary section of the paper.			
Report History:	N/A			
Executive Summary:	This report provides a summary of the quality, performance and finance reporting shared elsewhere on the agenda, whilst also providing an update on workforce across the ICS. Board members should also review the more detailed reports in the 'Supporting Documents' pack in the Board Papers.			
Recommendations:	The Board is asked to consider the report and the areas highlighted for discussion.			
Potential Conflicts of Interest:	*Indirect* ☐		*Non-Financial Professional* ☐	
	Financial ☐		*Non-Financial Personal* ☐	
	None identified ☒			
	N/A			
Implications / Impact:				
Patient Safety:	No			
Risk:	No			
Financial Implications:	*N/A*			
Patient/public engagement or consultation:	*N/A*			
Impact Assessments:	*Equality Impact Assessment:*	No		
	Quality Impact Assessment:	No		
	Data Protection Impact Assessment:	No		

1. Summary

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

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

Please note that performance relates to the report presented at the September STQI Committee which contained the latest data at time of publication (June/July).

2. Key issues highlighted

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

Area of concern/ improvement	Current situation
Finance position	The Hertfordshire and West Essex System remains on plan, reporting a Year-to-Date deficit of £25.375m at Month 4, which is adverse to plan by £0.028m.
Agency spend update	At M4 agency spend as a percentage of pay bill reduced by a very small amount and stands at 1.63% - remaining ahead of planned performance to meet the national target of 1.5% over the course of this financial year. Bank pay remains at 9% of pay bill – above the system's target of 7.4% for M4, and well above the national target of 6.2%, although it should be noted that the forecast end position for the system is 7.4%.
Performance	In the last 12mths, there has been a significant overall improvement in performance in a number of areas including: • Improvement in all areas of UEC; - Category 2 response times reduced to just over 35 mins in July and mean ambulance handover times, having reduced significantly since January, moved ahead of system plan in July. - 4-hour ED performance reached just over 79%, remains ahead of the system plan and is 10th best nationally. • There has been month on month improvement against the referral to treatment (RTT) standard over the last 12mths and June performance is ahead of system plan. • Cancer where the 62d interim standard of 75% has been met for 10 of the last 12mths and performance is 12th best nationally. However, there remain some challenges: Planned Care - Overall diagnostic performance has moved back to a variable trend but remains behind system plan. Excluding paediatric audiology, diagnostic performance continues on an overall trend of improvement, however, has seen a decline in recent months. There remains significant challenges to paediatric audiology particularly at ENHT, with focused work continuing to look at levelling up waiting times across the system.

	- RTT 65 weeks have continued to reduce to low levels however have not yet met the 0 target. 52 weeks continue on a trend of improvement however the percentage of 52 week waits is just behind system plan but is being met by ENH and SWH. Children and Young People - Our area of highest risk remains community waits for children with the main pressures being Community Paediatrics, Therapies, Audiology, ASD and ADHD. We continue to see waiting lists grow and times to treatment increase as funding/investment remains unresolved. - Although not achieving standard, the 28-day CAMHS access standard in Herts had been improving since Nov 24 however has now returned to a variable trend moving the indicator back to high risk. CHC - CHC 28-day performance has declined significantly, not achieving target in the last 4 months. Performance has moved back to high risk, with most notable decline at SWH. Revised quarterly targets have been agreed.

Performance Report:

Executive Summary: KPI Risk Summary

Further information regarding high level risks can be found within the accompanying Risk Report

Highest Risk	Programme
Community Waits (Children)	Community
Autism Spectrum Disorder (ASD)	Community

Lowest Risk	Programme
Learning Disability (LD) Health Checks	Primary Care

Low Risk	Programme
2 Hour UCR	UEC
NHS 111 Calls Abandoned	UEC
% of on the day GP Appointments	Primary Care
ED 4 Hour Standard	UEC
31 Day Standard	Cancer
62 Day Standard	Cancer

Variable Risk	Programme
28 Day Faster Diagnosis	Cancer
CHC Assessments in Acute	Community
Discharge Ready Date	UEC
Community Waits (Adults)	Community
% of <14 day GP Appointments	Primary Care
Dementia Diagnosis	Primary Care
Ambulance Handovers	UEC
Patients discharged before Noon	UEC
Talking Therapies	Mental Health
Severe Mental Illness (SMI) Health Checks	Mental Health
62 Day Backlog	Cancer
18 Week RTT	Elective
RTT 65 Week Waits	Elective
RTT 52 Week Waits	Elective
Ambulance Response Times	UEC
Community MH - Adult Waits for 2nd Appt	Mental Health

High Risk	Programme
CHC Assessments < 28 Days	Community
6 Week Waits	Diagnostics
Out of Area Placements	Mental Health
CAMHS 28 Day Standard	Mental Health
Community MH - CYP Waits for 1st Appt	Mental Health
ADHD	Community

Moved to lower risk category **Moved to higher risk category** **No change to risk category**

Executive Summary

Please note that data is to July 25 for UEC and June 25 for all other areas

URGENT CARE	4 Hour Performance	Region: HWE better than average	National: HWE better than average

- NHS 111 abandoned call performance continues on an improved trend, however performance remains slightly adrift of the 3% target, at 3.6% in July;
- Cat 2 ambulance response times continue at improved levels in July at just over 35 mins. Performance remains outside the 30-minute standard however and longer than the regional average of 32 mins 36 seconds;
- Mean ambulance handover times have reduced significantly since January; performance has now moved to a trend of improvement and is ahead of system plan reducing the indicator risk from high to variable;
- 4-hour ED performance continues on a trend of improvement reaching just over 79% in July and remains ahead of the system plan and of low risk.

PLANNED CARE	18 Week RTT	Region: HWE better than average	National: HWE worse than average

- The overall elective PTL size remains high following a significant increase in January with deferred referrals being added to the PAH PTL, however levels have started to see a significant reduction;
- 65 wk waits have continued to reduce to low levels; 32 remain at ENHT and PAH. 52 wks continue on a trend of improvement; the % of 52 wk waits is just behind system plan but is being met by ENH and SWH.
- The 18 wk position continues on a trend of improvement. Although behind national standard, June performance is ahead of system plan and has moved from high to variable risk.

DIAGNOSTICS	6 Week Waits	Region: HWE worse than average	National: HWE worse than average

- The overall PTL continues to increase and is far higher than the historic mean. Excluding paediatric audiology, diagnostic performance continues on an overall trend of improvement however has seen a decline in recent months. There remains significant challenges to paediatric audiology with variation by Trust; a return to reporting of the challenged service at ENHT in June 24 saw a step change decline in performance. Overall diagnostic performance has moved back to a variable trend and remains behind system plan, however performance is at similar levels to April 2024, before ENHT Audiology was reported.

CANCER	28 Day FDS / 31 Day / 62 Day	Region: HWE better than average	National: HWE better than average

- 28-day FDS performance improved in June but remains just below system plan; ENH and SWH are meeting plan. 31-day performance continues on an improved trend and met national standard in June. Performance against the 62-day standard has deteriorated moving from lowest to low risk; June performance dipped under the 75% National Planning Std and below our planning trajectory; PAH remains the most challenged Trust.

MENTAL HEALTH / LD	Community MH (2nd Appt)	National: HWE better than average (Adult)

- Similar numbers of HWE Out of Areas Placements in June at 30 against a plan of 15 with both West Essex and Herts continuing on a trend of variable performance; plans to reduce OOA placements commenced in April;
- Community Adult MH waits for a 2nd contact continue on a trend of improvement. The median wait decreased in June but continues on a variable trend; indicators continue to benchmark well against national average.

CHILDREN	Various	Community 18 Week %: HWE worse than national	Community MH 1st Appts: HWE better than national

- The number of children on community waiting lists remains very high, continuing as an area of highest risk. Waits over 52 wks remain on a deteriorating trend, increasing further over the last two months.
- 18 week % for children's community waits remains largely the same at c37% which is below the national average of c50%. The main pressures continue to be Community Paeds, Therapies and Audiology;
- Autism Spectrum Disorder (ASD) waiting lists and times continue to grow as funding/investment remains unresolved, continuing as an area of highest risk. ADHD services are also high risk due to rising demand & waits;
- Although not achieving standard, the 28-day CAMHS access standard in Herts had been improving since Nov 24 however has now returned to a variable trend moving the indicator back to high risk;
- Children's waits for a Community MH 1st appointment remain on a deteriorating trend however do continue to better the national average; there remains variation across the system.

COMMUNITY (Adults)	% <18 Weeks	National: HWE better than average	Adult waiting times better than CYP

- % of adults waiting <18 weeks saw a step decline in March with the inclusion of Circle data; performance has seen notable recovery since April however and moved back from high to variable risk. Plans are in place for Circle to deliver 18 weeks by the September reporting period.

PRIMARY CARE & CHC	CHC Assessments Within 28 Days:	HWE worse than regional and national average

- There has been sustained improvement in the % of gp appts seen on the same day, remaining at low risk. The % seen within 14 days continues along the mean and is marginally below this year's plan of 89%;
- CHC 28-day performance has declined significantly, not achieving target in the last 4 months. Performance has moved back to high risk, with most notable decline at SWH. Revised quarterly targets have been agreed.

Executive Summary: Performance against Operational Plan M3

RTT performance vs 18 week standard — March 2026 Target: 5% improvement

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	55.34%	55.96%	56.27%	57.31%	57.93%	58.65%	59.58%	59.68%	60.00%	60.57%	60.56%	60.89%
	OP Actuals	58.50%	59.88%	60.39%									
E&NH	OP Plan	59.50%	59.61%	59.92%	60.38%	60.94%	61.57%	62.22%	62.84%	63.41%	63.86%	64.16%	64.26%
	OP Actuals	62.70%	62.94%	63.29%									
WE	OP Plan	47.66%	49.46%	50.66%	51.86%	53.66%	54.36%	55.06%	56.46%	56.96%	57.66%	59.06%	60.01%
	OP Actuals	48.78%	50.80%	51.14%									
S&WH	OP Plan	59.63%	60.18%	60.73%	61.28%	61.83%	62.38%	62.93%	63.48%	64.03%	64.58%	65.13%	65.68%
	OP Actuals	62.20%	63.65%	64.50%									

Number of patients waiting 52 weeks as percentage of total PTL — March 2026 Target: <1%

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	2.36%	2.31%	2.22%	2.12%	2.02%	1.83%	1.69%	1.58%	1.47%	1.34%	1.13%	0.99%
	OP Actuals	2.80%	2.74%	2.73%									
E&NH	OP Plan	1.80%	1.80%	1.80%	1.79%	1.77%	1.73%	1.66%	1.56%	1.42%	1.24%	1.00%	0.70%
	OP Actuals	1.91%	1.95%	1.73%									
WE	OP Plan	5.00%	4.64%	4.28%	3.92%	3.56%	3.20%	2.84%	2.48%	2.12%	1.76%	1.40%	1.00%
	OP Actuals	4.68%	4.39%	4.68%									
S&WH	OP Plan	2.07%	1.96%	1.88%	1.79%	1.69%	1.60%	1.50%	1.40%	1.30%	1.20%	1.10%	1.00%
	OP Actuals	2.02%	1.85%	1.83%									

EB28 Diagnostic test waiting list - % over 6 weeks — Target: TBC

Included modalities are: MRI, CT, NOUS, Audiology, DEXA, ECHO, Gastroscopy, Colonoscopy, Flexi-sig

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	30.41%	30.26%	28.97%	28.08%	27.01%	26.01%	25.23%	24.00%	23.98%	22.60%	21.73%	20.61%
	OP Actuals	31.43%	33.26%	33.51%									
E&NH	OP Plan	54.68%	54.40%	51.92%	50.89%	49.87%	48.80%	47.76%	46.41%	47.15%	46.53%	45.14%	43.88%
	OP Actuals	51.90%	54.34%	54.39%									
WE	OP Plan	33.17%	33.76%	33.18%	32.30%	29.64%	27.12%	25.77%	22.69%	21.12%	17.26%	14.33%	10.04%
	OP Actuals	33.03%	34.22%	33.23%									
S&WH	OP Plan	5.86%	5.44%	5.22%	4.97%	4.74%	4.50%	4.21%	3.96%	3.71%	3.43%	3.13%	2.85%
	OP Actuals	9.80%	10.72%	13.50%									

EB35 Cancer 62-day standard. — March 2026 Target: 75%

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	76.98%	79.01%	78.80%	79.58%	80.32%	79.69%	81.09%	81.29%	81.28%	81.34%	82.40%	82.54%
	OP Actuals	72.53%	71.69%	69.77%									
E&NH	OP Plan	83.74%	85.89%	84.38%	85.71%	85.79%	84.05%	85.66%	85.38%	84.34%	84.13%	85.71%	85.56%
	OP Actuals	88.89%	86.94%	81.86%									
WE	OP Plan	65.29%	66.94%	71.09%	70.71%	71.90%	71.97%	72.86%	72.73%	74.22%	74.22%	74.38%	75.00%
	OP Actuals	53.05%	49.62%	41.79%									
S&WH	OP Plan	77.22%	77.78%	78.33%	79.44%	80.00%	80.56%	81.11%	82.22%	82.78%	83.33%	84.44%	85.00%
	OP Actuals	79.84%	77.36%	78.85%									

EB27 Cancer 28 day waits (faster diagnosis standard) — March 2026 Target: 80%

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	78.58%	78.77%	79.09%	78.86%	79.16%	79.12%	79.19%	79.55%	79.63%	79.81%	81.29%	81.95%
	OP Actuals	77.98%	77.28%	78.76%									
E&NH	OP Plan	77.32%	77.63%	78.27%	77.37%	77.44%	77.02%	77.26%	77.44%	77.26%	77.84%	78.42%	80.37%
	OP Actuals	77.83%	76.63%	80.17%									
WE	OP Plan	77.00%	77.00%	77.02%	76.98%	77.00%	77.02%	76.98%	77.00%	77.02%	77.02%	79.98%	80.03%
	OP Actuals	72.19%	71.34%	72.50%									
S&WH	OP Plan	80.98%	81.34%	81.75%	82.11%	82.46%	82.82%	83.18%	83.54%	83.90%	84.25%	84.61%	85.02%
	OP Actuals	84.68%	84.04%	85.39%									

EM13 Percentage of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours — Target by March 2026: 78%

MIU not included

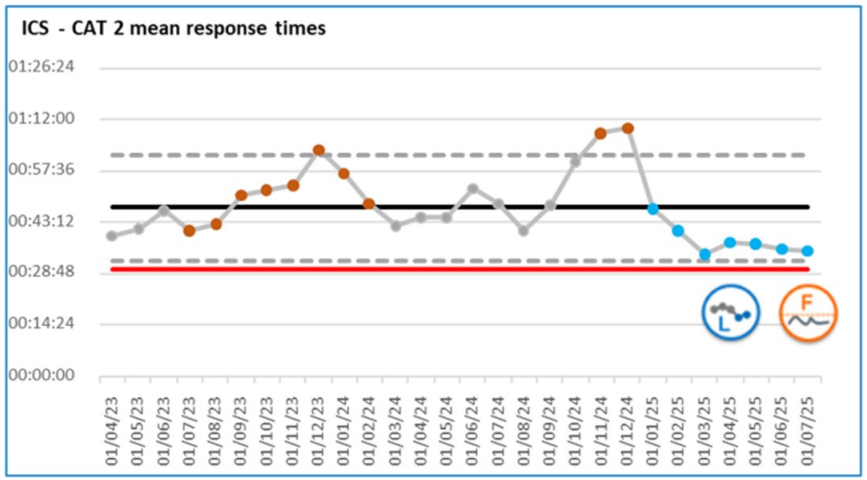
		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	72.80%	74.88%	76.32%	76.09%	77.52%	78.05%	77.16%	76.76%	74.51%	73.80%	77.87%	80.75%
	OP Actuals	76.17%	75.49%	78.24%									
E&NH	OP Plan	69.46%	72.04%	74.17%	73.36%	75.70%	75.92%	73.39%	73.14%	71.28%	69.08%	74.65%	78.34%
	OP Actuals	73.14%	74.25%	77.42%									
WE	OP Plan	67.00%	69.00%	70.00%	71.00%	71.00%	73.00%	73.00%	72.00%	71.00%	72.00%	74.00%	78.00%
	OP Actuals	68.14%	64.78%	68.25%									
S&WH	OP Plan	79.69%	81.68%	82.57%	81.99%	83.09%	83.36%	83.62%	83.61%	80.06%	79.40%	83.60%	85.00%
	OP Actuals	84.34%	83.72%	85.62%									

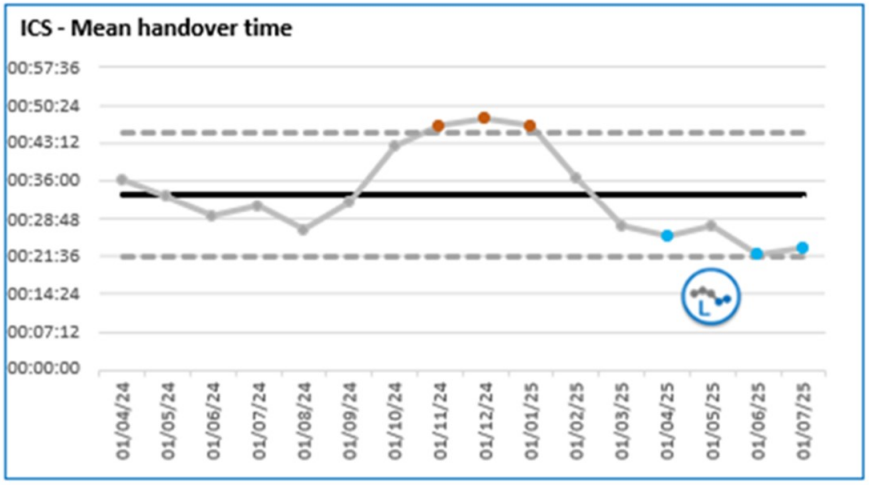
EB42 Mean handover time (minutes) — Target: <= 15 mins

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	00:30:09	00:30:12	00:28:08	00:29:05	00:27:59	00:29:54	00:32:39	00:32:50	00:36:44	00:37:16	00:32:10	00:28:30
	OP Actuals	00:25:44	00:27:35	00:22:06									
E&NH	OP Plan	00:30:00	00:30:00	00:27:00	00:30:00	00:27:00	00:30:00	00:35:00	00:32:00	00:43:00	00:42:59	00:30:00	00:30:00
	OP Actuals	00:29:43	00:32:35	00:21:41									
WE	OP Plan	00:35:00	00:35:00	00:35:00	00:35:00	00:35:00	00:35:00	00:37:00	00:39:00	00:41:00	00:43:00	00:44:00	00:30:00
	OP Actuals	00:25:38	00:28:36	00:25:42									
S&WH	OP Plan	00:27:15	00:27:22	00:24:44	00:24:38	00:24:19	00:26:38	00:28:05	00:29:36	00:29:20	00:29:11	00:26:24	00:26:24
	OP Actuals	00:22:39	00:23:04	00:19:51									

Hertfordshire and West Essex Integrated Care System

Urgent & Emergency Care (UEC) - Ambulance Response and Handover





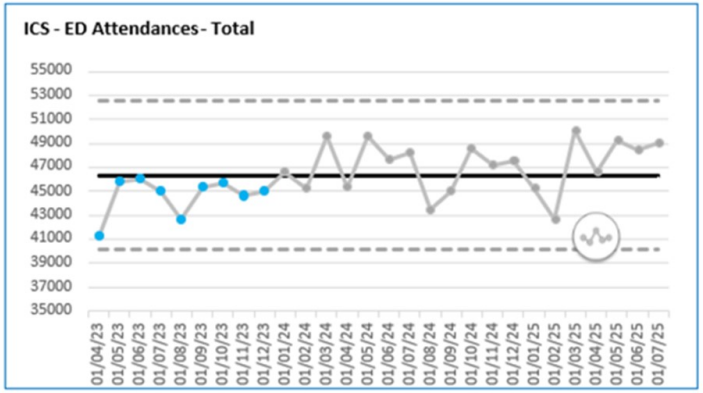
What the charts tell us

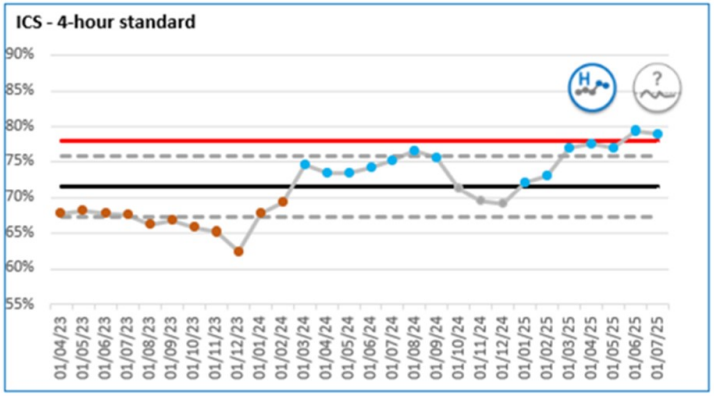
- In Jul-25 the mean Category 2 ambulance response time was 35m 12s. This remains worse than the 30 minute target but is lower than the long-term average for the system
- In Jul-25, mean Category 2 response times in HWE remained longer than the regional average (32m 36s) and were the second longest in the region
- The mean handover times have reduced significantly since January and were 23m 28s at a system level in July. This is better than the plan of 29m 5s from the FY2526 planning submission

ICB Issues and actions

- The overall number of ambulance incidents in HWE remain high. The number of incidents in M1-4 FY2526 was 5% higher than during M1-4 FY2425
- However, across the system, the number of conveyances to ED has been 3.5% lower in M1-4 FY2526 compared to M1-4 FY2425. This has been driven by factors including: the impact of the unscheduled care hub / alternatives to conveyance + an increase in hear-and-treat rates
- EEAST has a detailed operational performance improvement plan in place for FY2526. In HWE, in July six out of eight productivity metrics from this plan were being met
- There have been notable improvements in on-scene times for crews through FY2526 so far. There have also been notable improvements in the number of vehicles out-of-service
- Significant numbers of newly qualified paramedics are starting in Herts and West and Essex in Q3
- Hours lost to handover have continued to improve following a number of initiatives at the acute front doors, including: straight to Assessment Unit/SDEC pathways; continued focus on fit-to-sit patients; clarifications and standardisation of HALO role; senior clinical reviews of ambulance patients; front-door process redesign focusing on rapid assessment and treatment
- Capital work at ENHT for 8 designated handover cubicles to start in Dec-25

UEC – Emergency Department

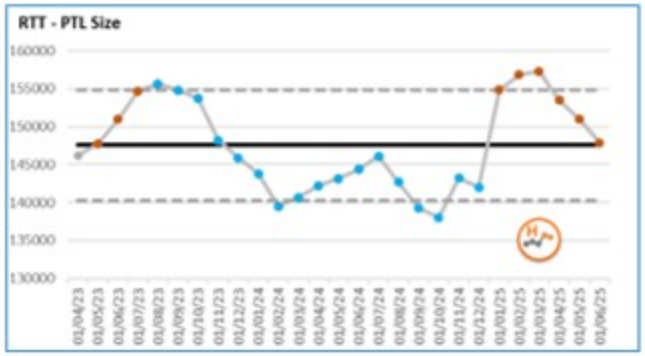


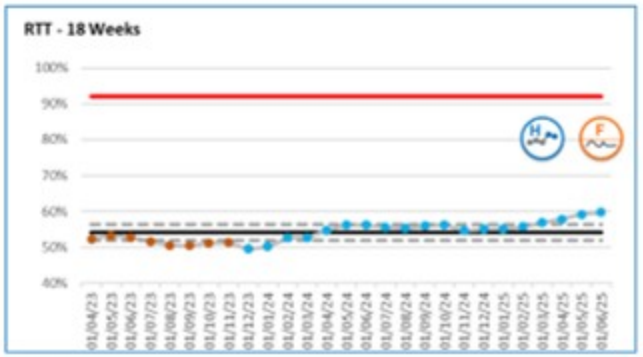


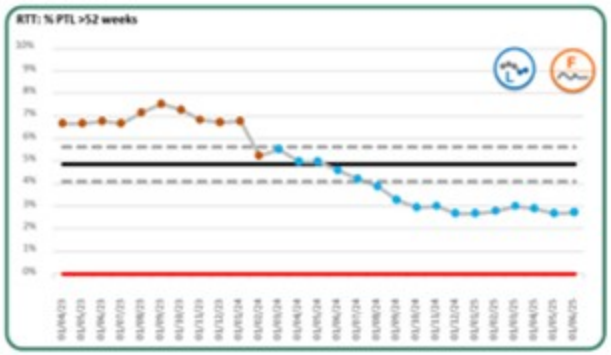
What the charts tell us	Issues	Actions

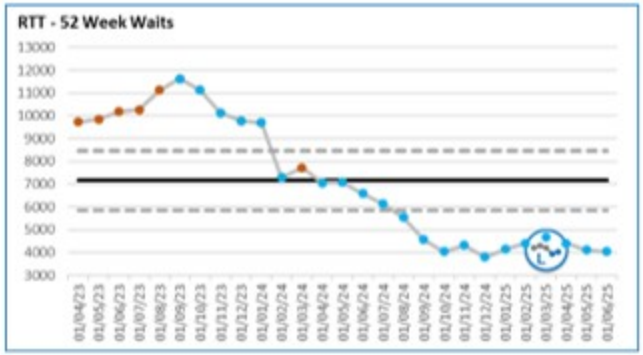
• ED attendances have been high in recent months and there have been five consecutive months where ED attendances have been above the long-term mean
• These high levels of attendances have mainly been driven by increases in type 3 activity at ENHT and type 1 activity at WHHT
• ED performance has improved noticeably over the last three months and reached 79.1% in Jul-25. This is ahead of the combined system plan of 77.9% for July
	• There remains significant variation at place level with West Essex continuing to be the most challenged. Performance against the 4-hour standard in July for each place was:
	  ○ SWH = 84.4%
	  ○ ENH = 79.4%
	  ○ WE = 71.7%
	• There remains continued high demand. However, the rate of growth may have slowed as ED attendances in M1-4 of FY2526 were only 1% higher than M1-4 of FY2425
	• Type 1 ED attendances appear to be reducing marginally and were 1% lower in M1-4 of FY2526 compared to M1-4 of FY2425
	• There is some evidence that there has been a general increase in acuity in ED presentations over the past two years
		System
		• The % of C3-C5 patients being conveyed to ED has reduced following the expansion of call-before-convey and initiatives at EEAST which have focused on improving hear-and-treat rates. E.g. the ITK link between EEAST and HUC is now live meaning that patients can be passed from the stack to HUC more efficiently. These initiatives have helped to mitigate the increased ED demand from walk-in patients.
		• The seven priority initiatives of the ICB frailty programme are ongoing and indications are that there have been fewer frailty admissions / ED attendances in FY2526 so far
		East and North Herts
		• During the MADE week, there was a trial of a different way of working for the frailty assessment unit which was successful. From Oct-25, Frailty Assessment Unit to manage all of CDU. 7 cubicles and 10 chairs
		• Focus in ED has been on reducing time to triage and wait-to-be-seen. Working group established reviewing overnight processes; protection of assessment spaces within ED and re-enforcing the 1pm huddle
		West Essex
		• Improvement work focussed around 4 key workstreams: optimising use of UTC; non-admitted patients (inc. SDEC optimisation / expansion); admitted patients (inc. Discharge Improvement Programme / H@H optimisation); paediatrics
		• Optimisation of alternative pathways and consistent use of escalation tool at peak times
		• Review / refresh of Full Capacity Protocol (FCP)
		South and West Herts
		• Work on the Transfer of Care Hub (previously SPOC) continues with the leadership structure agreed. The aim is to ensure the ToCH operates as one single function regardless of organisational boundaries.
		• Implementation of OPTICA has made significant progress. This is a Federated Data Platform app which provides a live workflow-based dashboard for ToCH

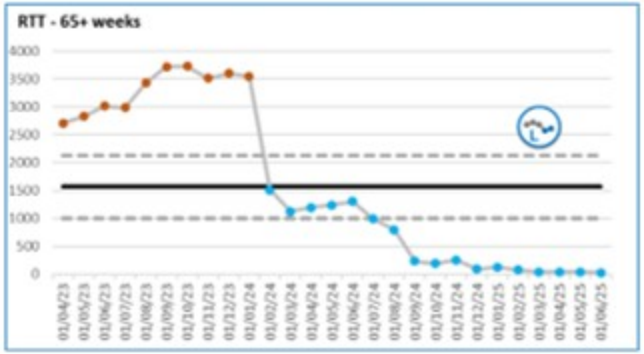
Planned Care – PTL Size and Long Waits

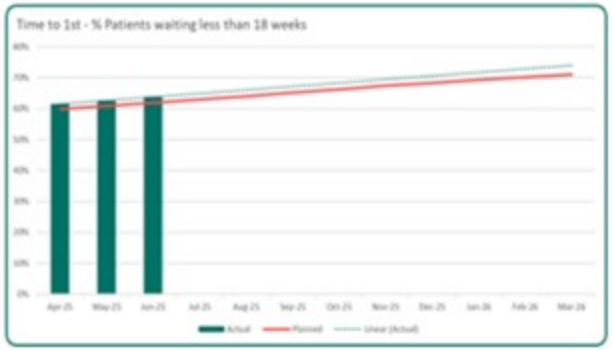












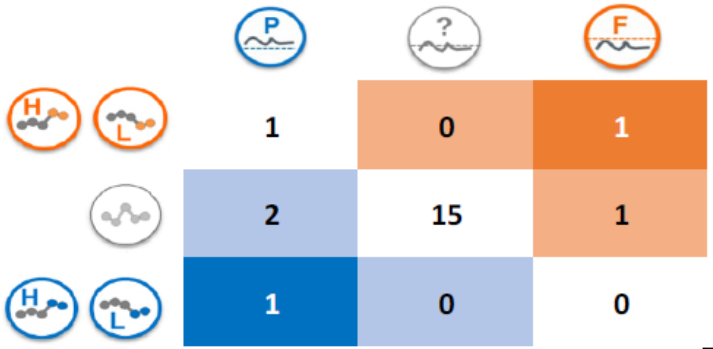
Community Paediatrics patients have been excluded from RTT reporting from February 2024 in line with national guidance
Waiting lists therefore show significant reductions

Planned Care – PTL Size and Long Waits

ICB Area	What the charts tell us	Issues	Actions

HWE	• The overall PTL size remains high although there have been significant reductions since the highest level in March 2025 of c.156000 to c.147900 in June 2025 which is 2% better than plan.
	• The overall number of patients waiting >65 weeks was minimal and remained static. There remains variation at place level but the ICB overall number of breaches at the end of June was 32
	  • ENHT: 19
	  • WHTH: 0
	  • PAH: 12
	  • ISP: 1
	• The number of patients waiting over 52 weeks reduced in May and remained static in June with the new metric of the number of patients who are waiting over 52 weeks as a % of the PTL reaching 2.7% for June. Therefore reaching just under the system plan for month 3 with a target of 1% by March 2026.
	• The number of patients waiting 18 weeks has been on an improving trend since November 2024 and is above planned trajectory for June 60.4% against a plan of 56.3%
		• The 65ww breaches forecast for end of August is 62 although the national expectation is zero. The increase comes from PAH which has an expectation of 50 breaches
		• Trauma and Orthopaedics (T&O) remains the main specialty under pressure across the system
		• Gynaecology is an emerging area of risk at PAH
		• Oral and pain management are areas of pressure at ENHT
		• Staffing remains a challenge across the system
		• There remain a number of planned care related Data Quality (DQ) issues at PAH following launch of Alex Health which are included with the Trust's improvement plan
			• There is a system focus on reducing the number of patients facing long waits, particularly those waiting over 65 and 52 weeks. Alongside regular performance meetings with the ICB and each Trust, there is both regional and national oversight
			• Demand, capacity & recovery plans are in place to monitor RTT
			• Weekly KLOEs in place with NHSE to track the 65-week and 52-week positions
			• The Q1 validation sprint is almost completed with positive results from each of the three trusts
			• Outpatients has a full programme of work to increase productivity including PIFU (patient initiated follow up), reducing follow ups including discharging where appropriate, and increasing take up of Advice & Guidance
			• In July, Princess Alexandra Hospital were moved from Tier 1 of the national oversight and support infrastructure to Tier 2 for Elective recovery, however remain in Tier 1 for Diagnostics recovery. Fortnightly tiering meetings with the NHSE EOE regional team are in place
			• At WHTH, the Elective Care improvement programme for 2025/26 has been finalised and is aligned to delivery of the national planning guidance target of 65.5% for RTT
			• WHTH have identified priority projects have been identified at each point of the pathway milestones and specialty improvement projects have been agreed following analysis of waiting list data and an assessment of issues and root causes
			• At ENHT, the delays with the rollout of the CBCT scanner for Oral surgery have now been resolved and the Trust is hoping to recover the position quickly
			• ENHT have recruited a new surgeon who can support the knee osteotomy which has been a particular area of challenge in T&O

KPI Risk Summary* - Quality



*Including NHS Oversight Framework metrics
*Note: Further information regarding risks can be found in the Committee's accompanying Risk Report

Highest Risk	Programme
Paediatric Audiology - HWE	Paitent Safety

High Risk	Programme
Maintaining High Quality Care	Patient Safety

Lowest Risk	Programme
Quality Improvement Progress	Nursing & Quality

Low Risk	Programme
Antenatal Education	LMNS
Digitilisation Progress	LMNS

Variable Risk	Programme
All Age Recent Care Leaver Death	Safeguarding
All Age Online Referral Portal	Safeguarding
All Age Complex Case Escalation	Safeguarding
ICB Systems & Process	Patient Experience
ICB Systems & Process	Patient Safety
Strategy Implementation	Patient Safety
Antimicrobial resistance: total prescribing of antibiotics in primary	Pharmacy & Medicines Optimisation Team
Antimicrobial resistance: proportion of broad-spectrum antibiotic	Pharmacy & Medicines Optimisation Team
E.coli	IPC
MRSA	IPC
C Diff	IPC

Variable Risk	Programme
Sepsis / Falls / VTE / Pressure Ulcers	Basic Care Measures
CAMHS - West Essex	Mental Health
Care Education Treatment Reviews	Mental Health
Transforming Care IP Levels - Herts	Mental Health
Workforce Culture	Workforce
Number of stillbirths per 1000	LMNS
Number of neonatal deaths per 1000	LMNS
Good experience when making a GP appointment	Primary Care
Workforce compassionate culture	Workforce
Workforce raising concerns	Workforce

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

Quality Executive Summary

West Hertfordshire Teaching Hospitals NHS Trust (WHTHT) - Never Event. Slide 17

Position since Previous Report: NEW.

- Never Event, retained foreign object following gynaecology day-surgery. Patient presented to hospital several days post-surgery where object was identified.
- Duty of Candour has been completed, and Patient Safety Incident Investigation is underway. Immediate learning has been put in place while review is undertaken.

Paediatric Audiology. Under current escalation to the HWE ICB System Quality Group (SQG) and Regional Quality Group (RQG). Slide 17.

Position since Previous Report: Continued oversight and further improvements required.

- Regular review of pathway development status to support opening of East and North Hertfordshire NHS Teaching Trust (ENHTT) pathways. Hearing Aid pathway opened March 2025 and Auditory Brainstem Response (ABR) pathway opened May 2025.
- System mutual aid discussions being held. Current timeline for ENHTT under 3s pathway is Spring 2026 due to required estates work.
- Following sample ABR review, Hertfordshire Community NHS Trust (HCT) has triggered full 5 year look back for ABRs.

East of England Ambulance Service Trust (EEAST). Under current escalation to RQG. Slide 18.

Position since Previous Report: Continued oversight and further improvements required.

- Updates show progress in mandatory training, call waiting times, and medicines management. Longer-term action plans in place around Emergency Operations Centre staffing, cultural improvements, and incorporating staff feedback.
- Criteria for EEAST to exit enhanced quality review by September 2025 has been defined with planned monthly monitoring.

Infection Prevention and Control- C difficile. Under current escalation to RQG. Slide 13.

Position since Previous Report: Continued oversight and further improvements required.

- Nationally, C. diff cases are above pre-pandemic levels and rising. In 2024, the United Kingdom reported the highest number of cases for 13 years. This has now been declared as a national incident. To date in 2025/26, WHTHT and Princess Alexandra Hospital Trust (PAHT) are above their allocated ceilings for this point in the year with ENHTT reporting below their set trajectory. ENHTT and WHTHT are above that of the regional rate with PAHT reporting below the regional rate.
- Ongoing review of system wide action plan. Individual action plans in place to address the high number of cases seen at ENHTT and WHTHT.

AJM Wheelchair Service. Under current escalation to SQG and RQG. Slide 20.

Position since Previous Report: Improving.

- Recovery trajectories are anticipated to be compliant overall across all key performance indicators by end of August 2025. Aligned quality action plan is finalised and assurances sought from AJM.
- Decreasing patient/carer complaints and increasing compliments being received by AJM. Improving system collaboration and satisfaction with the service.

Sharing Best Practice / Learning from Excellence

Infant Crying is Normal (ICON) Campaign.

ICON training to reduce infant head trauma was launched across Hertfordshire and west Essex (HWE) Integrated Care System (ICS) in September 2023 with oversight from Health and Social Care Partnership. The objectives are to support parents in understanding that infant crying is normal and provide support and strategies to manage crying, raising awareness that crying changes and when to seek help. The campaign aims to empower all agencies/organisations working with families to reiterate ICON messaging at all contacts.

The ICON roll out continues to thrive in HWE with over 2000 professionals trained from a variety of disciplines. ICON is now embedded into monthly midwifery training across both ENHTT and WHTHT and training has started rolling out across social work teams in Hertfordshire. The 3rd HWE ICON week returns 22-26 September 2025, bringing together professionals, organisations and communities for five days of learning, sharing and fundraising.

Princess Alexandra Hospital Trust (PAHT) - Plus Sized Patient Pathway.

A Trust-wide task group has been formed in response to safety incidents, led by the Clinical Quality and Governance team aiming to provide dignified, safe care for plus-size patients through tailored equipment, environments, and staff capability. A data-driven approach has identified high-demand wards and reduced delays from reactive equipment hire. Imaging capacity risks have been addressed through a formal Service Level Agreement with Newham Hospital to ensure safe access to Magnetic Resonance Imaging/Computed Tomography for patients exceeding PAHT's equipment limits (max 60-inch width).

A dedicated elective pathway is now in place, enabling early planning and reduced risk in surgical care. Next steps includes developing a Standard Operating Procedure, Electronic Patient Record alerts, training and estate upgrades to remove physical barriers, aligning with bariatric standards.

Essex Partnership University Trust (EPUT) - Launching the Frailty, End of Life, Dementia Assessment (FREDA) template.

Embedding the FREDA template into clinical workflows to improve early identification and care coordination. Enhancing digital infrastructure to support proactive, personalised care across frailty, dementia, and end-of-life pathways. Strengthening system-wide data capture to reduce unwarranted variation and improve continuity of care. Next steps include extending training across sectors for consistent, confident application, and use FREDA insights to drive patient-centred, digitally enabled ICS care.

Mount Vernon Cancer Centre - First in UK to Offer Immunotherapy Injection.

Mount Vernon Cancer Centre has become the first cancer centre in the country to treat a patient with an injectable form of immunotherapy called nivolumab. Approved for use in the UK earlier in 2025, the new under-the-skin injection means patients spend less time in hospital, with fortnightly or monthly treatment administered in 5 minutes rather than up to an hour via an intravenous drip. As part of a drive to offer patients faster access to the latest cancer treatments, the team prioritised prescribing guidelines and worked with the drug manufacturer to ensure they were ready to treat patients as soon as the injection was available in the UK.

West Hertfordshire Teaching Hospitals NHS Trust (WHTHT) - Reducing pressure related injuries in patients usings non-invasive ventilation masks.

A Quality Improvement project at Watford General Hospital led to over 2,500 pressure ulcer-free days for patients using non-invasive ventilation masks. This was achieved by introducing alternative mask options that offer the same therapeutic benefit while reducing pressure-related injuries. The initiative, now standard practice across WHTHT, has improved patient comfort, involved strong multidisciplinary collaboration, and has been nationally published on the *BMJ Open Quality* website. Work on further improvements continues.

My Healthcare Passport.

In August 2024, a Learning Disability Register update meeting was initiated to explore strategies for supporting children and young people in understanding the importance of Annual Health Checks. A need for development of a version of the purple folder tailored specifically for children and young people was identified and work on this is progressing rapidly. The passport will facilitate a seamless transfer of information into the Purple Folder at age 18, ensuring that all professionals involved have a comprehensive understanding of the individual's needs.

Key updates

Paediatric Audiology

There continues to be a significant focus on paediatric audiology improvement work, both at system level and specifically to support East and North Hertfordshire Teaching NHS Trust (ENHTT). All work continues to be aligned to the National Paediatric Audiology Improvement Programme.

ENHTT have continued to implement their improvement plans with progress ongoing and pathways for 3–5-year-olds, over 5s, auditory brainstem response (ABR) and hearing aids now open. However, the pathways for 0–3-year-olds and complex cases remain paused within the Trust.

The main risk relates to the lack of estates at ENHTT to see the youngest cohort of children (0-3 years), and limited mutual aid identified to support this cohort to date. Both the ICB and NHSE regional team continue to support discussions to identify mutual aid from within the system and beyond.

Within the wider HWE system, the sample ABR review for Hertfordshire Community NHS Trust (HCT) has now been completed as part of the National Paediatric Audiology Improvement Programme, and a full 5-year look back for ABRs has been triggered. The Trust, HWE ICB and NHSE are working together to ensure the process for the full look back is as efficient as possible to minimise impact on the service, whilst ensuring that any quality issues are identified and acted upon in a timely way.

AJM Wheelchair service

In previous reports concerns have been reported regarding waiting times and communication from AJM, the wheelchair provider for adults and children in Hertfordshire. These have impacted on adults and children using the service as well as system partners. There has been ongoing work within the ICB to ensure robust oversight of the recovery plans, with a co-ordinated approach across quality, commissioning and contracts teams to help drive the required improvements.

Agreed actions with the provider include delivery of recovery trajectories for the waiting lists, system wide arrangements between wider organisations and AJM to support risk-based equitable care across the system, and improved patient feedback processes within AJM. To support these actions, regular meetings have taken place with AJM, as well as a number of system quality meetings with wider system partners.

Progress has been positive, with recovery trajectories on track to be complaint across key performance indicators by end of August 2025. Improvements in communication have been noted by system partners, and there has been a reduction in patient and family complaints and concerns being raised alongside an increase in compliments received by AJM.

Ongoing monitoring will take place to ensure the improvements are sustained.

Finance

HWE System Revenue Year to Date (YTD) Position:

The Hertfordshire and West Essex (HWE) System reported a Month 4 YTD financial position of £25.375m overspent, which is behind the planned overspent position of £25.347m, reporting an overspend against plan of £0.028m.

HWE System Revenue Forecast Outturn (FOT) Position:

HWE System is now reporting expected achievement of breakeven, in line with the revised Control Total, by the end of the financial year.

MONTH 4 2025/26	YTD Plan	YTD Actuals	YTD Variance	Annual Plan	Forecast Outturn	FOT Variance
ORGANISATION	£'000	£'000	£'000	£'000	£'000	£'000
ENHT	(8,671)	(8,586)	85	0	0	0
HCT	0	0	0	0	0	0
HPFT	(3,479)	(3,448)	31	0	0	0
PAH	(1,994)	(2,174)	(180)	0	0	0
WHTH	(4,264)	(4,228)	36	0	0	0
TOTAL HWE ICS PROVIDERS	(18,408)	(18,436)	(28)	0	0	0
HWE ICB	(6,939)	(6,939)	0	0	0	0
TOTAL HWE ICS ORGANISATIONS	(25,347)	(25,375)	(28)	0	0	0

HWE System Capital Financial Position:

HWE System is expected to remain within the System Capital Departmental Expenditure Limit (CDEL) for 2025/26.

System Capital	System Allocations	Forecast Outturn							Variance to Allocation
		ENHT	HCT	HPFT	PAH	WHTH	ICB	System	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
CDEL BAU	81,348	21,495	7,962	12,547	18,117	21,226		81,347	1
UEC Allocation -WHTH	3,000					3,000		3,000	0
GPIT	2,952						2,952	2,952	0
GPIT ARRS	344						344	344	
Provider Agreed Allocation	**87,644**	**21,495**	**7,962**	**12,547**	**18,117**	**24,226**	**3,296**	**87,643**	**1**

HWE System Efficiency Delivery:

HWE System is £1.299m behind plan in delivering efficiencies at Month 4, with a broader review of efficiency delivery being undertaken to confirm likely forecast outturn.

Workforce

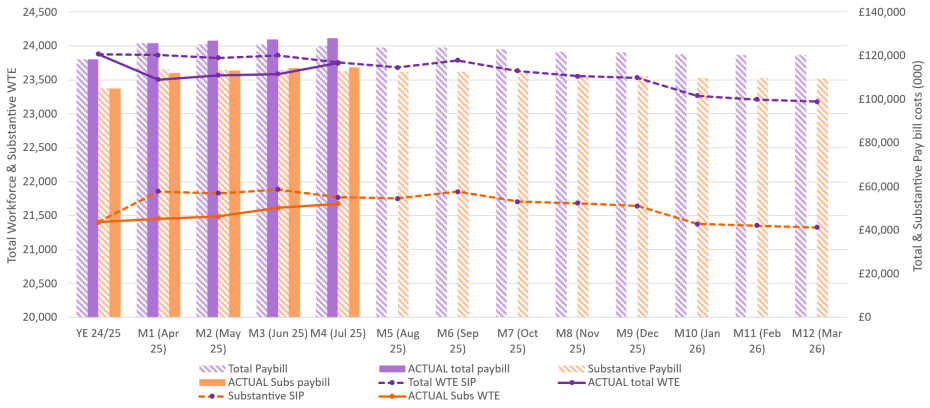
The trend for the system's overall workforce continues to show an increase in WTE across Hertfordshire and West Essex. Between M3 and M4 the workforce increased by 159.2 wte, with respective increases of 59 wte in substantive, 94 wte in bank and 5 in agency. Despite this increase total workforce usage remains overall projections for M4 of our operational plan, 8.00 wte (-0.03%).

Bank staff usage is flagged as a particular area for concern at M4. For the system we are now 116.2 wte over projection, equivalent to 6.17%. Over the course of the month there was an increase of 94.13 wte. This is particularly prevalent in the reg Nursing & Midwives and Medical & Dental staff groups across the system. Organisationally this is predominantly caused by high usage at West Herts. Substantive wte and agency wte continue to be below projected use at this point of the operational plans and therefore continue to bridge the overuse of bank staff.

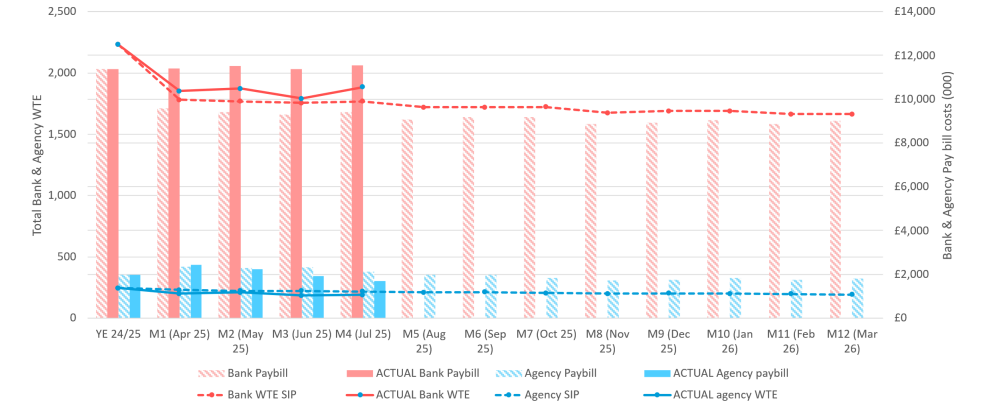
Despite the increase in workforce use there is more positive news in relation to the pay bill costs attached to workforce, with the gap to plan reducing by 0.5 per cent. At the end of M4, the system was £3m over budget – equivalent to 0.5%. This suggests that organisations across the system are enforcing improved rate usage and reducing the spend per employee. This is an improved position against the same point last year, where at M4 we were over 1% over budget – equivalent to +£5m.

Obviously, the area of continuing concern is Bank staff costs which have risen back to around £11.5m per month, and this has pushed the overall bank pay bill to £8m above pay bill budget at this point in the plan for bank staff (17.4%). These costs are somewhat offset by savings made in agency and substantive staffing costs, which are £1.1m and £3.8m under projected budget respectively. Bank pay costs continue to be the biggest area of discrepancy across organisations. West Herts continue to face significant challenges in this area, standing at £5.8m over budget (49%) however they have made significant progress in reducing their agency costs, which now stand at just 4% over budget.

HWE System Operational Plan 2025/26 – Total and Substantive WTE usage / Pay bill



HWE System Operational Plan 2025/26 – Bank and Agency WTE usage / Pay bill



The EoE Multiprofessional Healthcare Learner Toolkit App which was devised and developed within the Hertfordshire and West Essex system has been shortlisted for a further two awards, firstly in the 'Digital' category for the Nursing Times Awards and then secondly for the CAPHO awards. There is now a business plan that has been developed that could lead to the app being utilised nationally.

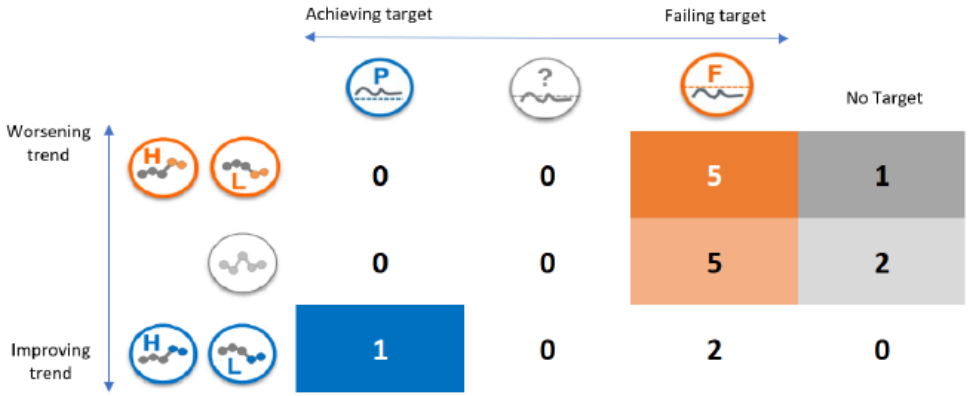
The ICB continues to work in partnership with the DWP and local council on a Get Hertfordshire Working plan due for completion in September this year. This is in response to the request from government for a localise response to the wider Get Britain Working Paper. The ICB is part of a core network of partners looking to work collaboratively to reduce the amount of people out of work due to ill health. In addition to this the workforce transformation team have had their bid successfully moved to phase 2 of the process for the Public Health Investment programme.

Medium Term Plan delivery:

Below provides a summary position for the system delivery against our Medium Term Plan (MTP) priorities. This is reported to the System Transformation and Improvement Committee, which also reviews the detail of each of the transformation priorities, including assurance of progress against anticipated trajectories, as well as risks to implementation and mitigating actions. In addition, on a rotating workplan, the committee also receives a deep dive on each of the transformation priorities, to look in greater depth at any key successes or challenges in the system, as well as understanding the local delivery approach and progress in each Health Care Partnership.

Following the July committee report, it was agreed that, recognising the amount of system resource and work required to support narrative in the full report, the MTP Dashboard report will be brought to the System Transformation and Improvement Committee every four months (every other committee), as opposed to every committee. The deep dives on each of the key areas will continue to be on the agenda of every committee meeting.

MTP Executive Summary



Static/ Non-moving Trend

Metric	Programme
Rate of non-elective admissions in people living with frailty (currently 65+ as proxy)	UEC
Rate of non-elective admissions for falls within the community for people aged 65+	UEC
Out of area inappropriate beds for adults requiring a MH inpatient stay	MH
Response to community Crisis Service urgent referrals	MH
Proportion of MH attendances spending over 12 hours in A&E	MH
Rate of A&E attendances for children and young people	CYP
Theatre Productivity	Elective Care

Improving Trend

Metric	Programme
Prevalence of hypertension in the most deprived 20% of the population	CVD
Hypertension QOF	CVD
Percent of patients waiting less than 6 weeks for diagnostic (excluding audiology)	Elective Care

Deteriorating Trend

Metric	Programme	Mitigating action identified
Patients with GP recorded hypertension whose last blood pressure was in target	CVD	TBC
Deaths with 3 or more emergency admissions in the last 90 days of life	UEC	Work is ongoing with EEAST colleagues to understand the quality of the ACPs and reasons for conveyance. There is an ICB wide review of the quality of ACPs ensuring they have enough detail they can be followed
Percent of Surgery consistently undertaken as a day case	Elective Care	Opportunities will be explored in General Surgery, Urology Orthopaedics and overall improvement opportunity at PAH
Total Elective PTL	Elective Care	Balance the waiting list so clock starts are less than clock stops. Clock starts reduction through improved referral management, use of advice and guidance, EBI, self-referral and clock stops through improvement in efficiency, theatres and outpatients
Reduce wait for community paediatric services greater than 65 weeks	CYP	A business case is being developed to pilot 3 CYP neighbourhood MDTs across the ICB, which have been evidenced to reduce community waiting times where successfully implemented.
Non-elective admission rates for children and young people	CYP	A business case is being written to extend the ENHT Asthma nurse pilot to allow for a more in-dept evaluation of the benefits. Funding to develop community-based models, such as hospital at home, and recognition of the importance of asthma and epilepsy nursing posts.

MTP Executive Summary

Reduce inequality with a focus on outcomes for CVD and Hypertension. Confidence in delivery of expected outcomes for 25/26: MEDIUM

- Work continues as per the Long-Term Conditions CVD Plan for 2025/2026. Practice level data is being utilised to identify opportunities and increase diagnoses of Hypertension. All community and acute trusts are offering BP checks in various settings and clinics.

Improve urgent and emergency care (UEC) through more anticipatory/same day emergency care (SDEC). Confidence in delivery of expected outcomes for 25/26: MEDIUM

- A recent report from the Population Health Management team using new patient level data shows the impact of these new ways of working, with a significant (62%) reduction in emergency admissions for people with frailty. Analysis covering approximately 60% of the registered population allows the ICB to identify the number of emergency admissions in people with a diagnosis of frailty and compare to admissions in non-frail patients aged 65 years and over.
- The preventative approaches within our 7 interventions is improving the reduction of non-elective admissions in people living with frailty, and we are also starting to see the impact in the implementation of ReSPECT and increased awareness of ACPs and alternatives to admissions pathways.
- A combination of services within our HCPs are impacting positively on the reduction of emergency admissions for falls, as well as an increasing number of people proactively completing falls risk assessments and signposting our population onto additional services.
- Regarding the negative trend, close work is ongoing with EEAST colleagues to understand the quality of our ACPs and reasons for conveyance.

Appendix A

NHS Oversight Framework 2025/26: Segmentation and Performance Dashboard Qtr 1

	Average Score	Financial Deficit	Segment	Rank
Acute Trusts				
ENHT	2.16	No	2	19/134
WHTHT	1.88	Yes	3	32/134
PAH	2.85	Yes	4	120/134
Ambulance Trusts				
EEAST	3.02	No	4	10/10
Non Acute Trusts				
CLCH	1.82	No	1	4/61
HCT	2.04	Yes	3	28/61
HPFT	2.13	Yes	3	29/61
EPUT	2.45	Yes	3	36/61

Average Score
Scored on up to 30 measures of performance metrics
1.00 (high performing) - 4.00 (low performing)

Domains	Sub-Domain
Access to services	Cancer care
	Elective care
	Mental health care
	Urgent and emergency care
Effectiveness and experience of care	Effective flow and discharge
	Effective out of hospital care
	Patient experience
Finance and productivity	Finance
	Productivity
Patient safety	Patient safety
People and workforce	Retention and culture

Segment
1 - High Performing
2 - Above Average
3 - Below Average and/or Financial Deficit
4 - Low Performing

Note: Organisations reporting a financial deficit or in receipt of deficit support can achieve no greater than segment 3

Rank
Based on segment score and then average performance score within segment

Hertfordshire and West Essex Integrated Care System

<table>
<tr><td>Meeting:</td><td colspan="2">Meeting in public</td><td>☒</td><td colspan="2">Meeting in private (confidential)</td><td>☐</td></tr>
<tr><td></td><td colspan="3">NHS HWE ICB Board meeting held in Public</td><td>Meeting Date:</td><td>26/09/2025</td></tr>
<tr><td>Report Title:</td><td colspan="3">ICB Committee Summary Reports</td><td>Agenda Item:</td><td>13</td></tr>
<tr><td>Report Author(s):</td><td colspan="6">Governance Leads, HWE ICB</td></tr>
<tr><td>Report Presented by:</td><td colspan="6">Committee Chairs / Executive Leads</td></tr>
<tr><td>Report Signed off by:</td><td colspan="6">Michael Watson, Chief of Staff</td></tr>
<tr><td>Purpose:</td><td colspan="6">Approval / Decision ☐ Assurance ☐ Discussion ☐ Information ☒</td></tr>
<tr><td>Which Strategic Objectives are relevant to this report
[Please list]</td><td colspan="6">■ Increase healthy life expectancy, and reduce inequality
■ Give every child the best start in life
■ Improve access to health and care services
■ Increase the numbers of citizens taking steps to improve their wellbeing
■ Achieve a balanced financial position annually</td></tr>
<tr><td>Key questions for the ICB Board / Committee:</td><td colspan="6">N/A</td></tr>
<tr><td>Report History:</td><td colspan="6">N/A</td></tr>
<tr><td>Executive Summary:</td><td colspan="6">Each ICB Sub-Committee has produced a summary document providing an update from the last meeting.

All summary reports can be found in the information section of the agenda – noting reference to Audit and Risk Committee in the table below:
<table>
<tr><th>Committee</th><th>Date of meeting</th><th>Chair</th></tr>
<tr><td>Audit and Risk Committee
- Verbal update to be provided as the Committee sat on the same day as HWE ICBs papers were published.</td><td>19th September 2025</td><td>Thelma Stober</td></tr>
</table></td></tr>
</table>

Hertfordshire and West Essex Integrated Care System

	System Transformation and Quality Improvement Committee	10th September 2025	Ruth Bailey
	Strategic Finance and Commissioning Committee	11th September 2025	Nick Moberly
	ENH HCP Board	5th September 2025	Elliott Howard-Jones
	WE HCP Board	18th September 2025	Thom Lafferty
	SWH HCP Board	13th September 2025	Matthew Coates
	Mental Health, Learning Disabilities and Autism Health and Care Partnership Board	11th September 2025	Karen Taylor/ Chris Badger

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

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document –

Alert, Advise and Assure Report to the Board of the Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

[Date of meeting]:	**System Transformation and Quality Committee 09.07.25**			
Signed off by Chair and Executive Lead:	**Chair – Trevor Fernandes** **Executives – Natalie Hammond/ Francis Shattock**			
Report Author:	**Simone Surgenor – Deputy Chief of Staff, Governance and Policy**			
Report to the ICB Board	**In public**		**In private**	**x**

Agenda items covered:

- Declarations – noting no receipt by the 31st July will be treated as non-compliant for this financial year.
- Workplan – look to flex with the transition.
- Health Care Partnership update:
  - West Essex HCP – have a separate Quality and Transformation Committee.
    - Transformation – of note: minor eye condition service. Identifying increased activity sitting in the South referral space. Currently understanding the triggers.
    - Performance – Trying to ensure this meeting is not an aggregator of what people have already raised in other committees, the key focus is spotting key areas for adoption. Pending update on when systems will be back in respect of reporting, noting there has been improvement in reporting but IT infrastructure still being developed and remains under escalation with the ICB. Two areas of particular focus: audiology and maternity with progress being monitored.
  - South West Herts HCP – report noted.
  - MHLD – three core items:
    1) System wide QI programme with a focus on mental health and reporting. Ongoing work as to how this programme will complement other areas in the system and system activity.
    2) Outcome of the Nottingham CQC review, and which of those actions sit outside of the mental health trust and the role of this HCP committee going forward.
    3) The Committee to validate and stress test integrated delivery plan. Therefore, an opportunity for cross system checking and to pick up on priorities.

    Noting by the Committee how the HCPs are consulting with the wider system with this being welcomed.
  - ENH – Paediatric audiology is a main focus. Noting capacity and comms particularly with parents and wider system. This comms includes the recovery work. Committee updated that this is a national incident, with mutual aid challenges – with national attention and national markers to support quality provisions and support for the system. System approach to recovery in place.
- Performance report –
- UEC performance for May 25, and all other date reported as at April 25:
  - Urgent care – NHS 11 abandoned call performance continues on an improved trend.

- Cat 2 ambulance response time continue at improved levels in May and have moved from high risk to variable risk. Committee querying what this meant from a patient's point of view – with waits and handovers.
- Mean ambulance handover times have improved significantly since January. Performance is on a variable trend and ahead of plan.
- Cancer 62-day performance has moved to the lowest risk. Seeing some variation between Trusts with PAHT the most challenged.
- 4-hour ED performance has moved to an improving trend at 77% in May and this remains at low risk.
- Diagnostics excluding paediatric audiology - overall diagnostic performance has improved and back to similar levels seen in April 2024.
- Mental Health - the Learning Disability Annual Health Checks of 75% was achieved by all three places.
- Community waits for adults – have now included Circle MSK data to reporting and seen a decline in waiting times. Some recovering noted in April and May.
- Community waits for children and ASD – remain our areas of highest risk and funding and investment remains unresolved and waiting lists increase.
- Committee noted the improved format of this report.

- Quality report –
  - Noting revised format of this report bringing the quality report and quality dashboard together to provide complementary information.
  - Progress with Acute colleagues with Never Events thematic review noted.
    - Paediatric audiology – biggest risk from a quality point of view in the system. Looking at a leveling up approach with focus on seeing those waiting in the right clinical priority order. Look back process under review and will come back to this committee.
    - Southwest Herts care home where the ICB does have ongoing safety concerns. ICB working closely with the Local Authority and CQC to ensure support surrounding care and the residents within the home.
    - Elysium healthcare – seen sustained improvement, and they have exited the safety improvement process with the ICB moving onto normal monitoring.
- Quality Accounts – full statements included within the appendix pack, and for the committee to note as part of national compliance.
- Neonatal Critical Care Review Project and Outcomes – HWE started project work across its trusts in 2020. Noted strength of work in this area. Committee thanked the team.
- Medium Term Dashboard – Noting revised format of the report. Further work to be undertaken in adapting the format to illustrate how we are having impact on the ground. Requested for this to be a quarterly report as opposed to every other month – noted the data is live on Delphy, and therefore trajectories can be sought sooner if needed.
- Deep dive – Frailty and End of Life Programme
- Long lie programme (on the floor for more than four hours) – community team pathway in place implemented across Herts and West Essex. Supportive when EEAST is under high pressure, with a two-hour community response. Metrics monitoring noting between April 24 and May 25 – 94% hospital admission avoidance – triggered by this programme. Noted Norfolk County Council using AI to identify individuals at risk of falling. Further work being undertaken in trusts including use of training recourses to support culture of deconditioning and reducing peoples care needs upon discharge. Updates received from each HCP –
  - Synergy across the places noted and supported by the committee. Particular projects discussed:

- Use of manga cushions
- Falls Response Vehicles.

- Patient Quality Feedback Group – noted work of spending more time about discussing patient story and patient views. Constructive scrutiny over whether the ICB is challenging trusts enough.
- Annual Patient Feedback Report – logged 76% more complaints. Increases seen in GP and CHC complaints. 74% of complaints directed to GP and dental services. Committee noting the length of time it takes to close complaints – linking this with the 10-year plan, alongside the complexity on a number of complaints involving multiple system partners. The team thanked and noting pressures against sustained increases of complaints against a plan in prevention and learning. Report approved for inclusion on the ICB public website.
- Annual Infection and Prevention Control Report – outlines the work of the ICB team undertaken from 24/25. Noting inclusive and system work. Committee noting Mpox downgraded. Measles pathway – welcoming work on the pathway, practicality of approach in providing the treatment queried for this to be picked up outside the meeting. Stress of need to keep things simple to avoid complicated commissioning arrangements delaying treatment. Further stress on communication to support wider system understanding the pathways and being up-to-date with any changes. Report approved.
- Risk register – noted paediatric audiology at 16.

Key discussion points and matters to be escalated from the meeting: *(From agenda)*

Alert: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy

-

Advise: The Board – of areas subject to on-going monitoring or development or where there is insufficient assurance

- Paediatric audiology – with national position noted. Close attention being kept on this area by the Committee.

Assure: Inform the Board – where positive assurance has been received.

-

Celebrating Success: Share any practice, innovation or action that the Committee considers to be outstanding

- Neonatal Critical Care Review Project and Outcomes – noting the strength of work and improvements. The region is noted as outstanding.

Forward plan issues:	• No additional items raised.
Date of next meeting	• 10th September 2025

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

ICB Committee Summary Document

Alert, Advise and Assure Report to the Board of the Integrated Care Board

Committee/board title **Date of meeting:**	**ICB System Transformation and Quality Improvement Committee** **Wednesday 10 September 2025**			
Signed off by Chair and Executive Lead:	**Chair – Ruth Bailey** **Executives – Natalie Hammond and Frances Shattock**			
Report Author:	**Committee Governance Leads – Jas Dosanjh**			
Report to the ICB Board:	**In public**		**In private**	✓

Agenda items covered (from agenda):

- **Meeting introduction** – quorate, the Chair commented on meeting format and changes to the governance arrangements in near future.
- **Declarations** – reminder that declarations for 2025/26 are required to maintain individual compliance, outstanding declarations to be submitted to the Governance Team.
- **Minutes** – amendments noted, approved.
- **Action tracker** – updates noted, approved.
- **Committee Workplan** – noted no changes recommended at this stage, developing a better understanding of organisational changes and the scope of ICB responsibilities which will impact on the remit of this Committee. To continue with existing workplan keep under review.
- **Committee Terms of Reference** – noted no changes recommended at this stage, as per Committee workplan, the existing arrangements are to continue until new Committee structures are established.
- **Update from Health Care Partnership (HCP) Quality and Performance Committees** – Chairs feedback that standardisation of reporting including summaries, actions being taken by the HCPs and matters requiring this Committees attention is still required. Further linking Medium Term Plan and key priorities, alongside identifying any blockages. Discussion points included:
  - West Essex HCP – winter planning key focus due to pressures faced last year.
  - East and North Herts HCP – noted that the nursing contract for Hertfordshire is currently under tender, outcome due by end of September 2025.
  - South West Hertfordshire HCP and Mental Health Learning Disability and Neurodiversity HCP – Chair to contact leads regarding regular attendance at meetings.

- **HWE Integrated Quality and Performance Report –**
  - **Performance –**
    - Highlighted that the NHS Oversight Framework 2025/26 has just been released, a new segmentation and performance dashboard for Q1, rating trusts across 30 metrics and 5 domains (and a number of sub-domains), placing them in 4 core segments; with performance and finance intertwined in the final ratings.
    - *Areas of improvement:*
      - UEC – continues on a trend of improvement, with reduced handover times and 4-hour ED performance remaining ahead of the system.
      - Planned Care – continues on a trend of improvement following implementation of the recovery plan, with reduction in wait times for adults, 52-week and 18-week improvement.
    - *Areas of challenge:*
      - CAHMS – remains an area of concern with the highest risk areas, waiting lists remain high for community waits (in particular Pediatrics, Therapies, Audiology, ASD and ADHD).
      - CHC performance declining and has not been met for 4 months, most notable decline in SW.
  - **Quality (including Quality Dashboard Highlight Report) –**
    - Paper includes a summary of quality visits undertaken by the Quality team, gives context to wider work, strengths and opportunities and challenges, linked to HCPs and will be fed back to the HCP Committees.
    - *Areas of improvement:*
      - Wheelchair services overall breaches are in decline with performance improvements. Ongoing action with system partners to support business as usual. Area of particularly focus – children and pediatric. Committee to be kept updated.
      - Trust successes: ENHT – improvements in workforce and estates, PAH – developed a Plus Sized Patient pathway, EPUT – launched Frailty, End of Life, Dementia Assessment (FREDA) template, WHTHT – non-invasive ventilation masks to reduce pressure related injuries.
    - *Areas of challenge:*
      - Highlighted clearly to the Committee that Pediatric Audiology remains one of the highest quality risks with inadequate services for younger children 0-3years and those with complex needs, although noting a significant reduction in waiting lists for children over 5 years.
      - HCT to carry out 5-year look-back review triggered regarding ABR case, potentially the exercise will also take place at PAH.
- **ICB Risk Register** – New risk ID.752 in relation to cross border maternity care scored as 16, challenges discussed, noted that the LMNS Partnership Board is overseeing the progress and workstreams by the Committee. No other significantly changes. Noted focus on risks through the meeting.
- **Herts and West Essex ICS Year 3 Quality Strategy Update** – noted the measures and actions outlined in the third and final year of the quality strategy.

- **Medium Term Dashboard** – report noted.
  - **Deep Dive: Children and Young People** – Committee noted the medium-term plan for children's services, key initiatives including Asthma, Epilepsy, Diabetes, Palliative Care, Neurodiversity, and challenges such demand for services, finances, and workforce. Current status noted and areas of future focus identified as SEND inspections and continued work on reducing wait times and improving service integration. However, current workplan will only ensure that the waiting list remains static. Further work is required to deliver a plan that will reduce waiting times and meet the medium-term targets.
- **All Age Continuing Care (AACC) Update** – update noted, 28-day KPI target of 80% completion of assessments has not been met by the ICB since February, a recovery trajectory has been set by NHS England with anticipated achievement by Q4 2025/26. The AACC Team vacancies make up 22% of the overall establishment, there is a recruitment plan and agency register in place.
- **Annual Safeguarding Children and Adults Report 2024/25** – noted the successes and challenges. Highlighted the tripartite collaboration and, that while risks exist, continuing current approaches without change would lead to increased pressure and financial demands, the new framework offers a chance to mitigate these risks by adopting a coordinated, system-wide approach.
- **Annual Child Death Overview Panel Reports 2024/25 for Hertfordshire and Essex** – noted the successes and challenges. Highlighted the importance of integrating the voice of the child across safeguarding, LMNS, and related processes, the Committee noted that a plan is in place to take forward the identified priorities.
- **Policy Review – Patient Safety Incident Response Policy and SOP** – the policy outlines the national expectations regarding the roles of ICBs within the framework of the PSIRF and is based on a national template provided by NHS England. The SOP explains the steps taken within the ICB to approve provider Patient Safety Incident Response Plans (PSIRPs). The Committee noted that this is a light-touch review that reflects updates to the current ICB governance arrangements and a more comprehensive review will be undertaken as part of a broader alignment initiative. The Committee agreed and recommended the documents for approval to the Executive Team.
- **Feedback from the Patient Quality Subgroup** – verbal update noted, with discission from meeting including wait times (scans and blood tests), winter pressures, AI development pro's and con's, positive feedback from the Advice and Guidance Questionnaire designed to facilitate consultations.
- **New Risks and Escalations from Committee and Review of Actions** – refer to section next section for key points/escalations (Alert/Advise/Assure).

Key discussion points and matters to be escalated from the meeting:	
Alert: Matters that need the Board's attention or action, e.g., an area of non-compliance, safety, or a threat to the ICS strategy	
• Children and Young People: current programme of work presented to the Committee will only keep waiting list static so presents a significant risk to achievement of the medium-term plan commitments. Recommended that new clusters commission work to understand what is required to put in place a plan which would result in a reduction in the waiting list for children and young people.	
Advise: The Board – of areas subject to on-going monitoring or development or where there is insufficient assurance	
• Health Care Partnerships reporting – ongoing review of HCP feed into this Committee, the assurance sought and mitigate against potential duplication. • Audiology performance – Pediatric audiology remains challenged system wide with a combination of long waiting times and workforce fragility. • CDiff – greater alignment needed to understand the disparity between improvements in the community which is not being seen in hospitals. • Maternity care cross border risk – area of concern as identified on the risk register. • AACC – 28-day KPI target of 80% not being met and NHSE have set a recovery trajectory for achievement by Q4 2025/26, ongoing workforce concerns with recruitment and retention with recruitment plan in place.	
Assure: Inform the Board – where positive assurance has been received	
• UEC performance risk – improving performance in the 4hour standard, ambulance handovers and Cat2 ambulance response times.	
Celebrating Success: Share any practice, innovation or action that the Committee considers to be outstanding	
• N/A	
Forward plan issues:	• Committee workplan and Terms of Reference are dependent on the outcome of the future agreed remit of the ICB as part of the multi-layered changes across the NHS.
Date of next meeting:	Wednesday 15 November 2025, 09:30 – 12:30.

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document – Public

Alert, Advise and Assure Report to the Board of the Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

[Date of meeting]:	NHS HWE ICB Strategic Finance and Commissioning Committee 11th September 2025			
Signed off by Chair and Executive Lead:	Chair – Nick Moberly (ICB NEM) Executives – Jonathan Wilson (ICB Chief Finance Officer)			
Report Author:	Deputy Chief of Staff – Governance and Policies.			
Report to the ICB Board	In public	x	In private	

Agenda items covered:

- Finance –
  - ICB/ICS In-year Financial Report – a risk to a break-even position for 25/26.

- Prescribing report – noted efficiencies obtained - 24/25 system wide prescribing financial plans totalled £12.2m with this efficiency target exceeded for 24/25 achieving £15.3m. 24/25 plans and key areas have been expanded and extended to achieve more in 25/26. Credit given to the team noted as high performing and the improvement achieved with patient outcomes. Committee querying the importance modelling these prescribing interventions to amplify the long-term benefits that might not be immediately visible. Risks being noted over continuity and the continued strong work being damaged in the long term by reducing the provisions in this area.

- CHC – update received by the committee noting linked reporting to the ICBs System Transformation and Quality Improvement Committee. Noting efficiencies identified at risk due to elements such as workforce pressures. Team preparation update for transition relayed, including west Essex handover element to Essex.

- Capital and Estates, Investments –
  - Capital allocations and approvals - NHSE advised HWE ICB of its 1- year System Capital Settlement covering 2025/2026 (Phase 1) in the last week of January 2025 and this was released in parallel with the 2025/2026 planning guidance. Capital allocations, approvals and number of projects working towards delivery in-year.
  - Hemel Hempstead Health Campus Strategic Outline case update – extraordinary meeting not being sought at this stage. Committee noting the progress.

- Committee update -
  - HCP Committee update reports –
    - South Herts HCP - Noting Neighbourhood approval. Referring to further delegation budgets from November.
    - East and North Herts HCP – Progress noted and move towards delegation.
    - West Essex HCP – verbal update. Noting logged transition risks with the ICB transition.

- Hertfordshire and West Essex Prescribing Committee Report -
  - HWE APC on mandatory NICE Technology Appraisal (TA) treatments and highlighted cost impact / pressures – approved by this committee.
  - HWE APC for treatments not included in the NICE work programme and highlighted cost impact / savings – approved by this committee.
  - HWE APC items – noted by the committee:
    - Information and agreed actions for drug safety updates/alerts
    - Publication of NICE TAs that are commissioning responsibility of NHS England
    - Guideline Updates, Pathways and other Information as specified

Key discussion points and matters to be escalated from the meeting: *(From agenda)*

Alert: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy

- ICB and system financial position – noting legacy handover, alongside need for Board to layering out what the position is and developing a framework over how we move this forward not forgetting the medium to long term transformation

Advise: The Board – of areas subject to on-going monitoring or development or where there is insufficient assurance

- As noted above.

Assure: Inform the Board – where positive assurance has been received.

- As noted above.

Celebrating Success: Share any practice, innovation or action that the Committee considers to be outstanding

- The work highlighted above, through the prescribing report and the performance of that team.

Forward plan issues:	• Committee members with wider colleagues asked to identify and relay to governance team forward plan issues in support of legacy transfer, and to align through transition governance.
Date of next meeting	• 13th November 2025 – nothing the transition governance.

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document –

Alert, Advise and Assure Report to the Board of the Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

[Date of meeting]:	ENH Health and Care Partnership Board 1st August 2025			
Signed off by Chair and Executive Lead:	**Chair -** Adam Sewell - Jones **Executive -** Sharn Elton			
Report Author:	Sharn Elton			
Report to the ICB Board	**In public**		**In private**	x

Agenda items covered:

The Integrated Delivery Plan (IDP) - was formally approved by the ICB public board on 27 June 2025, and the final version had been circulated to all members. The plans focus is on delivering the priorities for 2025/26, refreshing the strategic approach, and ensuring the operating model aligns with the new host provider arrangements and the 10-year plan.

Host Provider arrangements - formal move shadow transition took place on the 1st July 2025, with the meeting on the 1st August being the first meeting that was held as a committee-in-common. A series of engagement workshops are planned during July, August and September to consider the shared purpose of the partnership and how to work together to become an award-winning place. The Place-Based Executive Group had been re-established as the HCP Transition Group, which will focus on host provider work and the transition. A draft strategic narrative was presented, with the vision described as 'working as one for healthier communities'. A concise, impactful summary will be developed to communicate the essence of the Host Provider Model. It was acknowledged that the vision should be made more active, reflecting that the partnership was working together to improve community health and make a tangible difference in people's lives. A draft of Memorandum of Understanding was also presented.

Our National Neighbourhood Health Implementation Programme expression of interest would be submitted on 8 August 2025. Supported by population health management data the program will focus on patients with three or more co-morbidities in our most deprived areas. The HCP intends to move this work forward irrespective of the outcome of the bid submission.

Frailty - the impact of the 7 evidence-based interventions have been presented to the Clinical Professional and Transformation Committee where the positive impact of this work both locally within ENH and across the ICS were noted. Opportunities to enhance the Care Closer to Home and neighbourhood MDT approach by include additional patients in proactive pathways are being considered to support taking this work further in line with the NNIP proposal. Specifically, the work across GP practices in Welwyn and Hatfield focusing on medication reviews, where patient safety improvements have been demonstrated and partnerships between GP practices and community pharmacies have been strengthened.

Performance - positive performance over the last 12-18 months noted in relation to ED 4-hour performance, 52 week waits and cancer standards. The positive movement in diagnostic performance between May - July 2025, inclusive of audiology diagnostic waits, was also noted. Challenges remain for audiology and community waiting time notably paediatrics. The move to having oversight of performance information that is indicative of ENH's ability to meet our residents ongoing needs across all providers of health and care will support our priority areas of focus.
Local Government Review - an overview was presented to the board. The review is being led by the Ministry of Housing, Communities and Local Government is aimed at streamlining local government. Hertfordshire currently had 12 local government organisation's (10 district councils, a county council, and a police

and crime commissioner). The reform would restructure the existing system by April 2028 into unitary authorities. The submission deadline for a preferred plan for Hertfordshire is due in November 2025. Under the fair funding review Hertfordshire County Council's allocation is likely to reduce by £50 million over the next three years, which is in addition to the current required savings.

Key discussion points and matters to be escalated from the meeting: *(From agenda)*

Alert: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy

Advise: The Board – of areas subject to on-going monitoring or development or where there is insufficient assurance

The HCP are pleased to have received confirmation of recurrent investment in neurodiversity pathways however, the Partnership Board are aware of the ongoing challenges that this presents in being able to recover the overall waiting list position without seeing a significant reduction in referrals.

Assure: Inform the Board – where positive assurance has been received.

A series of workshops had been held to develop an integrated heart failure model for ENH. The draft implementation plan and model of care are being presented at the next CVD delivery group for review. The model aims to streamline communication lines, improve care plans, and enhance patient access. The results of the review would be presented to the partnership board.

Celebrating Success: Share any practice, innovation or action that the Committee considers to be outstanding

Please see key points as noted above and detailed within the CEO board report in relation to neighbourhood development.

Forward plan issues:	• Nil to note
Date of next meeting	17th October 2025

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document –

Alert, Advise and Assure Report to the Board of the Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

[Date of meeting]:	**West Essex Health & Care Partnership Board**			
Signed off by Chair and Executive Lead:	**Chair – Thom Lafferty** **Executive – Toni Coles**			
Report Author:	**Elizabeth Kerby – Development Director WE HCP**			
Report to the ICB Board	**In public**	**X**	**In private**	

Agenda items covered:

Neighbourhood Health model – update on the national programme progress
West Essex Winter Plan – update on the collaborative plan
NHS Planning Framework- partnership responsibilities
Locality progress with Integrated Delivery Plan and Community Hospital Bed review
Strengthening primary care representation at place discussion
Host provider – Delegated commissioning proposal
Host provider & HCP updated governance framework proposal
Sub-committee reports to Board.

Key discussion points and matters to be escalated from the meeting: *(From agenda)*

Alert: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy

None

Advise: The Board – of areas subject to on-going monitoring or development or where there is insufficient assurance

WEHCP Neighbourhood Health Implementation Programme successful application as wave one site. One of 42 out of 141 national applications.
Our initial focus is on adults with multiple long-term conditions and rising risk, starting in Harlow, our most deprived area, with plans to scale across West Essex.

Running alongside the Neighbourhood Health Implementation Programme is the Harlow Neighbourhood Plan regeneration project, which brings £20mill national resources to develop neighbourhoods looking at wider determinants actions. Harlow also has been awarded Sport England funding to improve physical activity inclusion and uptake.

The planning framework discussion included a request for focused work on children's waiting lists and joint assessment with the ICB of the risk in this area of commissioning sufficient capacity to meet the demand.

Discussion regarding the resourcing of primary care clinical leads in the future ICB resourcing models focused on the importance of primary care inclusion in Neighbourhood Health developments and care closer to home. A proposal will be prepared for ICB discussion.

The WE HCP Board approved the principle to progress with a phased approach to delegating commissioning and contract responsibility. Request to amend to give a particular focus to mitigate any separation of physical from mental health in service delivery. Further detail is to be added to the paper and circulated to Board members. Following recommendations supported: recommend approval to the PAHT Board and Essex Joint Committee (TBC); To continue working with PAHT to complete due diligence on the proposed contract, managed via the Finance and Commissioning Committee; Work with ICBs to secure resources needed to implement the host provider model, aiming for a decision by end of October; Complete a self-assessment of readiness for delegation and agree on an assurance and governance framework with ICBs for the transition.

Assure: Inform the Board – where positive assurance has been received.

Robust winter plan for West Essex health services has been drawn up, social care plan being finalised and will be incorporated with health. Will identify key measures to monitor the learning from this year's plans.

Locality reports highlighted a successful implementation of integrated training posts with CUH and primary care in North Uttlesford, EPUT looking at developing for other areas of West Essex. Whipps Cross have implemented a centre of excellence for older people which primary care are involved with.

Celebrating Success: Share any practice, innovation or action that the Committee considers to be outstanding

- West Essex HCP have been selected for the first wave of the national Neighbourhood Health Implementation Programme, reflecting our strong INT maturity, robust governance and delivery models such as Care Closer to Home, supported by delegated commissioning and data sharing agreements.

Forward plan issues:	• Approval of the 3 year plans for West Essex Providers • Regular reporting on progress of the Neighbourhood Health Implementation Programme and also to review the Harlow Neighbourhood Plan regeneration bid.
Date of next meeting	November 20th 2025

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document –

Alert, Advise and Assure Report to the Board of the Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

[Date of meeting]:	**South and West Hertfordshire Health and Care Partnership Board**			
Signed off by Chair and Executive Lead:	**Chair – Matthew Coats, Chair, HCP Board** **Executives – Matt Webb, Place Director, SWH HCP**			
Report Author:	**Ros Nerio, Development Director, SWH HCP**			
Report to the ICB Board	**In public**	**X**	**In private**	

Agenda items covered:

- HCP executive report
- Report from Quality and Performance Committee
- Report from Finance and Commissioning Committee
- Neighbourhood updates
- Phase 2 delegation
- Frailty and end of life workstream

Key discussion points and matters to be escalated from the meeting:

The HCP Board received report and had discussion for information and assurance on the following matters:

- **HCP Executive report**: The Board received updates on neighbourhood development, next steps on the implementation of the host provider model, progress in implementing the proactive care model and service development and transformation opportunities
- **Neighbourhood updates**: The Board received an update about the HCP's approaches to developing neighbourhood leadership tams and work taking place at neighbourhood level including neighbourhood winter plans
- **Quality report:** The Board received an update from the HCP's quality and performance committee, noting areas of strong performance and areas of high risk
- **Finance report:** The Board receive an update on the HCP's financial position
- **Phase two delegation:** The Board received an update on the next steps for delegating commissioning responsibility from the ICB to the WHTH, as host provider
- **Frailty and end of Life:** The Board received an update on work being undertaken within the HCP to reduce non-elective admissions for frail older people and noted the process made in reducing these admissions

Alert: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy

N/A

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document –

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NHS Hertfordshire and West Essex Integrated Care Board

Advise: The Board – of areas subject to on-going monitoring or development or where there is insufficient assurance	
• The board noted that waiting times for children with ADHD remains an area of high risk for the HCP and the quality and performance committee are providing continued oversight of this area • The board noted that all delegated contracts are currently performing to plan with the exception of the Circle MSK contract which is overperforming due to planned reduction in patients waiting over 18 weeks and the Finance and Commissioning Committee has requested a paper setting out the risks and mitigations to the HCP of overperformance • The board noted progress in reducing non-elective admissions for frail older people and commended the progress made to-date, which has been led by the HCP's Frailty, End of Life and Care Closer to Home working group. The board also noted a corresponding increase in emergency admissions in people aged over 65 who are not classified as frail and the HCP will seek to understand and mitigate this increase through the Frailty, End of Life and Care Closer to Home working group with oversight of this progress through the HCP's Quality and Performance Committee	
Assure: Inform the Board – where positive assurance has been received.	
• The board endorsed the proposals for next steps for implementing phase 2 of delegating commissioning responsibility from the ICB to WHTH, as host provider, on behalf of the HCP • The board received updates about the neighbourhood winter plans and were assured on the progress made in developing these plans for this winter • The committee noted areas of improving and strong performance across the HCP including ambulance mean handover time, 4 hour performance in ED and cancer performance and improvements in AJM Wheelchair service's performance and in waiting times for the Circle MSK service.	
Celebrating Success: Share any practice, innovation or action that the Committee considers to be outstanding	
The HCP's Quality and Performance Committee noted areas of strong performance including: • Ambulance mean handover time (surpassing plan in M3) • 4 hour performance is 85.6% against a monthly target of 82.6% • All three core cancer standards have been met and surpassed the recovery targets in May	
Forward plan issues:	The committee agreed to receive the following updated at the next HCP Board meeting: • Update on the Hemel Health Campus, with a focus on the communications strategy • Neighbourhood winter plans
Date of next meeting	08/10/2025

Herts Mental Health, Learning Disability and Neurodiversity Health and Care Partnership

Meeting:	**MHLDN Health and Care Partnership Board summary**			
	Meeting in public	☐	*Meeting in private (confidential)*	☒
Date:	**Friday 11 September 2025**			
Time:	**09.30 - 11.30**			
Venue:	**Da Vinci A & B, Colonnades, Hatfield**			
Chair:	**Karen Taylor**			

Agenda items covered

Declarations of Interest

- No declarations made.

Minutes

- Minutes from 11 July 2025 were approved as an accurate record.

Action tracker

- The MHLDN HCP Board noted the action tracker and that all actions were with complete or in progress.

Development Director's Report

- The MHLDN HCP Board noted activity that had taken place across the MHLDN HCP since its last meeting and received updates regarding:
    - **Publication of the national LeDeR report** – originally due to be published last year, the report found that in 2023 adults with a learning disability on average died 19.5 years younger than the general population, at 62.5 years. Avoidable deaths have declined since 2021 (from 46.1% to 38.8%). However, the rate for adults with a learning disability who died in 2023 is still nearly double the rate compared to the general population. The three most common causes of avoidable deaths are influenza and pneumonia, cancers of the digestive tract and ischemic heart disease.A full analysis of the Annual Report's findings alongside Hertfordshire's own LeDeR report will be considered by the MHLDN HCP's Learning Disabilities & Autism Strategic Partnership Board in October and the MHLDN HCP Board in November 2025.
    - **Publication of the NHS national planning framework** and the opportunity it presents for medium-term planning. The MHLDN HCP Board will play a pivotal role this year in the development of this work to ensure alignment to the MHLDN HCP's Integrated Delivery Plan
    - **Confirmation of the new chairing arrangements for the Integrated Care Boards.** HWE ICB will continue until at least April 2026 while working more closely with the other ICBs in the new cluster
    - **Hertfordshire Health and Wellbeing Board endorsement for the MHLDN HCP's Integrated Delivery Plan** and recognition of the role of the MHLDN HCP in delivering the priorities of the Hertfordshire Health and Wellbeing Strategy. The Health and Wellbeing Board agreed that the MHLDN HCP will report to the Health and Wellbeing Board as one of its governance sub-committees, assuming the reporting responsibilities currently fulfilled by the Hertfordshire and West Essex ICB Mental Health, Learning Disabilities and Autism Programme Board
    - **Connect and Prevent** - On 01 September 2025, Hertfordshire County Council's (HCC) Adult Care Services directorate held a workshop to co-create a vision for the future of its Connect & Prevent programme. Connect & Prevent is an Adult Social Care initiative with the aim of supporting people to be healthier and more independent for longer (using proactive prevention practices as a key activation). The outputs of the workshop will inform how HCC will continue to embed prevention and other strategic priorities across Adult Social Care and wider services.

    - **Prevention and public health communications** – the MHLDN HCP is leading two communications campaigns, one related to modifiable risk behaviours for Dementia and one around co-occurring mental health and substance use. The latter is focused on 'myth-busting' some of the existing preconceptions around co-occurring mental illness and substance use and will be promoted with GPs and the wider public.
    - **New crisis care provision** – the successful procurement of the new crisis house in Buntingford which will provide short term (7-14 days) support for people in mental health crisis with a focus upon recovery, daily living skills and empowerment in a non-restrictive setting. The service is currently scheduled to go-live from December 2025 and will be monitored and supported as part of the MHLDN HCP Crisis Care Partnership Board's work programme
    - **National Neighbourhood Health Implementation Programme** submission. Although the bid was unsuccessful the MHLDN HCP has made and received commitments from both Place-Based HCPs that we will work together to aligning implementation irrespective of who was successful
    - **Intensive and Assertive Outreach** – an update on the submission and self-assessment made to NHS England on Intensive and Assertive Outreach review. HWE ICB's overall rating found that, although progress is being made, both systems are not yet able to provide full assurance of meeting the needs of the target population group, particularly in regard to the prescribed caseload sizes and therefore intensity required. The process identified there are resourcing implications to meet full fidelity, particularly in increasing capacity to enable the smaller caseloads identified in the model to achieve the intensity of input required
    - **Children and Young People's Neurodiversity** – update on the successful procurement of CYP Neurodiversity Support which will be provided by Add-vance for a three-year period. It is likely that OFSTED will be undertaking a further review of local progress and will want to understand progress in relation to CYP autism and ADHD waits.

Hertfordshire Dementia Programme – delivery and progress report

- The MHLDN HCP received an update on the progress and delivery of the Hertfordshire Dementia Strategy which specifically highlighted the improvement in EMDASS performance and a sustained growth in the dementia diagnosis rate.

- The MHLDN HCP Board noted the development of the Dementia Friendly Hertfordshire Accreditation scheme and the functionality that would allow residents to see the different types of dementia friendly provision available across the County.

- The Board considered how the activity and work to deliver the Dementia Strategy has directly informed HCC's new Care Home commissioning strategy for older adults which will result in sustainable, large-scale changes in local residential and nursing provision services.

- The MHLDN HCP endorsed the commissioning strategy

Volunteering for Health

- The MHLDN HCP received a presentation on the Volunteering for Health programme and how it would support the delivery of MHLDN HCP objectives.

- This 2-year grant-funded initiative aims to improve the accessibility of volunteering opportunities across health and social care services. The presentation sets out the programme's outcomes, its test and learn approach and specific activity in support of mental illness, learning disabilities and neurodiversity.

- The initiative has dedicated capacity to support the MHLDN HCP and will be working closely with partner agencies to review and improve volunteering infrastructure, communication and opportunities. The MHLDN HCP welcomed the initiative and emphasised the importance of making sure that volunteering opportunities were accessible for people with mental illness, people with learning disabilities and neurodivergent people.

- The MHLDN HCP Board welcomed the presentation and asked that the Volunteering for Health programme escalate any issues that could benefit from MHLDN HCP Board attention.

Hertfordshire Suicide Prevention Plan

- The MHLDN HCP Board considered the draft Hertfordshire Suicide Prevention Strategy and its 5 key priorities to prevent suicide but also to provide support and postvention for families and carers of people who have died by suicide.

- The MHLDN HCP endorsed the strategy and welcomed its clear alignment to the wider activity of the MHLDN HCP.

- The Board considered how the new strategy could support the wider adoption of the Suicide Prevention Pathway, developed and led by HPFT, across professionals and the wider public.

Alert: Matters that need the Board's attention or action
• None
Advise: areas subject to ongoing monitoring or develop or where there is insufficient assurance
• Ongoing activity to develop neighborhood working model in conjunction with the two place-based partnerships
Assure: where positive assurance has been received
• The development and co-production of the Hertfordshire Suicide Prevention Strategy • Successful procurement of new crisis services and new neurodiversity support services
Date of next meeting – 10 October 2025

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document –

Alert, Advise and Assure Report to the Board of the Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

[Date of meeting]:	**Patient Engagement Forum 9 September 2025**			
Signed off by Chair and Executive Lead:	**Chair – Alan Bellinger Executives – Michael Watson**			
Report Author:	**Heather Aylward, Engagement Manager**			
Report to the ICB Board	**In public**	**x**	**In private**	

Agenda items covered:

ICB Update:

- Change and transition update
- Integrated Neighbourhood teams/National Neighbourhood Health Implementation Programme
- National Oversight Framework assessments for NHS Trusts in our system
- HWE ICB Annual Assessment letter 2024/25

Members update:

- Measuring impact of patient involvement (Kevin), PEF activities (John), impact model (Alan)
- PPG network / PPG Forum
- PEF Facebook group– numbers/activity

PEF Chairing arrangements

- Survey responses showing majority preference for keeping current chairs and vice-chairs until March 2026 (in the context of ICB change)

PEF Workplan

- Mount Vernon Cancer Centre Review Consultation
- Hemel Health Hub
- Communications Group
- Hypertension
- Medicines

- Planned Care
  - Condition-specific: Urology, Gynaecology, Ophthalmology, MSK, Theatre, Outpatients
  - St Albans Surgical Centre
  - Advice and Guidance process
- Frailty and virtual hospitals
- Urgent and Emergency Care
-

Key discussion points and matters to be escalated from the meeting: *(From agenda)*

Actions:

1. *Details of GP practices closing/GPs leaving from Primary Care requested*
2. *Look at the Market Place site option for Hemel Health Campus and share previous documentation*
3. *Undertake two year patient led PEF review*
4. *Arrange a one topic (winter planning) Communications Group*

Alert: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy

None

Advise: The Board – of areas subject to on-going monitoring or development or where there is insufficient assurance

PEF is monitoring Hemel Health Campus options, proposals and engagement.
PEF continuing engagement on MTP – CVD Programme, Elective Recovery, UEC Progress

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Assure: Inform the Board – where positive assurance has been received.	
Positive reaction to Flu Prevention Promotion	
Celebrating Success: Share any practice, innovation or action that the Committee considers to be outstanding	
•	
Forward plan issues:	• PEF ongoing governance assured and full support for transition of patient engagement activity
Date of next meeting	13 October 2025