NHS Hertfordshire and West Essex ICB Board - held in Public - Latton Bush

Latton Bush Conference Centre

Harlow

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	x☐	*Meeting in private (confidential)*	☐			
	NHS HWE ICB Board Meeting in Public				**Meeting Date:**	**26th September 2025**	
Report Title:	**HWE ICB QUALITY ESCALATION REPORT**				**Agenda Item:**		
Report Author(s):	Multiple authors including relevant quality leads, collated by Shazia Butt - Assistant Director for Quality Assurance and Improvement, HWE ICB.						
Report Presented by:	Natalie Hammond, Director of Nursing and Quality.						
Report Signed off by:	Natalie Hammond, Director of Nursing and Quality.						
Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☐	**Information** X ☐
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.						
Key questions for the ICB Board / Committee:	Does the report provide sufficient information for the Board to be assured regarding the work undertaken to manage risks and drive forward needed quality improvements? Alongside this question, the Board is asked to note that work is ongoing to develop and refine the Quality Escalation Report and the Quality Dashboard.						
Report History:	The full report was presented and discussed at the ICB System Transformation and Quality Improvement Committee on 10th September 2025. This version has been adapted to ensure it is appropriate for public discussion. At the Committee the Quality Escalation Report is presented alongside the quality dashboard that contains additional information relating to several key metrics and quality performance.						
Executive Summary:	This paper provides a summary position relating to quality and safety across Hertfordshire and West Essex.						

	Areas included relate to sharing of best practice and learning from excellence as well as highlighting key areas of challenge and risk. Areas of best practice includes; • Infant Crying is Normal 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 the Health and Social Care Partnership. • Mount Vernon Cancer Centre - First in UK to Offer Immunotherapy Injection. • West Hertfordshire Teaching Hospitals NHS Trust (WHTHT) - Reducing pressure related injuries in patients usings non-invasive ventilation masks. Key challenges includes; • One Never Events occurred at West Herts Teaching Hospital Trust (WHTHT) – related to a retained foreign object. • East of England Ambulance Service Trust (EEAST) - Progress in mandatory training, call waiting times, and medicines management. Longer-term actions in place around Emergency Operations Centre staffing, cultural improvements, and incorporating staff feedback. • Paediatric Audiology – 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 continue. • AJM Wheelchair Services – AJM led system quality meetings in place and improvements in key areas for performance noted.
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*** x☐ n/a
Implications / Impact:	
Patient Safety:	Patient Safety is a driving principle and at the core of the Quality Report. The paper flags areas of good practice, identifies risks to patient safety and provides information about mitigation and actions to manage risks to patient safety.
Risk: *Link to Risk Register*	Links to Nursing and Quality Directorate Risk Register. Datix Refs: • 530 Maintaining High Quality Services • 649 Paediatric Audiology

Financial Implications:	n/a	
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:***	n/a
	Quality Impact Assessment:	n/a
	Data Protection Impact Assessment:	n/a

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care Board (HWE ICB) Quality Escalation Report

September 2025

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

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.

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Sharing Best Practice / Learning from Excellence

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 – all in support of keeping babies safe.

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 Tomograpghy 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.

Sharing Best Practice / Learning from Excellence

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.

Staff awards.

- Hertfordshire Community Trust (HCT) - in June 2025, HCT celebrated the exceptional work and dedication of staff at the 2025 Leading Lights Awards.
- East and North Hertfordshire Teaching Hospital Trust (ENHTT) - in July 2025, ENHTT held their annual Time to Shine Awards to celebrate the achievements, dedication and hard work of staff across the Trust.
- WHTHT - Two WHTHT colleagues have been recognised at the NHS East of England Perinatal Awards for their outstanding work supporting babies and families. One received the 'Excellence in Experience' award for improving neonatal care and championing bedside treatment for mothers and babies. The other was runner-up in the 'Midwife of the Year' category, praised for inspiring leadership, compassionate care, and support across the region to improve maternity services and staff wellbeing.
- Central London Community Hospital NHS Trust (CLCH) - A band 7 team lead has been presented with the Mesi award for contributions to leg ulcer research and development. By equipping community nursing teams with a kit to measure ankle brachial index (ABI), within 18 months 100% of appropriate patients are now receiving an ABI assessment (previously 20%), lower limb diagnosis has increased from 20% to 80% and full compression treatment increased from 8% to 61%. Early diagnosis will enable timely interventions and provide improved outcomes for patients.

Essex Partnership University NHS Foundation Trust (EPUT) - Improved Care Quality Commission rating.

The Care Quality Commission (CQC) has published its latest report following a recent inspection of EPUT's acute wards for adults of working age and psychiatric intensive care units. The CQC has upgraded EPUT's overall rating from Inadequate to Requires Improvement. In addition, the CQC has formally lifted the Section 29A warning notice previously issued to EPUT, reflecting the progress made in addressing areas of concern.

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Key Priority Areas

Please note subsequent slides include RAG ratings. Please find key below:

	Ongoing/In progress		On track		Complete/To be closed

Patient Experience - HWE ICB

Area (June/July 2025)	Issue and Impact	Mitigating Action
Patient Experience Main Themes.	Between 1 June and 29 July, the Patient Experience Team (PET) received 454 queries. This is an increase of 38% on the last 2-month reporting period. Complaints 72, Patient Advice and Liaison Service (PALS) 344, Member of Parliament PALS 29, Other/s 9. 40% of queries relate to the ICB – access to services, commissioned pathways, funding decisions, Covid vaccinations (13%). 30% of queries relate to Primary Care.	There has been an increase in queries with no prominent theme or topic. Examples are: • Non routinely funded care or procedures. • Weight loss injectables that people do not meet the current criteria for. • Dissatisfaction with access to GP services. • Delays for appointments in secondary care. The PET will continue to monitor this situation and identify specific themes and where action can be taken to improve services.
Patient Experience Routine and Consistent Themes.	Areas below outline consistent concerns that the Patient Experience Team have enquires about each month: • Shared care, particularly related to Attention Deficit Hyperactivity Disorder (ADHD) medications. • Access to Primary Care, concerns related to triage in some areas. • Finding an NHS dentist. • Right to choose pathway. • Continuing Healthcare (CHC) decisions, reduced care packages and appeals.	Examples of key actions taken include: • HWE ICB reinforcing GP communications on shared care agreements, including ADHD medication, aiming to ensure fairness, consistency and transparency. • Dental concerns reflect national access issues and the HWE ICB PET are reiterating the process for registration of NHS dentists to enquirers and providing signposting for the urgent dental treatment pathway (accessed via NHS111) to support patients in need. • CHC team are strengthening their communication materials, with the help of families resulting in clearer responsibilities for clinical staff with specific localities oversight.
Key Performance Against Acknowledgement of Complaints.	As of 17 July 2025, 96.6% of acknowledgements were completed in 3 days from January 2025 - June 2025 (202 of 209 complaints).	• The PET have reviewed non-compliant cases for learning and made changes and improvements to the triage process for daily emails. • The ICB Business Intelligence team are working in partnership with PET to understand complaint trends and performance, against both acknowledgement and full responses for local / statutory timescales. Further details to be shared in next Committee report.

Patient Safety – ICB Overview

ICB Area (June/July 2025)	Provider Queries at 25/7/25	Serious Incidents (SI) / Patient Safety Incident Investigations (PSII) at 25/7/25	Never Events (also included in PSII numbers) at 25/7/25
East and North Hertfordshire	61	2	0
South and West Hertfordshire	29	4	1
West Essex	58	2	0
Other ICB/area	1 (Arden and Gem)	0	0
Totals	149	8	1

Priority Area	Current Position	Mitigations and Action
Never Events.	Never Event declared in July 2025 relating to a retained foreign object. This is being managed in line with the Patient Safety Incident Response Framework (PSIRF) framework.	• Information on actions and learning to date has been requested via Trust. • Further information can be found on slide 17.
SI/PSII.	A SI has been declared in July 2025 by a GP practice. This relates to inappropriate use of equipment during minor surgery clinics. The GP practice involved has not yet adopted the PSIRF so the process will be managed under the SI framework.	• The practice involved is receiving support from the ICB as well as UK Health Security Agency (UKHSA) to ensure prompt action to contact and screen the small number of patients affected. • Risk to patients advised as very low. • The ICB has discussed with the practice, CQC and the Local Medical Committee (LMC). Actions are being progressed, and relevant assurances being sought. Minor surgery has been paused whilst the investigation proceeds. • Further information can be found on slide 13.
Provider Queries.	Several queries have been reported by GP practices across HWE in relation to the new pathology service. The queries are varied with issues such as samples not being processed due to labelling, results not going back to the ordering clinician, and delays in abnormal results.	• The ICB Patient Safety team met with both the provider, and the Pathology Business Unit to ensure a robust process is in place for managing incidents and queries. • The Patient Safety and Quality team are involved in contract review meetings and have fed into Terms of Reference review to strengthen ICB oversight.

National Patient Safety Strategy Implementation

Priority Area	Current Position	Status for HWE ICB
Safety Culture.	• Compliance rates of Level 1 training for all staff have reduced in the last few months. A reminder has been included in the weekly comms bulletin to staff in July and progress will continue to be monitored.	In progress.
Ongoing implementation of the Patient Safety Incident Response Framework (PSIRF).	• The ICB continues to focus on PSIRF transition for our smaller and independent sector providers. • Several updated provider plans have been reviewed and signed off in recent months. • Work is ongoing with the ICB's Patient Safety Network to review and align system priorities and system-wide learning.	On track.
System-wide Learning from Deaths Forum.	• The next meeting takes place in September 2025, with a focus on learning from deaths of patients with Learning Disabilities and Autism. Case studies from the Learning from Lives and Deaths programme will be shared.	On track.
National Patient Safety Alerts.	• The ICB has refreshed its process for managing safety alerts. • Robust processes although in place within providers, are varied, and discussions are underway with the Patient Safety Network to understand how these might be aligned in the future.	On track.
Improving Patient Safety in Primary Care.	• Focused work on the implementation plan through the internal working group, although some areas have been put on hold in line with other ICBs in the region due to the transformation of ICBs. • The ICB continues to support the practice piloting PSIRF, who has moved into Phase 2 of the programme involving its wider Primary Care Network (PCN). • The Patient Safety team is currently supporting several practices with patient safety incidents. Learning from these incidents will be shared across HWE practices.	In progress.
Supporting organisations to transition to and embed the Learning from Patient Safety Events (LFPSE).	• Issues with the functionality of the system remain for ICB oversight. Incidents meeting PSII or Never Event criteria continue to be logged on the historical system for ICB awareness.	On track.
Ongoing implementation of the framework for involving Patients in Patient Safety.	• The next meeting of the system-wide Patient Safety Partner group is scheduled for late September 2025.	On track.
Patient Safety Specialists Priorities.	• An update on the priorities will be discussed at the next Patient Safety network meeting, scheduled for September 2025.	In progress.

Quality Improvement (QI)

Priority Area of QI Delivery Plan	Current Position	Status
Priority 1: Developing our shared purpose and priorities	• Agreement to have the priority area for our system as high intensity users linked to urgent and emergency care. • The High Intensity System Collaborative had a successful launch on 29th July 2025 with over 50 staff and 9 teams participating from acute, community, mental health providers, voluntary sector teams and local authorities.	On track.
Priority 2, 3 and 5: Building Improvement capability and capacity, leadership behaviors and embedding QI in systems/processes through ICB QI 3-year delivery plan.	• Scoping work has been completed. HWE QI offers include building capability and capacity within the ICB and across the system for our staff, smaller providers and primary care are in place. • 'HWE QI approach': Currently a total of 87 staff have been trained across HWE ICS, with 76 trained staff from HWE ICB and we have successfully achieved our 10% ICB goal for year 1 (2025/26). 28 QI coaching clinic sessions delivered (January to July 2025).	On track
Priority 4 and 5: Investing in people and culture through developing QI communications plan: - To build the 'will' to create a movement for QI. - Promoting HWE QI Network System update as an enabler for change.	• NHS Futures Platform dedicated page and 'Weekly Wednesdays' updates are in place on local, national and evidence-based resources for QI. Positive feedback from network members has been received. Continued engagement with staff, patients and partners to build the will for QI and to ensure sustainability of the network activities meet staff needs. The network membership is steadily increasing and currently up to 147 members. • The aim to deliver 6 network 'Learn and Celebrate' events in 2025/26 which we have achieved, co-hosted with all 6 of our providers. A 2025/26 timetable and network event planner is in place. Positive feedback continues to be received which is used to shape future network events, masterclasses to accelerate adoption and learning of QI in the system. A successful and well received workshop on 'Improving collaboration skills across boundaries' was run in partnership with Health Foundation with requests to run it again.	On track.

Safeguarding All Age

Theme	Issue and Impact	Mitigating Action	Timescale
Health and Social Care Partnership Referral Portals. Introduction of safeguarding children section 17 and section 47 portal. Safeguarding referral portal introduced 18 months ago.	• Issues of Information Technology (IT) compatibilities leading to some delays and non-submission of referrals. • Delayed response to safeguarding cases. • Interoperability of the new portal is now on the NHS provider's risk registers. • Causing both strategic and operational concerns across the system.	• ICB has led partnership work with Hertfordshire County Council (HCC) and providers. • Solutions and actions identified and are being implemented.	On track.
Looked After Children Services. Introduction of the new Public Health Nursing (PHN) specification service procurement. This relates to the Health and Social Care Act 2012 and Children Act 1989/2004.	• PHN will no longer be able to undertake statutory health reviews for Review Health Assessments. • Reputational risk. HWE ICB may breach its statutory duties to delivery Review Health Assessments for Children in Care. • Potential impact on the timely identification of health needs of children who are looked after.	• A review of current model delivery is underway. • Issues escalated to the NHS England regional team to find a regional solution to current model of delivery. • ICB leads will be raising this as part of an open book exercise which involves Health, Police, Education and Local Authority.	Ongoing.
Casey Report. Safeguarding team including Named GPs are working together to identify and understand implications of the Casey Report for the ICB safeguarding teams.	• Children at risk of exploitation in grooming across Herts and West Essex. • Grooming not always recognised potentially leading to children being further endangered.	• ICB to outline its position on the review and outline responsibilities. • To explore how the ICB can influence practice by ensuring grooming is incorporated in practice and that providers are supported in delivery.	Ongoing.

Infection Prevention and Control (IPC)

Area	Issue	Mitigating Action	Timescale
C. difficile (C.diff).	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. At the end of June 2025, HWE ICB, East and North and South West Herts Places were showing to be above their set trajectories at this point in the year with West Essex place reporting to be below trajectory. However, all three Places were either the same as, or below that of the East of England regional rate. So far in 2025/26, WHTHT and 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.	• The next healthcare associated infection (HCAI) oversight group meeting will be attended by all 3 Places. The August 2025 agenda will focus on C. diff and revisit the previously agreed system wide action plan. • Individual action plans are in place to address the high number of cases seen in April 2025 at ENHTT and WHTHT. • Primary care representatives are invited to attend ENHTT case reviews. • Case reviews for community C. diff infections collated and analysed. However, ICB IPC team has limited access to community patient data. • ICB Antimicrobial Stewardship Lead and ICB IPC Senior Nurse presented a paper at May 2025 System Transformation and Quality Improvement Committee, analysing data from case studies involving C. diff and antimicrobial prescribing. A further deep dive has been presented at the System Quality Group in August 2025.	Ongoing. August 2025.
Minor surgery procedure in Primary Care – Risk of blood borne virus transmission.	A small number of patients being called back for screening for blood borne viruses following inappropriate use of equipment during a minor surgery procedure. The risk has been identified as being minimal.	• Discussions held jointly with UKHSA, CQC and the Local Medical Council (LMC) to determine actions required and next steps. • A look-back exercise implemented to establish the at-risk patients. • All at-risk patients being followed up with an initial phone call and offer of a face-to-face appointment, and a follow up letter inviting the patients to come into the surgery for testing for blood borne viruses. • Standard operating procedures and IPC policies to be reviewed. • Minor injury procedures temporarily put on hold.	Ongoing.

Mental Health - Children's

Area	Issue and Impact	Mitigating Actions	Timescale
Southend, Essex and Thurrock Children's and Adolescents Mental Health Services (CAMHS) - Workforce vacancies.	Recruitment frozen for a period during budget review which is impacting on existing staffing levels. Services are experiencing staff sickness, long term sickness and attrition challenges. Areas particularly impacted are the Crisis Team and Single Point of Access (SPA). SPA triage backlogs are increasing for west and mid Essex.	• Quality impact assessment has been undertaken for teams impacted by vacancies and recruitment freeze. • Additional support offered to team managers and staff to promote wellbeing. • Crisis team are reviewing the service offer and support provided to other agencies so that clinical prioritisation is maintained. • SPA are developing a plan with a trajectory to reduce the triage backlog which aims to make significant improvements by Quarter 3. The service is currently rolling out risk formulation training. • Monitoring will continue via contractual mechanisms.	Ongoing.
Hertfordshire – Transforming Care Children and Young People (CYP).	Increasing inpatient numbers of Transforming Care CYP, currently above trajectory in Hertfordshire.	• Multi-disciplinary discussions continue to consider the most appropriate discharge option to meet the needs. This considers the needs of CYP holistically, including social and environmental factors which could influence positive and sustainable discharge in community. • Work continues with CYP networks to formulate discharge plans that ensure sustainability.	Ongoing.

Local Maternity Neonatal System – LMNS (1/2)

Area	Issues and Overview	Mitigating Action	Timescale
Maternity Care - Antenatal, Intrapartum and Postnatal Out of Area. "Cross Border Care"	Within HWE ICS, there is no ability to share patient records due to lack of interoperability between electronic patient record systems. No access to patient information from out-of-area providers. This has been identified as a theme by LMNS from Patient Safety Incident Investigations.	• LMNS Cross Border improvement plan written. Cross border documentation hub developed. • Cross Border group meeting monthly to discuss actions completed against LMNS designed improvement plan and explore challenge. • Governance process identified to support progression through LMNS Partnership Board. • Digital complexity of cross border working escalated to ICB. • Regular review of incidents with a Cross-Border component is in place. • Currently considering how additional appointment time can be facilitated. • ENHTT have a shared drive accessible for Cross Border care cases. • West Hertfordshire have a shared caseload drive. • ENHTT seeing Bedfordshire women at 16 and 36 weeks additionally to Bedfordshire antenatal cases. • Risk added to ICB Corporate risk register.	Ongoing.
Digital and Data.	New electronic patient record system implementation at PAHT has caused challenges in reporting clinical quality data. Reduced oversight of quality metrics on LMNS dashboard. ENHT have experienced similar challenges with improvements being made. Impacting on regional and national submissions.	• Added to PAHT risk register and escalations of further concern will be directly escalated to LMNS Quality and Safety Lead. • Resolution at ENHTT unable to support PAHT as different digital Electronic Patient Record (EPR) systems are in place. Providers encouraged to shared verbal updates on quality metrics and key performance indicators. • LMNS are meeting PAHT to assess impact on LMNS and National deliverables. • EPR added to LMNS risk register.	Ongoing.

Local Maternity Neonatal System – LMNS (2/2)

Area	Issues and Overview	Mitigating Action	Timescale
System Wide- Prescribing to pregnant / postnatal women.	• Historically, Midwives may diagnose low risk women with common conditions observed in pregnancy (anaemia, urinary tract infection) and refer them to their GP for prescription as Midwives do not prescribe. • Women are reporting that the GP is no longer prescribing and is referring them into hospital for medication. • Women who cannot receive medication locally through the GP may not attend hospital for treatment which poses potential risk.	• LMNS has set up a working group with the Pharmacists across the ICB to enable seamless care for women. • LMNS has provided antenatal pathway of care to demonstrate midwife only care to support the understanding and challenge. • Primary care involvement at LMNS Partnership Board for sharing understanding and involved in the working group. • Aiming towards service users' journey to be the focus of any new pathway. If medication becomes difficult to access, this will carry risk and implications during pregnancy, birth and the postnatal period. • LMNS met with regional and national colleagues. Interim guidance has been drafted nationally indicating that it is within the GP contract to issue prescriptions for both service users accessing primary care whilst pregnant and via midwifery requests. This guidance is being brought to the General Medical Council Executive GP committee and, if approved, should then roll out to Local Medical Committees.	Ongoing.
PAHT: Saving Babies Lives.	Saving Babies Lives v3.2 requires the provision of hybrid closed loop pump systems for diabetic women who become pregnant. PAHT does not currently have any provision for an adult pump system and are at risk of failing Saving Babies' Lives and thus Maternity Incentive Scheme on this issue.	• Service users are being sent to ENHTT to receive care including birth care. • A business case is being prepared by PAHT, timescales to be confirmed by the Trust.	Ongoing.

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

Area	Issues and Overview	Mitigating Action	Timescale
WHTHT – Never Event, retained foreign object following gynaecology day-surgery.	Patient presented at hospital several days days post-surgery where object was identified. Confirmed by Consultant Gynaecologist as the cap of a uterine manipulator (used to improve visibility during the procedure).	• Detailed Duty of Candour undertaken. Patient being supported by GP. • Follow-up appointment booked under different consultant. • Patient Safety Incident Investigation (PSII) is underway. Immediate actions include all-staff briefing across Trust, implementation of counting in/out process for this piece of equipment. • Case review, including kit and processes, taken place at morbidity and mortality meeting in July 2025 attended by all relevant staff.	Ongoing.
ENHTT – Paediatric Audiology. (Please also note HCT paediatric audiology update on slide 20)	Ongoing risks due to a range of factors including estates, workforce competency, capacity, with limitations around mutual aid.	• ENHTT continue to progress workstreams in a range of areas, supported by both NHS England (NHSE) Region and HWE ICB. Whilst work continues at pace, progress remains challenging. • Regular review of pathway development status to support opening is in place. Hearing Aid pathway opened March 2025 and Auditory Brainstem Response pathway opened May 2025. • Over 5 jumbo clinics have successfully reduced waiting lists in this area. • System mutual aid and levelling up discussions being held in addition to wider mutual aid discussions regionally. • Current timeline for ENHTT under 3s is Spring 2026 due to required estates work. Estates work is linked to a bid for national capital funding. • Emerging issues regarding requirement for full ABR look back at HCT following sample reviews. This may impact ability to provide mutual aid within the system.	Ongoing. Spring 2026.

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

Area	Risk	Mitigating Action	Timescale
PAHT - Waiting times for Rapid Chest Pain Clinic.	Current wait time for the PAHT Rapid Access Chest Pain Clinic is approximately 12 weeks, which may delay diagnosis and treatment for patients with potentially serious cardiac symptoms. Increased referral volumes, including inappropriate referrals, are contributing to delays and may affect patient experience.	• Consultant-led triage of all referrals to ensure appropriate care pathways. • Redirection of inappropriate referrals back to GPs or to Cardiology Outpatient Department. • Expansion of consultant-led clinic capacity to accommodate more patients. • Collaboration with Cardiology Cardiac Nurse Specialist team to develop sustainable solutions. • Ongoing monitoring of referral patterns and clinic capacity. • Implementation of a recovery trajectory to reduce wait times progressively. • Integration of long-term planning into quality reporting and Health and Care Partnership discussions to ensure sustained improvement in access and patient flow.	Ongoing.
EEAST Section 29a notice, and regulation breaches (17 and 12) issued by Care Quality Committee (CQC).	If EEAST do not meet CQC standards, then there is a risk of poor patient outcomes and experience alongside impacts on staff.	• EEAST's updates show progress in mandatory training, call waiting times, and medicines management. Longer-term plans in place around Emergency Operations Centre staffing, cultural improvements, and incorporating staff feedback. Standing agenda at regional quality and safeguarding meeting to monitor progress. • Criteria for EEAST to exit enhanced quality review by September 2025 agreed.	Ongoing.
EEAST Non-Emergency Patient Transport (NEPTS) - Delayed arrival and collection.	The rising demand for non-emergency patient transport services is exceeding available capacity, reflecting regional and national trends. Overbooking is resulting in delayed pickups, prolonged wait times, and increased pressure on staff.	• Clinical risk management and prioritisation processes agreed with system partners, with oversight in place. The essential journeys list, approved and under continuous review, prioritises urgent medical appointment's, helping prevent cancellations. • Weekly reviews of booking data and turn-away rates monitor trends and risks. An agreed escalation process addresses routine and clinical concerns. • System support plans respond to emerging issues around transport cancellations for 2-week wait appointments.	Ongoing.
WHTHT- Calibration issue for Menarini analyser.	A calibration issue affecting the Menarini analyser has affected multiple Trusts across the country, impacting on HbA1c results and potentially over-diagnosing patients with diabetes. This links to tests undertaken in 2024. WHTHT is the only laboratory within HWE using this specific analyser.	• WHTHT and ICB engaging with NHSE as part of national Task and Finish Group. • Data collected within the Trust as well as using primary care data to identify whether results at WHTHT are affected. Initial analysis indicates 2-3 months where results might be impacted. • Ongoing work underway to determine appropriate actions required including review of patient cohort.	Ongoing.

Assurance and Oversight – Adult Mental Health

Area	Issue and Impact	Mitigating Action	Timescale
Clinically Ready for Discharge (CRFD) to the maintained at a minimal level (Previously Delayed Transfers of Care).	EPUT. 2 delayed discharges for adult services in July 2025, a decrease from 4 in June 2025.	• Ongoing weekly escalation meetings with EPUT and all system partners continue. • Mini-multi agency discharge events that started in August 2025 are focusing on overcoming barriers to discharge. • Weekly meetings held with the community team to ensure reviews of inpatients, aimed at supporting discharges.	Ongoing.
	HPFT. 16.45% for May 2025, which is over the agreed target of 3.5%, but improved from 17.5% in April 2025. The increased pressure for beds has had an impact on delays to discharge.	• Trust-wide divisional plan to reduce out of area beds includes focusing on the top 20 service users with the longest length of stay. • Strengthened contractual management arrangements to introduce contractual lengths of stay targets. • Executive lead supporting placement of longer-term complex CRFD. Weekly Trust-wide CRFD meeting held. • Analysis of reasons for different types of CRFD and focussed action plan developed against key themes. • Medical lead twice weekly clinical review meetings are in place. • Ongoing regular internal multi agency discharge events for the Trust and individual service users.	Ongoing
Hertfordshire Supported Living Provider -Magic Life.	Some quality issues identified regarding placements into Magic Life where HPFT or Hertfordshire County Council commission packages of care. This is linked to complex out of area placements with limited handover to local services. Enfield Council have commenced provider concerns process regarding the organisation related to a CQC registered location in Enfield (not in Hertfordshire). Note - in Hertfordshire locations are supported living and do not require a CQC registration.	• Joint quality visit between HPFT and ICB took place in June 2025. Focus areas included care planning, risk assessments, formulation, evidence of patient / family involvement and safeguarding. • Good practice examples identified, alongside key areas for improvement for Magic Life. Actions are overseen by HPFT as the delegated commissioner for placements. • The ICB will maintain oversight of the identified areas for improvement through contract and quality review meetings and updates from HPFT.	Ongoing

Assurance and Oversight - Community

Area	Issue and Impact	Mitigating Action	Timescale
AJM Healthcare - Wheelchair Services.	Equipment provision improvement trajectory has not been met when previously reporting. Adult and children's health, education and wellbeing, outcomes and end-of-life experiences are being negatively impacted. Improvement seen over recent months linked to quality and safety.	• Recovery period trajectories are on track to be fully compliant across all key performance indicators by end of August 2025. • Aligned quality action plan is being finalised to ensure performance is sustained. Timeframes for delivery against each of the areas are being agreed through the escalated and contractual routes as relevant. • Decreasing patient/carer complaints and increasing compliments being received by AJM. • AJM led system-wide forum took place in July 2025. Attendees gave positive feedback in relation to visible service improvements and increasing satisfaction with the service. Improved collaboration approaches in place moving forward. Meetings in place for future AJM-led system meetings.	September 2025. Ongoing. Closed.
HCT- Paediatric Audiology. (Please also note ENHTT paediatric audiology update on slide 17)	Following the completion of a sample Auditory Brainstem Response (ABR) review, a full 5 year look back has been triggered.	• Sample review was completed as part of the national paediatric audiology improvement programme. • Work is ongoing with the Trust, ICB and regional NHSE colleagues to look at streamlining the sample review processes to ensure the full look back is as efficient as possible, to minimise impact on the service. • SMEs being sought from the national team to support the ABR reviews as well as harm review process. • Assurances being sought regarding current ABR practice in addition to the look back exercise. • Ongoing work to ensure all staff are supported.	Ongoing.

Assurance and Oversight - Primary Medical Care

Primary Medical Care	ICB Place	Inadequate	Requires Improvement	Good	Outstanding	Awaiting publication	Total
	East North Hertfordshire (ENH)	0	4	42	0	1	47
	South and West Hertfordshire (SWH)	0	2	45	1	1	49
	West Essex (WE)	1 (awaiting new rating)	2	23	1	3	29

GP Practice	Issue	Mitigating Action	Timescale
Practice in WE.	Currently rated Inadequate (March 2024). Re-assessed by CQC in November 2024. Full outcome awaited.	• ICB support provided to address CQC issues raised. • Next steps to be agreed when CQC assessment outcome known.	Ongoing.
Practice in SWH.	CQC report published June 2025 - Requires Improvement overall (Inadequate for Safe and Requires Improvement for all other domains). Placed in special measures for 6 months.	• Practice action plan in place. • ICB support being provided to the Practice with addressing CQC issues raised.	Ongoing.
Practice in SWH.	Whistleblowings received by ICB and CQC. CQC assessment carried out followed by the request for action plans to address issues raised. Full outcome is awaited.	• Support being provided by ICB teams including 2 weekly meetings with the Practice and CQC. • Practice have put in an application for resilience funding.	Ongoing.
All Practices in Hertfordshire and West Essex.	There is a risk that practices are yet to be identified as not meeting the required quality standards.	• Resilience Index Tool used in risk and information sharing meetings, with targeted support offers to reduce risks. Format is currently being reviewed. • Pilot ICB Contract Quality review/visit rolling programme commenced April 2025 until September 2025. All Practices (over 3 years) will receive a desk top review with decision to visit based on risk and need. • Pilot CQC assessment preparation support pilot now being evaluated.	Ongoing.

Assurance and Oversight - Care Homes

CQC	2 Inadequate	52 Requires Improvement	210 Good	9 Outstanding	39 Not Yet Rated
PAMMS	15 Poor	42 Requires Improvement	190 Good	14 Excellent	Not Yet Rated

Area	Issue	Mitigating Action	Timescale
East and North Hertfordshire.	No Care Homes are in a Safety Improvement Process (SIP).		
	1 Supported Living Provider is in a SIP due to: • Consistency in management oversight, audits and governance. Impact - service provision, resident experience and safety.	• ICB Care Home team supporting County Council led Quality Assessment and Monitoring (QAM) process for oversight and assurance. Provider working with Health Care Providers Association for training support.	Ongoing.
South and West Hertfordshire.	2 Care Homes are in a SIP with issues regarding; Home 1 • Medication administration system and processes. • Unstable leadership. • Provider slow to engage/recognise improvements required. Improvements not being seen. • CQC enforcement action. Home 2 • Leadership oversight and management across the home. • Governance audits and care planning not person-centred. • Restrictive practices; locking food away, inaccessible to residents. 3 Supported Living Providers are in a SIP due to: • Consistency in management oversight, audits and governance. Impact - service provision, resident experience and safety.	Home 1 • Increased System Wide Intervention Meeting (SWIM) process with action improvement plan oversight. • Embargo to all admissions to the home. • Professional support, ICB care home team and Hertfordshire County Council. • Home has independent pharmacist support for medication improvement. Home 2 • ICB Care Home team supporting County Council led oversight visits and SIP for oversight and assurance. • Embargo to new admissions. Supported Living Providers • ICB Care Home team supporting County Council led QAM/SWIM for oversight and assurance. • Providers working with Health Care Providers Association for training support.	Ongoing.
West Essex.	1 Care Home is in a formal safeguarding process. Quality concerns relate to areas related to safety alongside slow progression with improvement actions.	• Home placed into suspension of admissions. • Regular visits in place from across the ICB multidisciplinary teams to support improvement actions and oversight. • New manager has commenced in post.	Ongoing.

Acronyms

ABI	Ankle Brachial Index
ADHD	Attention Deficit Hyperactivity Disorder
CAMHS	Children and Adolescent Mental Health Service
CHC	Continuing Healthcare
CLCH	Central London Community Healthcare NHS Trust
CQC	Care Quality Commission
CYP	Children and Young People
DfE	Department for Education
EEAST	East of England Ambulance Service NHS Trust
ED	Emergency Department
ENH	East and North Hertfordshire
ENHTT	East and North Hertfordshire Teaching NHS Trust
EPR	Electronic Patient Record
EPUT	Essex Partnership University NHS Foundation Trust
GP	General Practitioner
HCAI	Healthcare Acquired Infection
HCT	Hertfordshire Community NHS Trust
HPFT	Hertfordshire Partnership University NHS Foundation Trust
HWE	Hertfordshire West Essex
ICB	Integrated Care Board
ICS	Integrated Care System
ICU	Intensive Care Unit
iGAS	Invasive Group A Streptococcus
IMT	Incident Management Team
IPC	Infection Prevention and Control
IT	Information Technology
LFPSE	Learning from Patient Safety Events
LMC	Local Medical Committee
LMNS	Local Maternity and Neonatal System
NHS	National Health Service
NHSE	NHS England
NEPTS	Non-Emergency Patient Transport Services
OOA	Out of Area
PAHT	Princess Alexandra Hospital NHS Trust
PALS	Patient Advice and Liaison Service
PET	Patient Experience Team
PHN	Public Health Nursing
PSG	Patient Safety Group
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
QAM	Quality Assessment and Monitoring
QI	Quality Improvement
SACH	St Albans Community Hospital
SAHN	St Andrews Healthcare Northampton
SI	Serious Incident
SIP	Safety Improvement Process
SNEE	Suffolk and North East Essex
SPA	Single Point of Access
SWH	South and West Hertfordshire
SWIM	System Wide Intervention Meeting
UKHSA	United Kingdom Health Security Agency
VRE	Vancomycin Resistant Enterococcus
WE	West Essex
WHTHT	West Hertfordshire Teaching Hospitals NHS Trust

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board				**Meeting Date:**	**26/09/2025**	
Report Title:	**2025/26 Month 4 Finance Report**				**Agenda Item:**		
Report Author(s):	Debbie Griggs, Deputy Chief Finance Officer, HWE ICB						
Report Presented by:	Jonathan Wilson, Chief Finance Officer, HWE ICB						
Report Signed off by:	Jonathan Wilson, Chief Finance Officer						
Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☒	**Information** ☒
Which Strategic Objectives are relevant to this report **[Please list]**	■ Increase healthy life expectancy and reduce inequality ■ Improve access to health and care services ■ Achieve a balanced financial position annually						
Key questions for the ICB Board / Committee:	For discussion and noting						
Report History:	This report has been shared with the HWE ICB Executive Team. This report was noted and discussed at the HWE ICB Strategic Finance and Commissioning Committee.						
Executive Summary:	**2025/26 HWE ICS Financial Position at Month 4:** At Month 4 (July), Hertfordshire and West Essex (HWE) Integrated Care System (ICS) reported a Year to Date (YTD) deficit position of £25.38m. The ICS planned to be overspent by £25.35m at Month 4, so the YTD variance is **adverse to plan by £0.03m**. Except for PAH, all ICS organisations are reported to be on plan or better at Month 4, with PAH reporting an adverse position of £0.18m against the YTD plan. The variance between Month 3 and Month 4 moved adversely by £0.657m, largely due to Direct Industrial Action costs in PAH (£0.335m). The planned and actual overspend positions for the ICB correlate to the £35.9m stretch efficiency target that the ICB is currently holding on behalf of the ICS. This efficiency target needs to be achieved through ICS System transformation initiatives in 2025/26.						

	2025/26 HWE ICS System Support: The ICS has received non-recurrent Deficit Support funding from NHS England in 2025/26, which was fully distributed to trusts. The receipt of this support is dependent on the financial performance of the ICS, and to date, the ICS has received the funding for both Quarters 1 and 2. The further stretch efficiency target of £35.9m was established to bring four of the five trusts into financial balance, but requires the agreed System Transformation initiatives to deliver these savings in year. **2025/26 HWE ICS Efficiencies:** At Month 4, the ICS planned to deliver £73.81m of efficiencies, and the ICS has reported an underachievement of the target of £1.30m (1.76%). **2025/26 HWE ICB Financial Position at Month 4:** At Month 4, the ICB reported an overspent position of £6.939m. The ICB planned to overspend by £6.939m and is therefore reporting a breakeven position to plan. **2025/26 Capital Position at Month 4:** At Month 4, the ICS is expecting to spend the 2025/26 System Capital allocation of £87.6m in full by the end of the year.
Recommendations:	The Board is asked to: ■ Note the financial position of HWE ICB at Month 4 2025/26 ■ Note the financial position of the HWE ICS System at Month 4 2025/26

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*	This paper is linked to *Risk 679 – Achieve a balanced financial position annually* in the Risk Register.

Hertfordshire and West Essex Integrated Care System

HWE ICB Board

Finance Report for Month 4 2025/26

Working together
for a healthier future

2025/26 Month 4 Financial Position - Overview

Month 4 Financial Position Overview – Revenue

- HWE ICS reported a YTD deficit of £25.375m at Month 4, which is adverse to plan by £0.028m. There is an overall improvement in the straight-line run rate between Month 3 and Month 4 of £2.017m, driven by four of the five trusts reporting an improvement in the month.

Key Movements between Month 3 and Month 4

- The variance has moved adversely by £0.657m since Month 3.
  - Direct Industrial Action in July impacted all trusts, with PAH incurring £0.335m, with the trust reporting an adverse YTD variance of £0.18m.
  - The non-delivery of the ICS stretch Transformation Schemes in Month 4 impacted the ICB, reducing the favourable YTD variance reported in Month 3.

HWE ICS 2025/26 Forecast Outturn

- The FOT for the HWE System is breakeven.
  - This represents the expected delivery of planned efficiency schemes during 2025/26.

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**

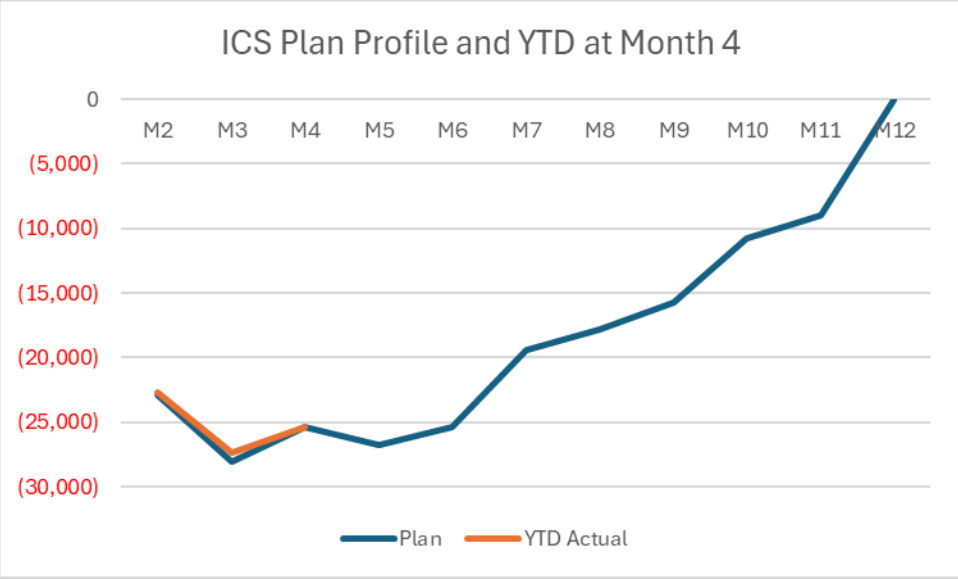
Risk and Mitigations

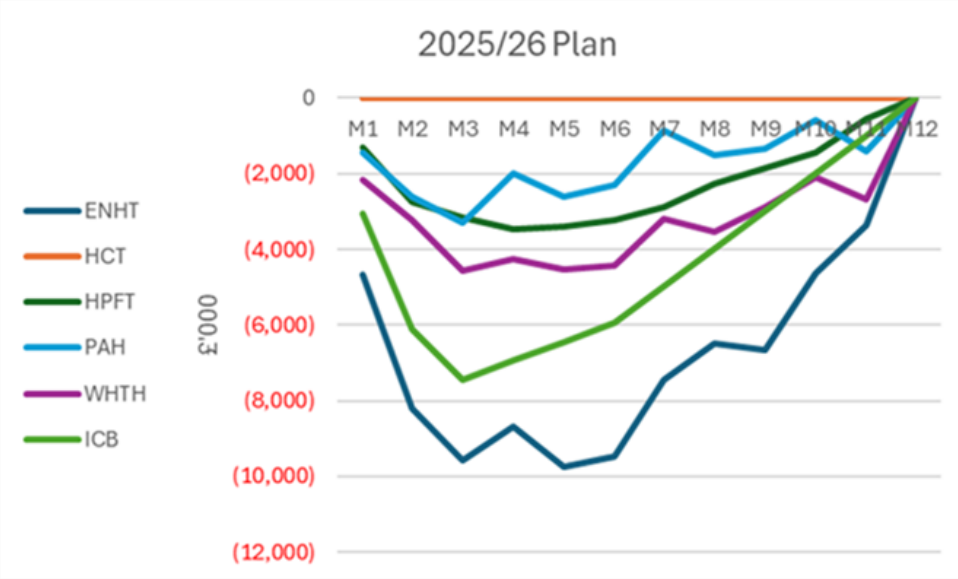
- The ICB has identified the following risks:
  - ICS Transformation Schemes – (£31.8m) a review of year to date and forecast outturn delivery is currently being undertaken by the ICS Financial Recovery Director, and a separate paper detailing the progress to date and any identified mitigations will be shared with the Strategic Finance and Commissioning Committee when the review is complete. Year to date performance at Month 4 has been supported by use of the non-recurrent reserves of £5.144m pending finalisation of the aforementioned review.
  - Independent Sector Providers – the level of activity has not reduced to the planned levels, and on a straight-line basis, the unmitigated risk is c£15m. A separate paper detailing the risk and potential mitigations is also being completed to assist in bringing expenditure back to plan.
- The ICS Trusts have identified the following risks:
  - Delivery of Efficiencies – trusts are expected to deliver efficiencies between 5% and 5.8% and whilst performance is currently on plan it is noted that the profiling of delivery is back-ended. Efficiency risk and profile is highlighted on slides seven and eight.
  - Other areas of pressure – trusts are also highlighting other areas of pressure, such as staffing costs, out-of-area mental health beds, and negotiation of pay award uplift for local authority contracts.

2025/26 Month 4 Forecast Overview

Month 4 Forecast Position

- HWE ICS reported a Forecast Outturn position of breakeven, which is shown in the table on the left.
- The table on the right shows how the individual organisations plan to move towards breakeven by the end of the financial year. Other than HCT, which is planning to break even each month, the other organisations have back-ended delivery of efficiencies into the second half of the year.





Month 4 – In month performance by trust

MONTH 4 2025/26 Spend by Trusts	ENHT			HCT			HPFT			PAH			WHTH		
	YTD Budget	YTD Actual	YTD Variance	YTD Budget	YTD Actual	YTD Variance	YTD Budget	YTD Actual	YTD Variance	YTD Budget	YTD Actual	YTD Variance	YTD Budget	YTD Actual	YTD Variance
ORGANISATION	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income - YTD	**(233,570)**	**(235,113)**	**1,543**	**(57,926)**	**(57,202)**	**(724)**	**(152,937)**	**(153,615)**	**678**	**(143,101)**	**(143,401)**	**300**	**(194,405)**	**(198,781)**	**4,376**
Substantive Pay	134,997	134,807	190	42,705	41,965	740	79,385	79,665	(280)	84,882	82,128	2,754	115,771	113,849	1,922
Bank Pay	11,589	13,106	(1,517)	1,047	1,117	(70)	10,586	9,867	719	8,716	9,958	(1,242)	5,877	11,689	(5,812)
Agency Pay	3,218	2,878	340	383	765	(382)	1,814	1,488	326	2,108	1,159	949	1,887	1,973	(86)
All other Pay	(792)	(1,135)	343	152	156	(4)	325	358	(33)	0	1,126	(1,126)	472	461	11
TOTAL Pay	**149,012**	**149,656**	**(644)**	**44,287**	**44,003**	**284**	**92,110**	**91,378**	**732**	**95,706**	**94,371**	**1,335**	**124,007**	**127,972**	**(3,965)**
Non-Pay	90,757	91,560	(803)	13,449	12,934	515	63,189	64,719	(1,530)	47,553	49,538	(1,985)	71,154	71,912	(758)
Non-operating Items	2,472	2,483	(11)	190	265	(75)	1,117	966	151	1,836	1,666	170	3,508	3,125	383
TOTAL Non-Pay	**93,229**	**94,043**	**(814)**	**13,639**	**13,199**	**440**	**64,306**	**65,685**	**(1,379)**	**49,389**	**51,204**	**(1,815)**	**74,662**	**75,037**	**(375)**
TOTAL SPEND HWE ICS ORGANISATIONS	**(8,671)**	**(8,586)**	**85**	**0**	**0**	**0**	**(3,479)**	**(3,448)**	**31**	**(1,994)**	**(2,174)**	**(180)**	**(4,264)**	**(4,228)**	**36**

Month 4 – In month performance by trust

- The trusts' YTD position in Month 3 was £20.273m overspent, so the Month 4 YTD position of £18.436m overspent is an improvement of £1.837m.
- Of the £1.837m in-month improvement:
  - HPFT's YTD overspend deteriorated by £0.312m; however, this is in line with the YTD plan. HPFT remains ahead of plan by £0.031m.
  - All other trusts planned to improve the YTD spend in Month 4.
  - PAH improved the YTD overspent by £0.932m in Month 4; however, this was behind the planned improvement of £1.311m. This was due to the increased staffing costs from the Industrial Action in July 2025.
  - Income - WHTH reported a lower favourable variance against income in Month 4, although it remains ahead of plan by £4.376m.
  - Pay - ENHT and HPFT reported an improved variance against pay in Month 4, although ENHT remains behind plan due to higher spend on bank staff than anticipated in Month 4. It should be noted that the profile for the bank staff in WHTH was incorrect when submitted; WHTH remains on track to deliver the required savings on this spend line.
  - Non-Pay - HCT and WHTH reported an improved variance against non-pay in Month 4, although WHTH remains behind plan by £0.375m.

Month 4 – Run Rate performance by trust

Month 4 – Run Rate performance by trust

- The ICS' YTD positions for this financial year, shows a reduction of £2.017m from Months 3 to 4. Of the £1.837m in-month improvement:
  - HPFT's YTD overspend deteriorated by £0.312m; however, this is in line with the YTD plan
  - All other trusts and the ICB reported a positive movement in Month 4.

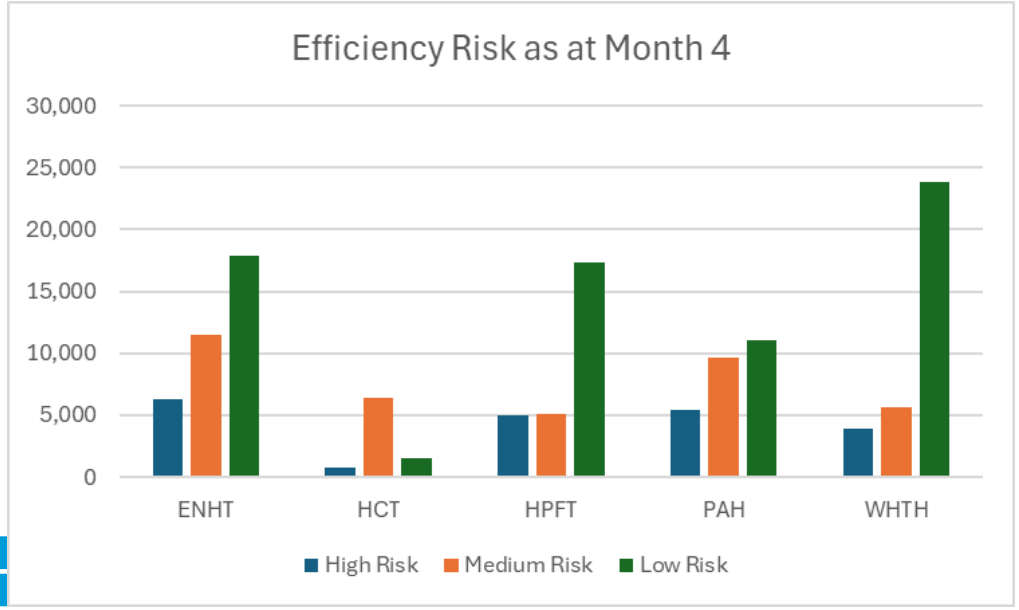
M4 2025/26 Run Rate ORGANISATION	M2 YTD Actual £'000	M3 YTD Actual £'000	Movement £'000	M4 YTD Actual £'000	Movement £'000
ENHT	(8,160)	(9,477)	(1,317)	(8,586)	891
HCT	0	0	0	0	0
HPFT	(2,724)	(3,136)	(412)	(3,448)	(312)
PAH	(2,536)	(3,106)	(570)	(2,174)	932
WHTH	(3,198)	(4,554)	(1,356)	(4,228)	326
TOTAL HWE ICS PROVIDERS	**(16,618)**	**(20,273)**	**(3,655)**	**(18,436)**	**1,837**
HWE ICB	(6,105)	(7,119)	(1,014)	(6,939)	180
TOTAL HWE ICS ORGANISATIONS	**(22,723)**	**(27,392)**	**(4,669)**	**(25,375)**	**2,017**

Month 4 - Efficiency delivery by the ICS

MONTH 4 2025/26 Efficiencies	ENHT			HCT			HPFT			PAH			WHTH			ICB			ICS Transformation			TOTAL ICS		
	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance
Category of Efficiency	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Recurrent																								
Pay - Recurrent	2,654	2,105	(549)	1,169	1,114	(55)	2,451	3,255	804	3,591	3,983	392	3,856	1,325	(2,531)									
Non-Pay - Recurrent	1,288	1,084	(204)	428	368	(60)	4,020	3,244	(776)	1,592	1,329	(263)	3,161	1,855	(1,306)									
Income - Recurrent	308	595	287	0	0	0	0	0	0	92	380	288	0	2,487	2,487									
TOTAL Recurrent Efficiencies	**4,250**	**3,784**	**(466)**	**1,597**	**1,482**	**(115)**	**6,471**	**6,499**	**28**	**5,275**	**5,692**	**417**	**7,017**	**5,667**	**(1,350)**	**37,288**	**37,288**	**0**	**5,144**	**5,144**	**0**	**67,042**	**65,556**	**(1,486)**
Non-Recurrent																								
Pay - non-recurrent	0	55	55	1,044	588	(456)	789	584	(205)	1,071	1,179	108	1,286	1,894	608									
Non-Pay - non-recurrent	0	28	28	232	803	571	468	739	271	828	142	(686)	1,052	10	(1,042)									
Income - non-recurrent	0	310	310	0	0	0	0	0	0	0	161	161	0	464	464									
TOTAL NR Efficiencies	**0**	**393**	**393**	**1,276**	**1,391**	**115**	**1,257**	**1,323**	**66**	**1,899**	**1,482**	**(417)**	**2,338**	**2,368**	**30**	**0**	**0**	**0**	**0**	**0**	**0**	**6,770**	**6,957**	**187**
TOTAL EFFICIENCIES HWE ICS ORGANISATIONS	**4,250**	**4,177**	**(73)**	**2,873**	**2,873**	**0**	**7,728**	**7,822**	**94**	**7,174**	**7,174**	**0**	**9,355**	**8,035**	**(1,320)**	**37,288**	**37,288**	**0**	**5,144**	**5,144**	**0**	**73,812**	**72,513**	**(1,299)**

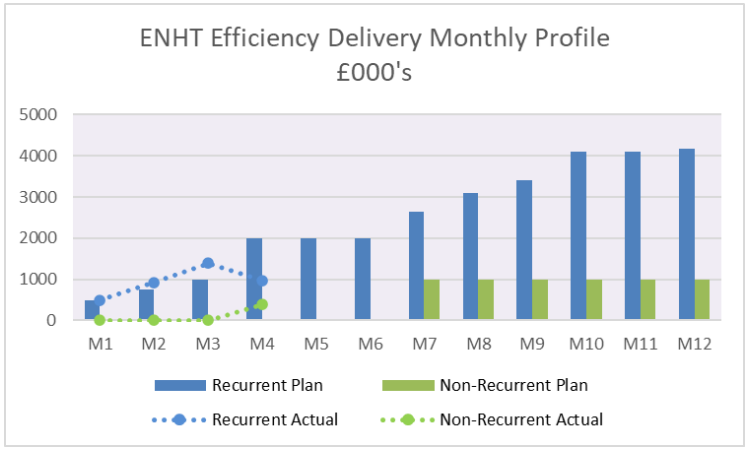
Month 4 – In-month performance by ICB

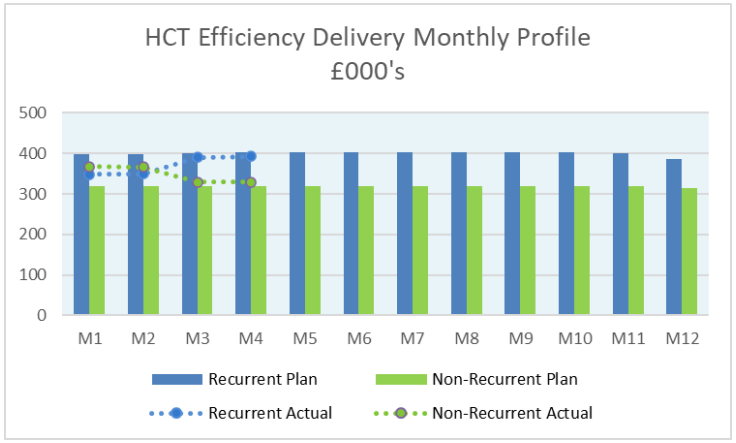
- The ICS is £1.299m behind plan in delivering efficiencies at Month 4.
- At Month 4, the delivery of the ICS Transformation Schemes has been met through the deployment of non-recurrent ICB reserves of £5.1m. This is the totality of the non-recurrent resources available, leaving the balance of £26.7m to be delivered through the identified workstreams.
- A full review of the current delivery and identification of duplicate efficiency schemes is being undertaken.

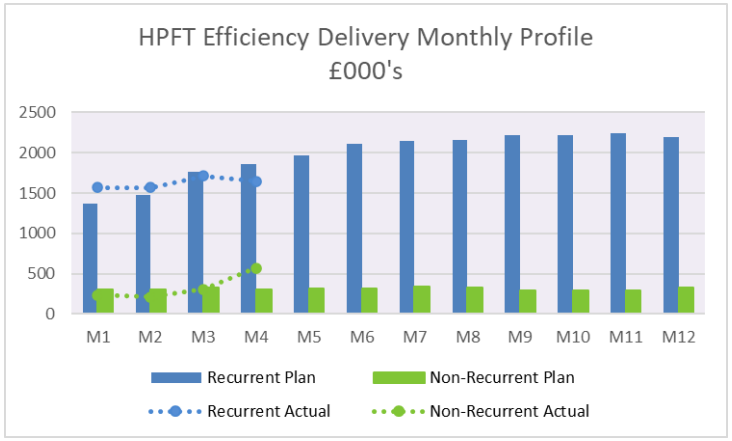


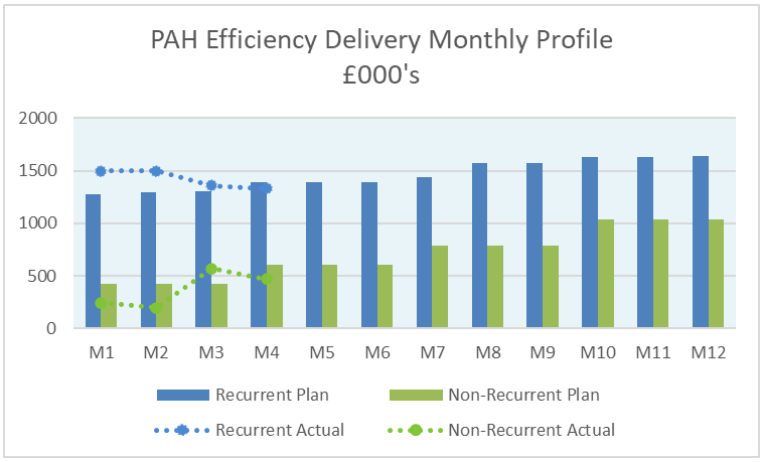
Hertfordshire and West Essex Integrated Care System

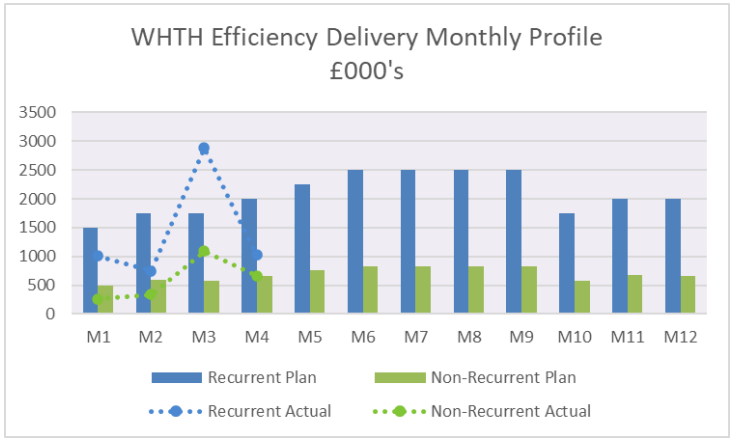
Month 4 - Efficiency delivery by organisation

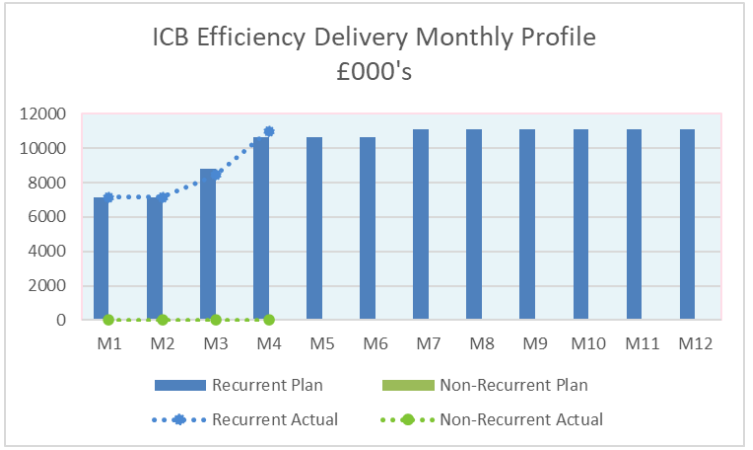












Month 4 – Workforce Reporting

Month 4 – Compliance with the Agency Cap

- The ICS has planned to spend 85% below the annual System Agency Cap Ceiling.
- As of Month 4, HCT is spending twice as much as planned on agency staff.
- WHTH is also above the planned level of spend on agency at Month 4.
- As a System, the ICS is spending less than the year-to-date planned value and is below the agency cap ceiling by 4%.

AGENCY CAP COMPLIANCE	ENHT	HCT	HPFT	PAHT	WHTH
YTD Plan	3,218	383	1,814	2,108	1,887
YTD Actual	2,878	765	1,488	1,159	1,973
YTD Variance	**340**	**(382)**	**326**	**949**	**(86)**

System Level Agency Spend	Value £'000	% of Ceiling
System Agency Cap Ceiling	29,068	100%
Agency Annual Plan	24,721	85%
Agency YTD Plan	9,410	32%
Agency YTD Spend	**8,263**	**28%**

Month 4 – Compliance with the Bank Cap

- The ICS has planned to spend 86% below the annual System Bank Cap Ceiling.
- As of Month 4, HPFT is the only trust to be spending less than planned.
- WHTH is spending twice as much as planned on bank staff at Month 4. There is a correlating reduction in spend on substantive staff, with significant establishment controls in place to increase the level of savings made in total pay.
- As a System, the ICS is spending more than the year-to-date planned value and is above the bank cap ceiling by 6%.

BANK CAP COMPLIANCE	ENHT	HCT	HPFT	PAHT	WHTH
YTD Plan	11,589	1,047	10,586	8,716	5,877
YTD Actual	13,106	1,117	9,867	9,958	11,689
YTD Variance	**(1,517)**	**(70)**	**719**	**(1,242)**	**(5,812)**

System Level Bank Spend	Value £'000	% of Ceiling
System Bank Cap Ceiling	**127,012**	**100%**
Bank Annual Plan	109,835	86%
Bank YTD Plan	37,815	30%
Bank YTD Spend	**45,737**	**36%**

Month 4 – System Capital Report

Month 4 – Capital Performance
- The 2025/26 System Capital has been fully allocated to the providers.

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**

SYSTEM CAPTIAL including IFRS 16	YTD				FOT		
	Plan	Actual	Variance	Variance % of Plan	Plan	Forecast	Variance
	£'000	£'000	£'000		£'000	£'000	£'000
ENHT	7,087	6,958	129	2%	21,495	21,495	0
HCT	1,761	1,295	466	26%	7,962	7,962	0
HPFT	3,817	2,273	1,544	40%	12,547	12,547	0
PAH	4,882	5,986	(1,104)	-23%	18,117	18,117	0
WHHT	9,470	11,495	(2,025)	-21%	21,226	21,226	0
WHTH - UEC Performance Bonus					3,000	3,000	
Total	**27,017**	**28,007**	**(990)**	**-4%**	**81,347**	**81,347**	**0**

Month 4 – Reported Capital Position
- ENHT is behind the windows rollout, but ahead on backlog maintenance.
- HCT and HPFT are behind on several capital projects and have both overspent on Backlog maintenance.
- PAH is overspent on the Electronic Health Record (EHR) system
- WHTH is overspent on the Elective Hub (internally funded).

Month 4 – Cash and Better Payment Practice Code (BPPC) Performance

Month 4 – Cash performance by trust

- The Cash Forecast Trigger Point is 4 working days, as this is deemed to be the minimum level of cash required for Trusts to operate effectively.
- At Month 4, WHTH hits this trigger, with the forecast showing a gradual improvement over the coming 3 months.
- The ICS is undertaking an internal exercise, between the five trusts, to ensure that cash within the System is maximised.

CASH FORECAST	Actual	Forecast	Forecast	Forecast	Operating Expenditure days	Operating Expenditure days	Operating Expenditure days	Operating Expenditure days
Month	M4	M5	M6	M7	M4	M5	M6	M7
	£000's	£000's	£000's	£000's	Days	Days	Days	Days
ENHT	37,320	37,298	38,807	40,316	20	21	21	23
HCT	14,510	13,309	12,108	10,907	33	30	23	22
HPFT	39,943	41,953	44,022	46,277	32	35	36	39
PAH	18,785	21,792	19,243	20,598	16	20	17	19
WHTH	5,805	7,287	8,913	11,182	4	5	6	7

BPPC Performance	Performance By Value		BPPC - Total By Number		Creditor Days	Debtors Days
	M12 2024/25	M4 YTD	M12 2024/25	M4 YTD	M4	M4
ENHT	86%	89%	94%	85%	127	20
HCT	93%	93%	93%	94%	143	42
HPFT	94%	95%	94%	96%	121	24
PAH	91%	96%	94%	92%	129	19
WHTH	66%	50%	47%	72%	142	29
ICB	99%	99%	99%	100%	77	18

Month 4 – Better Payment Practice Code

- The Better Payment Practice Code (BPPC) expects all NHS organisations to pay invoices within 30 working days of receipt of a valid invoice.
- The ICB and HPFT achieve BPPC on both the value of invoices paid and the volume of invoices paid.
- PAH achieves BPPC on the value of invoices paid, but not the volume of invoices paid.
- WHTH's performance is low at 50% for the value of invoices paid, which is a direct result of the low cash balances indicated in the table above.

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 September 2025**	
Report Title:	**HWE ICS Performance Report**				**Agenda Item:**		
Report Author(s):	• Stephen Fry, Head of Performance West Essex, Hertfordshire & West Essex ICB • John Humphrey, Head of Performance, East and North Herts, Hertfordshire & West Essex ICB • Alison Studer, Head of Performance, South and West Herts, Hertfordshire & West Essex ICB • Jo O'Connor, Deputy Director of Performance, Hertfordshire and West Essex ICB						
Report Presented by:	Frances Shattock, Director of Performance and Delivery, Hertfordshire & West Essex ICB						
Report Signed off by:	Frances Shattock, Director of Performance and Delivery, Hertfordshire & West Essex ICB						
Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☒	**Information** ☐
Which Strategic Objectives are relevant to this report	■ Improve access to health and care services ■ Increase healthy life expectancy, and reduce inequality						
Key questions for the ICB Board / Committee:	■ Review / discuss the content of the report ■ Agree actions and items for escalation to ICB Board						
Report History:	N/A						
Executive Summary:	The ICS Performance Report provides an overview of the performance of services being delivered by the system against key standards and benchmarks. Issues are escalated by exception with a focus on actions and next steps being taken to address. Performance highlights and challenges are detailed in the Executive Summary on pages 2 to 6 of the report, including benchmarking by Provider and Place and performance against Operational Plan.						

Recommendations:	N/A			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A			
Implications / Impact:				
Patient Safety:	Actions detailed by programme area to support timely patient flow through the system, reduce length of waits for treatment and mitigate risk to patient safety where performance is poor.			
Risk: *Link to Risk Register*	Linked to Performance Directorate Risk Register. Datix Refs: • 608 Urgent & Emergency Care • 610 Planned Care Improvement			
Financial Implications:	N/A			
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:***	N/A		
	Quality Impact Assessment:	N/A		
	Data Protection Impact Assessment:	N/A		

Hertfordshire and
West Essex Integrated
Care System

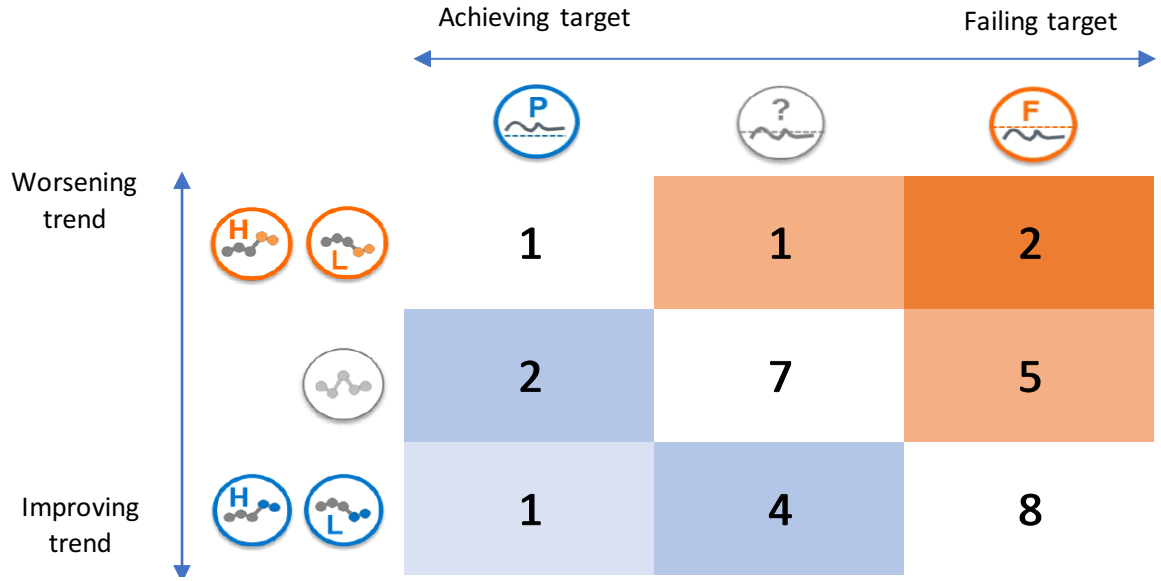
HWE ICS Performance Report

September 2025

Working together
for a healthier future

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 Benchmarking by Provider / Place

June 2025

Hertfordshire and West Essex ICB (PROVIDERS)

	Activity	Data Published	East and North Herts Trust	Trend Aagainst Last Month	Position Against National	Position Against Region	Provider Ranking	West Herts Teaching Hospital Trust	Trend Aagainst Last Month	Position Against National	Position Against Region	Provider Ranking	The Princess Alexandra Hospital Trust	Trend Aagainst Last Month	Position Against National	Position Against Region	Provider Ranking
A&E	% Seen Within 4 Hours (with additional mapped activity)	July 25	79.38%	✗ -0.28%			34	84.37%	✗ -1.457%			11	71.70%	✓ 0.840%			98
	% >12hr Waits in ED From Arrival	July 25	[no data]	— 0.00%	no data	no data	no data	5.88%	✗ 1.28%			41	8.37%	✗ 23.53%			59
Cancer	28 Days Faster Diagnosis	June 25	80.17%	✓ 4.416%			51	85.39%	✓ 1.58%			21	72.50%	✓ 1.60%			120
	31 Days Standard	June 25	96.38%	✗ 1.54%			56	98.72%	✓ 0.93%			23	93.87%	✓ 4.64%			79
	62 Days Standard	June 25	81.86%	✗ -6.20%			20	78.85%	✓ 1.88%			27	41.79%	✗ -18.74%			141
RTT	Incomplete Pathways <18 weeks	June 25	63.30%	✓ 0.56%			69	64.50%	✓ 1.32%			59	51.14%	✓ 0.66%			144
	52+ Weeks as % of Total PTL	June 25	1.73%	✓ -12.24%			63	1.83%	✓ -1.22%			69	4.68%	✗ 6.16%			140
	65+ Weeks as % of Total PTL	June 25	0.04%	✓ -128.68%			81	0.00%	— 0.00%			29	0.02%	✗ 75.58%			71
	78+ Weeks as % of Total PTL	June 25	0.00%	— 0.00%			73	0.00%	— 0.00%			29	0.00%	— 0.00%			65
Diagnostics	% Waiting 6+ Weeks	June 25	53.49%	✗ 0.51%			148	14.35%	✗ 17.68%			67	33.74%	✓ -3.19%			130

	Activity	Data Published	East and North Herts (06K)	Trend Against Last Month	Position Against National	Position Against Region	Provider Ranking	South and West Herts (06N)	Trend Against Last Month	Position Against National	Position Against Region	Provider Ranking	West Essex (07H)	Trend Against Last Month	Position Against National	Position Against Region	Provider Ranking
Mental Health	Dementia Diagnosis Rate	July 25	62.9%	✓ 0.79%			80	64.0%	✓ 0.47%			75	74.9%	✓ 0.93%			16
	Out of Area Placements	June 25	15	✓ -6.67%	n/a	n/a	n/a	15	✓ -6.67%	n/a	n/a	n/a	15	✗ 40.00%	n/a	n/a	n/a
CHC*	% of Eligibility Decisions Made Within 28 Days	June 25	54.7%	✗ -6.90%	55.90%	55.90%	96	24.6%	✗ -171.11%	50.79%	50.79%	101	60.0%	✗ -1.45%	65.79%	65.79%	81
	% of Assessments Carried Out in Acute Settings	June 25	1.9%	✗ 100.00%	0.85%	0.85%	90	0.0%	— 0.00%	4.82%	4.82%	103	0.0%	— 0.00%	0.00%	0.00%	66

LEGEND

Performance against National/Regional
- Better
- Worse

Performance against previous month
- ✓ Improvement
- ✗ Deterioration
- — No change

Provider Ranking
- First quartile
- Middle quartile
- Lowest quartile

Performance Benchmarking (ICB)

June 2025

Hertfordshire and West Essex ICB

Area	Activity	Latest Published Data	Data Published	Trend Aagainst Last Month	NATIONAL Position National vs (ICB)	REGIONAL Position EoE Region vs (ICB)	ICB Ranking
111	Proportion of Calls Answered < 60 secs	76.4%	July 25	✓ 1.48%	85.94% (Worse)	85.08% (Worse)	23
	Proportion of Calls Abandoned	3.6%	July 25	✓ -6.09%	2.53% (Worse)	2.54% (Worse)	19
A&E	% Seen Within 4 Hours (with additional mapped activity)	79.1%	July 25	✗ -0.566%	76.40% (Better)	77.00% (Better)	10
	% >12hr Waits in ED From Arrival	7.2%	July 25	✗ 19.78%	8.33% (Better)	6.99% (Worse)	15
Cancer	28 Days Faster Diagnosis	78.8%	June 25	✓ 1.88%	76.83% (Better)	72.04% (Better)	16
	31 Days Standard	94.7%	June 25	✓ 2.04%	91.74% (Better)	89.16% (Better)	12
	62 Days Standard	69.8%	June 25	✗ -2.76%	67.09% (Better)	62.04% (Better)	13
RTT	Incomplete Pathways <18 weeks	60.4%	June 25	✓ 0.85%	61.5% (Worse)	57.0% (Better)	27
	52+ Weeks as % of Total PTL	2.73%	June 25	✓ -0.22%	2.60% (Worse)	3.92% (Better)	27
	65+ Weeks as % of Total PTL	0.07%	June 25	✓ -5.92%	0.14% (Better)	0.23% (Better)	15
	78+ Weeks as % of Total PTL	0.00%	June 25	✓ -31.56%	0.01% (Better)	0.02% (Better)	15
Diagnostics	% Waiting 6+ Weeks	33.7%	June 25	✗ 0.79%	21.32% (Worse)	29.21% (Worse)	41
Mental Health	Dementia Diagnosis Rate	65.9%	July 25	✓ 0.61%	66.10% (Worse)	64.70% (Better)	21
	Out of Area Placements	30	June 25	✗ 16.67%	n/a	n/a	n/a
CHC *	% of Eligibility Decisions Made Within 28 Days	42.4%	June 25	✗ -46.30%	75.61% (Worse, at 55.40%)	75.10% (Worse, at 55.40%)	36
	% of Assessments Carried Out in Acute Settings	0.7%	June 25	✓ -12.10%	0.69% (Worse, at 2.73%)	0.62% (Worse, at 2.73%)	39

LEGEND

Performance against National/Regional
- Better
- Worse

Performance against previous month
- ✓ Improvement
- ✗ Deterioration
- No change

Provider Ranking
- First quartile
- Middle quartile
- Lowest quartile

*** CHC benchmarking and ranking** is based on quarterly data only.
The latest data is Q1 for 2025/25 (covering Apr - Jun 2025).

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%	1.98%	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%	33.28%	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

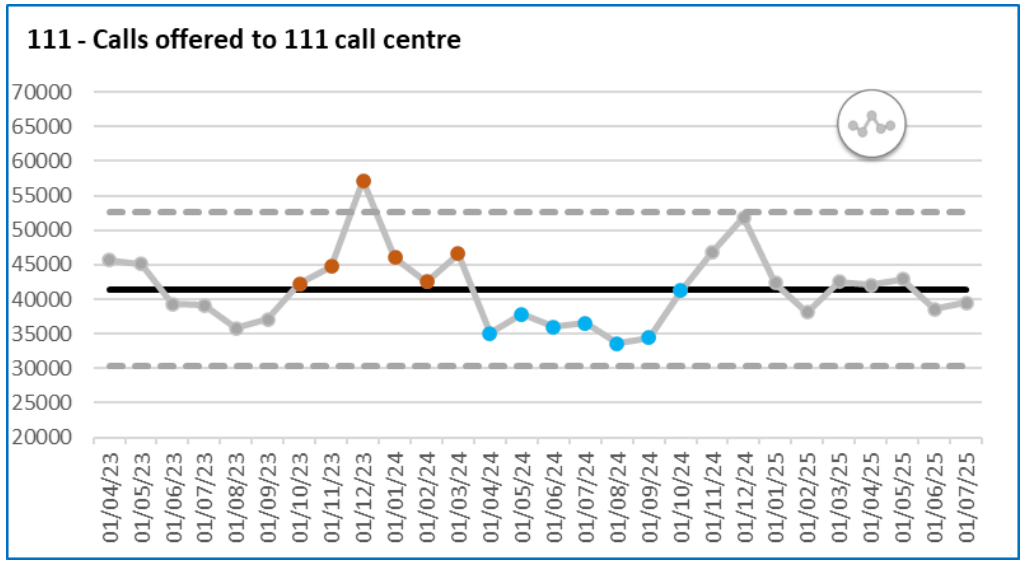
		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	00:30:09	00:30:12	00:28:08	00:29:05	00:27:59	00:29:54	00:32:39	00:32:50	00:36:44	00:37:16	00:32:10	00:28:30
	OP Actuals	00:25:44	00:27:35	00:22:06									
E&NH	OP Plan	00:30:00	00:30:00	00:27:00	00:30:00	00:27:00	00:30:00	00:35:00	00:32:00	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									

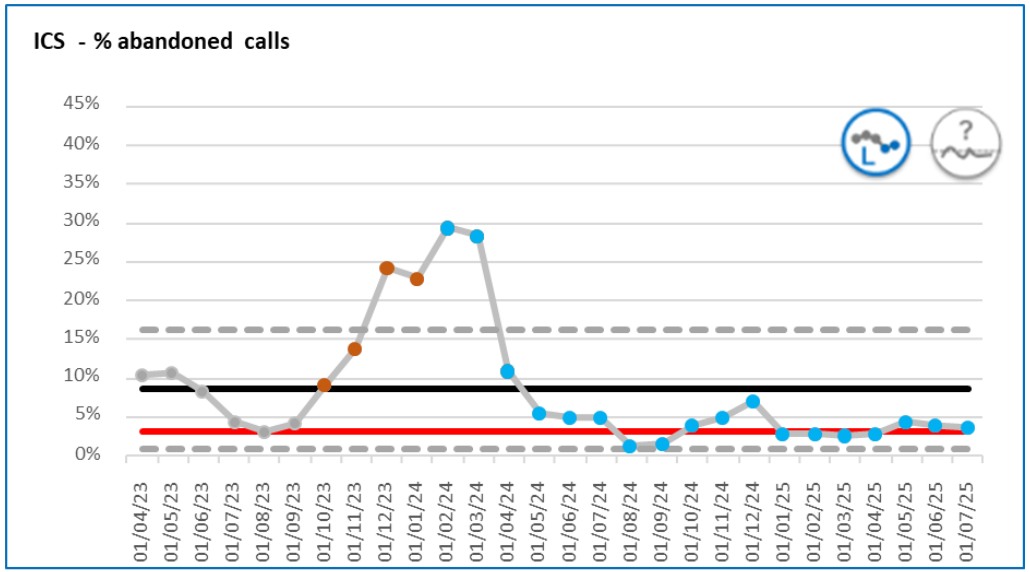
Hertfordshire and West Essex Integrated Care System

Performance by Work Programme

Click link to relevant slides:

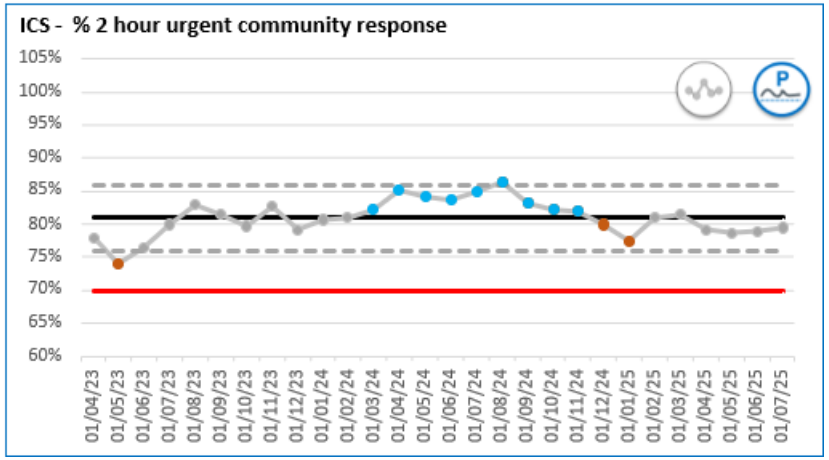
NHS 111

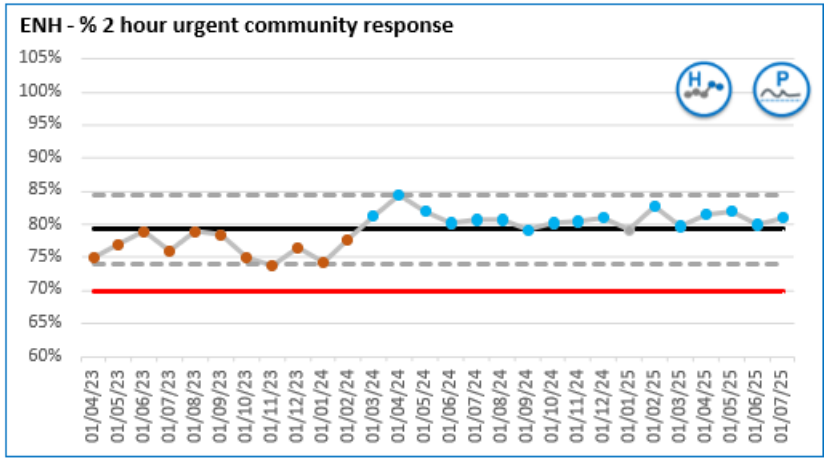


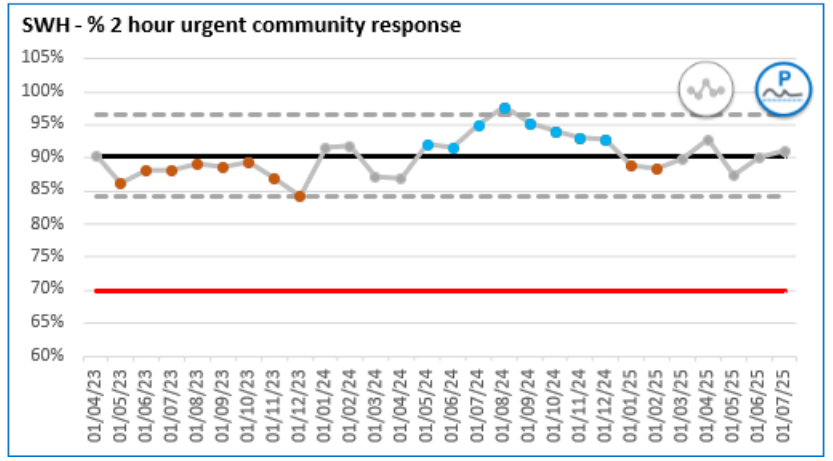


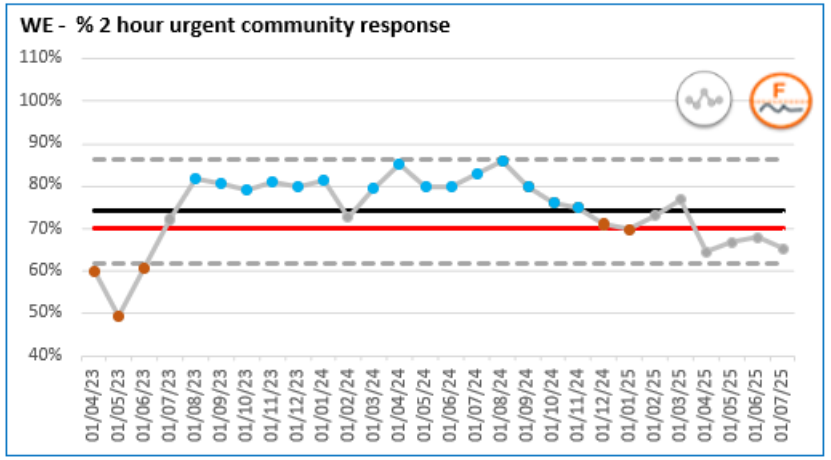
ICB Area	What the charts tell us	Issues	Actions
HUC	• Call volumes have reduced from the peaks seen in winter and are within expected common cause variation limits • The % of 111 calls abandoned improved from 3.9% in June to 3.6% in July. This is slightly worse than the target of 3% but remains better than the historical average	• Call volumes in Jul-25 were 8% higher than in Jul-24 • Rotas remain a challenge despite continued efforts to align the workforce with the PAN HUC rota patterns • Performance was impacted in July by technical issues with the directory of services system on two separate days	• Recruitment priorities have been reassessed, with current efforts directed towards addressing the most pressured parts of the service at evenings and weekends • Continue to monitor productivity and Average Handling Time (AHT) closely to maintain operational efficiency • Preparations for the expected Winter pressures to ensure resources are in place to meet demand

Urgent 2 Hour Community Response (UCR)







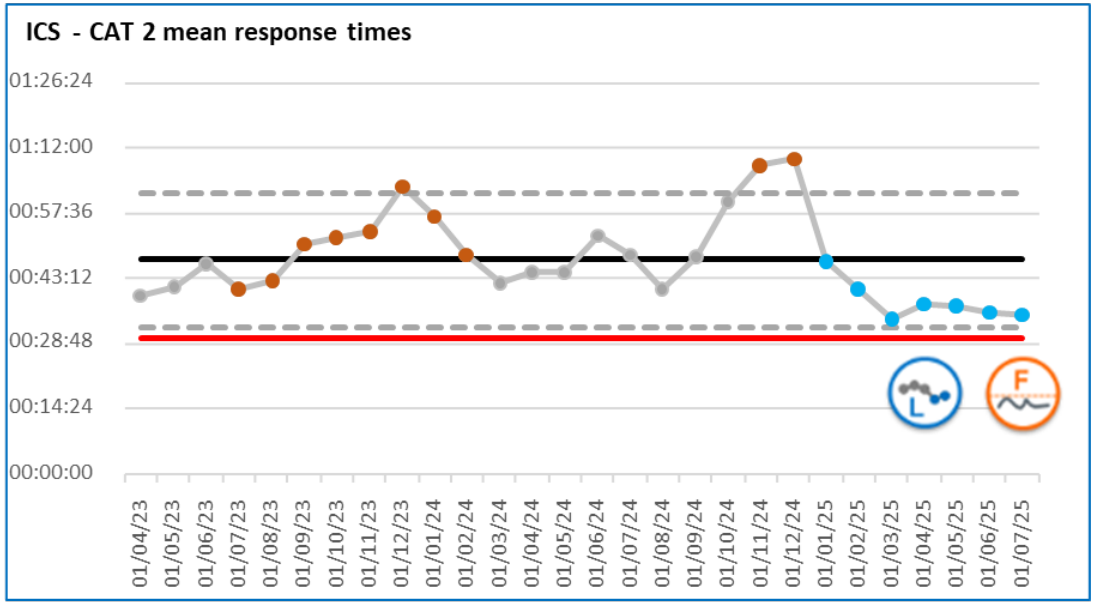


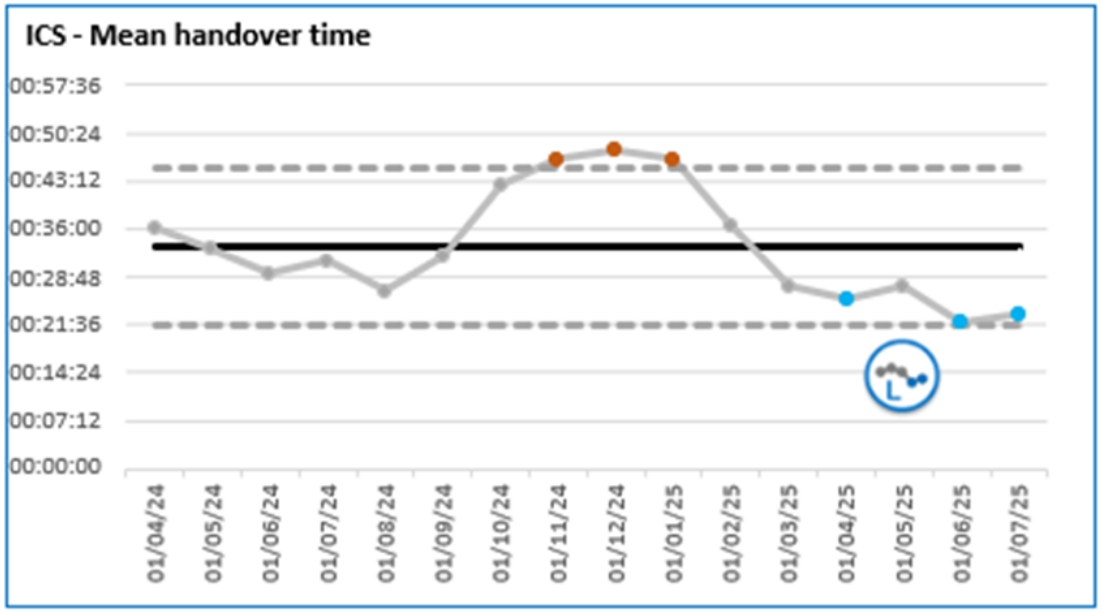
Referrals	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
West Essex	461	386	454	511	483	558	724	629	636	636	608	627	537
East & North Herts	659	676	657	678	717	688	763	583	671	608	627	634	593
South & West Herts	363	352	319	370	414	340	376	506	508	576	590	544	586

ICB Issues, escalation and next steps

- The ICS achieved the 70% national standard, with ENH and SWH achieving at Place
- West Essex performance continues on a variable trend dropping just below standard over the last four months. Demand is regularly exceeding capacity, with referrals exceeding 500 per month appearing to be the trigger for failing the national standard> Referrals in June were the lowest in 2025 to date however still reached 540.
- Notable increase in SWH activity following inclusion of the HAARC vehicle numbers

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





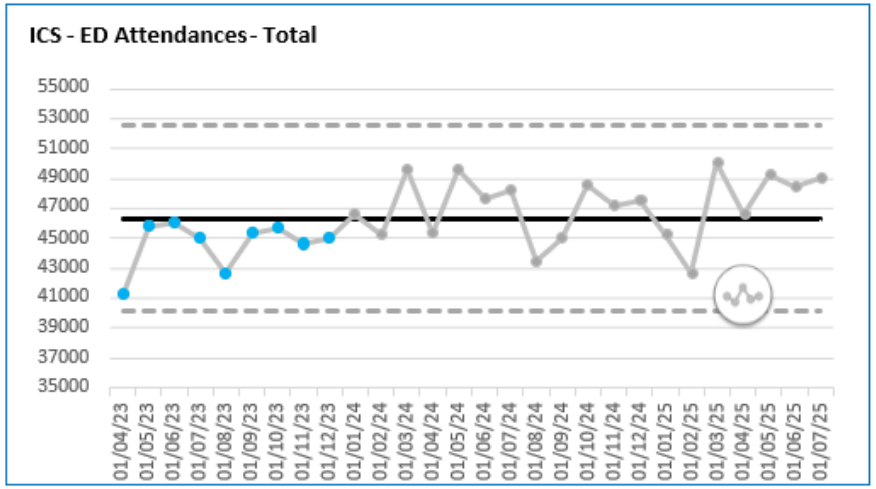
What the charts tell us

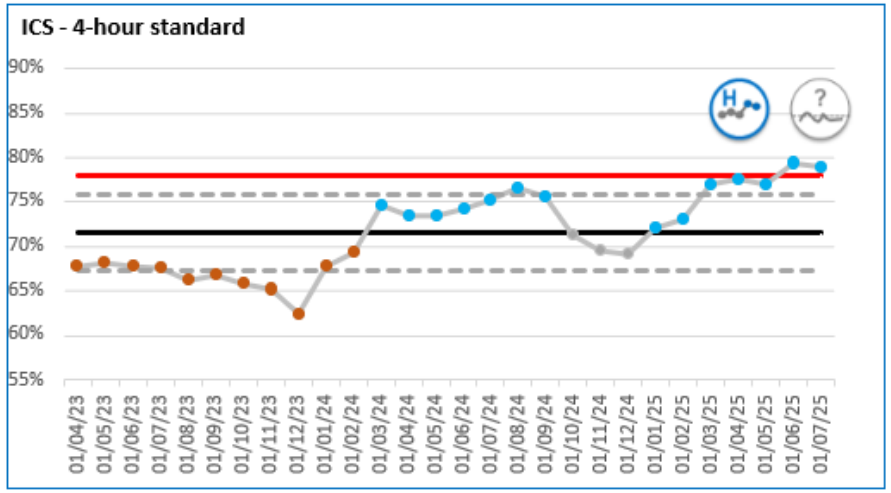
- In Jul-25 the mean Category 2 ambulance response time was 35m 12s. This remains worse than the 30 minute target but is lower than the long-term average for the system
- In Jul-25, mean Category 2 response times in HWE remained longer than the regional average (32m 36s) and were the second longest in 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

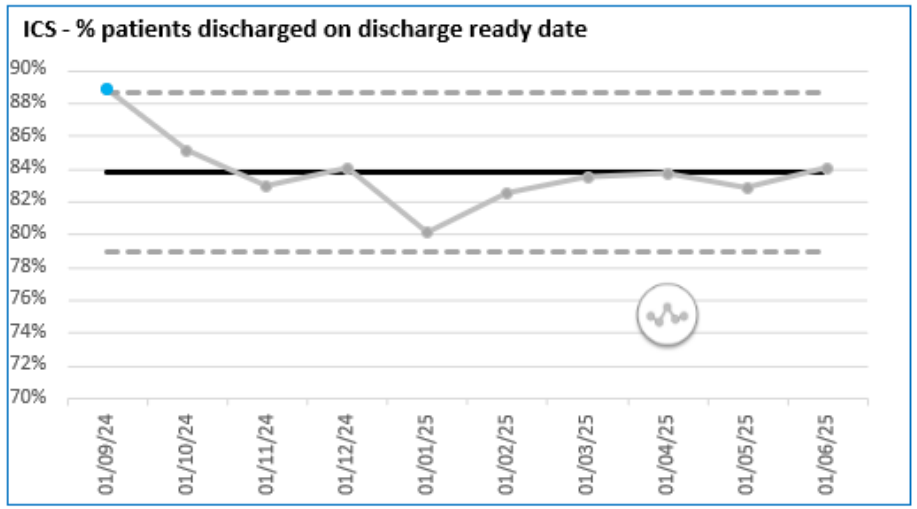
UEC – Emergency Department

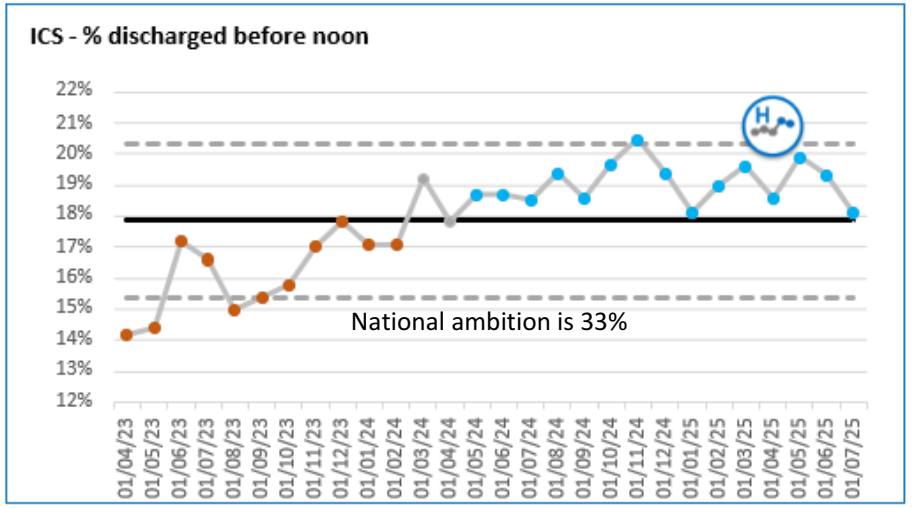




What the charts tell us	Issues	Actions
• ED attendances have been high in recent months and there have been five consecutive months where ED attendances have been above the long-term mean • These high levels of attendances have mainly been driven by increases in type 3 activity at ENHT and type 1 activity 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: o SWH = 84.4% o ENH = 79.4% o 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

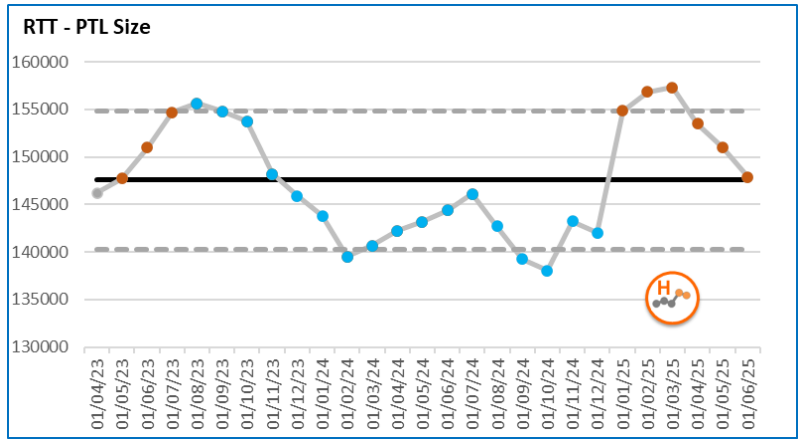
UEC – Discharge & Flow

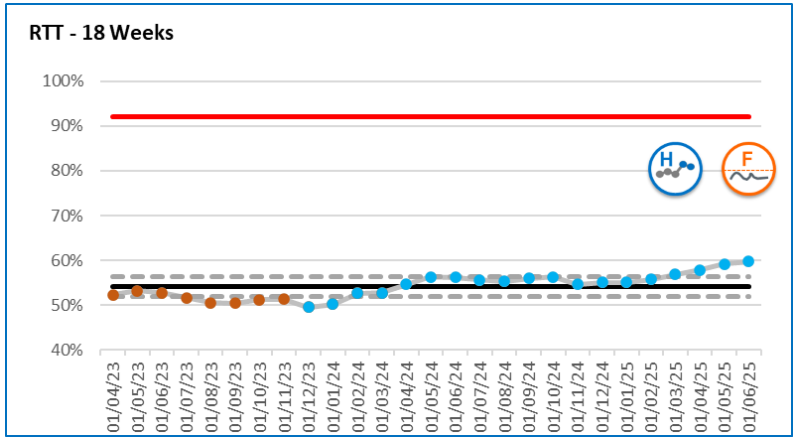


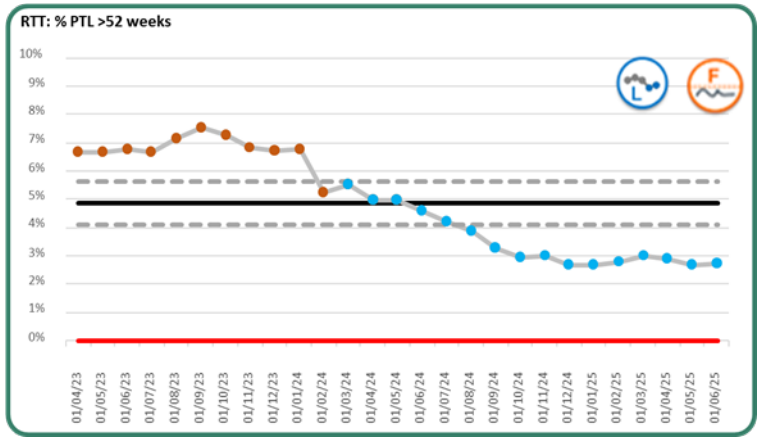


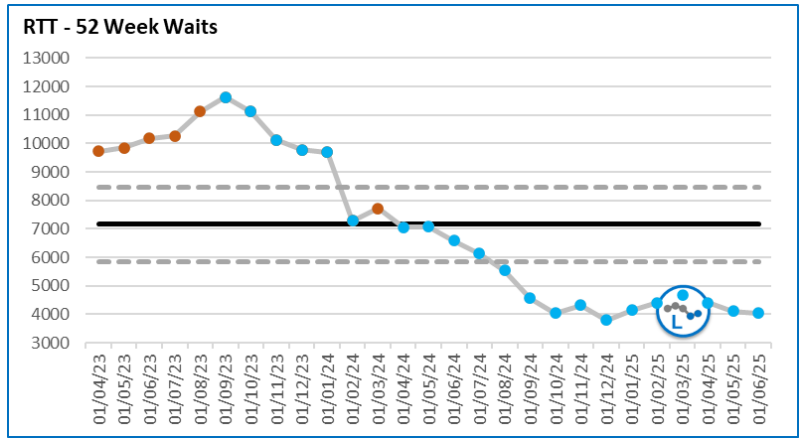
What the charts tell us	Issues	Actions
• At a system level, 84.1% of patients were discharged on their discharge ready date in Jun-25. This is better than the system target of 83% for Jun-25. However, this data does not include data from PAH as the data quality is not sufficiently high to be published • The % of patients discharged before noon was 18.1% in July. This is above the historical mean, but below the national target of 33%	• There remains significant variation across the three HWE acute trusts for the % of patients discharged before Noon. In Jul-25: o ENHT – 13.2% o WHTH – 25.8% o PAH – 13.6% • The issues are typical discharge challenges, including: o Availability of care home / community capacity o Complex discharges o Internal process challenges	East and North Herts • MADE week took place in Jul-25 with a focus on frailty • The Trust is currently investigating how pre-noon discharges are reported when the patient uses the discharge lounge prior to discharge • New acquired brain injury level 1 rehab waiter pathway West Essex • Work underway with Fleming Ward & Surgical teams on criteria-led discharge. • Alex Health now captures criteria-to-reside, pathways codes and real-time updates. • Improve flow of medically optimised patients out of PAH. Working with transfer of care team and allocated team member for ED / OPAL referrals South and West Herts • A review of pathway 0 processes has begun in the Division of Surgery with support from the QI team. This aims to bring forward the time of discharge • The referral process for the Virtual Urgent Case Review is now in place for ED with a plan to roll out across inpatient wards

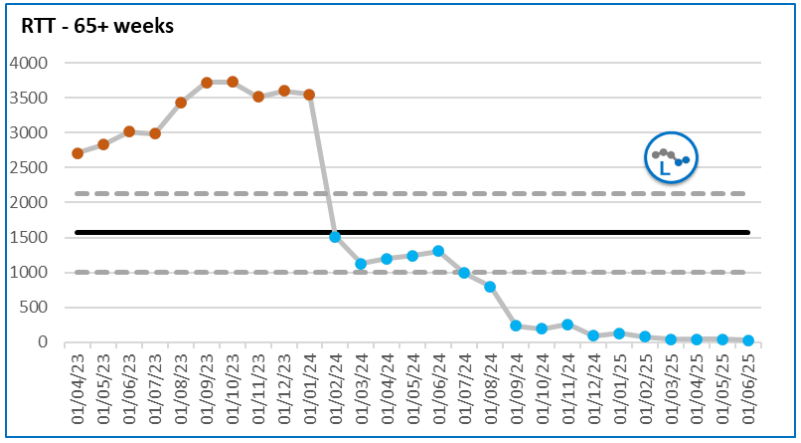
Planned Care – PTL Size and Long Waits

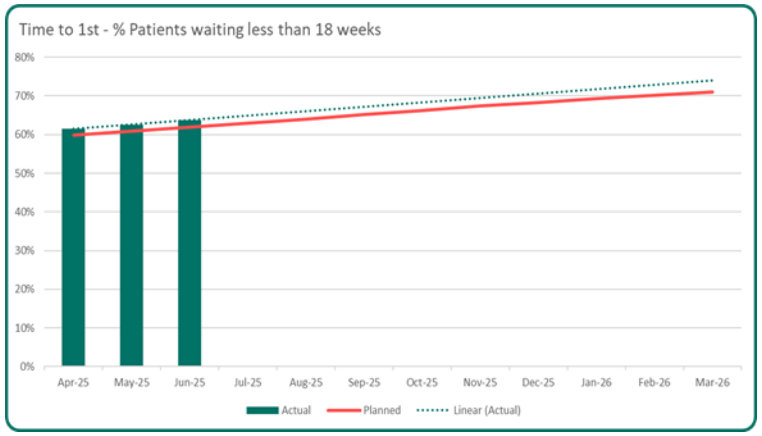












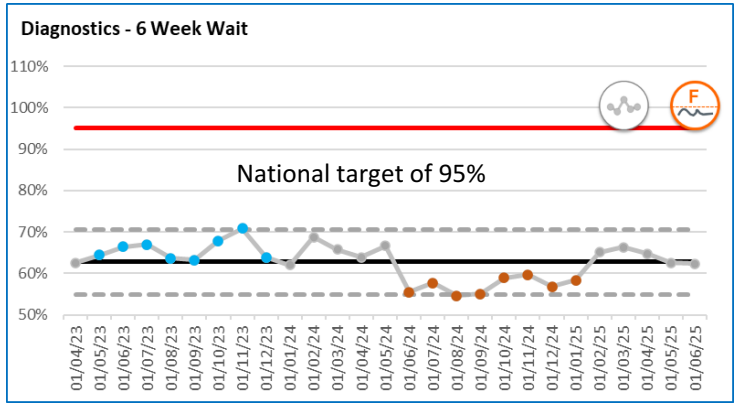
Community Paediatrics patients have been excluded from RTT reporting from February 2024 in line with national guidance
Waiting lists therefore show significant reductions

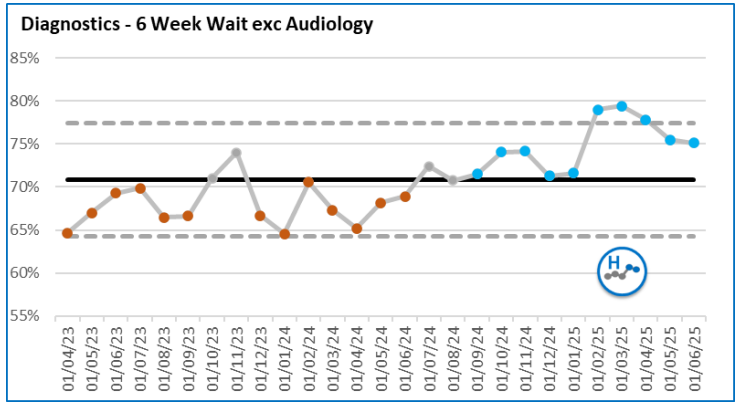
Planned Care – PTL Size and Long Waits

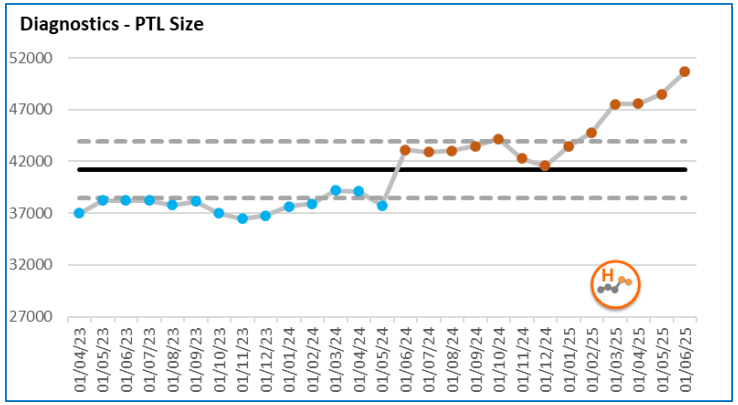
ICB Area	What the charts tell us	Issues	Actions

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

Planned Care – Diagnostics



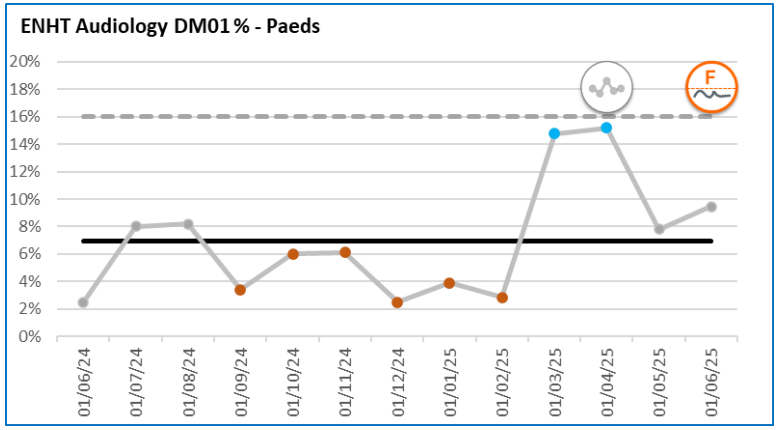


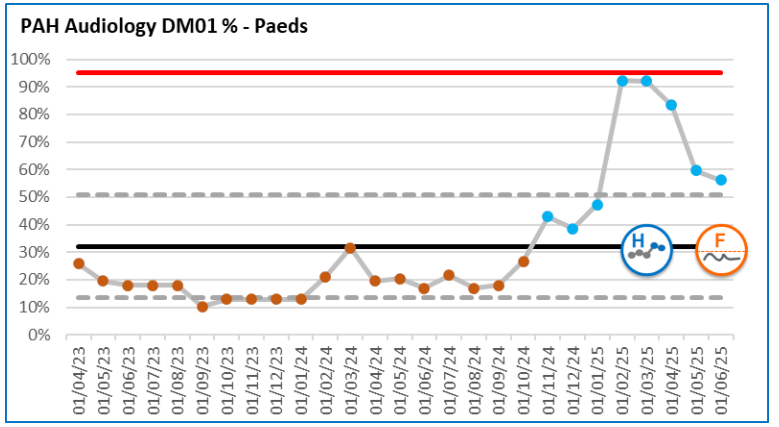


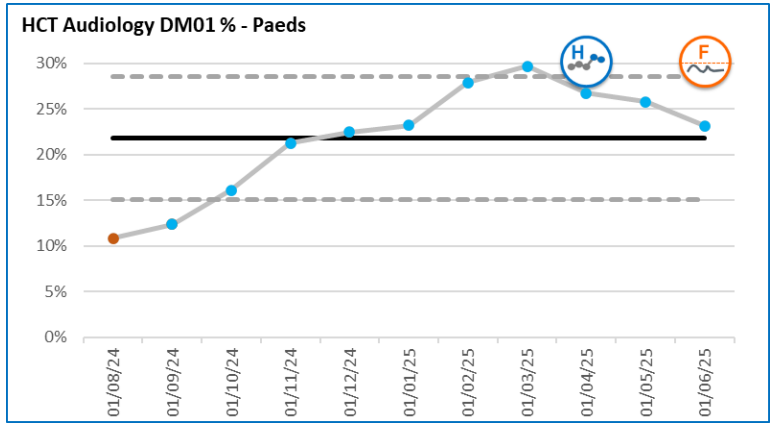
What the charts tell us	Issues	Actions

• Although performance deteriorated slightly from April, May and June have remained static with performance at similar levels to April 2024, before Audiology was added to the data. There are also continued issues inaccurately reporting DM01 backlog for multiple modalities, primarily Endoscopy, following Alex Health launch at PAH
 	
• There is significant variation in Trust performance:
  • ENHT – 46.5%
  • WHTH – 85.6%
  • PAH – 66.3%
• Excluding audiology, performance has declined over the last three months however remains on a trend of improvement overall.
• The primary drivers for PTL growth ENHT audiology and WHTH NOUS
	ENHT
	• The most significant long waiters remain in Audiology. In adult audiology only 2% of patients are waiting <6 weeks
	• In paediatric audiology 9.4% of patients are waiting <6 weeks
	• Outside of audiology, MRI and Ultrasound remain the most challenged modalities
	PAH
	• Continued issues in accurately reporting DM01 backlog for multiple modalities, primarily Endoscopy, following Alex Health launch
	• The most challenged tests in June were Audiology (18.6%), Gastroscopy (20.3%), Colonoscopy (24.0%) & Flexi Sig (26.6%)
	WHTH
	• The most challenged modalities in June were NOUS, Cystoscopy and cardiac MRI
		ENHT
		• Further detail on paediatric audiology is outlined on the following slide
		• Adult audiology: Lister estates work has finished on three booths which opened on 10 June; successful recruitment, where there are 4 new band 6s and 1 new band 8a due to start in the coming months
		• MRI – Pinehill contract has now been agreed and patients being booked. InHealth van being utilised for two days per week; approval has been granted to convert temporary spend to substantive post that will support the provision of 7-day service
		• Ultrasound – hoping to start insourcing from September; two new sonographers recently recruited; using booking production boards to ensure full utilisation; additional head and neck lists; some sonographers increasing their hours
		PAH
		• Reporting issues being progressed as part of Alex Health data quality improvement programme. New data extraction processes expected to be live in August have been delayed until September
		• Additional 75 Audiology assessments per week once CDC at full capacity
		• 2 x Diagnostic Imaging capital bids nearing completion
		• Continued Paediatric Audiology support to the wider system is impacting recovery of Adult services. Additional recruitment underway with revised trajectory expected in September
		WHTH
		• There has been challenges in cardiac MRI which has been a 3 day service due to capacity issues. From July, the service has moved to a 5 day service which will aid recovery
		• Recovery actions are in place for cystoscopy which are longer term and focus on resource
		• As increase in number of referrals in NOUS has added pressure for the service and extra capacity is being reviewed

Planned Care - Paediatric Audiology Diagnostics

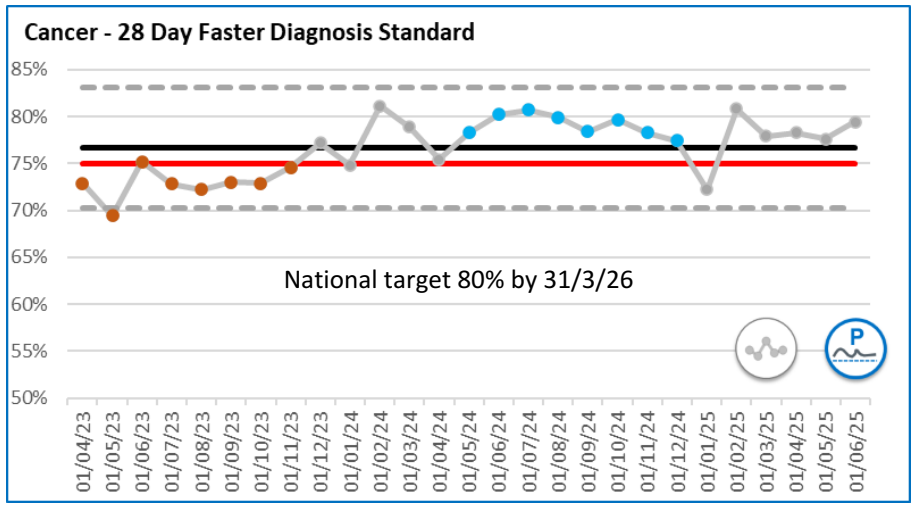


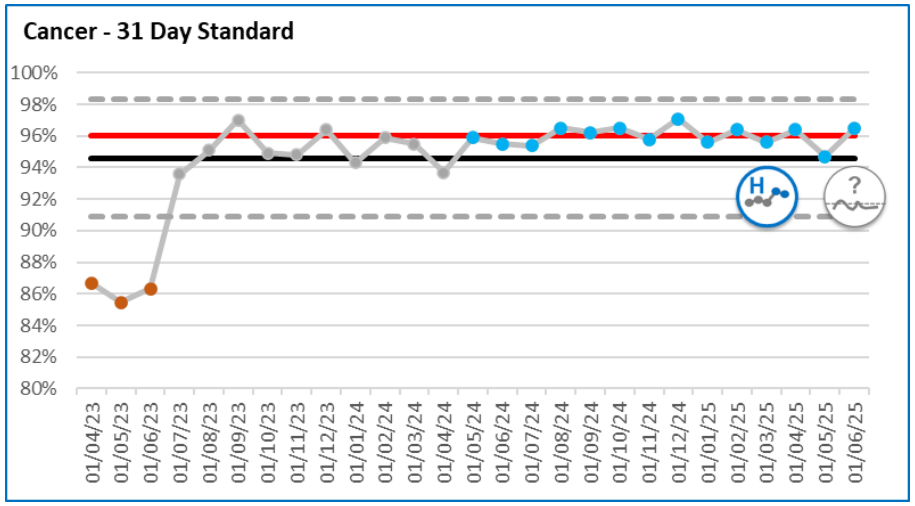


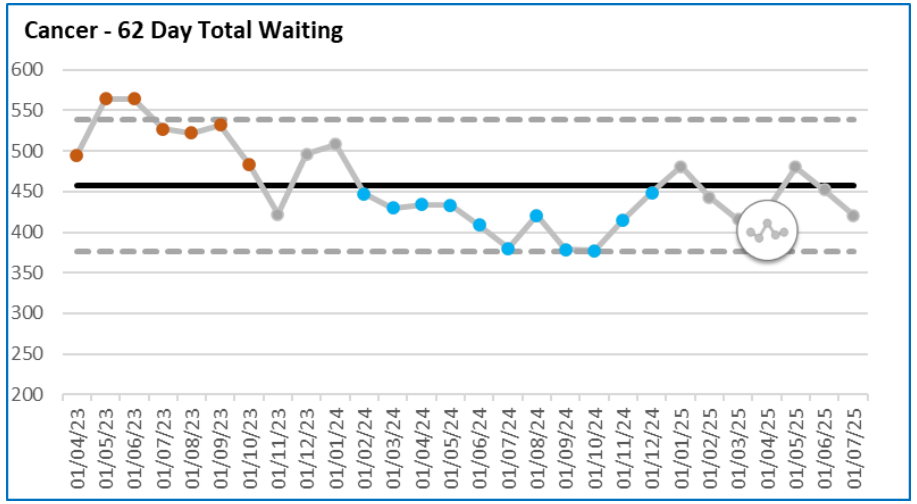


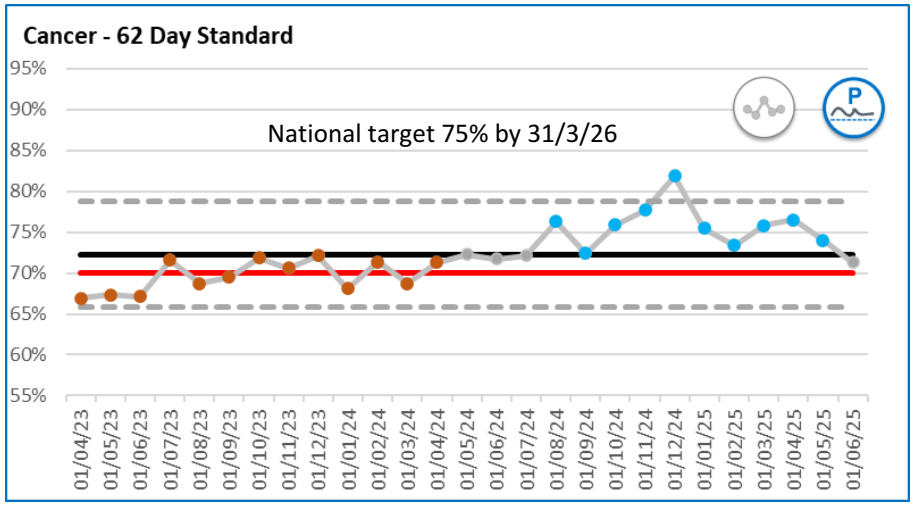
What the charts tell us	Issues	Action
• All providers are significantly below the DM01 performance target of 95%, however with the exception of ENHT, continue on improved trajectories. There is a large variance in performance by provider: • After a significant improvement seen in the early part of 2025, PAH performance has dropped over the last few months to 56% in June. • HCT has also seen a drop in performance over the last couple of months to 23% in June. • With significantly lower performance levels that have averaged c7% over the last 6 months, ENHT performance continues on a variable trend, at 9% in June.	• ENHT remains significantly challenged with paused pathways for 0–3-year-olds and complex patients. Key issue relates to estates for this patient cohort. • Limited mutual aid available within the Herts and west Essex system, in part due to estates challenges and workforce capacity. There is also limited mutual aid available externally to the system. • Site visits to HCT and PAH as part of the National Paediatric Audiology Improvement Programme have confirmed HCT and PAH to be delivering safe services. However, HCT have triggered a full 5 year look back for their auditory brainstem response (ABRs). PAH may also trigger the 5 year look back for ABRs, awaiting confirmation from NHS England. • Workforce is relatively fragile across all paediatric audiology services; this is a similar picture regionally and nationally.	• System wide paediatric audiology oversight group in place with monthly meetings to oversee key actions at system level and progress required improvements. ICB escalation team in place with weekly meetings. • Working with system partners to identify any possible mutual aid within the local system and review of potential levelling up. ENHT in direct conversation with BLMK regarding repatriation of patients. NHSE supporting with mutual aid options outside of local system. Ongoing review of PTLs by pathway to help manage children waiting as safely as possible, looking to ensure they are seen appropriately based on clinical need. • ENHT estates work completed at Lister site. Plans for Hertford County in progress, linked to national capital bid funding. Required estates work completed at HCT and on track at PAH. Also looking at sharing of estates e.g. HCT offering facilities one day per week to ENHT. • Work has been undertaken to map all audiology workforce across HWE, including bandings, skills and competencies. Focused recruitment where vacancies remain. Seeking external workforce to assist with mutual aid. • Data task and finish group delivering consistent local datasets and a new report which enables a view of paediatric audiology waiting time and referral trends split by provider, age cohort and patient pathway.

Cancer


Cancer - 28 Day Faster Diagnosis Standard
85%
80%
75%
70%
65%
60%
55%
50%
National target 80% by 31/3/26
P
01/04/23
01/05/23
01/06/23
01/07/23
01/08/23
01/09/23
01/10/23
01/11/23
01/12/23
01/01/24
01/02/24
01/03/24
01/04/24
01/05/24
01/06/24
01/07/24
01/08/24
01/09/24
01/10/24
01/11/24
01/12/24
01/01/25
01/02/25
01/03/25
01/04/25
01/05/25
01/06/25


Cancer - 31 Day Standard
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
H
?
01/04/23
01/05/23
01/06/23
01/07/23
01/08/23
01/09/23
01/10/23
01/11/23
01/12/23
01/01/24
01/02/24
01/03/24
01/04/24
01/05/24
01/06/24
01/07/24
01/08/24
01/09/24
01/10/24
01/11/24
01/12/24
01/01/25
01/02/25
01/03/25
01/04/25
01/05/25
01/06/25

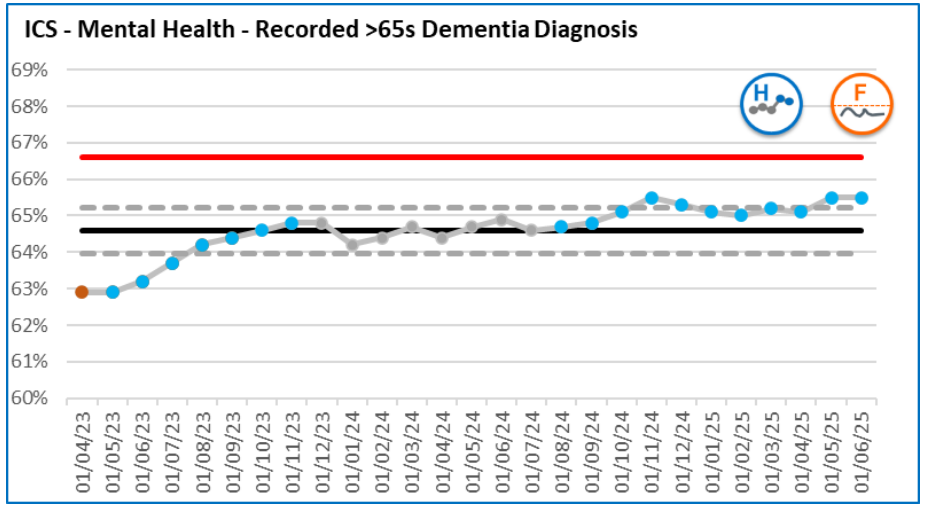

Cancer - 62 Day Total Waiting
600
550
500
450
400
350
300
250
200
01/04/23
01/05/23
01/06/23
01/07/23
01/08/23
01/09/23
01/10/23
01/11/23
01/12/23
01/01/24
01/02/24
01/03/24
01/04/24
01/05/24
01/06/24
01/07/24
01/08/24
01/09/24
01/10/24
01/11/24
01/12/24
01/01/25
01/02/25
01/03/25
01/04/25
01/05/25
01/06/25
01/07/25


Cancer - 62 Day Standard
95%
90%
85%
80%
75%
70%
65%
60%
55%
National target 75% by 31/3/26
P
01/04/23
01/05/23
01/06/23
01/07/23
01/08/23
01/09/23
01/10/23
01/11/23
01/12/23
01/01/24
01/02/24
01/03/24
01/04/24
01/05/24
01/06/24
01/07/24
01/08/24
01/09/24
01/10/24
01/11/24
01/12/24
01/01/25
01/02/25
01/03/25
01/04/25
01/05/25
01/06/25

Cancer

What the charts tell us	Issues	Actions
• The 28-day Faster Diagnosis Standard (FDS) performance improved in June after three months of static performance reaching 78.7% against a M3 plan of 79%. However, there is variation across the system: | | Plan | Actual | |---|---|---| | ENHT | 78.3% | 80.2% | | WHTH | 81.7% | 85.4% | | PAH | 77.0% | 72.5% | • The 31-day target was achieved, reaching over 96% in June • Performance against the 62-day standard deteriorated in both May and June dipping under the 75% standard expected in the National Planning Guidance and below our planning trajectory for June • The 62-day backlog is variable but deteriorating over both May and June	ENHT • ENHT met two out of three standards in June. The 62 day standard was not met but ENHT was the 9th best performing trust nationally • Urology remains the most challenged of the high-volume pathways. For Urology, the Trust is dealing with increased demand of c.7% year-on-year • There has been a deterioration in the lung faster diagnosis standard in May and June. This is primarily because lung cancer screening hasn't been reported in these months. Reporting due to start again in July. WHTH • 28-day FDS performance maintained although particular challenges remain in the Haematology and Urology pathways • 31-day performance standard has been met across all specialities, except for Gynae and Urology. The 96% target was missed by 2.7% in Gynae and 1.1 % in Urology. • 62-day- Haematology, Head and Neck and Urology have continued to have challenges in meeting the 62-day target. Pathway complexity, late pathway transfers, out-patient capacity and histology delays, cited as the main reasons for delays. PAH • Urology (31.8%), Lower GI (46.5%) and Head & Neck (64.0%) were the biggest FDS challenges in June. Endoscopy staffing and Urology prostate triage, MRI and MDT clinic capacity are the key issues • Overall, 62-day performance fell to 41.8% in June, but this was largely driven by the progress made in reducing the >62-day backlog • 62-day performance is forecast to improve to c.54% in July • Greater than 62-day waits are continuing to improve with the Trust now achieving their fair shares target. As of 10/8 the latest backlog was 109 patients	ENHT • ENHT has been putting in place pathway changes / additional capacity in Urology. These include: MRI van at the Lister; one-stop flexi-cystoscopy pathway and additional TP biopsy capacity. However, the impact of these interventions has been limited due to the increases in demand. • Breast performance recovered in June to 80.26% and the locum breast radiologist has now started with a new permanent staff member starting in September • Haematology – to introduce bloods clinic at Lister McMillan Cancer Centre to start in September WHTH • Cancer Improvement Programme Board continues to oversee service level plans and service developments. Weekly long wait meetings continue and 2/3 times weekly breach validation reviews in place. • Haematology USC referral booking transferred to Cancer Scheduling Team and new USC appointments ringfenced. Service demand and capacity modelling in progress • Post Advertised for a new H&N consultant, unfortunately no applications received and therefore exploring alternative solutions. Daily cancer outpatient appointments now available for H&N USC referrals. • Recruitment almost completed for Bladder one-stop pathway. Planned move of clinics to SACH in October to create additional clinic capacity. CDC bid submitted for additional U/S machine to support the cystoscopy service • One Stop Prostate service to restart, registrar appointed to start in September 2025. • Exploring digital solutions for PSA monitoring. PAH • PAH remains in Tier 1 of the national oversight and support infrastructure for Cancer recovery • Cancer improvement funding bids approved totalling £660k • Weekly meetings to review recovery trajectories and improvement plans are being led by the Deputy COO for Urology, Upper GI and Lower GI • Lower GI: Endoscopy insourcing in place from August and performance is improving; Audit of the Bowel Prep / Low Residual Diet pathway complete with changes now in development; More efficient process for removing benign patients being implemented in August • Urology: Prostate triage now fully embedded by day 3 of the pathway; Additional MRI capacity now in place and being fully utilised; Programme to improve turnaround times for pathology and to introduce mpMRI which should reduce the need for some patients to have a biopsy • Stretch trajectory agreed to further reduce >62-day backlog to 80

Mental Health – Dementia Diagnosis in Primary Care



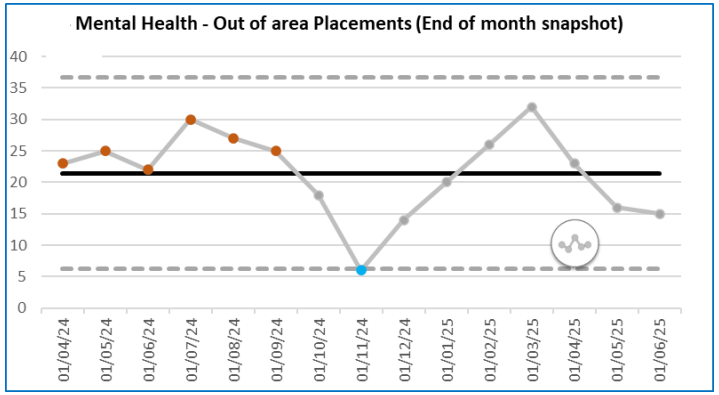
ICB Area	What the charts tell us	Issues	Actions
Dementia Diagnosis in Primary Care	• National data for end of July 2025 shows the ICS dementia diagnosis rate continuing on an improved trend at 65.9% for the ICB against the national target of 66.7%. There is continued variance at Place: • South and West Herts: 64.0% • East and North Herts: 62.9% • West Essex: 74.9% July 2025	Herts • Dementia prevalence rate rises every month • Demand for memory clinic assessments via HPFT EMDASS remains very high West Essex • No concerns identified	Herts • Hertfordshire memory service continues to reduce its backlog, with the lowest waiting list so far this year. • In June, 73.46% of people were diagnosed within 12 weeks of being referred.

Mental Health – Inappropriate Out of Area Placements (OAPs)

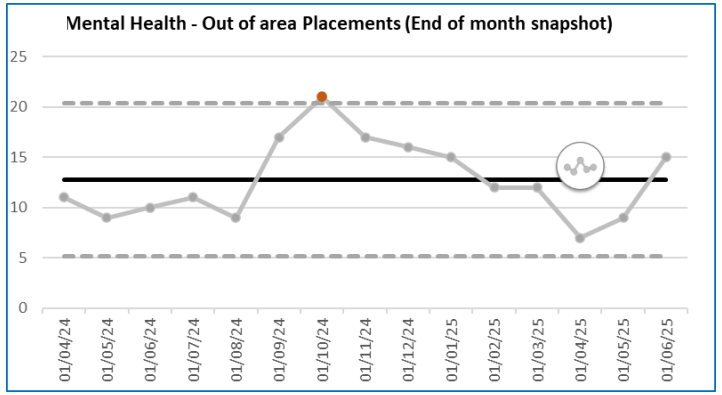
- The basis for measurement of OAPs has changed for 24/25
- Previous reporting was based on the number of out of area bed days in the month
- From April 24, reporting is based on the number of active OAPs at month end

HWE end of June total out of area placements:
30 vs. 15 plan

Hertfordshire



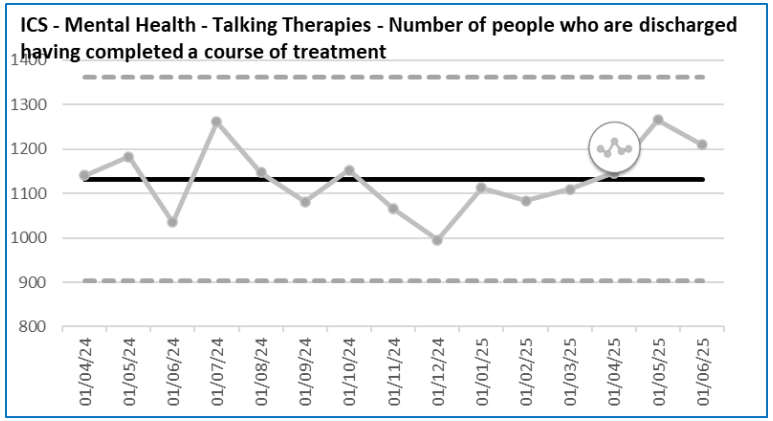
West Essex

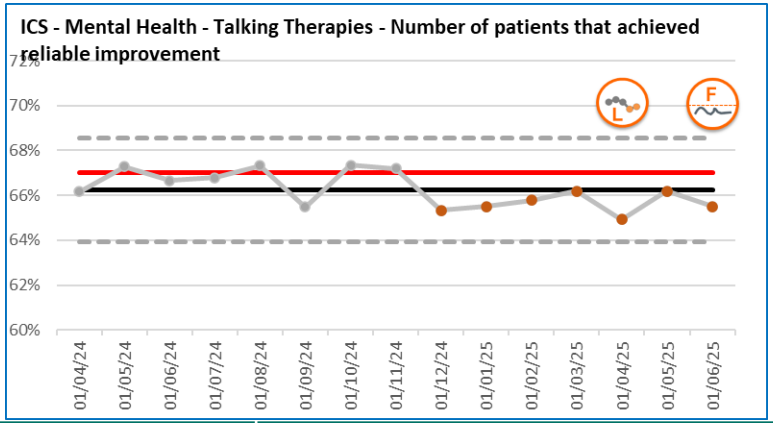


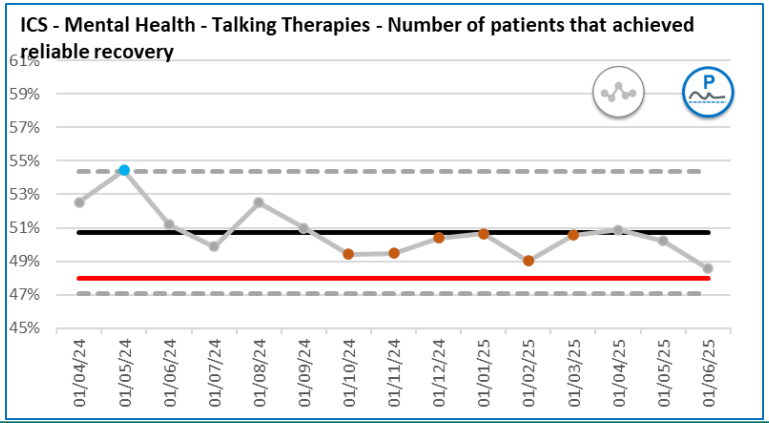
ICB Area	What the charts tell us	Issues	Actions
West Essex	An increase in numbers has been seen in west Essex across the last two months with 15 out of area placements reported at the end of June.	Previous concerns continue to place pressure on the system such as increased bed demand.	• Essex wide review has seen a new bed model being introduced to free up capacity and repatriate people back closer to home – example being; West Essex beds occupied by NE Essex residents being repatriated to the north of County into a NEE bed. • Although west Essex remain within planned OOA bed numbers there has been a contract performance notice served and meeting held with wider Essex leads and EPUT to agree an action plan.
Herts	June saw a further decline in numbers to 15 from a peak in March of 32 (as measured on the last day of the month)	• Hertfordshire has a low number of beds per population and there is ongoing support for provision of additional block beds • National shortage of MH beds, high occupancy rates and use of OOA beds is likely to continue • Placement challenges for service users with complex needs who are ready for discharge • There is a Trust Wide plan across divisions to reduce the OOA placements which commenced in April	• Alternatives to admission continue to be developed, including HPFT complex need crisis house, and MHUCC • Wider Executive led work at system level to support placement of longer term CRFDs. • Bed management system continues to be developed and implementing plan to include OAPs. • Continue to strengthen relationships with contracted bed providers emphasising LoS management, to reduce the number of inappropriate beds and to ensure all Service Users are within Hertfordshire boundaries. • Conducting clinical visits to contracted bed providers to support discharge planning. • Holding ongoing daily Bed Management meetings (3 x a day) to explore all alternatives to admission. • Senior, clinically led team attending independent providers ward rounds in person to unblock and support discharge • Collaborative working with HCC reviewed support service users requiring HCC involvement for discharge.

Talking Therapies

Number of people who are discharged having completed a course of treatment
Percentage of patients that achieved reliable recovery
Percentage of patients that achieved reliable improvement



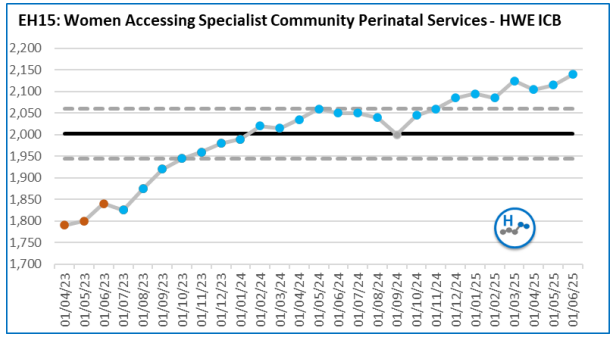


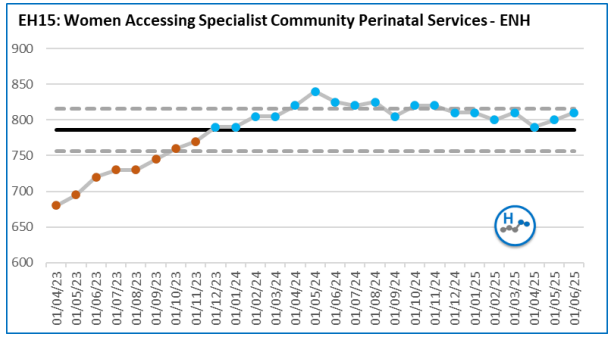


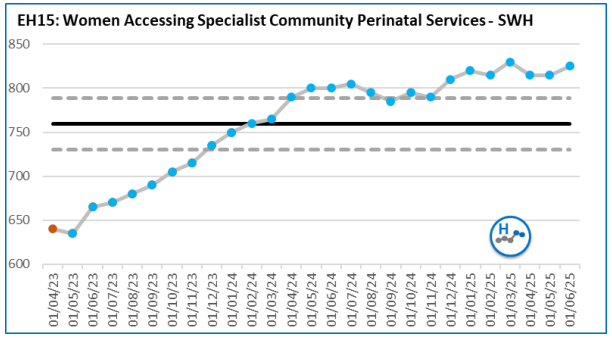
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	West Essex (JULY) • Referrals (689) increased during July from previous month (+97) • Reliable Recovery rate is 46.4% in July and Reliable Improvement 64.6%. Hertfordshire • Increase in completed treatments since February 2025 • 63% reliable improvement rate in July 2025 • 48% reliable recovery rate in July 2025.	• Measurement now relates to completion of a course, with at least two appointments. Previously access / first appointments • Consistency of data collection and quality across the system continues to be monitored due to changes in the MHSDS. • Continuing focus on addressing attrition and drop-out rates following the change in counting for 24/25 • CFD procurement complete, implementation period for new providers will limit capacity until training complete. • In Hertfordshire the pressure remains at Step 3; more assessments required and a greater need for step 3 treatment	• NHSE advise that positive practice guide being drafted to support services reducing dropouts • NHS England system wide planning calls scheduled to support ICBs throughout 25/26 • NHS England representation embedded within West Essex contract meetings • Increased access to funded training posts via NHSE • SDF funding now in place for Herts that will increase HIT workforce with immediate support to Step 3 pressures. • 6 providers In place to support 'Counselling for depression pathway' training places allocated for counsellors with training commencing September onwards. Service Improvements and Limbic System: The Limbic system was introduced to enhance referral quality by collecting more information before assessment. The service also emphasized the stepped care model, with new clinical lead roles at both step 2 and step 3, and a focus on recovery training and appropriate referrals. HPFT Actions: • Choose & Book has been rolled out to all Herts team to increase the flow of patients from referral to initial appointment. This is to be reviewed for efficiency and improvements now that it is established in all teams. We are looking to expand this to include choose and book for treatment sessions. This will be piloted in SW. • The Time to Change group-based initiative continues to be rolled out across Herts to improve the engagement in treatment at Step 3. There is now an additional offer of a single session to improve accessibility. • All teams are required to offer clients further resources and support whilst waiting, such as the webinars and online self-help information. • Workforce, productivity, adjusted caseloads are under regular review.

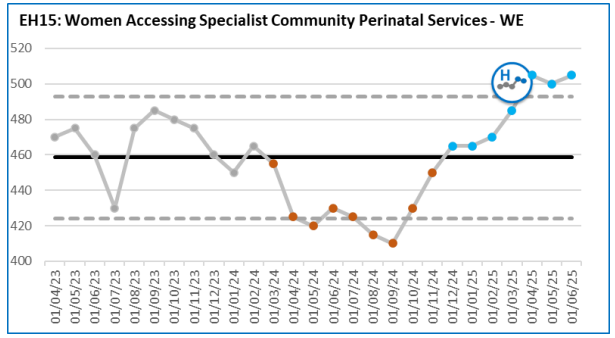
Community Perinatal Mental Health

Number of women accessing (1+ contact) specialist community PMH and MMHS services in the previous 12 months









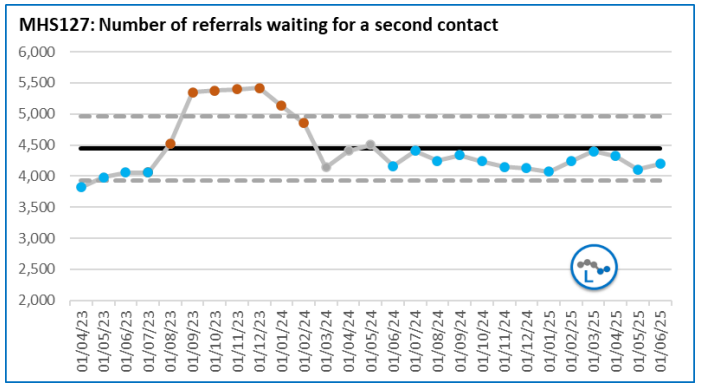
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	West Essex • Consistently exceeding national target at 10.44% • Accessing service (new clients) 138 to date this financial year. July saw 29 referrals of which 22 were seen within 4 weeks and 419 contacts with new patients. Hertfordshire • Consistently exceeding national target	West Essex • No concerns identified Hertfordshire • Contractual reporting has been changed to reflect national 12 month rolling measure	Hertfordshire West Essex • Continually monitor local services on the 12-month access target to ensure services remain on track

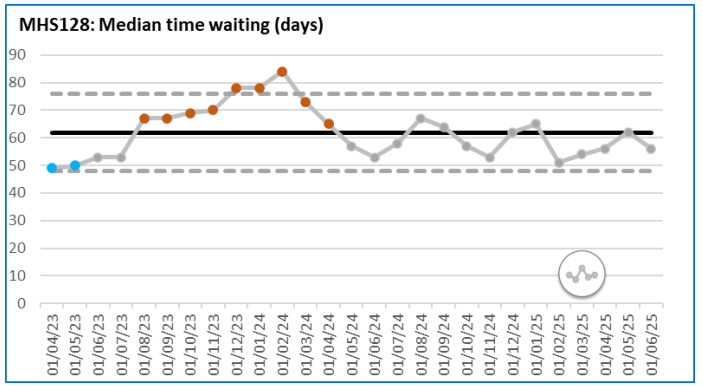
Hertfordshire and West Essex Integrated Care System

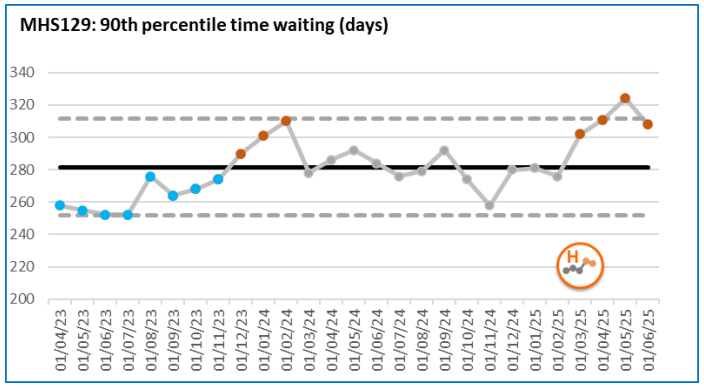
Mental Health – Community Waits

Adults and Older Adults – time still waiting for second contact*

* Please note NHS community MH dashboard waiting times front page states experimental waiting times and this section is being reported to support data quality improvement. Therefore, the data should not be used at this point to assess local activity and performance.



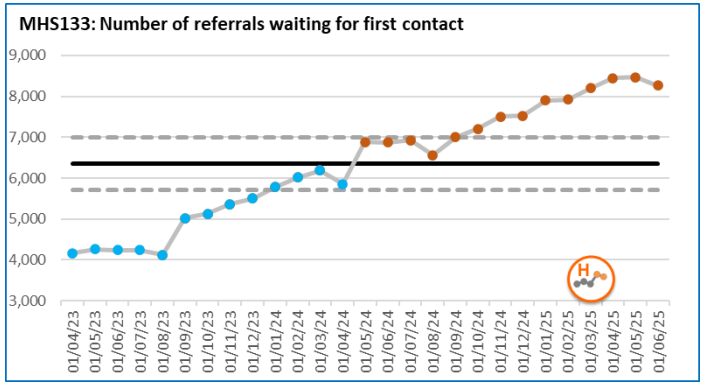


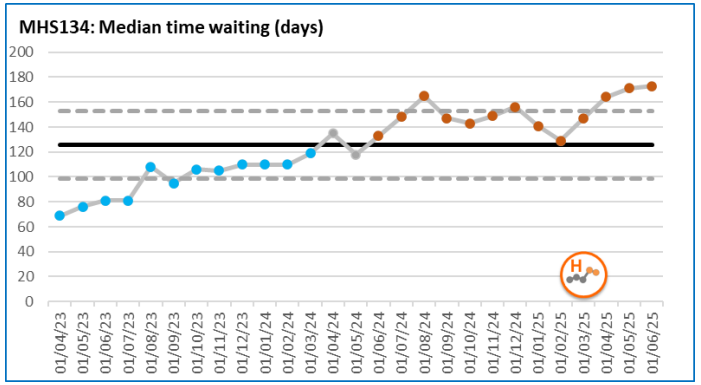


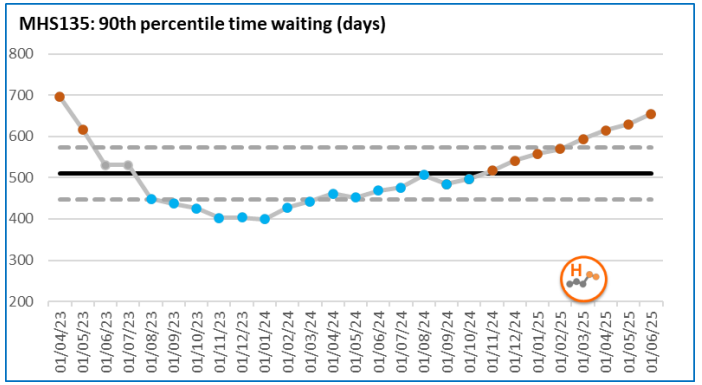
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	West Essex • Referrals spells started June 2025 – 315, previous month % change is 290.0 (+8.6%). • Referrals spells closed in June – 340 • Referrals spells open in June – 1,725 • Referrals spells still waiting for second contact 265 (previous month change -3.6%). Hertfordshire • As of June, there were 71.4% of referrals with 2 plus contacts and a SNOMED assessment compared to the national average of 41.5%. • Referrals with 2 plus contacts and a baseline outcome measure were at 87.6% compared to the national position of 45.9% (latest data June 2025).	West Essex • Although there has been an increase in referrals (8.6%) patients waiting for a second contact reduced by 3.6% however there is local recognition that second contact remains high. • 249 patients DNA'd in June 2025. Hertfordshire • The data flow from Primary Care and VCSFE providers to MHSDS or the GP equivalent continues to be a challenge. This relates to the transformed PCN areas that have ARRS workers and Enhanced Primary Care. The data collection from these new services is recorded locally on System one or EMIS but this is not a shared system with the MH Trust (West Essex VSCE data flow is via a shared system with MH trust).	• Community First steering group established across Essex. This is a strategic initiative to review and redesign community mental health teams, establishing a standardised, equitable, and sustainable model of care. • In Hertfordshire, a Trust-wide waiting times steering group is in place to ensure the care and safety of all people waiting for services. • HPFT Service lines are incorporating the new waiting times into their transformation work. SNOMED codes have been re-mapped on the HPFT EPR, PARIS, and continue to be reviewed as changes are made at National level. Internal Power BI reporting has been developed and key areas for action are being determined. • All ICBs and providers of services continue to engage with NHSE with regional discussions being held regarding the MH data platform and progress is being made to capture accurate data for all pathways

Mental Health – Community Waits

Children – time still waiting for a first contact* *Please note NHS community MH dashboard waiting times front page states experimental waiting times and this section is being reported to support data quality improvement. Therefore, the data should not be used at this point to assess local activity and performance.

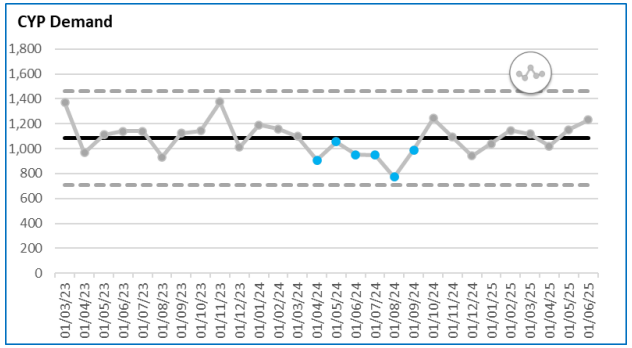


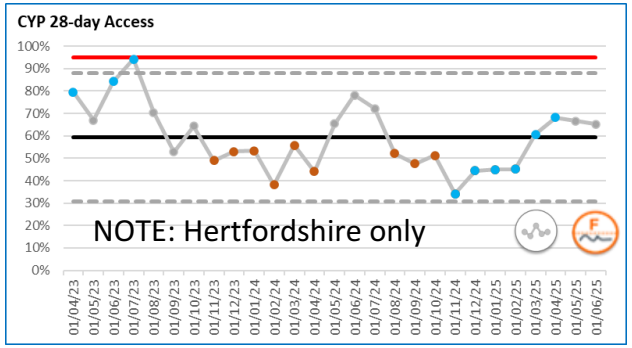


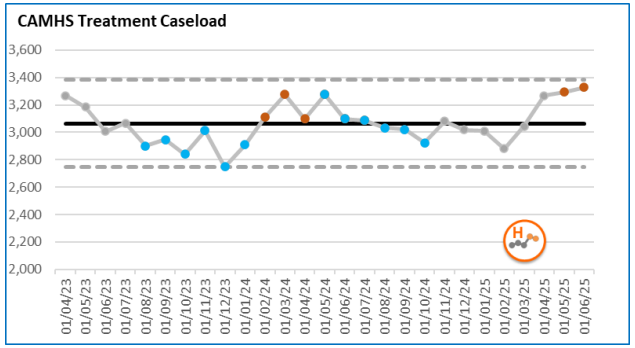


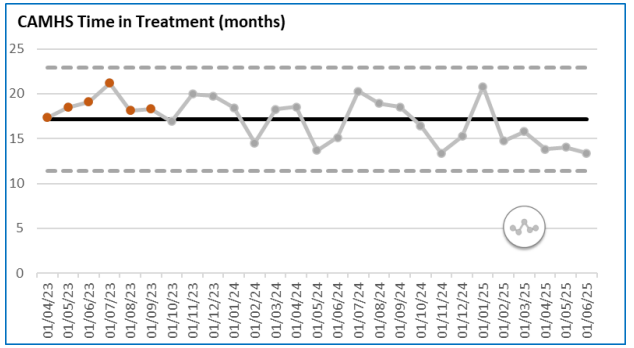
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• The number of referrals waiting for first contact continues on a trajectory of deterioration, remaining high at 8,265 across the ICS. • There remains significant variance by place with 6,385 waiting at SWH, 1,580 at ENH and 300 at WE. • The median and 90th percentile time waiting also continue to increase at 173 and 655 in June respectively across the ICS. • Again there is significant variance at place with the longest time waiting at SWH (204 day median time), followed by ENH (82 day median time) and WE (26 day median time).	• The biggest impact on the Hertfordshire waiting list and long waiters is Autism & ADHD backlogs / waiting lists for diagnostic pathways • South & West Hertfordshire data is reflective of the historically longer waiting times in the patch, due to ASD / ADHD backlogs (for East & North these services are delivered by ENHT not HPFT/HCT)	• CYP services in Herts are incorporating the new waiting times in their transformation work and service design. SNOMED coding has been re-mapped on the HPFT EPR, PARIS and internal reporting is available for Teams to review elements of the waiting time standard • An HPFT Trust-wide waiting times steering group is in place to ensure the care and safety of all people waiting for services • Local provider dashboards are in place for assessment & treatment activity, caseloads and waiting times. Average waits not always reflective of challenges experienced by service, but recovery action plans in place where applicable and closely monitored by commissioning leads • Commissioners, HPFT and now an HCT representative are linked into EOE waiting times standards group. Long waiters in HPFT all relate to ADHD backlog • Across NELFT all teams have systems in place to review treatment waiters in their MDT's and team managers review patterns of data errors to ensure that training is delivered to staff if needed

Mental Health – CAMHS Services









What the charts tell us

West Essex

- West Essex does not have a formal KPI for 28 days; the cohort of YP seen <4 weeks is monitored at monthly provider meetings
- There has been a slight decrease in demand during Q1 2025
- Numbers on caseload remain consistent with those as at the end of Q4 2025
- Time in treatment has increased but reflects acuity and complexity of caseload

Herts – HPFT only

- Demand into the service has seen a slight increase in June
- 28-day performance has been improving since November 2024 however has moved to a variable trend over the last couple of months, achieving 65% in June
- Caseloads have risen in the last 3 months
- Time in treatment has been reducing for the last 4 months

Issues

West Essex

- The SPA continues to see a steady demand in referrals but following review clinical triage is back on track and throughput is swifter.
- The rise of acuity / complexity of referrals continues, this is monitored via RAG systems for triage
- Team manager CAMHS hub team has returned from long term sickness
- Clinical lead role remains vacant.

Herts – HPFT only

- Active issue regarding recruitment to vacancies impacting on capacity and performance, cover provided by agency staff to mitigate
- Acquiring highly skilled CYP clinicians remains difficult. Non-health support roles being used to bolster teams

Actions

West Essex

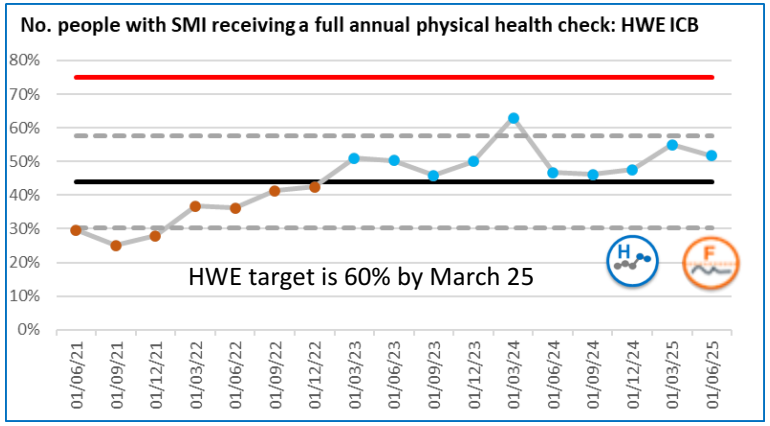
- Strong team in West Essex with additional support provided by the clinical lead and Head of Service across Essex. Clinical lead role out for recruitment

Herts – HPFT only

- Service has been improved to level 2 of trust escalation framework
- P1s are prioritised with more robust processes & oversight
- Recovery trajectories have been updated and are on track
- Recruitment gaps are being addressed through active recruitment and bank and agency cover.
- Clear patient safety focused plan in situ and held at weekly Quadrant Safety Group
- Care of Waiters protocol is in place with longest waiters regularly reviewed.
- Caseload management tool developed and in active use across the quadrants. Improvements in recording are underway to facilitate reporting of treatment waits.

Severe Mental Illness (SMI) Health Checks

Number of people with severe mental illness (SMI) receiving a full annual physical health check – percentage achievement in the 12 months to the end of the period



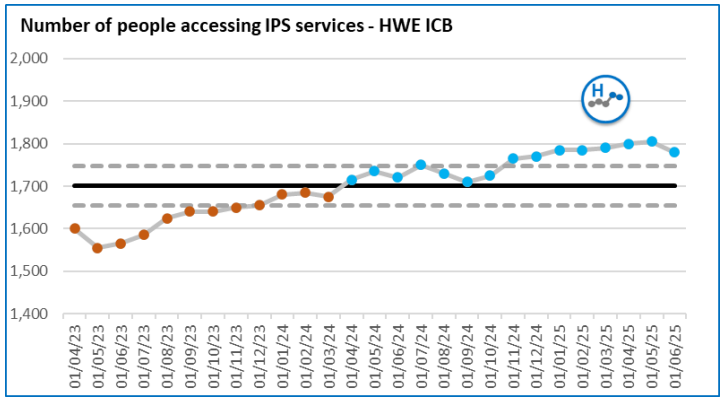
	2021/22				2022/23				2023/24				2024/25				2025/26
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
East and North Herts Place	19.6%	11.9%	15.1%	25.8%	24.0%	36.3%	40.4%	45.9%	49.7%	47.7%	49.4%	60.5%	52.3%	52.7%	53.6%	61.9%	57.3%
South West Herts Place	39.4%	38.2%	39.5%	47.5%	44.6%	46.4%	43.6%	55.9%	51.0%	44.8%	52.2%	66.9%	38.9%	36.8%	38.1%	42.9%	43.0%
West Essex Place	28.9%	24.5%	30.6%	36.5%	38.5%	38.9%	44.0%	50.4%	49.4%	44.8%	46.4%	59.2%	52.1%	52.4%	55.3%	66.4%	59.4%
NHS Herts & West Essex ICB	**29.6%**	**25.1%**	**27.9%**	**36.7%**	**36.1%**	**41.3%**	**42.4%**	**51.0%**	**50.2%**	**45.9%**	**50.0%**	**63.0%**	**46.8%**	**46.1%**	**47.5%**	**54.9%**	**51.7%**

- The systems for submitting and reporting of SMI Health Checks data has changed for 24/25
- Health Checks undertaken in Secondary Mental Health Services may not currently be fully captured, and therefore a direct comparison to last year's data is not possible at present. This is a known national issue

What the charts tell us	Issues	Actions
• Current data is not capturing all health checks undertaken in secondary care MH services • National data indicates South & West Hertfordshire is notably performing lower at 43% than East & North at 57.3% • ICB data pulled from Ardens however shows the following performance for quarter 1 - East and north Herts at 58% - Southwest Herts at 58% - West Essex at 58%	• Data quality issues as per NHSE disclaimer. The data presented here is considered 'experimental' due to known issues of incompleteness both in terms of the number of Practices who have not supplied information, and that some that have supplied information have supplied partial data. The experimental label of these statistics will be reviewed and removed once data completeness improves sufficiently.	• The data is being extracted from General Practice Extraction Service (GPES), an alternative system this year in Primary Care. There is a piece of work that needs to take place in order that the GPs are recording the data for health checks undertaken in primary care, as well as those carried out when a person is under the care of the MH Trust. This is a known national issue • Data by practice in place showing those practices current performance against target to be shared with practices : ongoing • Work with ICB BI leads and Provider leads to understand reporting requirements of secondary mental health services and primary care QOF data to ensure clear guidance and responsibilities, in line with the NHSE reporting procedures • Standardise record checking process agreed as an action for the Data Subgroup of the contract meeting • HCP place meetings in SW and ENH attended to present current support offer to GPs and identify further actions to support programme of work • Support the improvement of interoperability and provider electronic care records and information systems to enable monitoring of performance against equity of access to care • Working with Regional MH Team to look at shared care protocols to detail who is responsible for the physical health check, and how support for people who only engage with secondary care and not primary care will be captured, awaiting response • SW primary care outreach support has stopped due to financial position • Support via a proof of concept with HPFT for those who attend the Clozapine clinics to work with MiMH to assertively outreach and support tests in clinics DATA SHARING PERMITTING • Investment into Physical health professionals in the trust has made it possible to work in partnership with clinical and data governance and honorary contracts to be in place

Individual Placement and Support Access

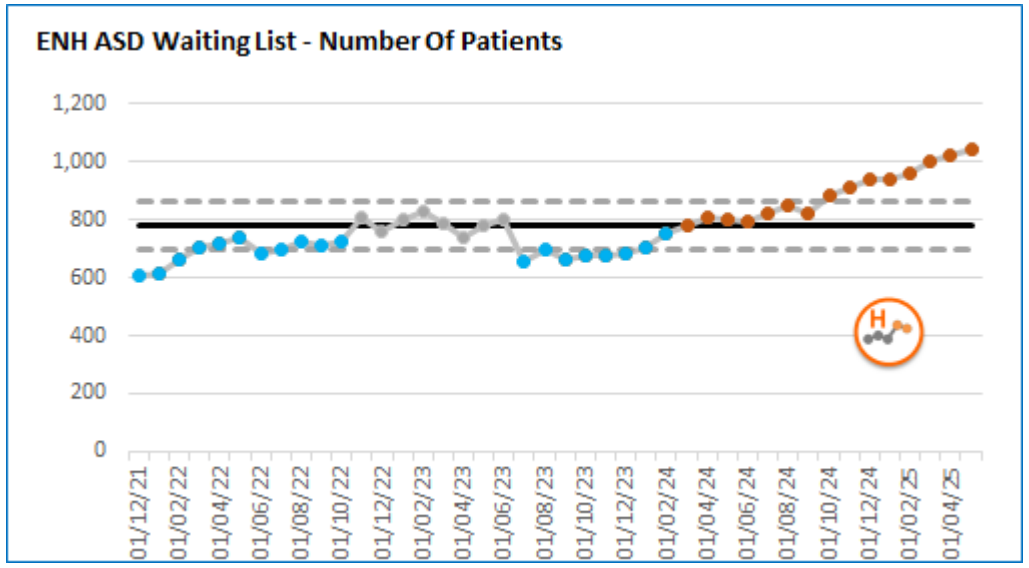
E.H.34 Number of people accessing Individual Placement and Support



	2023/24												2024/25												2025/26		
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06K	525	495	515	535	545	540	525	535	540	550	530	505	535	550	520	525	510	505	500	520	525	535	530	550	560	575	565
NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06N	675	675	680	695	715	725	745	725	720	715	745	755	745	735	730	715	695	695	685	675	660	640	615	575	555	540	525
NHS HERTFORDSHIRE AND WEST ESSEX ICB - 07H	400	385	370	355	365	375	370	390	395	415	410	415	435	450	470	510	525	510	540	570	585	610	640	665	685	690	690
HWE ICB	**1600**	**1555**	**1565**	**1585**	**1625**	**1640**	**1640**	**1650**	**1655**	**1680**	**1685**	**1675**	**1715**	**1735**	**1720**	**1750**	**1730**	**1710**	**1725**	**1765**	**1770**	**1785**	**1785**	**1790**	**1800**	**1805**	**1780**

	Issues	Actions
• The number of people accessing individual placement and support remains on an improved trajectory, however fell slightly in June to 1,780 for the ICS. • Variation at Place: - ENH: 565 - SWH: 525 - WE: 690	• No concerns identified with current provision as service commissioned above the national ask. • Transition to new service following procurement may result in drop in referral rates • The currently commissioned service is not at the full IPS Grow recommended rate. • The recording of data needs to be confirmed with NHSE and IPS grow.	West Essex • Ongoing conversations with NHSE and system partners regarding Essex wide services to ensure transition to new services Herts • A business model on numbers of people supported and the gap in finance and workforce will be advised, this will be reported through Hertfordshire Contract Review Meeting. • A meeting has been arranged for the data to be discussed with NHSE data leads IPS grow and HPFT leads. • Regular regional meetings to discuss this is being attended • A regular local meeting to discuss employment across Hertfordshire has been taking place with HCC and HPFT and commissioning to seek support from the HCP on wider employment strategies. Programme plan in place with HCP • Meeting has taken place with NHSE and IPS grow, relevant measures are being taken to ensure the data on those who are actively taking up this service is corrected. • Meeting with HPFT and data leads to agree the action plan to re establish the service, move into the Primary Care space and mobilise the new team members • The data will fall below the trajectory, an action plan to monitor this is under development

Autism Spectrum Disorder (ASD) – East & North Hertfordshire



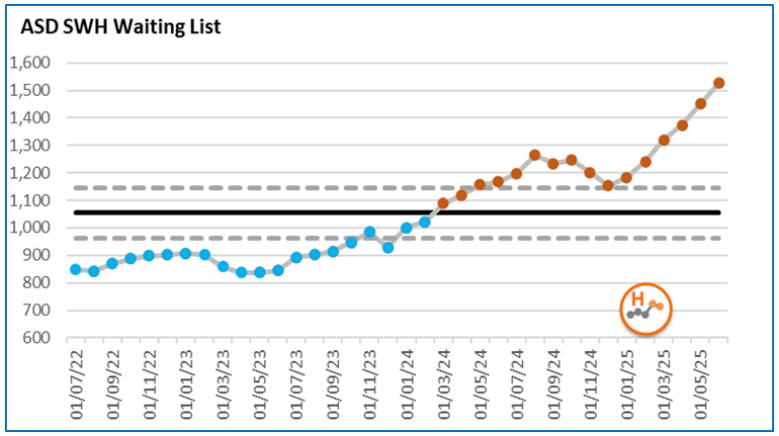
- In ENH, patients have a first appointment with Community Paediatrics. If the clinician, then considers that the patient requires an ASD assessment then they are added to the ASD waiting list
- Data is available on the waiting times for the first community paediatrics appointments and also for ASD assessments once a patient has been added to the ASD assessment waiting list. However, data is not available for both pathways combined
- The chart opposite shows the trend in the number of patients waiting for an ASD assessment once they have been referred by a community paediatrician
- The table below summarises how long patients on the ASD waiting list have been waiting (as of Mar-25):

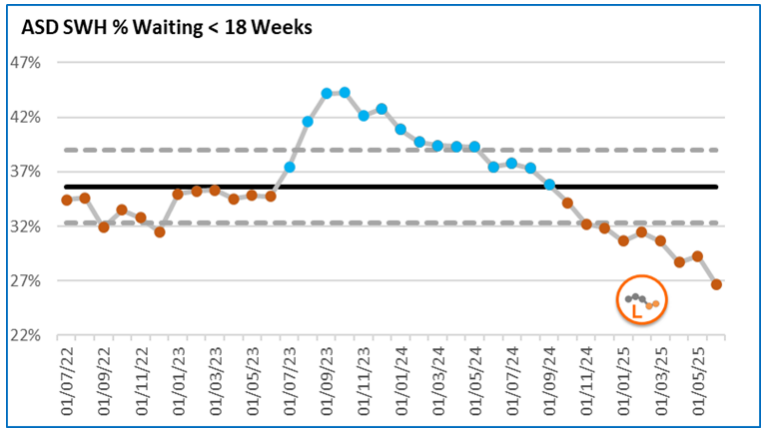
Waiting list bucket	Number of patients (Mar-25)	Number of patients (May-25)
<18 weeks	118	167
18 – 65 weeks	487	476
66 – 78 weeks	100	102
>78 weeks	295	300

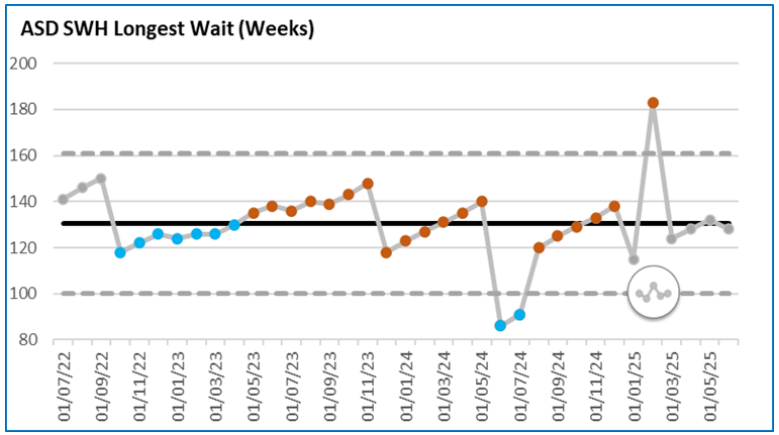
ICB Area	What the charts tell us	Issues	Actions
East & North Herts	• The ASD waiting backlog waiting list continues to increase and reached 1045 patients in May-25 which is the highest recorded level • The number of patients waiting >78 weeks for an ASD assessment has risen from 86 in Dec-23 to 300 in May-25 • The waiting list shown above does not include patients waiting for their first Community Paediatrics appointment, even if they have been referred by their GP as query ASD. It only shows patients who have been assessed by a community paediatrician and referred for a detailed ASD assessment	• Demand continues to far exceed capacity.	• Ongoing Hertfordshire wide ASD/ADHD transformation programme led by MHLDN HCP. • Support whilst waiting initiatives continue to be promoted and developed. • Additional recurrent funding agreed to support growth in capacity.

Autism Spectrum Disorder (ASD) – South & West Hertfordshire

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	Children	1450	1526	↑	29.24%	26.70%	↓	132	128	↓	June



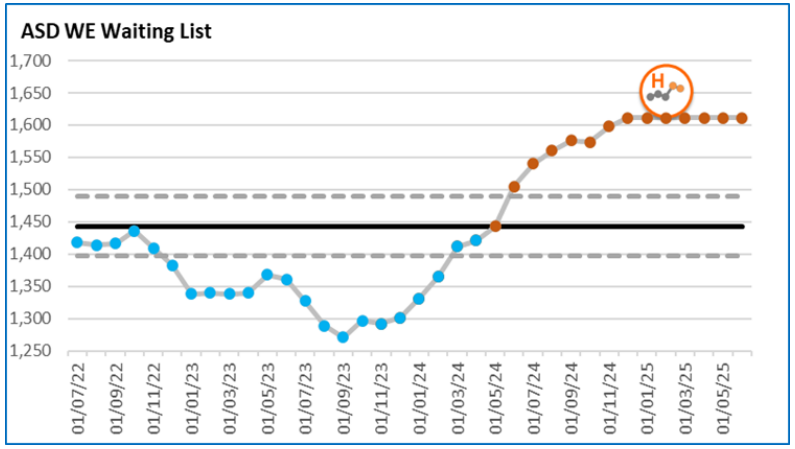


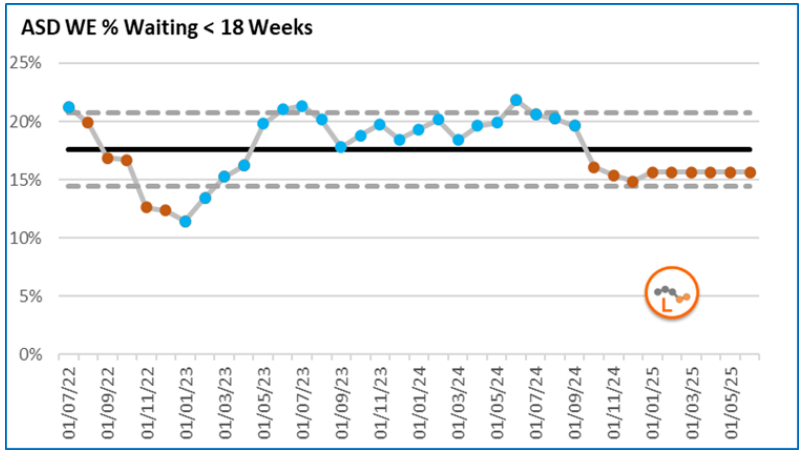


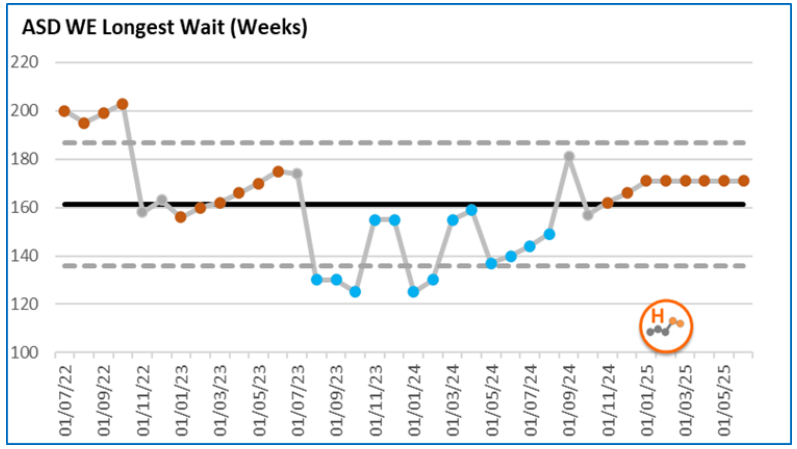
ICB Area	What the charts tell us	Issues	Actions
South & West Herts	• The ASD waiting list has continued to increase and remains consistently above the historic average • The % of ASD waiters <18 weeks remains low declining further in June. • The longest wait has returned to mean levels over the last few months, at 128 weeks in June	• Demand continues to far exceed capacity.	• Ongoing Hertfordshire wide ASD/ADHD transformation programme led by MHLDN HCP. • Support whilst waiting initiatives continue to be promoted and developed. • Additional recurrent funding agreed to support growth in capacity.

Autism Spectrum Disorder (ASD) – West Essex

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	HCRG	Children	1611	1611	→	15.64%	15.64%	→	171	171	→	June



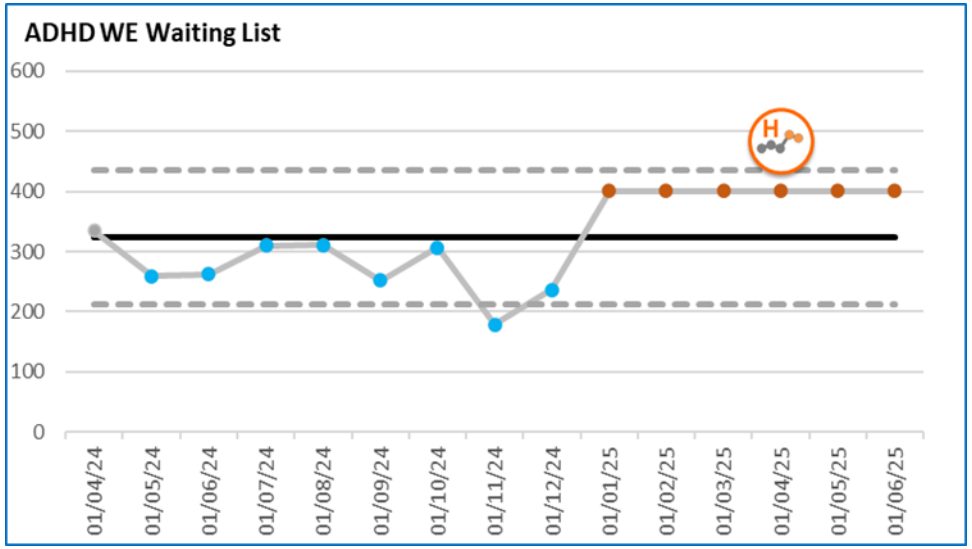


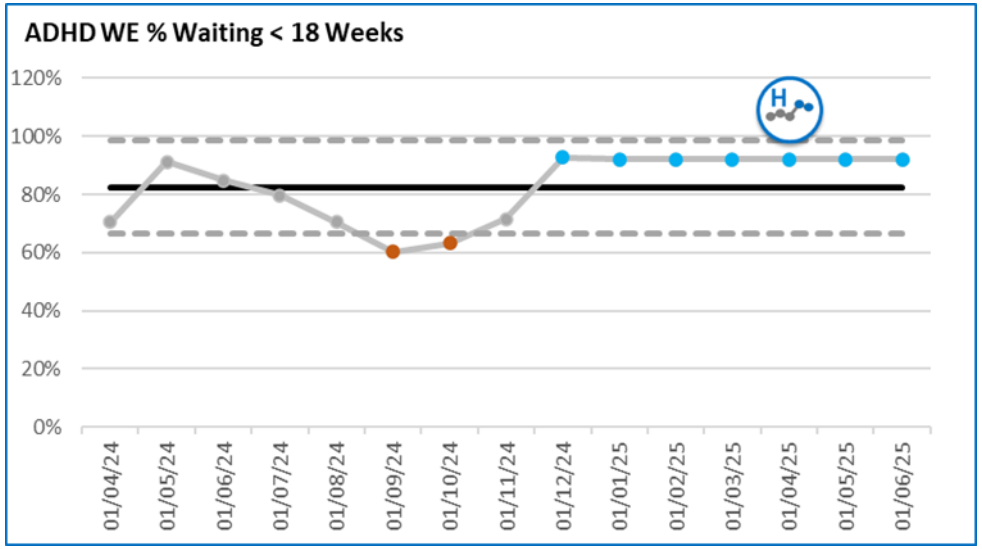


ICB Area	What the charts tell us	Issues	Actions
West Essex	• To note, data has been copied over from January in the absence of any new data being available to April • The ASD waiting list remains very high • The % of waiters <18 weeks remains low and fell in each of the six months leading up to January • The longest wait has been steadily increasing but remains within common cause variation limits	• Awaiting data reporting to resume following cyber incident. • No change: demand continues to far exceed capacity.	• Once access to data platforms have been reopened, HCRG will provide back-dated performance data which will be reflected on this report • 'Waiting well' workstream continues with local partners at Place, led by trainee psychologist at HCRG • Additional recurrent funding agreed to support growth in capacity.

Attention Deficit Hyperactivity Disorder (ADHD)
West Essex & East & North Hertfordshire

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	HCRG	Children	401	401	→	92.02%	92.02%	→	40	40	→	June

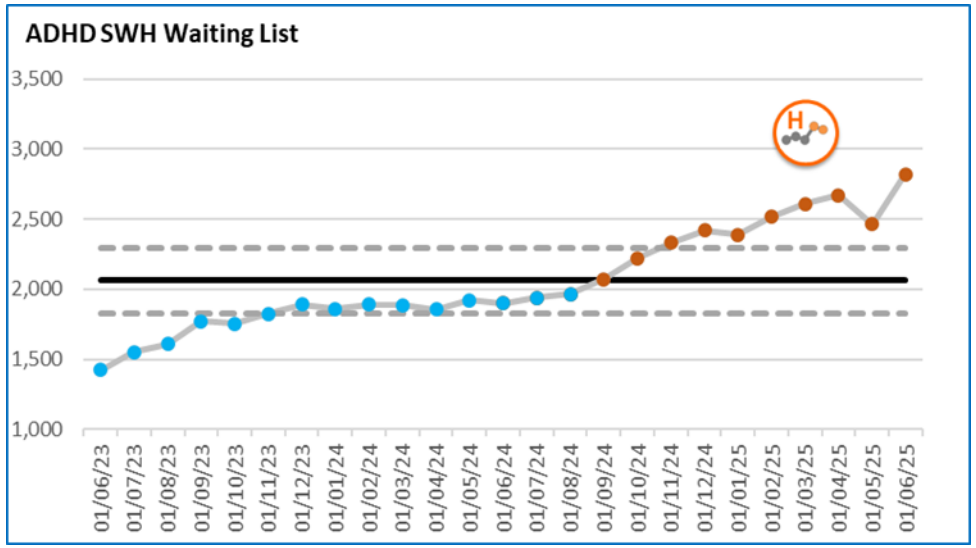


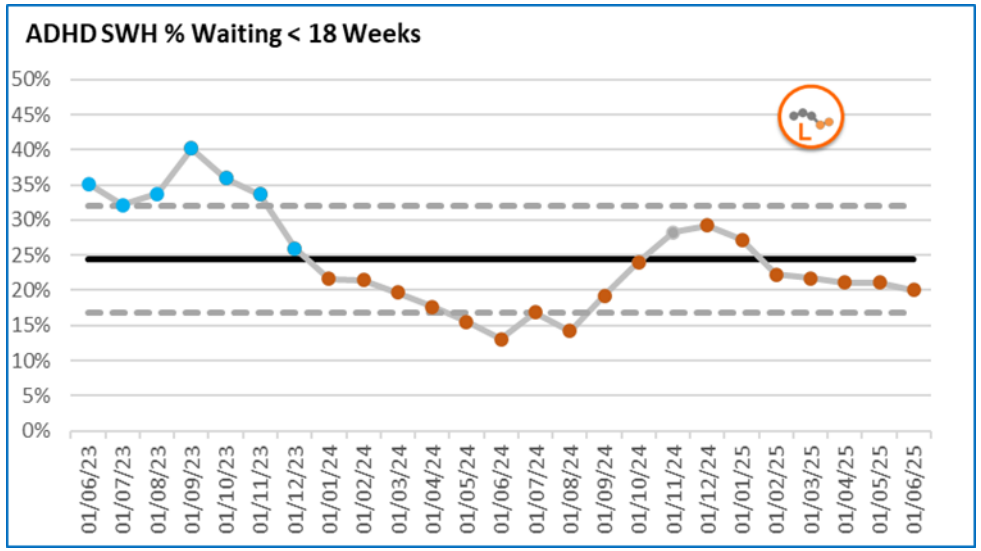


ICB Area	What the charts tell us	Issues	Actions
West Essex	• West Essex data has been copied over from January in the absence of any new data being available to April • West Essex waiting lists continue to fluctuate at historic average levels • The % of children waiting <18 weeks are also within common cause variation limits	• No change: demand continues to far exceed capacity. • ENHT is not currently able to report on waiting times / waiting list sizes for patients waiting for an ADHD assessment • Awaiting WE data reporting to resume following cyber incident. • WE Adult services continue to limit the number of young people transitioning to adult care, resulting in Paediatrics holding an increasing caseload of >18yrs	• Once access to data platforms have been reopened, HCRG will provide back-dated performance data which will be reflected on this report • WE Adult transition issues have been raised, however the number of referrals accepted is limited under contract activity plans. There is no resource in the system to increase capacity for adult transition • Additional recurrent funding agreed to support growth in capacity.

Attention Deficit Hyperactivity Disorder (ADHD) – South & West Hertfordshire

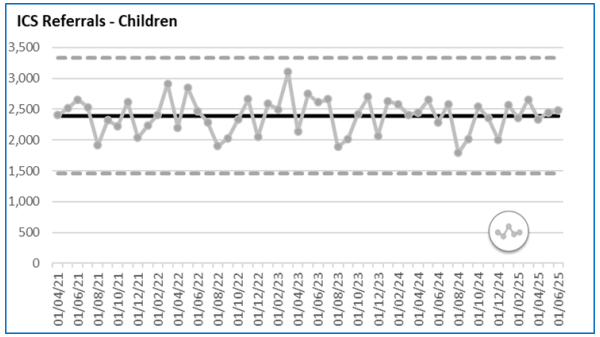
			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HPFT	Children	2463	2821	↑	21.07%	19.99%	↓	203	209	↑	June

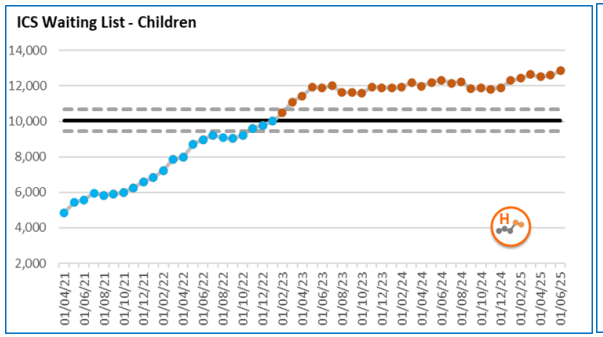


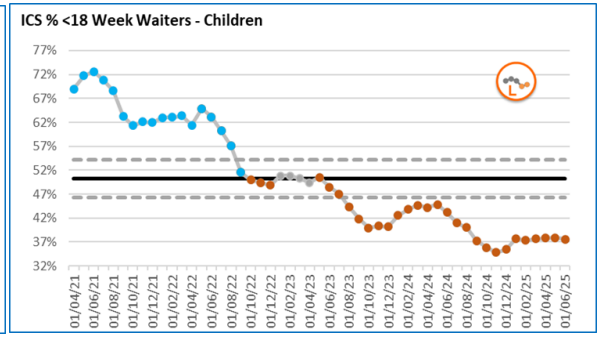


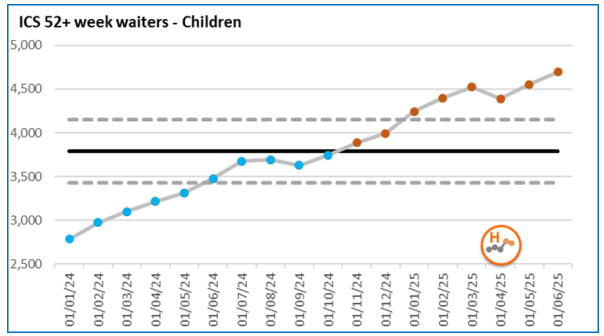
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Overall waiting list was relatively stable but has notably increased over the last ten months • The % of ADHD patients waiting <18 weeks has declined in recent months and is now on a deteriorating trend.	• No change: demand continues to far exceed capacity.	• Ongoing Hertfordshire wide ASD/ADHD transformation programme led by MHLDN HCP. • Support whilst waiting initiatives continue to be promoted and developed. • Additional recurrent funding agreed to support growth in capacity.

Community Waiting Times (Children)









		Referrals			Patients Waiting			% waiting <18 weeks			Patients Waiting >52 weeks			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Children	2447	2476		12594	12847		37.89%	37.57%		4553	4694		June

		Referrals			Patients Waiting			% waiting < 18 weeks			Patients Waiting >52 weeks			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	338	381		605	655		83.97%	82.60%		0	1		June
ENH	AJM/Millbrook	22	20		100	104		92.00%	93.27%		0	0		June
ENH	ENHT Community Paeds.	193	238		6700	6802		12.84%	12.72%		4274	4371		June
ENH	**All**	**553**	**639**		**7405**	**7561**		**19.72%**	**19.88%**		**4274**	**4372**		**June**

		Referrals			Patients Waiting			% waiting < 18 weeks			Patients Waiting >52 weeks			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	1340	1285		3884	3981		55.97%	55.04%		279	322		June
SWH	AJM/Millbrook	21	15		101	100		96.04%	91.00%		0	0		June
SWH	Communitas ENT													
SWH	**All**	**1361**	**1300**		**3985**	**4081**		**56.99%**	**55.92%**		**279**	**322**		**June**

		Referrals			Patients Waiting			% waiting < 18 weeks			Patients Waiting >52 weeks			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT - Wheelchairs	14	18		24	25		91.67%	92.00%		0	0		June
WE	HCRG/Virgin	519	519		1180	1180		86.36%	86.36%		0	0		June
WE	**All**	**533**	**537**		**1204**	**1205**		**86.46%**	**86.47%**		**0**	**0**		**June**

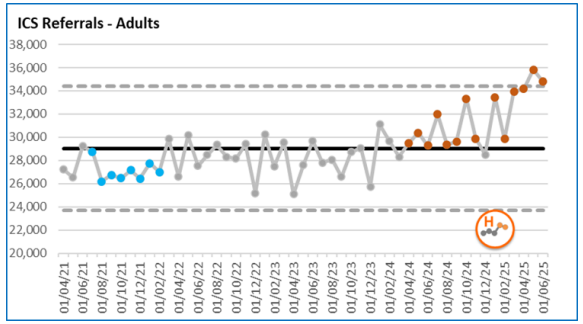
Hertfordshire and West Essex Integrated Care System

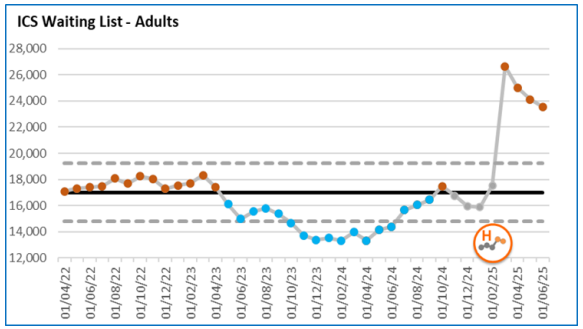
Community Waiting Times (Children)

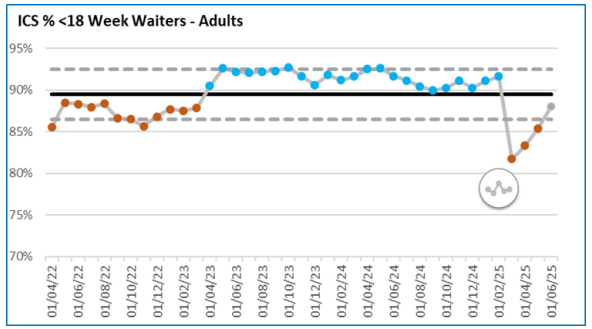
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services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

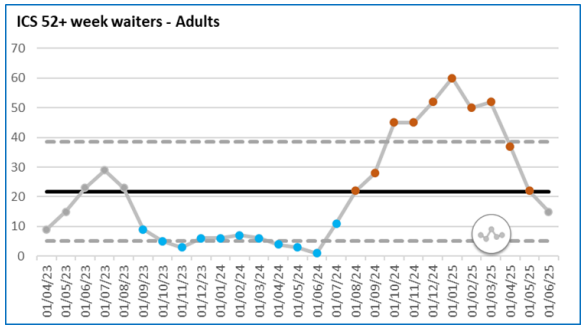
ICB Area	What the charts tell us	Issues	Actions
ICB	• The total number of children on waiting lists remains very high, but has plateaued at c.12,000 • The % of children waiting less than 18 weeks is broadly unchanged at c.37%, compared to the national average of c.50% • The number of waits over 52 weeks has seen in an increase in both the last two months. The longest waits are within the ENHT Community Paediatrics Service where there are now 4,371 x 52 week waits • There are additionally 322 x 52 week waits within HCT services in South & West Hertfordshire which has continued to increase • Consultant led 18-week RTT performance: SWH Community Paediatrics HCT 35.1% SWH Children's Audiology HCT 40.4% ENH Community Paediatrics ENHT 12.7% WE Community Paediatrics HCRG – no data received	ICS Wide: • No change in specialist services continuing to experience a marked increase in demand impacting on waiting times for both first and follow-up appointments. • Special School Nursing, Therapies and Comm Paeds are not able in the current format to meet demand for any projected increases in special school places and complexity. • ASD/ADHD assessment continues to be a significant pressure with increase in requests for assessments rising at 24% per year. Hertfordshire • Most significant pressures in Audiology (ENH) and Children's Community Nursing (ENH). • Significant pressures in Physiotherapy demonstrated through business case which could not be supported through contract negotiation. • Struggling to find theatre space for tooth extraction with paed anaesthetist. West Essex (WE) • Still waiting for HCRG performance reporting to resume following cyber incident	• Audiology action plan in place with ENHT and HCT, including recruitment and capital build. • Load Levelling requested across the ICS to support Audiology pressures, although puts relatively good performance in WE and SWH at risk. • Director level engagement around special school place projections continues. • Theatre space for Tooth Extraction to be raised via HCP governance.

Community Waiting Times (Adults)









		Referrals			Patients Waiting			% waiting <18 weeks			Patients Waiting >52 weeks			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Adults	35826	34787		24127	23563		85.40%	88.05%		22	15		June

		Referrals			Patients Waiting			% waiting < 18 weeks			Patients Waiting >52 weeks			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	9621	9106		10880	11361		87.14%	87.33%		21	14		June
ENH	AJM/Millbrook	139	114		401	417		92.77%	92.09%		0	0		June
ENH	**All**	**9760**	**9220**		**11281**	**11778**		**87.34%**	**87.49%**		**21**	**14**		**June**

		Referrals			Patients Waiting			% waiting < 18 weeks			Patients Waiting >52 weeks			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	CLCH	7753	7854		1526	1672		99.93%	100.00%		0	0		June
SWH	HCT	892	893		1012	1022		99.31%	98.34%		0	0		June
SWH	AJM/Millbrook	122	135		408	438		94.36%	93.84%		0	1		June
SWH	Circle Health MSK	3564	3394		6639	5641		70.33%	78.62%		0	0		June
SWH	Communitas ENT													
SWH	The Gynaecology Partnership													
SWH	**All**	**12331**	**12276**		**9585**	**8773**		**79.12%**	**85.75%**		**0**	**1**		**June**

		Referrals			Patients Waiting			% waiting < 18 weeks			Patients Waiting >52 weeks			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT	13620	13190		2520	2290		99.68%	99.87%		0	0		June
WE	EPUT - Wheelchairs	115	101		134	137		97.01%	95.62%		0	0		June
WE	Mayflower				607	585		86.49%	85.64%		1	0		June
WE	**All**	**13735**	**13291**		**3261**	**3012**		**97.12%**	**96.91%**		**1**	**0**		**June**

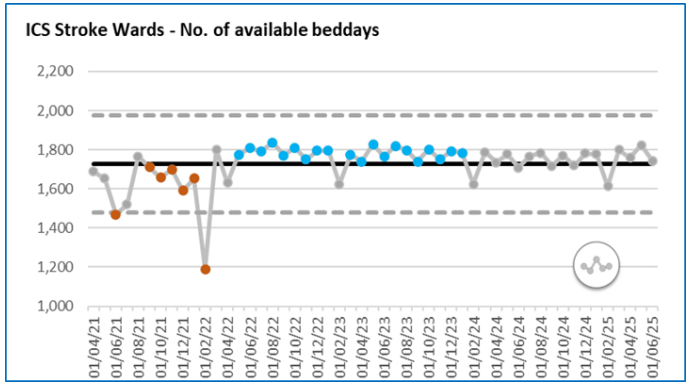
Hertfordshire and West Essex Integrated Care System

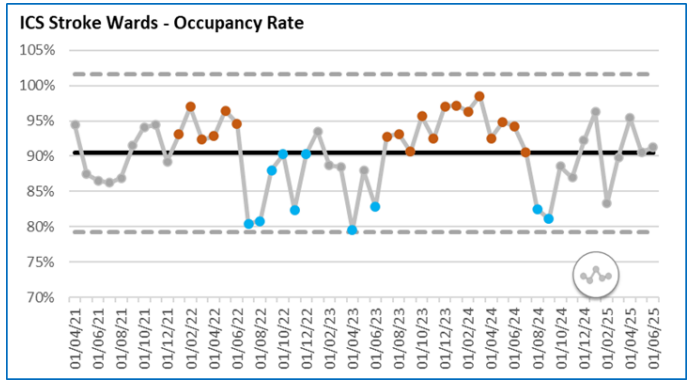
Community Waiting Times (Adults)

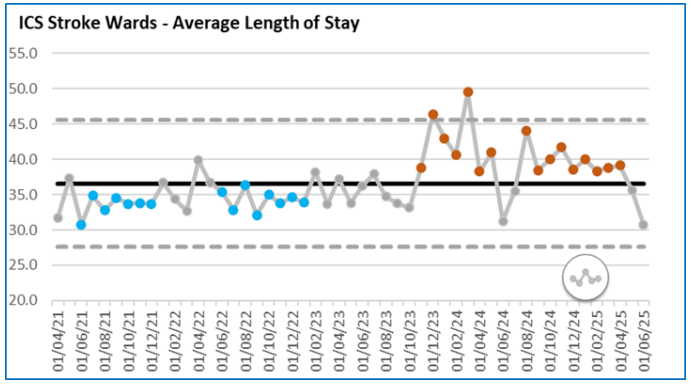
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Adult community services this include Skin Health (ENH), Respiratory (S&W), and Podiatric Surgery (WE). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services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

ICB Area	What the charts tell us	Issues	Actions
ICB	• Data for two community providers is currently excluded from the overall HWE system position as noted on the previous slide and work is ongoing to resolve reporting. Please note that Circle data has been included from March 25 which has resulted in step changes in reporting • The % of patients waiting less than 18 weeks declined in March with the inclusion of Circle data, however started to recover from April • Overall waiting lists saw an increase in March with the inclusion of Circle data but again have been decreasing since. • 52 week waits continues to reduce overall. • Consultant led 18-week RTT performance: ENH Skin Health HCT 88.1% SWH Respiratory CLCH 100.0% WE Podiatric Surgery EPUT 100.0%	East & North Hertfordshire (ENH) • Increase in referrals compared to 2024/25 • Slight reduction in the 'waiting within target' performance in recent months when compared to the pre-pandemic baseline and last year South & West Hertfordshire (SWH) • Community MSK services delivered by Circle from 1 April 2024 with significant backlog of 22,000 cases transferred from previous service. • July community MSK data shows a similar trend to the previous months in that the provider is seeing a lot more patients/activity to try and reduce the waiting list as soon as possible. There are plans in place to achieve 0 waits over 18 weeks by September reporting period. • Community Gynae and ENT services have been recommissioned under new contracts from 1 April 2025. Commissioners are working with providers to submit data in line with new contract requirements to enable reporting of community waiting times. • CLCH – Slight decrease in number of referrals received in month and decrease in total number of patients waiting on caseload. There are no patients waiting more than 18 weeks. AJM (Hertfordshire wide wheelchair service) • 0 over 52 weeks and 79 over 18 weeks. Initial reason for the delays is due to the time it is taken the national procurement team to process the orders. This has now been brought in house in the Hertfordshire service and CS team will order equipment going forward. Provider to share an exception report on the equipment HO status of the over 18 week patients. West Essex (WE) • Parkinsons's longest wait 19 weeks due to vacancy • Wheelchair services longest wait 25 week all pts have chairs awaiting parts from supplier • Mayflower longest waiters are in Dermatology	East & North Hertfordshire (ENH) • All waits, especially longer waits, are closely monitored and subject to robust internal governance • Service productivity initiatives continue • Comprehensive health inequalities metrics in place and analysis has allowed the Trust to compare waiting times and DNA rates for those living in relative deprivation versus those that do not. Targets have been set to address discrepancies • Extensive focus on digital initiatives to support and improve patient access • Forecasting suggests a generally stable trend over the next 12 months South & West Hertfordshire (SWH) • ICB working with Circle to achieve target of 0 over 18 week waits by September reporting period • Contract and BI teams working with the other community providers to achieve new reporting requirements for 25/26 • CLCH - daily and weekly monitoring remain in place. Additional external support sourced for services to try and reduce waiting times as much as possible. West Essex (WE) • Community neurology specialist nurse will commence July 2025 joint post with PAH • Mayflower longest waiters and overall PTL now improving following recovery discussions at last SPQRG meeting

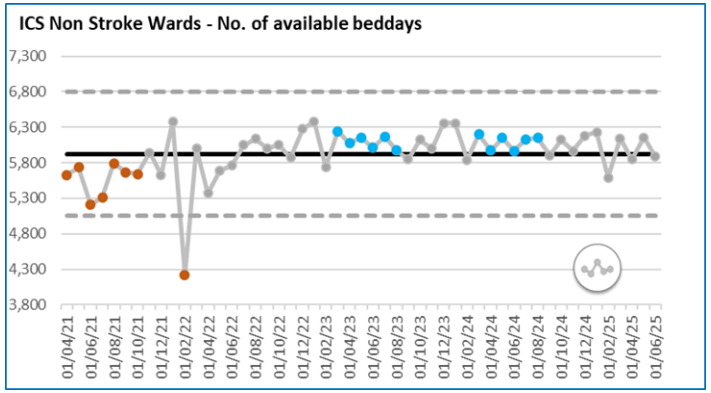
Community Beds (Stroke & Non-Stroke)

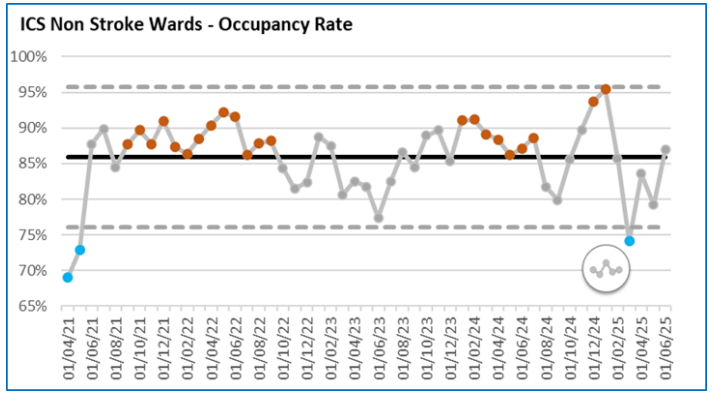


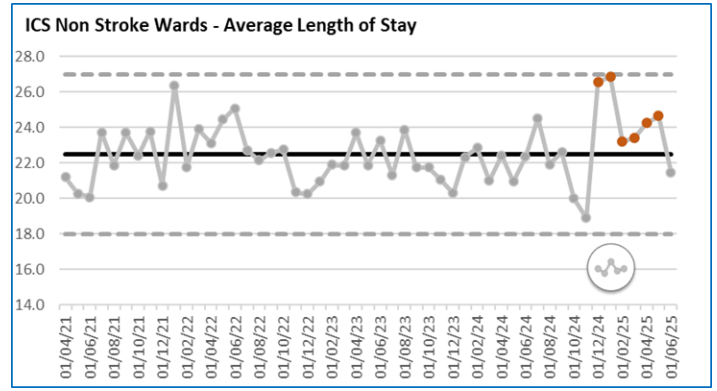




Stroke Wards			Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	744	720		92.61%	91.53%		37.9	27.9		June
SWH	CLCH	All	646	603		97.83%	96.52%		24.7	29.5		June
WE	EPUT	All	434	420		76.27%	83.10%		52.0	38.0		June
ICS	**All**	**All**	**1824**	**1743**		**90.57%**	**91.22%**		**35.7**	**30.7**		**June**





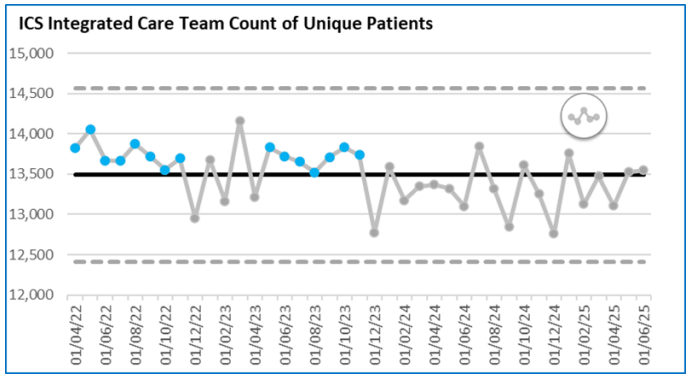


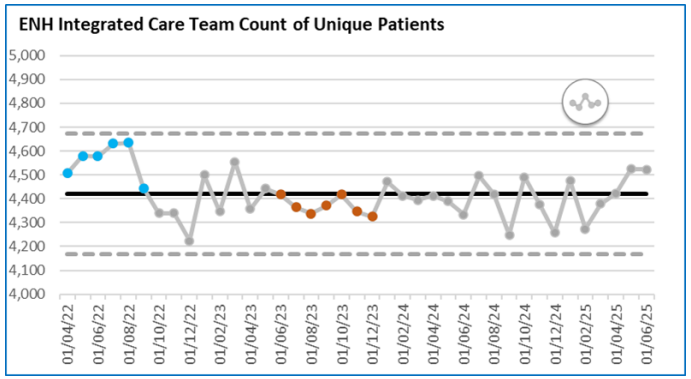
Non Stroke Wards			Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	1643	1498		78.03%	83.85%		22.5	21.4		June
SWH	CLCH	All	2248	2195		87.86%	88.93%		24.6	22.3		June
WE	EPUT	All	2263	2190		71.54%	87.03%		26.4	20.7		June
ICS	**All**	**All**	**6154**	**5883**		**79.23%**	**86.93%**		**24.7**	**21.5**		**June**

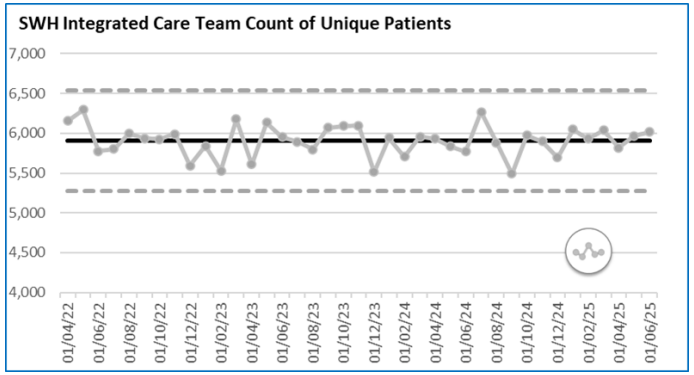
Community Beds (Stroke & Non-Stroke)

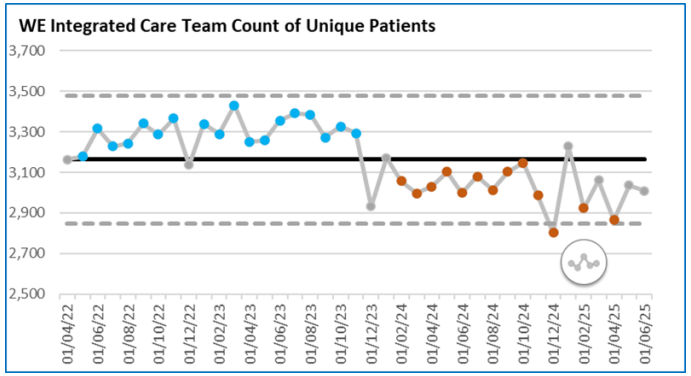
ICB Area	What the charts tell us	Issues	Actions
ICB	Stroke Beds • Available stroke bed days remain stable • Overall stroke bed occupancy rates have continued on a variable trend, close to the mean for the last two months • CLCH occupancy remains the highest at 96.52% in June • Overall length of stay has continued to reduce over the last couple of months across the system and at all providers with the exception of CLCH. The longest average length of stay remains EPUT. Non-Stroke Beds • Available non-stroke bed days continues on a variable trend close to the mean • Non-stroke bed occupancy rates have also returned to the mean in June at just under 87% • Overall length of stay continues along the average of c.22 days	East & North Hertfordshire (ENH) • Bed occupancy remains the highest at Danesbury with an average of 88% over the past 12 months. Herts & Essex and QVM have a 12-month average occupancy of 84% and 78% respectively • Average length of stay over the past 12 months for Herts & Essex averaged 22 days, and 27 days at QVM. At Danesbury, there is now normal variation with an average of 37 days. Admissions into community hospitals show no significant change in trend at Herts and Essex and QVM • Danesbury has the least admissions with an average of 17 a month, with QVM averaging 18, and Herts & Essex averaging 37 South & West Hertfordshire (SWH) • Further reduction in occupancy rates from previous month, this remains high • Increase in average length of stay but within target for stroke beds West Essex (WE) • Stroke/neuro bed occupancy increased in June and LOS reduced • Non-stroke bed occupancy has increased in June from May 2025 and Length of stay reduced from 26.4 in May to 20.7 in June 2025	East & North Hertfordshire (ENH) • New process regarding criteria to reside in place to support discharge • Step up as well as step down in place South & West Hertfordshire (SWH) • Beds model work for the future provision of community beds in SWH underway • TOCH has now gone live and further development taking place West Essex (WE) • WECHP are undertaking a review of the community hospitals in West Essex with system partners – report expected July 2025 this has been delayed until September 2025

Integrated Care Teams (ICT)









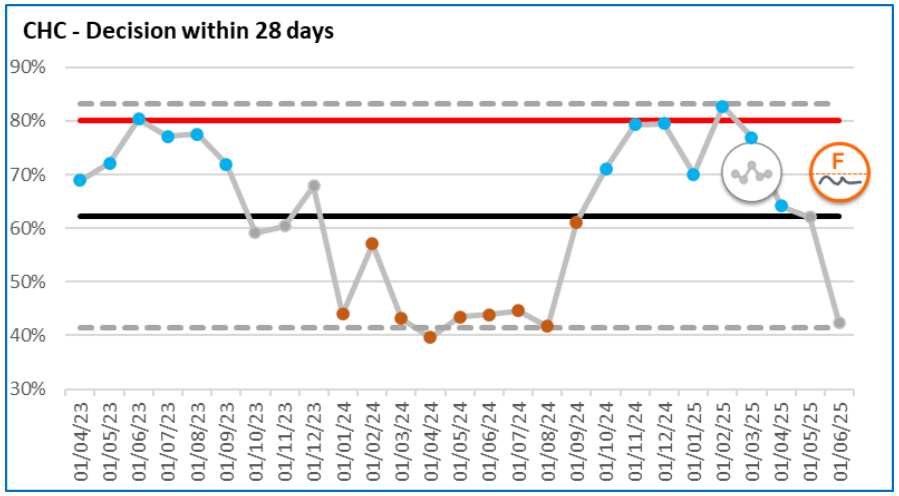
			Contacts (unique patients)			Contacts (unique patients) per 1000 population			
Place	**Provider**	**Age**	**Previous Month**	**Current Month**	**Month Change**	**Previous Month**	**Current Month**	**Month Change**	**Latest data**
ENH	HCT	All	4524	4522	↓	7.2	7.2	↓	June
SWH	CLCH	All	5966	6018	↑	8.6	8.7	↑	June
WE	EPUT	All	3037	3010	↓	9.0	9.0	↓	June
ICS	**All**	**All**	**13527**	**13550**	↑	**8.1**	**8.2**	↑	**June**

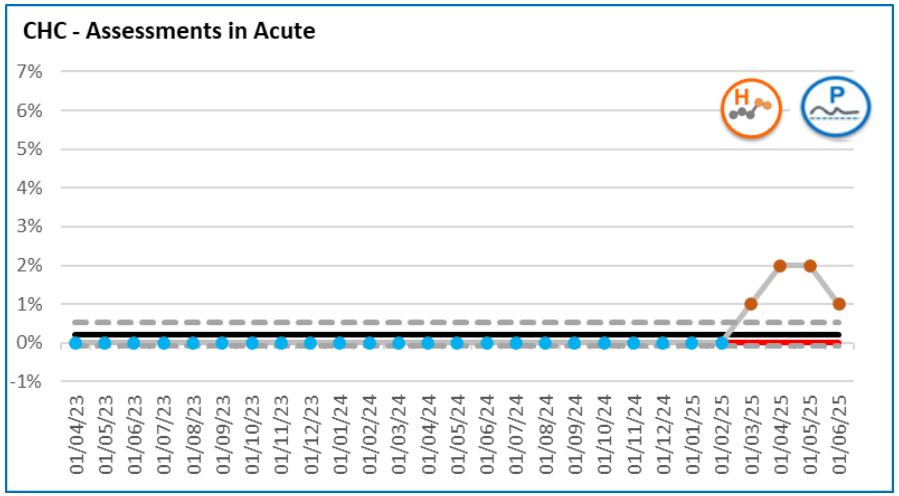
Hertfordshire and West Essex Integrated Care System

Integrated Care Teams (ICT)

ICB Area	What the charts tell us	Issues	Actions
ICB	• Unique contacts across the ICS and within each place are within common cause variation limits, all on a variable trend.	East & North Hertfordshire (ENH) • The number of individuals rereferred to the ICT is similar to pre-pandemic • There is an increase in the first-to-follow-up appointment ratio linked to increased acuity • The overall caseload is much higher than in 2019/20 across all localities • Patient complexity is increasing, with more intensive treatments required. e.g. numbers of intravenous antibiotics (IV) and End of Life (EOL) patients South & West Hertfordshire (SWH) • Slight reduction in contacts; continue to monitor month on month West Essex (WE) • Slight reduction in contacts from May, 2025 unique contacts per 1000 population stable.	• Care Closer to Home programme underway across HWE to reduce variation and shift to reporting outcomes and impact, to compliment the activity driven data that exists East & North Hertfordshire (ENH) • A comprehensive transformation programme in place focused on workforce, wound care and diabetes management with the ICT • Model being developed to improve capacity, agility and consistency across ICTs • Comprehensive SystmOne optimisation project continues roll out - aiming to streamline use of clinical systems with a prospective productivity gain • The Hospital at Home services appear to be effectively supporting reduced Acute demand South and West Hertfordshire (SWH) • Work underway to improve vacancy rate for district nursing services • Alignment with INTs already in place, but discussions regarding embedding services further underway at place West Essex (WE) • Harlow South PCN – 169 patients consented to proactive care, 153 desktop reviews completed with 64 F2F a further 41 patients identified total will be 194 , expansion to North Harlow PCN in October 2025 • Community Matron and TL away day to progress delivery of the “care closer to home” model

Continuing Health Care (CHC)

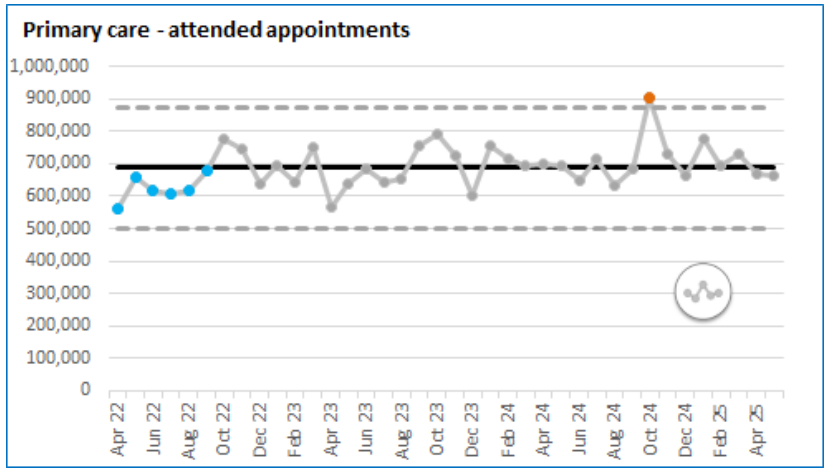


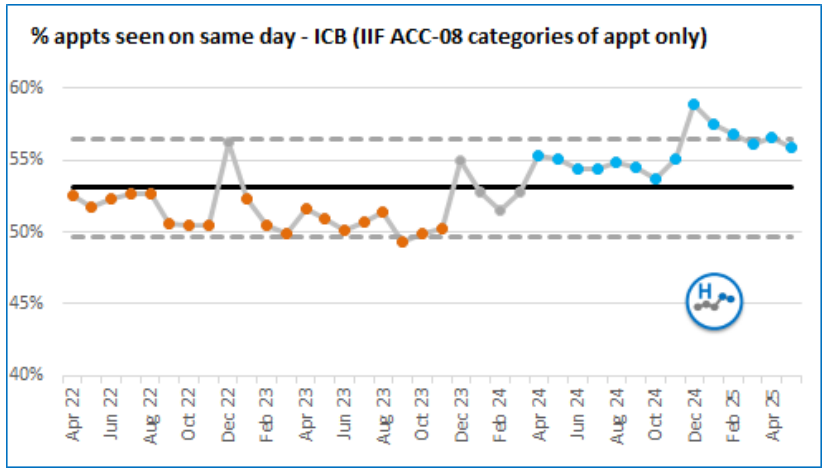


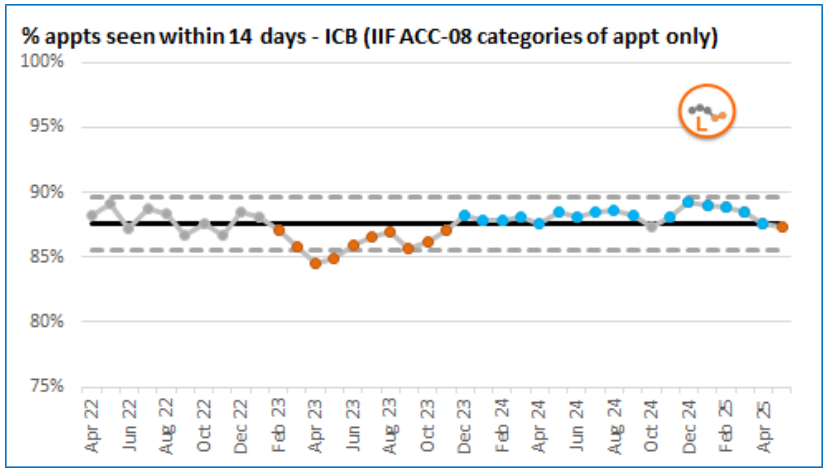
	What the charts tell us	Issues	Actions

HWEICB	• The 28-day standard declined significantly in June across the ICB, most notably in SWH.
	• As a result, the ICB has not achieved the national target (>=80%) since February and are currently working towards revised quarterly targets agreed with NHSE of Q1 – 50%, Q2 – 65%, Q3 – 75% and Q4 – 80% :
	  ○ Overall ICB – 42.45%
	  ○ West Essex – 60.00%
	  ○ ENH – 54.72%
	  ○ SWH – 24.59%
	• The assessments in an acute setting <15% standard continues to be achieved although there was a 2% increase over the last two months - these cases were by exception
		• Continued staff capacity across all areas is predicted to have a negative impact on the 28-day KPI.
		• Two assessments in acutes were due to be undertaken however, one has since been withdrawn and one is being taken forward due to health needs.
			• Recovery plans are being drafted with locality leads to provide assurance that the 28-day standard is achieved and remains on track going forward
			• Frequent meetings are currently in place across all areas to monitor performance and provide assurance, in addition to assurance meetings held with NHSE.
			• Ongoing training sessions have been implemented to assist both current and new staff to ensure day-to-day operational tasks are carried out both effectively and efficiently

Primary Care







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

What the charts tell us

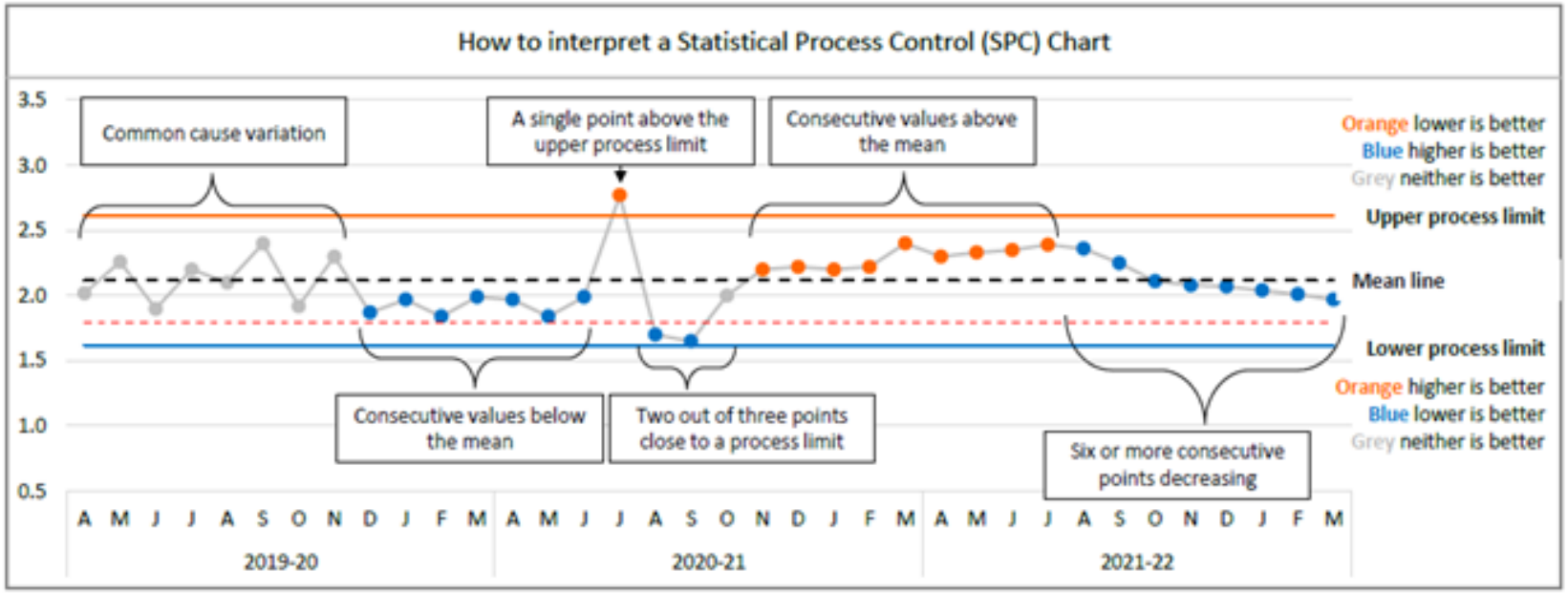
- Although the number of primary care attended appointments continues to show standard normal variation, there is a continued slight upward trend in the number of attended appointments. For example, there were 4.2% more appointments attended in FY2425 compared to FY2324.
- The % of appointments seen on the same day of booking has been above the long-term mean for the last twelve months, suggesting that there has been a sustained improvement in this metric. The chart above now shows the % of same day appointments for a subset of appointment types where the patient would typically want the first available appointment, rather than reviews / check-ups (IIF ACC-08 categories of appointment)
- The % of appointments which were seen within 14 days of booking has typically been above the long-term mean over the last 18 months. However, more recently, the % seen within 14 days has decreased for five consecutive months which is worth monitoring going forward. The chart above now shows the % of same day attendances for a subset of appointment types where the patient would typically want the first available appointment, rather than reviews / check-ups (IIF ACC-08 categories of appointment)

Primary Care

Issues	Actions

• National contract for 24/25 imposed without agreement and Collective Action in Primary Care added to the risk register – new contract for 25/26 agreed however while formal collective action stood down the principle of not undertaking unfunded work remains
• General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal
• 24/25 focus on cutting bureaucracy, helping practices with cash flow and increase financial flexibilities and continue to improve patient experience of access
• 25/26 greater emphasis on performance management with launch of new Primary Care General practice dashboard and supporting elective recovery through Advice and Guidance Local Enhanced Service, reducing bureaucracy continues with reduction in QOF indicators, and new contract requirement for access to online consultations
• Changes to GP contract from October 1st requiring practices to have all access channels open throughout core hours. Note possibility of further industrial action as BMA considers response.
• 25/26 contract changes for Dental and Community Pharmacy
	Engagement with the National Access Recovery Plan
	• Annual GP Patient Survey (GPPS) was published in July 2025. Positive improvement for HWE across GP, Dental and Pharmacy Metrics.
	  • 75% of patients expressed overall satisfaction with their GP practice, compared with 72% last year – in line with the national average of 75%
	  • 91% of patients expressed overall satisfaction with local pharmacy services, compared with 89% last year. This is higher than the national average which is 88%
	  • 77% of patients expressed overall satisfaction with local NHS dental services, compared with 75% last year. This is higher than the national average which is 71%
	• National Monthly Health Insights survey Wave 13 (published Aug25) shows 68% of patients rated their overall experience of general practice as good, the percentage satisfied with NHS dental care received, for those who had an NHS dental appointment in the last 28 days was 86.4%
	• Many practices transitioning to Modern General Practice (MGP) through demand / capacity analysis, use of cloud-based telephony, roll out NHS app, online GP registration, development of GP and PCN websites and testing triage models. Audit undertaken of the latest position for all practices for 24/25 year-end update.
	• Local CAIP – new scheme for 2025/26 launched with 2/3 of funding set against implementation of Modern General Practice and the final 1/3 on a new indictor looking at risk stratification and continuity of care.
	• All practices now have Cloud Based Telephony of some level. Looking at options for improving services at the circa 25 practices who are on the lowest level of CBT
	• Support Level Framework (SLF): Self-assessment tool to support practice teams in understanding what they do well, what they might wish to do better, and where they might benefit from development support. Roll-out of SLF facilitated sessions for practices at increased pace in 24/25 and further practice identified to take part in the Practice Level Support programme in 2025/26
	• The majority of practices have progressed towards full enablement of prospective records access; over 725k patients across HWE have access to their records; 60% of practices have 90%+ of patients with online access + records access enabled; over 80% of practices with 80%+
	• Partnership working to increase self-referrals in high volume services: Physio, IAPT, Podiatry etc.
	• Communications to support ICB and practice websites, media statements and patient comms re the Delivery Plan
	• Inclusion of newly qualified GPs in the ARR scheme from Oct 24, with 21 of 35 PCNs claimed by end of Jan-25. Workforce Leads engaging with PCNs to support further recruitment
	• Review of newly launched national CATS GP Performance Dashboard, noting initially negative variation identified in Access and Patient Experience for 21 practices, however this is reduced to 11 in the July data refresh. Further analysis planned through conversation with BI, monthly Access MDT and Risk and information sharing groups. The CATs tool will feed into local contract monitoring noting limitations of using bottom decile and take as a starting point for discussion with practices to understand if variation is unwarranted.
	• Planning for June submission of GP practice plans focussed on access and unwarranted variation. High level plan discussed at Primary Care Commissioning Committee and submission 30th June. Detailed practice level plans developed which will be reviewed via monthly MDT and though PCCC and the private session of Primary Care Transformation Committee. Feedback on this plan from National/Regional was very positive. Targeted plans for each practice showing negative variation on the CATS tool for access have been developed.
	• Advice and Guidance DES now live and active monitoring of activity in place.
	Other
	• All practices signed up to the Enhanced Commissioning Framework (ECF) for 25/26, active monitoring of new elements.
	• Trend analysis to identify practices with poor access via complaints and patient contacts
	• Initiatives for Primary Care Workforce to support recruitment and retention, supported by the HSE ICB Training Hub. New Workforce Dashboard developed.
	• Daily review of OPEL reporting by practices and follow up by place Primary Care Teams with individual practices
	• Pharmacy First now live, work with Community Pharmacy leads and practices to promote service
	• Approval of extension of Urgent Dental Access pilot to support Operating Plan submission to ensure delivery of our required additional dental appointments
	• Child Focused Dental pilot agreed

Appendix B: Statistical Process Control (SPC) Interpretation



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

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

Appendix C: Glossary of acronyms (1 of 2)

A&E	Accident & Emergency
AAU	Ambulatory Assessment Unit
ADHD	Attention Deficit Hyperactivity Disorder
AHC	Annual Health Check
ASD	Autism Spectrum Disorder
BAME	Black Asian & Minority Ethnic
BAU	Business As Usual
CAMHS	Children & Adolescent Mental Health Service
CCATT	Children Crisis Assessment & Treatment Team
CCC	Care Coordination Centre
CDC	Community Diagnostic Centre
CDU	Clinical Decision Unit
CHAWS	Child Health and Women's Service
CHC	Continuing Healthcare
CISS	Community Intensive Support Service
CLCH	Central London Community Healthcare NHS Trust
CPCS	Community Pharmacy Consultation Service
CQI	Continuous Quality Improvement
CQC	Care Quality Commission
CT	Computerised Tomography (scan)
CYP	Children & Young People
D2A	Discharge to Assess
DEXA	Dual Energy X-ray Absorptiometry (bone density scan)
DMAS	Digital Mutual Aid System
DQ	Data Quality
DST	Decision Support Tool
DTA	Decision To Admit
DTOC	Delayed Transfer of Care
DWP	Department for Work & Pensions
EAU	Emergency Assessment Unit
ECAT	Emergency Clinical Advice and Triage

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

Glossary of acronyms (2 of 2)

LA	Local Authority
LD	Learning Disability
LDAHC	Learning Disability Annual Health Checks
LMNS	Local Maternity Neonatal System
LMS	Local Maternity System
LoS	Length of Stay
MADE	Multi Agency Discharge Event
MDT	Multi Disciplinary Teams
MH	Mental Health
MHSOP	Mental Health Service for Older People
MOU	Memorandum Of Understanding
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal
NHSE	NHS England
NICE	The National Institute for Health & Care Excellence
NMCTR	Not Meeings Criteria To Reside
NOK	Next Of Kin
NOUS	Non-Obstrtric Ultrasound
OOAP	Out of Area Placements
OPEL	Operational Pressures Escalation Levels
OT	Occupational Therapy
PAH / PAHT	The Princess Alexandra Hospital NHS Trust
PCN	Primary Care Network
PEoLC	Palliative & End of Life Care
PIFU	Patient Initiated Follow-Up
PMO	Project Management Office

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

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Item 11 – Governance Update – Appendices

- Appendix A - Governance Framework:
  - Annex A - Memorandum of Understanding
  - Annex B - Data Sharing Agreement

- Appendix B – Board Assurance Framework

Annex A

Memorandum of Understanding

Between

1. NHS Hertfordshire and West Essex Integrated Care Board (ICB)
2. NHS Cambridge and Peterborough ICB
3. NHS Bedford, Luton and Milton Keynes ICB
4. NHS Mid and South Essex ICB
5. NHS Suffolk and North Essex ICB
6. NHS Norfolk and Waveney ICB

1. Purpose and Status of this Memorandum of Understanding (MoU)

1.1 Until 31 March 2026 the three ICBs with a geographical area in Essex, and three ICBs with a geographical area in the new cluster arrangement known as Central East will retain sole accountability for planning and commissioning healthcare services for the population within their ICB areas.

1.2 In support of the Model integrated Care Board Blueprint and Fit for the future: 10 Year Health Plan for England, this Memorandum of Understanding (MoU) sets out delivery and governance arrangements for system oversight covering a period prior to the following being dissolved and transitioned into new ICB entity structures:

a) Mid and South Essex ICB; and the Essex related areas for Suffolk & North East Essex and the Hertfordshire & West Essex ICBs will be disestablished on 31 March 2026 and a single ICB covering the totality of the Essex geography will be created.
b) Central East collaborative – formed of Bedford, Luton, Milton Keynes ICB, Cambridge and Peterborough ICB, and the Hertfordshire area of Hertfordshire and West Essex ICB will be disestablished on 31 March 2026 and a single ICB known as Central East ICB will be created.
c) For the purposes of this document, Norfolk and Waveney ICB – will encompass~~ing~~ the Suffolk area of Suffolk & North East Essex ICB.

1.3 While the Chair and senior appointment roles may be held across more than one ICB pending the new national ICB map, each ICB will retain its sovereign status until dissolution, and new ICBs are formed.

1.4 This Memorandum is not a legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Parties from this Memorandum.

However, it is a formal understanding between all of the Parties who have each entered into this Memorandum intending to honour all their obligations under it. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils. Instead, it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

1.5 Nothing in this Memorandum is intended to, or shall be deemed to, establish any partnership or joint venture between the Parties to the Memorandum, constitute a Partner as the agent of another, nor authorise any of the Parties to make or enter into any commitments for or on behalf of another Parties.

2. Scope of this MoU

2.1 Included within this document is the following on the understanding that flexibility will be sought as the ask and scope of ICBs settles, further the Parties acknowledge that the MoU and appended content will need to be reviewed and updated following the establishment of a new statutory Integrated Care Boards:

- Quality governance arrangements. *A shared commitment to quality* and monitoring and escalation of quality issues and concerns.
- The oversight mechanisms and structures that reflect delivery and governance arrangements.
- Healthcare data and analytics - this includes a Data Sharing Agreement (found at Appendix A) to support the sharing of intelligence in a compliant manner during a period of transition.
- Strategy – whilst maintaining day-to-day business as usual. This will be supported by a revised governance structure that works alongside providing effective assurance with agility, alongside recognising the interplay with system including Health Care Partnerships and Neighbourhood arrangements.
- Intelligent healthcare payer – having financial governance arrangements that will support the effective management of resources within the system financial envelope, that complement the evolving landscape incentivising quality improvement and innovation.
- User involvement and co-design –patients, service users, carers, and community groups in designing the future landscape and solutions.

3. Quality governance arrangements

There will be a shared commitment to quality and monitoring and the escalation of quality issues and concerns. This will include clear lines of responsibility regarding complaints management and Serious Incident Reporting. Assurance will be monitored through relevant identified committees in both clusters. These committees will be cited in HWE ICBs Scheme of Reservation and Delegation (SoRD).

4. The oversight mechanisms and structures that reflect delivery and governance arrangements

4.1 HWE ICB will through pre-transition, have a SoRD and Standing Financial Instructions (SFI's) that set out the arrangements for delegation of functions and assurance forming clear audit trails.

4.2 A transition structure will be established to oversee transition, and to ensure Where possible we operate Board and sub-Committees of the Board using the in-Common or Joint Committee models. 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.

4.3 Parties will adopt a safe but pragmatic approach to governance with the following core principles of:

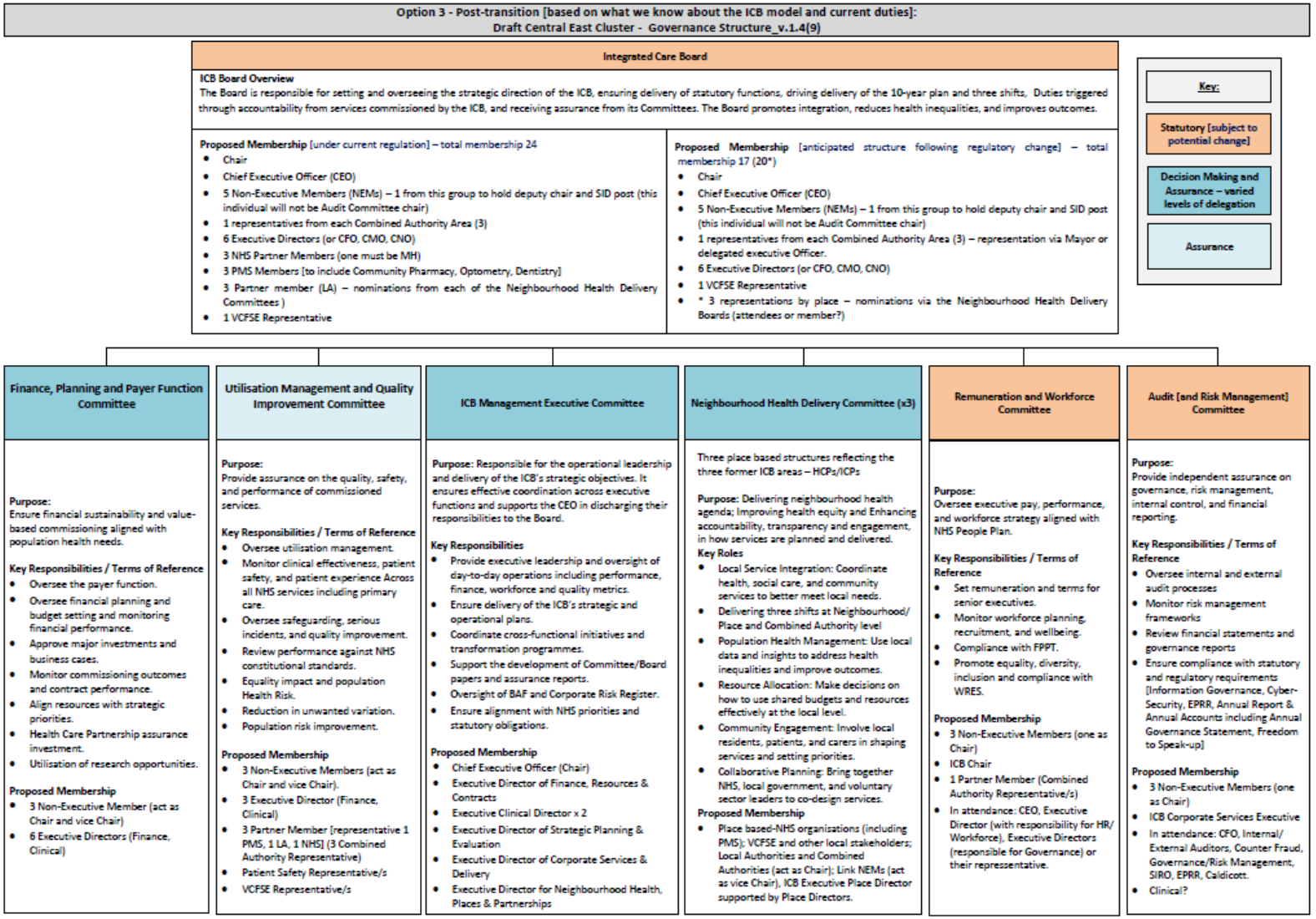
- Lean and Focused: Reducing duplication and bureaucracy, and language where possible being kept consistent e.g. the term
- Committee being used to denote a status of decision making or accountable assurance.
- Assurance-Oriented: Clear separation between assurance (Board Committees) and delivery (Management Executive).
- Inclusive: Representation from local authorities, providers, and communities.
- Aligned with SoRD: Decision-making thresholds and delegated authority clearly defined.

4.4 The governance framework for each of the referenced clusters is as follows:

- Essex collaboration:

  [add diagram]

- Central East cluster:



5. Healthcare data and analytics

In compliance with the ICB Model Blueprint and to support the safe and compliant sharing or publication of in particular - workforce information or potentially commercially sensitive data:

- Parties to this MoU will enable decisions to be guided by population health data and insights. This will be supported by a Data Sharing Agreement found at appendix A to this MoU and signed by signatories for an on behalf of each entity party.
- In respect of data sharing with system partners including Health Care Partnerships - parties agree to ensure the Data Sharing Agreement found at appendix A is shared with all employees, but with particular focus on teams likely to work with or relay particularly sensitive detail – these include HR, contract and procurement teams.

6. Strategy – whilst maintaining day-to-day business as usual

Parties to this MoU will develop effective strategy capability to foster a greater understanding of value-based healthcare alongside the ability to synthesise a range of information (qualitative and quantitative) and develop actionable insights to support prioritisation.

This work will be aided by the safe and compliant use of data as referenced in paragraph 5 above.

7. Intelligent healthcare payer

There will be a shared commitment to ensure the effective use of public resources so that investment decisions are guided by relative value, not just demand or precedent. This will require the deliberate use of tools such as programme budgeting and decommissioning frameworks to support allocative efficiency.

8. User involvement and co-design

The NHS is a service, funded by taxpayer money and accountable to the public. There will be a systematic approach to co-production – meaningfully involving patients, service users, carers, and community groups in designing solutions. Parties will continue working with the ICB Blueprint and supporting guidance in developing a systemic approach to co-production involving patients, services users, carers, and community groups in designing solutions.

9. Variations

This Memorandum, including the Schedules, may only be varied by written agreement of all the Partners

10. Confidentiality

In addition to the Data Sharing Agreement referenced in paragraph 5 and found in appendix A to this MoU - each Party shall keep in strict confidence all Confidential Information it receives from another Party in connection with the developing cluster arrangements and the terms of this MoU, except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner.

11. Jurisdiction

This MoU shall be governed by and construed in accordance with the laws of England and Wales.

12. Signatories

Chief Executive Officer:	For and on behalf of:	Date signed:
Name: Signature:	Hertfordshire and West Essex ICB	
Name: Signature:	Cambridge and Peterborough ICB	
Name: Signature:	Bedford, Luton and Milton Keynes ICB	
Name: Signature:	Mid and South Essex ICB	
Name: Signature:	South and North Essex ICB	

Name: Signature:	Norfolk and Waveney ICB	

APPENDIX A: Data Sharing Agreement

Annex B

DATA SHARING AGREEMENT

Issued under UK General Data Protection Regulation (UK GDPR)
and Data Protection Act 2018

BETWEEN

The Controller(s)
as set out below

(Collectively the 'Parties'.)

NHS Hertfordshire and Weste Essex Integrated Care Board
NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board
NHS Cambridgeshire and Peterborough Integrated Care Boards
NHS Mid and South Essex Integrated Care Board
NHS Suffolk, Norfolk and East Essex Integrated Care Board
NHS Norfolk and Waveney Integrated Care Board

In support of

The Processing (including sharing) of personal data in the operation of services within the health and care system as set out in in Part 1.

Part 1

Scope of agreement

Following publication of the Model integrated Care Board Blueprint and Fit for the future: 10 Year Health Plan for England, this Data Sharing Agreement (DSA) supports the development and operation of collaborative arrangements across the participating Integrated Care Board (ICB) organisations – pending transition into new ICB entities. These ICBs are likely to require the sharing of performance and/or workforce information – which may, at times, include commercially sensitive information or identifiable personal data where necessary to support effective service delivery and operational planning:

1. Mid and South Essex ICB; and the Essex related areas for Suffolk & North East Essex and the Hertfordshire & West Essex ICBs will be disestablished on 31 March 2026 and a single ICB covering the totality of the Essex geography will be created.
2. Central East collaborative – formed of Bedford, Luton, Milton Keynes ICB, Cambridge and Peterborough ICB, and the Hertfordshire area of Hertfordshire and West Essex ICB will be disestablished on 31 March 2026 and a single ICB known as Central East ICB will be created.
3. For the purposes of this document, Norfolk and Waveney ICB – will encompass~~ing~~ the Suffolk area of Suffolk & North East Essex ICB.

The lawful and proportionate sharing of such information will be undertaken in accordance with:

- The UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018;
- The common law duty of confidentiality; and
- Applicable NHS information governance policies, national guidance and terms held within the NHS Standard Contract.

Each ICB remains an independent Data Controller for the personal data it holds, this will continue until either they merge into a single legal entity or enter into a formal collaboration agreement underpinned by appropriate Data Processing Agreements. This will be the case where ICBs remain independent Data Controllers but share resources – such as staff and systems.

The signatories to this DSA agree to share relevant information where required, to enable joint working, service improvement, and the efficient use of shared resources within the collaborative arrangements.

This DSA has been developed to support a pre-transition collaborative arrangement. It is a live document that will be updated and amended as collaborative arrangements evolve and as further details on information flows and operational processes emerge.

All sharing and processing activities will be underpinned by the principles of data minimisation, necessity, proportionality, and security, with identifiable data used only where it is not possible to achieve the purpose through anonymised or pseudonymised information. Each party will ensure that their respective Privacy Policies, for both staff and patients, are updated to maintain transparency for data subjects.

The Definitions in Part 2 of the Agreement shall also apply to this Part 1.

In the event of any inconsistency between Part 1 and Part 2 of this Agreement, the provisions of this Part 1 shall prevail.

1. **Set out what this Agreement will cover.**

NHS plans involve changes to Integrated Care Board (ICB) footprints, including potential mergers and shifts in their strategic commissioning role. ICBs are also expected to play a key part in delivering net-zero targets and adopting digital technologies. These changes are part of a broader NHS effort to streamline operations, improve efficiency, and focus on strategic commissioning.[i]

[x] Controller to Controller data sharing
With the potential of:

[x] Joint Controller arrangement

Or

[x] Controller to Processor arrangement as and when it becomes applicable .

2. **Summary of how data will be used and shared.**

Under the collaborative arrangements, information may be shared between participating organisations to support implementation of the NHS workforce planning, service coordination, and operational delivery. For example, staff rotas and contact details may be shared to enable cross-cover arrangements between sites, and relevant patient information may be shared to facilitate safe and timely care when patients receive services from a neighbouring provider within the collaborative.

All such sharing will be proportionate, limited to what is necessary, and conducted in compliance with UK GDPR, the Data Protection Act 2018, and the common law duty of confidentiality.

3. **Data Protection Impact Assessment (DPIA)**

A DPIA to be approved by the 6 current ICBs will be written and maintained by the relevant IG leads and will sit as an appendix to this agreement

4. **Confirm the level of identifiability of the data for each party.**

Each party will confirm the level of identifiability of the data it will share or receive under this DSA, distinguishing between identifiable, pseudonymised, and anonymised data as appropriate for the specific purpose. This assessment will be based on the current operational requirements of the collaborative arrangements and in line with UK GDPR and common law obligations. As further information on data flows, purposes, and operational processes becomes available, this DSA will be updated accordingly to reflect any changes in the level or type of data shared.

5. **What are the purposes for using or sharing the data?**

The data shared under this DSA will be used solely to support the effective operation between the above ICBs, and as set out in the NHS England plans. This includes enabling workforce coordination, ensuring safe and timely patient care across organisational boundaries, supporting operational planning, monitoring service performance, and facilitating system interoperability.
Where possible, anonymised or pseudonymised data will be used. Identifiable data will only be shared where necessary to achieve these purposes and where it is not practicable to use de-identified data.

As transition arrangements develop and additional purposes are identified, this DSA will be updated to reflect any new or amended data uses.

6. What are the benefits of using or sharing the data?

The sharing and use of data under this DSA will deliver measurable benefits at multiple levels:

Benefits to Individuals (Staff and Patients):

- Ensures that patients receive safe, timely, and coordinated care, even when it is delivered by a neighbouring provider within the collaborative.
- Reduces delays in care by enabling faster access to relevant patient information and clinical histories.
- Improves continuity of care through better coordination between clinicians and services.
- Supports staff by enabling accurate workforce planning, minimising rota gaps, and facilitating access to necessary systems and resources.

Benefits to the Organisations:

- Improves operational efficiency through shared workforce resources and better alignment of staffing levels across sites.
- Supports compliance with statutory duties and NHS England requirements for integrated care delivery.
- Enables more accurate service planning and performance monitoring using combined data sets.
- Facilitates quicker decision-making based on shared, up-to-date information.

Benefits to the Wider Public and System:

- Contributes to more resilient health and care services across the collaborative area.
- Reduces duplication of effort and administrative burden, releasing resources back into frontline care.
- Enhances public confidence in the NHS by demonstrating joined-up working and effective use of resources.
- Supports population health management by enabling targeted interventions based on shared intelligence.

As collaborative arrangements develop, the specific benefits of data sharing will be kept under review and this DSA will be updated to reflect new evidence of impact.

7. For this agreement, which types of personal data do the Parties need to use and why?

[x]	Forename	[x]	Physical description, for example height	[x]	Photograph / picture of people
[x]	Surname	[x]	Phone number	[ ]	Location data e.g. • IP address • Other

[x]	Address	[x]	Email address	[x]	Audio recordings
[x]	Postcode full	[x]	GP details	[x]	Video recordings
[x]	Postcode partial	[x]	Legal representative name (personal representative)	[ ]	Other
[x]	Date of birth	[x]	NHS number (pseudonymised)	[ ]	None
[x]	Age	[x]	National insurance number		
[x]	Gender	[x]	Other numerical identifier e.g. hospital number where appropriate.		

8. Which types of sensitive (including special category) data do the Parties need to use or share?

[[x] inserted for areas that apply]

Type of data		**Reason why this is needed (leave blank if not applicable)**
[x]	Information relating to an individual's physical or mental health or condition, for example information from health and care records	The data shared under this DSA will be used solely to support the effective operation of the collaborative arrangements, as set out in the NHS England plans. This includes enabling workforce coordination, ensuring safe and timely patient care across organisational boundaries, supporting operational planning, monitoring service performance, and facilitating system interoperability. Where possible, anonymised or pseudonymised data will be used. Identifiable data will only be shared where necessary to achieve these purposes and where it is not practicable to use de-identified data.
[ ]	Biometric information in order to uniquely identify an individual, for example facial recognition	
[ ]	Genetic data, for example details about a DNA sample taken as part of a genetic clinical service	
[x]	Information relating to an individual's sexual life or sexual orientation	As above
[x]	Racial or ethnic origin	As above
[ ]	Political opinions	

[x]	Religious or philosophical beliefs	As above
[x]	Trade union membership	As above
[x]	Information relating to criminal or suspected criminal offences	As above
[ ]	None of the above	

9. Who are the individuals that can be identified from the data?

[[x] inserted for areas that apply]

[x] Patients or service users
[x] Carers
[x] Staff
[x] Wider workforce
[ ] Visitors
[x] Members of the public
[ ] Other

10. Describe the flows of data.

An appendix of data flows is attached to this agreement.

11. Under Article 6 of UK General Data Protection Regulation (UK GDPR), what is the lawful basis for processing personal data?

[x] (e) **We need it to perform a public task**

[ ] **Other**

12. Under Article 9 of UK General Data Protection Regulation (UK GDPR), what is the lawful basis for processing special category data?

[x] (h) **We need it to comply with our legal obligations to provide or manage health or social care services**

[ ] **Other**

[ ] **Not applicable**

13. What is the legal basis for sharing or using health and care data under the common law duty of confidentiality?

[x] **Implied consent** - for individual care or local clinical or care audits.

[ ] **Explicit consent**

[x] **Section 251 support** - all organisations currently have s.251 support, this will be amended to the new legal entities when applicable**.**

[ ] **Legal requirement**

[ ] **Overriding public interest**

[ ] **Not applicable**

14. How will the Parties ensure that information is safe and secure?

[ ] Encryption
[ ] Password protection
[x] Role based access controls (RBAC)
[ ] Restricted physical access
[ ] Business continuity plans
[ ] Security policies
[ ] Other

15. For this Agreement, how long are the Parties planning to use the data for?

We intend to start using the data on 1st September 2025 and will finish using the data when new entities are formed (current expect to be from 1st April 2026.

16. For this Agreement, how long do the Parties intend to keep the data?

In line with the Records Management Code of Practice.

17. What will happen to the data at the end of this Agreement?

[ ] Secure destruction (for example by shredding paper records or wiping hard drives with evidence of a certificate of destruction)
[ ] Permanent preservation by transferring the data to a Place of Deposit run by the National Archives
[ ] Transfer to another organisation
[ ] Extension to retention period
[ ] It will be anonymised and kept
[x] The Controller(s) will manage as it is held by them
[ ] Other

18. How will the Parties comply with the following data subject rights (where they apply)?

Individual right	**How the Parties will comply (or state *not applicable* if the right does not apply)**

The right to be informed The right to be informed about the collection and use of personal data.		We have assessed how we should inform individuals about the use of data. We consider the communications methods below meet this obligation.
	[x]	Privacy notice(s) for all relevant organisations.
	[ ]	Information leaflets
	[ ]	Posters
	[ ]	Letters
	[ ]	Emails
	[ ]	Texts
	[x]	Social media campaign
	[ ]	DPIA published (best practice rather than requirement)
	[ ]	Other
	[ ]	Not applicable
The right of access The right to access details of data use and receive a copy of their personal information - this is commonly referred to as a subject access request.	Subject Access requests (SARs) will be managed under current SAR policies for each of the current ICBs until such time as the new legal entities are formed at which point agreements over processes for open SARs to be managed will come into force in the new ICBs	
The right to rectification The right to have inaccurate personal data rectified or completed if it is incomplete.	Managed under current ICB policies until such time as the new legal entities are formed.	
The right to erasure The right to limit how their data is used, if applicable.	Not applicable.	
The right to restrict processing The right to limit how their data is used, if applicable.	Not applicable.	
The right to data portability The right to obtain and re-use their personal data, if applicable.	Not applicable.	
The right to object The right to object to the use and sharing of personal data, if applicable.	Not applicable.	

19. Will the national data opt-out need to be applied? Which organisation is responsible for managing this process?

Current arrangement for national data opt out will continue to apply where applicable.

20. List the organisation(s) that will decide why and how the data is being used and shared (Controllers).

The ICBs listed as Controllers in this agreement will be making the decisions, for example:

- To collect the data in the first place
- What data is being collected
- What it is being used for
- Who it is being collected from

The organisations are likely to have a direct relationship with those the data is being collected from, for example patients, service users or employees.

21. List the organisation(s) that are being instructed to use or share the data (Processors).

See appendix on data flows under this agreement that will specify where data processors are being used.

22. List any organisations that have been subcontracted by your Processor to handle data (Sub-Processors).

23. How will the Parties ensure data accuracy and that updates to the data are communicated where necessary?

As per current ICB policies and procedures

24. Describe how data breaches will be managed.

As per current ICB policies and procedures

25. Set out any terms agreed by the Parties regarding liability.

26. If applicable, provide details of any agreed variation of terms from Part 2 of this agreement.

This will be as agreed between the parties.

27. Set out the mechanism for issuing a variation to this agreement.

This will be as agreed between the parties.

28. Detail any processing that has not been captured above.

Not applicable.

29. Set out the review period for this agreement.

This agreement will be kept under continued review through the referenced period of transition.

30. Reviewers

This Agreement has been reviewed by:

Name	**Role**	**Organisation**
Tania Palmariellodiviney	Interim Data Protection Officer	HWE ICB
Jane Marley	Head of IG & DPO	MSE ICB
Paul Cook	Associate Director of Data Security, Risk and Protection and DPO.	SNEE ICB
Martin Whelan	Head of Governance and Data Protection Officer	C&P ICB

[Add additional approval sections as required locally.]

31. Signatories

Authorised signatory on behalf of the Controller

Name	Role	Organisation	Signature	Date

Authorised signatory on behalf of the Processor

[Add additional lines for multiple Processors. Electronic signatures or clicking 'Accept' through data sharing management portals are acceptable.]

Name	Role	Organisation	Signature	Date

Part 1

Annex 1 – List of Controllers and Processors and their named points of contact

[add additional lines where necessary]

Name	Role	Organisation	Contact

Part 2

1. **BACKGROUND AND SCOPE**

1.1. This Part 2 of this Agreement sets out the general terms and conditions relating to inter-Party Data Processing Activities which the Parties agree to meet.

1.2. Part 1 of the Agreement sets out the specific details of what each Party has agreed to in respect of any intended inter-Party Processing of Personal Data.

1.3. The Parties agree that no Party will access or otherwise Process Personal Data that solely relates to any other Party's individual Processing purpose, which is outside of the scope of the Processing set out in Part 1 of the Agreement.

1.4. To the extent that any other agreement between the Parties in relation to these Data Processing activities contains any provisions which govern the Processing of Personal Data by the Parties, the Parties agree and acknowledge that the provisions of this Agreement shall prevail in the event of any conflict or inconsistency.

1.5. Data Protection Legislation requires that "[w]here two or more controllers jointly determine the purposes and the means of Processing they shall be joint controllers." It also requires that Joint Controllers determine their respective responsibilities for compliance "…in a transparent manner…by means of an arrangement between them…" This Agreement meets the requirement of having an arrangement. All Parties shall meet the additional transparency requirements under clause 13.

IT IS AGREED as follows:

2. **DEFINITIONS AND INTERPRETATION**

2.1. The following definitions shall apply in this Agreement:

Commencement Date means between any two Parties or more the date from which the last of those Parties have signed this Agreement in respect of any Data Processing Activities (or such other date as those Parties may agree);

Controller means a natural or legal person, public authority, agency or other body which, alone or jointly with others, determines the purposes and means of the Processing of Personal Data;

Data Guidance means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with the Data Protection Legislation (whether specifically mentioned in this Agreement or not) to the extent published and publicly available or their existence or contents have been notified to the Parties by NHS England and/or any relevant Regulatory, Advisory or Supervisory Body. This includes but is not limited to guidance issued by the National Data Guardian for Health and Care, the Department of Health and Social Care, NHS England, the Health Research Authority, Public Health England (now the UK Health Security Agency) and the Information Commissioner;

Data Loss Event means any event that results, or may result, in unauthorised Processing of Personal Data held by the Parties under this Agreement or the loss of Personal Data that the Parties have responsibility for under this Agreement including without limitation actual or potential loss, destruction, corruption or inaccessibility of Personal Data, including any Personal Data Breach;

Data Processing Activities means the data Processing activities described in Part 1 of this Agreement;

Data Protection Impact Assessment (DPIA) means an assessment by the Controller(s) of the impact of the envisaged Processing on the protection of Personal Data;

Data Protection Legislation means UK Data Protection legislation currently comprising (i) the DPA 2018 (ii) the UK GDPR, the Law Enforcement Directive and any applicable national Laws implementing them as amended from time to time (iii) all applicable Law concerning privacy, confidentiality or the Processing of personal data including but not limited to the Human Rights Act 1998, the Common Law Duty of Confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003;

Data Protection Officer (DPO) shall be the individual designated as such by Controllers and Processors where required by the Data Protection Legislation;

Data Subject means an identified or identifiable natural person whose Personal Data is being Processed;

DPA 2018 means the Data Protection Act 2018;

EU means the European Union;

Information Commissioner means the Information Commissioner's Office (ICO) which is the independent authority established to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals and any other relevant data protection or supervisory authority recognised pursuant to the Data Protection Legislation;

International Data Transfer Agreement (IDTA) means the documents approved for the restricted transfer of Personal Data to countries not covered by UK adequacy regulations. The documents can be found on the Information Commissioner's website;

Joint Controller means where two or more Controllers jointly determine the purposes and means of Processing;

Law means any law or subordinate legislation within the meaning of Section 21(1) of the Interpretation Act 1978, by-law, enforceable right within the meaning of Section 2 of the European Communities Act 1972, regulation, order, regulatory policy, mandatory guidance or code of practice, judgement of a relevant court of law, or directives or requirements with which the Parties are bound to comply;

LED means the Law Enforcement Directive (Directive (EU) 2016/680);

Party or Parties shall mean any and all signatories to this agreement, including Controllers and Processors and signatories acting as Sub-Processors;

Personal Data means any information relating to an identified or identifiable natural person. An identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person;

Personal Data Breach shall take the meaning given in the Data Protection Legislation, and shall also include events that would have been regarded as Personal Data Breach but which relate to information about deceased individuals where a duty of confidentiality is still owed;

Processor means a natural or legal person, public authority, agency or other body which Processes personal data on behalf of a Controller or (where a Party to this Agreement this shall include Processors acting as Sub-Processors, provided that the relevant Processing is described Part 1 of this Agreement). A Controller may instruct a Processor who is not a Party to this Agreement, provided such contractual provisions as are required by the Data Protection Legislation are in place with such a Processor;

Processing and cognate terms mean any operation or set of operations which is performed on personal data or on sets of personal data, whether or not by automated means, such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure or destruction;

Protective Measures means appropriate technical and organisational measures which may include: pseudonymisation and encrypting Personal Data; ensuring confidentiality, integrity, availability and resilience of systems and services; ensuring that availability of and access to Personal Data can be restored in a timely manner after an incident; and regularly assessing and evaluating the effectiveness of such measures;

Regulatory or Supervisory Body means any statutory or other body having authority to issue guidance, standards or recommendations with which the Parties and/or their staff must comply or have regard to, including:

(i) The Care Quality Commission (CQC);
(ii) NHS England;
(iii) the Department of Health and Social Care;
(iv) the National Institute for Health and Care Excellence;
(v) Healthwatch England and Local Healthwatch;
(vi) UK Health Security Agency;
(vi) The General Medical Council
(vii) The General Dental Council
(viii) The Nursing and Midwifery Council
(ix) the General Pharmaceutical Council;
(x) the Healthcare Safety Investigation Branch; or
(xi) the Information Commissioner.

Respective Responsibilities means for each Controller who is a Joint Controller the responsibilities which must, in a transparent manner, be determined for compliance with the Data Protection Legislation

Responsible Controller means (i) in the event of a Personal Data Breach by a Processor, the Controller who instructed that Processor (ii) in the event of a Personal Data Breach by a Controller, that Controller (iii) where Joint Controllers have designated one party as the Responsible Controller in relation to the relevant Personal Data Breach under the Agreement, that designated Controller, (iv) where there is no agreement then each of the Joint Controllers shall be a Responsible Controller;

Staff means any and all persons employed or engaged from time to time in the provision of the Data Processing Activities whether employees, workers, consultants or agents of any Party or any subcontractor or agent of any Party;

Subject Rights Request means a request made by, or on behalf of, a Data Subject in accordance with rights granted pursuant to the Data Protection Legislation including to access their Personal Data (including a "subject access request");

Sub-Processor means any organisation appointed by a Processor to Process Personal Data on behalf of a Processor;

UK GDPR has the meaning given to it in section 3(10) (as supplemented by section 205(4)) of the Data Protection Act 2018; and

Working Day means a day other than a Saturday, Sunday, or public or bank holiday in England.

2.2. The following rules of interpretation shall apply to this Agreement:
reference to any legislative provision shall be deemed to include any statutory instrument, by-law, regulation, rule, subordinate or delegated legislation or order and any rules and regulations which are made under it, and any subsequent re-enactment, amendment or replacement of the same;
2.2.1. words in the singular shall include the plural and in the plural shall include the singular; and
2.2.2. references to clauses and Annexes are to clauses and Annexes to this Agreement.

3. DURATION AND CONSIDERATION

3.1. This Agreement shall commence on the Commencement Date and shall continue until termination or expiry for whatever reason.

3.2. This Agreement is entered into in consideration of the mutual trust, convenience and benefit of all the Parties and in consideration of the benefits to the health and care system.

4. GENERAL OBLIGATIONS

4.1. A Controller remains legally responsible for the Personal Data where it is being Processed by a Processor and therefore the Controller must take steps to ensure the information assets remain protected and that the liabilities and risk are

appropriately managed, Personal Data is Processed lawfully, and the Agreement is legally enforceable.

4.2. A Processor is nevertheless also legally responsible for the Personal Data to the extent required under Data Protection Legislation and in any relevant Personal Data Processing contract.

4.3. Each Party shall ensure that it has in place Protective Measures in relation to the Personal Data Processed under this Agreement, which are appropriate to protect against a Data Loss Event having taken account of the:

4.3.1. nature of the Personal Data to be protected;

4.3.2. harm that might result from a Data Loss Event;

4.3.3. state of technological development; and

4.3.4. cost of implementing any measures;

Processors who are Party to this Agreement are subject to additional requirements under clause 6.7.2. Where a Controller instructs a Processor who will Process Personal Data in relation to this Agreement and such Processor is not a Party to this Agreement, the instructing Controller shall ensure that contractual provisions complying with the Data Protection Legislation are in place with such Processor.

4.4. Each Party shall ensure that its staff involved in the Processing of Data under this Agreement have undergone adequate training in the use, care, protection and handling of Personal Data that enables them and the Processor to comply with their responsibilities under the Data Protection Legislation and this Agreement. Processors are subject to additional requirements under clause 6.7.3.

4.5. All Parties shall in good faith cooperate fully during any handover arising from the cessation of any part of the Data Processing Activities. Processors are subject to additional requirements under clause 6.7.7.

4.6. All Parties shall be under a duty to notify any potentially impacted Parties where they become aware of or reasonably suspect a Data Loss Event; or become aware of or reasonably suspect that it has in any way caused, or might reasonably be considered to be likely to cause, a breach of Data Protection Legislation by another Party. Processors are subject to additional requirements under clause 6.8.

5. CONTROLLER OBLIGATIONS

5.1. Each Controller shall at all times ensure Personal Data is Processed fairly, lawfully and transparently in accordance with Data Protection Legislation.

5.2. Each Controller warrants that any instructions it issues to a Processor in respect of the Personal Data are lawful.

6. ADDITIONAL ALL PARTY AND PROCESSOR SPECIFIC OBLIGATIONS

6.1. The following obligations within this clause 6 shall apply where at least one Processor has been identified in Part 1 of this Agreement. Where the Processor is not a Party to this Agreement, the Controllers who instruct them must ensure that

any contracts with such Processors provide equivalent protection to the clauses set out in clause 6 of this Agreement. Where indicated, the obligations shall apply to any Party to this Agreement not just Processors.

6.2. The Parties acknowledge that for the purposes of the Data Protection Legislation in relation to the Data Processing Activities, the Controller(s) and the Processor(s) are as set out in Part 1 of this Agreement. A Processor must Process the Processor Data only to the extent necessary to perform the Data Processing Activities and only in accordance with the written instructions set out in Part 1 of this Agreement.

6.3. A Processor must use the Personal Data shared solely for the purposes as instructed and shall not Process the Personal Data for any other purposes.

6.4. Each Party agrees to treat the data (including Personal Data) received by them under the terms of this Agreement as confidential and shall safeguard it accordingly.

6.5. All Parties must provide all reasonable assistance to one another and in particular to any Controller in the preparation of any Data Protection Impact Assessment prior to commencing any Processing under this Agreement. Such assistance may include:

6.5.1. a systematic description of the envisaged Processing operations and the purpose of the Processing;

6.5.2. an assessment of the necessity and proportionality of the Processing operations in relation to the Data Processing Activities;

6.5.3. an assessment of the risks to the rights and freedoms of Data Subjects; and

6.5.4. the measures envisaged to address the risks, including safeguards, security measures and mechanisms to ensure the protection of Personal Data.

6.6. Any Party requested, but in particular any Processor who is a Party to this Agreement, shall provide all reasonable assistance to a Controller if the outcome of the Data Protection Impact Assessment leads the Controller to consult the Information Commissioner concerning any proposed arrangements.

6.7. A Processor must (and must be required in any contractual documentation where such Processor is not a Party to this Agreement), in relation to any Personal Data Processed in connection with its obligations under this Agreement:

6.7.1. Process that Personal Data only in accordance with the documented instructions of a Controller, unless the Processor is required to do otherwise by Law. If it is so required, the Processor must promptly notify the Controller before Processing the Personal Data unless such notification is prohibited by Law;

6.7.2. Ensure that it has in place Protective Measures, which have been reviewed and approved by the Controller as appropriate to protect against a Data Loss Event having taken account of the:

6.7.2.1. nature of the Personal Data to be protected;
6.7.2.2. harm that might result from a Data Loss Event;

6.7.2.3. state of technological development; and

6.7.2.4. cost of implementing any measures;

6.7.3. ensure:

6.7.3.1. when delivering the Data Processing Activities, the Processor Staff only Process Personal Data in accordance with this Agreement;

6.7.3.2. it takes all reasonable steps to ensure the reliability and integrity of any Processor Staff who have access to the Personal Data and ensure that they:

6.7.3.2.1. Are aware of and comply with the Processor's duties under this clause;

6.7.3.2.2. Are subject to appropriate confidentiality undertakings with the Processor and any Sub-Processor that are in writing and are legally enforceable;

6.7.3.2.3. Are informed of the confidential nature of the Personal Data and do not publish, disclose or divulge any of the Personal Data to any third Party unless directed in writing to do so by the Controller or as otherwise permitted by this Agreement; and

6.7.3.2.4. Have undergone adequate training in the use, care, protection and handling of Personal Data that enables them and the Processor to comply with their responsibilities under the Data Protection Legislation and this Agreement. The Processor shall provide the Controller with evidence of completion and maintenance of that training within three Working Days of request by the Controller.

6.7.4. At the written direction of the Controller, delete or return Personal Data (and any copies of it) to that Controller on termination of the Data Processing Activities and certify to the Controller that it has done so within five Working Days of any such instructions being issued, unless the Processor is required by Law to retain the Personal Data;

6.7.5. If the Processor is required by any Law or Regulatory or Supervisory Body to retain any Processor Data that it would otherwise be required to destroy under this clause 6, notify the Controller in writing of that retention giving details of the Processor Data that it must retain and the reasons for its retention;

6.7.6. Notify the Controller immediately if it considers that carrying out any of the Controller's instructions would infringe Data Protection Legislation. This obligation extends to breaches concerning the systems on which the data shared under this Agreement are held, even if the data shared under this Agreement is not directly affected;

6.7.7. Cooperate fully with the Controller during any handover arising from the cessation of any part of the Data Processing Activities, and if the Controller directs the Processor to migrate Processor Data to the

Controller or to another nominated organisation, provide all reasonable assistance with ensuring safe migration including ensuring the integrity of Personal Data and the nomination of a named point of contact for the Controller (as set out in Annex 1 of Part 1 of this Agreement).

6.8. Subject to clause 6.10, a Processor must notify the relevant Controller immediately if it:

6.8.1. Receives a Subject Rights Request (or purported Subject Rights Request);

6.8.2. Receives a request to rectify, block or erase any Personal Data;

6.8.3. Receives any other request, complaint or communication relating to obligations under Data Protection Legislation owed by the Processor or Controller;

6.8.4. Receives any communication from the Information Commissioner or any other Regulatory or Supervisory Body (including any communication concerned with the systems on which Personal Data is Processed under this Agreement);

6.8.5. Receives a request from any third Party for disclosure of Personal Data where compliance with such request is required or purported to be required by Law;

6.8.6. Becomes aware of or reasonably suspects a Data Loss Event; or

6.8.7. Becomes aware of or reasonably suspects that it has in any way caused the Controller to breach Data Protection Legislation.

6.9. The notification under clause 6.8 shall be given by emailing any relevant request and any subsequent communications to the Controller's Data Protection Officer immediately, and in no longer than one Working Day of receipt by the Processor.

6.10. A Processor shall not respond substantively to the communications listed at clause 6.8 save that it may respond to a Regulatory or Supervisory Body following prior consultation with the Controller.

6.11. A Processor's obligation to notify under clause 6.8 includes the provision of further information to the Controller in phases, as details become available.

6.12. A Processor must provide their instructing Controller with all reasonable assistance in relation to either Party's obligations under the Data Protection Legislation and any complaint, communication or request made under clause 6.8 (and insofar as possible within the timescales reasonably required by the Controller) including by promptly providing:

6.12.1. The Controller with full details and copies of the complaint, communication or request;

6.12.2. The Controller with any Personal Data it holds in relation to a Data Subject;

6.12.3. Such assistance as is reasonably requested by the Controller to enable the Controller to comply with a Subject Rights Request within the relevant timescales set out in the Data Protection Legislation;

6.12.4. Such assistance as is reasonably requested by the Controller to enable the Controller to comply with other rights granted to individuals by the Data Protection Legislation including the right of rectification, the right to erasure, the right to object to Processing, the right to restrict Processing, the right to data portability and the right not to be subject to an automated individual decision (including profiling);

6.12.5. Assistance as requested by the Controller following any Personal Data Loss Event;

6.12.6. Assistance as requested by the Controller in relation to informing a Data Subject about any Data Loss Event, including communication with the Data Subject;

6.12.7. Assistance as requested by the Controller with respect to any request from the Information Commissioner, or any consultation by the Controller with the Information Commissioner.

6.12.8. A Processor shall designate a Data Protection Officer if required by the Data Protection Legislation, and shall communicate to the Controller the name and contact details of any Data Protection Officer.

6.13. A Processor must allow for reasonable audits of its delivery of the Data Processing Activities by the Controller or the Controller's designated auditor at no additional cost to the Controller.

6.14. For the avoidance of doubt:

6.14.1. A Processor must not novate this Agreement nor assign, delegate, subcontract, transfer, charge or otherwise dispose of all or any of its rights or obligations or duties under this Agreement without the prior written approval of the instructing Controller. The approval of any sub-processing or subcontracting arrangement may include approval of the terms of the proposed subcontract;

6.14.2. Subcontracting any part of this Agreement will not relieve a Processor of any of its obligations or duties under this Agreement. A Processor will be responsible for the performance of and will be liable to the Controller for the acts and/or omissions of all Sub-Processors as though they were their own;

6.14.3. Any positive obligation or duty on the part of the Processor under this Agreement includes an obligation or duty to ensure that all subcontractors and Sub-Processors comply with that positive obligation or duty. Any negative duty or obligation on the part of the Processor under this Agreement includes an obligation or duty to ensure that all subcontractors and Sub-Processors comply with that negative obligation or duty.

6.15. Without prejudice to clause 6.16, before allowing any Sub-Processor to Process any Personal Data related to this Agreement, a Processor must:

6.15.1. Notify the relevant Controller in writing of the intended Sub-Processor and Processing;

6.15.2. Obtain the written consent of the relevant Controller;

6.15.3. Carry out appropriate due diligence of the Sub-Processor and ensure this is documented;

6.15.4. Enter into a binding written agreement with the Sub-Processor which includes equivalent terms to those set out in this Agreement; and

6.15.5. Provide the relevant Controller with such information regarding the Sub-Processor as the Controller may reasonably require.

6.16. The Parties agree to take account of any guidance issued by the Information Commissioner. A Controller may (or where there is more than one Controller they may by agreement) on not less than 30 Working Days' notice to the Processor amend this Agreement to ensure that it complies with any guidance issued by the Information Commissioner.

6.17. A Controller may (or where there is more than one Controller they may by agreement), at any time on not less than 30 Working Days' notice, revise this Agreement by adding to it any applicable Controller to Processor standard clauses or similar terms forming part of an applicable certification scheme (which shall apply when incorporated by attachment to this Agreement).

6.18. A Processor shall maintain complete and accurate records and information to demonstrate its compliance with this Agreement, the Data Protection Legislation and Data Guidance. A Processor must create and maintain a record of all categories of data Processing activities carried out under this Agreement, which must be made available to the instructing Controller within two Working Days of a written request, containing:

6.18.1. The categories of Processing carried out under this Agreement;

6.18.2. Details of categories of Data Subjects;

6.18.3. Where applicable, transfers of Personal Data to a third country or an international organisation, including the identification of that third country or international organisation and, where relevant, the documentation of suitable safeguards;

6.18.4. A general description of the Protective Measures taken to ensure the security and integrity of the Personal Data Processed under this Agreement; and

6.18.5. A log recording the Processing of Personal Data in connection with this Agreement comprising, as a minimum, details of the Personal Data concerned, how the Personal Data was Processed, where the Personal Data was Processed and the identity of any individual carrying out the Processing.

6.19. A Processor warrants and undertakes that it will deliver the Data Processing Activities in accordance with the Data Protection Legislation and this Agreement

and in particular that it has in place Protective Measures that are sufficient to ensure that the delivery of the Data Processing Activities complies with the Data Protection Legislation and ensures that the rights of Data Subjects are protected.

6.20. A Processor must assist the Controller in ensuring compliance with the obligations set out at Article 32 to 36 of the UK GDPR and equivalent provisions implemented into Law, taking into account the nature of Processing and the information available to the Processor.

6.21. A Processor must assist the Controller in ensuring compliance with the obligations set out in Articles 32 to 36 of the UK GDPR (security of Processing, obligations with regards to Personal Data Breaches and conducting Data Protection Impact Assessments) and equivalent provisions implemented into Law, taking into account the nature of Processing and the information available to the Processor.

6.22. A Processor must take prompt and proper remedial action regarding any Data Loss Event.

6.23. A Processor must assist the Controller by taking appropriate technical and organisational measures, insofar as this is possible, for the fulfilment of the Controllers' obligation to respond to requests for exercising rights granted to individuals by Data Protection Legislation.

6.24. A Processor must promptly (and in any event within a maximum of four (4) Working Days) comply with any request of the Controller or the Information Commissioner to provide a copy of any or all Personal Data which is under the Processor's custody or control, in the format and on a media reasonably specified by the Controller or the Information Commissioner.

6.25. A Processor must not transfer Personal Data outside the UK except to countries covered by adequacy regulations, unless the prior written consent of their instructing Controller has been obtained and the following conditions are fulfilled:

6.25.1. Appropriate safeguards in relation to the transfer are in place as determined by the instructing Controller;

6.25.2. The Data Subject has enforceable rights and effective legal remedies;

6.25.3. The Party transferring the data complies with its obligations under Data Protection Legislation by providing an adequate level of protection to any Personal Data that is transferred (or, if it is not so bound, uses its best endeavours to assist the relevant Controller in meeting its obligations); and

6.25.4. The Processor, where one has been appointed, complies with any reasonable instructions notified to it in advance by the relevant Controller with respect to the Processing of the Personal Data.

7. PERSONAL DATA BREACHES

7.1. A Responsible Controller will notify the other Controllers who are Parties to this Agreement of a Data Breach if, acting reasonably, they consider that the interests of those Controllers may be affected by any Personal Data Breach for which it is the Responsible Controller. In the case of Joint Controllers, each of

the Joint Controllers shall notify the other Joint Controllers of any Personal Data Breach of which it becomes aware.

7.2. A Responsible Controller will determine whether to notify Personal Data Breaches to the Information Commissioner.

7.3. A Responsible Controller will determine whether and how to notify Personal Data Breaches to the Data Subjects.

7.4. The Responsible Controller will monitor Personal Data Breach responses to ensure compliance with statutory timescale and any other requirements arising by Law or under this Agreement.

8. DATA SECURITY ARRANGEMENTS

8.1. All Parties shall:

8.1.1. Have in place appropriate technical and organisational security measures designed to protect Personal Data against accidental events or unlawful or malicious actions that compromise the availability, integrity and confidentiality of the Personal Data, and ensure that such measures are appropriate to the harm which might result from any unauthorised or unlawful Processing, accidental loss, destruction or damage to the Personal Data and have regard to the nature of the Personal Data which is to be protected;

8.1.2. Ensure that all Personal Data Processed by any Party and its staff are subject to the technical and organisational security measures the Party implements and maintains, pursuant to clause 8.1.1 above;

8.1.3. Have procedures in place to monitor access to the Personal Data and to identify unauthorised and unlawful access and use of Personal Data;

8.1.4. Where health and care data is accessed by a Party, that Party must complete and publish an annual information governance assessment in accordance with, and comply with the mandatory requirements of, the NHS Data Security and Protection Toolkit, as applicable to the Data Processing Activities and the Party's organisation type. Where health and care data is not accessed, any Party accessing other Personal Data must maintain annual governance assessments to any agreed equivalent standard; and

8.2. A Processor shall:

8.2.1. Immediately report any untoward incidents, near misses or activities that suggest non-compliance with this Agreement to the Controller and cooperate with the Controller to carry out a risk assessment, root cause analysis and identify any corrective action required. A Processor will cooperate with the Controller in implementing any required corrective action agreed between the Parties. (N.B. It is the Controller's responsibility to ensure that any incidents are reported in accordance with the Department of Health and Social Care policy and procedures and for informing the relevant Data Subjects as appropriate.)

9. LIABILITY

9.1. The Parties shall not do or omit to do anything that will put any other Party in breach of the Data Protection Legislation or the Data Guidance.

9.2. The rights and remedies provided under Part 1 of this Agreement are in addition to, and not exclusive of, any rights or remedies provided by Law or in equity.

9.3. A waiver of any right or remedy under Part 1 of this Agreement or by Law or in equity is only effective if given in writing and signed on behalf of the Party giving it and any such waiver so given shall not be deemed a waiver of any similar or subsequent breach or default.

9.4. A failure or delay by a Party in exercising any right or remedy provided under Part 1 of this Agreement or by Law or in equity shall not constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict any further exercise of that or any other right or remedy. No single or partial exercise of any right or remedy provided under this Agreement or by Law or in equity shall prevent or restrict the further exercise of that or any other right or remedy.

10. VARIATION OF AGREEMENT

10.1. Any proposed changes to this Agreement, including the addition or removal of parties, the purposes of the information sharing, the nature or type of information shared or manner in which the information is to be Processed must be notified promptly to the Information Compliance/Governance leads so that the impact of the proposed changes can be assessed.

10.2. No variation of this Agreement shall be effective unless it is in writing and signed by all Parties to this Agreement.

11. FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

11.1. Where a Controller is a public authority, the Parties acknowledge that such a Controller is subject to the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR).

11.2. A Controller as set out in clause 11.1 will be statutorily required, subject to any applicable exemptions, to disclose information about the Data Processing Activities provided under this Agreement or the Agreement itself in response to a specific request under FOIA or EIR. In which case:

11.2.1. A Processor shall provide its instructing Controller with all reasonable assistance and co-operation to enable the Controller to comply with its obligations under FOIA or EIR; and

11.2.2. A Controller as set out in clause 11.1 Controller shall consult any Party it reasonably considers relevant or who may have a legitimate interest in respect of any commercial, confidential or other issues in relation to the Agreement relevant to the issue of whether the information is exempt from disclosure or not; however the final decision about disclosure of information or application of exemptions shall rest solely with the Controller which has received the request.

12. GENERAL

12.1. A Processor, where appointed, shall not assign, transfer, mortgage, charge, subcontract, declare a trust over or deal in any other manner with any or all of its rights and obligations under this Agreement without the prior written consent of their instructing Controller.

12.2. This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

12.3. It is an offence under the Data Protection Legislation for any Party to knowingly or recklessly re-identify any data that is de-identified without the consent of the Controller that has provided the information.

13. TRANSPARENCY

13.1. All Parties agree that the Controllers shall:

13.1.1. Ensure publication of a summary of the Data Processing Activities, provided in a concise, transparent, intelligible and easily accessible form;

13.1.2. Ensure Data Subjects are appropriately instructed on how they can exercise their rights under Data Protection Legislation, including where they must contact another Party; and

13.1.3. To reference other Parties' transparency materials published under 13.1.1.

14. DISPUTE RESOLUTION

14.1. Parties shall aim to resolve all disputes, differences and questions by means of cooperation and consultation.

14.2. If any dispute arises, the Parties in dispute must first attempt to settle it with a written offer of negotiation by any of the Parties to the other Parties. During the following 15 Business Days Period each of the Parties in dispute must negotiate and be represented:

14.2.1. For the first 10 Business Days, by a senior person who where practicable has not had any direct day-to-day involvement in the matter and has authority to settle the Dispute; and

14.2.2. For the last 5 Business Days, by their chief executive, director, or equivalent senior individual who has authority to settle the dispute.

14.3. Where practicable, no Party in dispute should be represented by the same individual for the different stages described in 14.2.1 and 14.2.2 above.

14.4. If the Parties in dispute are unable to settle the Dispute by negotiation, they must, within 5 Business Days after the end of the Negotiation Period, submit the Dispute to mediation by the Centre for Effective Dispute Resolution (CEDR) or other independent body or organisation agreed between the Parties which will follow the mediation Process of CEDR or other independent body or organisation as agreed.

14.5. This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the Law of England.

14.6. Each Party irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this Agreement or its subject matter or formation (including non-contractual disputes or claims), provided that nothing in this clause shall prevent a Party from enforcing any judgement obtained in the court of England and Wales in any other court with jurisdiction over the other Party.

15. TERMINATION

15.1. These arrangements may be terminated in respect of a Party by that Party giving reasonable notice to the other Parties. Termination by one Party shall not terminate the Agreement in respect of the other Parties.

15.2. The Parties may terminate this Agreement by mutual agreement.

15.3. Without affecting any other right or remedy available to it, a Controller may immediately terminate this Agreement by notice in writing to a Processor if the Processor commits a material breach of any provision of this Agreement, or the Processor repeatedly breaches any of the provisions of this Agreement.

Part 3

Data Flow Template for data being shared under this DSA

- Data Flow Name

- Purpose of Data Flow

- Sending Organisation

- Receiving Organisation

- Description of Data to be Shared

- Where staff or patient data is being shared is it: (please put an x in the relevant box)

[ ] Anonymised

[ ] Pseudonymised

[ ] Identifiable

- If Data being shared is Identifiable what Identifiers are being shared: (please put an x in the relevant boxes)

[ ] Forename

[ ] Surname

[ ] Address

[ ] Postcode

[ ] Date of Birth

[ ] Gender

[ ] Physical description

[ ] Phone number

[ ] Email address

[ ] GP details

[ ] NHS Number

[ ] National Insurance Number

[ ] Photograph

[ ] Other (please specify)……
……
……

[i] https://www.england.nhs.uk/long-read/update-on-the-draft-model-icb-blueprint-and-progress-on-the-future-nhs-operating-model/

Hertfordshire and West Essex ICB's Board Assurance Framework

Date: 12/11/2024

APPENDIX A: Assurance Framework Report (16+)

SO IDs	2022/27 Strategic Objectives	No of risks	Strategic Leads
SO1	Increase healthy life expectancy and reduce inequality	0	Rachel Joyce
SO2	Give every child the best start in life	1	Prof. Natalie Hammond
SO3	Improve access to health and care services	2	Frances Shattock
SO4	Increase the number of citizens taking steps to improve their well-being	1	Beverley Flowers
SO5	Achieve a balanced financial position annually	1	Alan Pond

Assurance Statement

We assure the Audit and Risk Committee that we have conducted a comprehensive review of the corporate risks facing the ICB. The Datix Risk Register currently lists 72 risks, of which 21 are identified as corporate risks (rated 12+). Among these, 5 have been classified as the most critical (rated 16+) and are highlighted in this Board Assurance Framework (BAF). These critical risks are associated with IDs 608, 610, 649, 526 and 679.Risk ID 608 was rated 20 but has been lowered to 16 and remains on the BAF.

RAG rating of overall perfomance

Amber

g

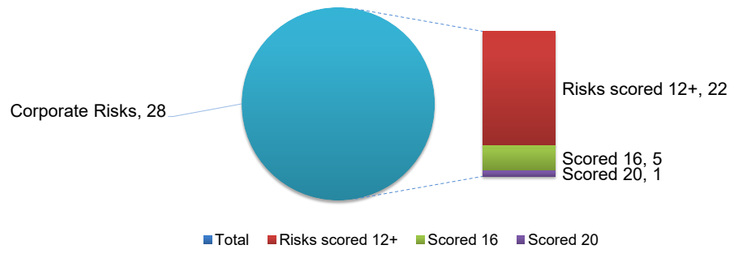
Progress

TRIGGER ZONES FOR MANGEMENT ACTION PLANS

Risk Matrix		Consequence (C)				
		1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
Likelihood (L)	5. Almost Certain					
	4. Highly Likely			5	6	1
	3. Possibly				16	
	2. Unlikely					
	1. Rare					

No#	HWE ICB Directorates	No of risks (12+)
1	Chief of Staff (Communication, Corporate Governance, Information Governance)	1
2	Finance and Premises	2
3	Medical (Digital Transformation & Medical)	0
4	Operations (3 Places, Contracts & HBLICT)	15
5	Performance (Business Intelligence & Performance)	2
6	Primary Care	2
7	Quality and Nursing	2
8	ICB Strategy (People, Workforce, Strategy)	4
		28

Further breakdown into principal risks scored 12+



RISK ID	Date open	SO ID	Risk Owner	Directorates	Risk Description (16+)	Rationale for current risk score	Risk Appetite	L = Likelihood C = Consequence L	C	Current risk score L x C = RS	Key Controls	Direction	Assurance levels 1st line	2nd line	3rd line
6															
722	12/09/2024	SO3	Karen Stagg	Operations (including Place and ICT)	If the CHC team remains understaffed, with high vacancy, sickness rates and leavers and lacks the in-house knowledge, skills, and experience to respond effectively, THEN the team's ability to deliver safe and compliant care will be compromised, RESULTING IN backlogs in casework and failure to meet national standards and efficiency targets.	Vacancy rate of 22% in July 2025 Whole team (19.05 clinical posts /5 Non clinical posts). Sickness rate of 9.7% (upward trend) 3.80 Business as usual clinical agency workers recruited to commencing 1st September 2025 to mitigate risk. 5.00 WTE Clinical leavers in August 2025 Local induction in development to support retention. Competency framework drafted to support developmental needs across the service in September 2025	Open	4	4	16		⇆			
698	01/02/2021	SO4	Karen Stagg	Operations (including Place and ICT)	**CoPDoLs**: IF there is no clear pathway, process, and resources in place to deliver the work for individuals who meet the acid test and lack Court of Protection Deprivation of Liberty Safeguard orders (CoPDoLS), THEN vulnerable CHC patients may be unlawfully deprived of their liberty, RESULTING IN potential legal challenges against the ICB due to breaches of individuals' Article 5 rights under the European Convention on Human Rights.	Risk needs to remain at current level due to lack of dedicated workforce to the workstream. BAU team supporting where they can and are able with the casework already generated from previous project team, however this is slowing progress and impacting on BAU activities. ASSURANCES: Highest 'risk' cases or those with existing court deadlines are being support by the AACC BAU team.	Open	4	4	16	CONTROLS: As mitigation business case with options outlined to Board and exes agreed with 'bronze' option approved meaning minimum level of workforce approved to work on the highest of 'rag' rated cases. Recruitment underway with agency staff 'infill' until fuller substantive recruitment can be completed or clustering of ICB's concluded with agreement from cluster as to levels of workforce and establishment make up needed to address demands.	⇆	Limited	Reasonable	Reasonable
745	17/04/2025	SO3	Jo Burlingham	Operations (including Place and ICT)	**Health care systems running costs reduction:** IF health care systems including ICBs, NHS England & UKHSA lose their EPRR staff because of the current uncertainty around the future of their posts THEN the wider health care systems ability to maintain current structures during the forthcoming transition period will be compromised RESULTING IN detrimental impacts on these systems resilience and business continuity of service delivery through loss of local knowledge of the health systems, geography and insufficient staffing to be able to meet statutory responsibilities as Category 1 & 2 responders as defined within the Civil Contingencies Act this includes a 24/7 on call function. Additionally IF local EPRR functions are removed as part of the upcoming restructures THEN this could RESULT IN detrimental impacts on health care systems resilience and business continuity of service delivery through loss of local knowledge of the health systems, geography, local Incident Co-ordination Centres and insufficient staffing to be able to meet statutory responsibilities as defined within the Civil Contingencies Act. Furthermore, the proposed UK Government Devolution plans anticipate improved local responsiveness and localised decision making and the potential removal or loss of local health systems EPRR functions would conflict with these intentions. There is the potential for the impact of healthcare organisations reductions and integration to detrimentally impact on EoE resilience in the following ways: 1). People a). Welfare	Risk broadened to include potential impact for wider health care systems. Risk reviewed in conjunction with NHSE devolution risk no.24 on their register, updated July 2025. Scores for both ICB and NHSE risk remains at a score of 20 in line with NHSE integration score. Risk further broadened to include impact shared elements of NHSE integration into DHSC risk (no.25). Key controls & gaps in controls added from NHSE integration risk no.25.	Cautious	5	4	20	01 April 25: Jim Mackay's letter to ICBs 02 May 25: Draft ICB Blueprint Rationalisation of workstreams? Existing On Call and Incident response structures Risk identified, added to register and subject to regular review. Ongoing national and local modelling / discussions Employee Assistance Programme Regular touchpoints to update staff on progress Support signposted to help staff manage mental health / anxieties /concerns / queries Integration of NHSE into DHSC, Transition Team Guidance? (Await further advice regarding if this is NHSE key control). Rationalisation of workstreams? (Await further advice regarding whether this is an NHSE key control.	⇆	Reasonable	Reasonable	Reasonable

Hertfordshire and West Essex ICB's Board Assurance Framework

Date: 12/11/2024

RISK ID	Date open	SO ID	Risk Owner	Directorates	Risk Description (16+)	Rationale for current risk score	Risk Appetite	L = Likelihood C = Consequence		Current risk score	Key Controls	Direction	Assurance levels		
6								L	C	L x C = RS			1st line	2nd line	3rd line
649	08/08/2023	SO3	Natalie Hammond	Nursing & Quality	**Paediatric Audiology Service Delays and Patient Safety Concerns**: If the timeliness and quality of care provided across the HWE paediatric audiology services (recognising current quality challenges identified at ENHT) does not meet the UKAS accredited standards, then there is a risk that access to time critical testing does not occur in a safe and timely way resulting in potential harm to our population both in terms of safety and patient experience.	August 2025- risk score remains the same. Some progress with ENHT pathways with hearing aid and ABR pathways open, however significant backlog and risk of harm remains due to size and length of waits within the waiting list. Discussions ongoing re mutual aid and levelling up. Additional risk (which balances progress) around ABR reviews, with HCT triggering full 5 year look back and PAH at risk of requiring full 5 year look back.	**Seek**	4	4	**16**	Further site visits taking place to clarify urgent estate needs. Limited mutual aid in place, discussions taking place within ICS and via NHSE outside the ICS. System - Audiology reviews with all appropriate providers via QI/assurance mechanisms NHSE Desktop reviews completed for PAH and HCT ICB Internal weekly escalation meetings occurring with key leads such as performance and estates Monthly whole HWE system audiology meeting established. Chaired by ICB Director of Nursing/ System Quality Director NHSE/ICB site visits undertaken for PAH and HCT Nov 24 (awaiting reports) Mapping of estates and workforce at system level to support improvement actions Demand and capacity modelling complete. NHSE/ICB site visits undertaken for PAH and HCT November 2024, reports have been shared. NHSE regional and national reporting established. Exploring options for capital estates funding. April 2025 the Hearing aid pathway has now opened in addition to 3-5 and over 5 pathways ENHT - ICB led fortnightly oversight meetings ENHT to progress action plans, trajectories and known interdependencies Regular updates to ICB STQI Committee, System Quality Group, Regional Quality Group, Board etc NHSE oversight and support via new regional PMO team Jumbo clinics in place for over 5 pathway.	⇔	Reasonable	Reasonable	Reasonable
610	10/03/2023	SO3	Frances Shattock	Performance, Business Intelligence	**Planned Care Improvement:** If waiting lists for elective and diagnostics are not reduced, there a risk to patient health and outcomes, then patients conditions may worsen resulting in deterioration of patient health. Additionally there is a reputational risk to the ICB which carries a risk of NHSE interventions.	The constitutional standards for 18 weeks are not being met. Plans to meet 65ww target of 0 by end December 2024 were not met although there has been significant improvement of long waits. The 65ww forecast for end of August is 50. The overall PTL has been on a steadily decreasing trend since March 2024. 6-week wait diagnostic performance across the ICS decreased in May and has remained static in June reaching 63.3% (target of 95% by March 2026)	**Open**	4	4	**16**	Work is continuing at both system and providers to reduce waiting lists with a focus on 65ww. Performance is discussed at weekly place based senior team meetings and monitored at fortnightly place based performance meetings with providers. ICB wide issues are discussed at the planned care group which will escalate to the Planned Care Committee. Additionally, performance is monitored at the bi-monthly performance Committee and escalated to the ICB board. Work is continuing at both system and providers to reduce waiting lists with a focus on 78ww and 65ww. Work is ongoing regarding the High Volume Low Complexity (HVLC) programme with a focus on improving efficiency and increasing theatre utilisation Quality risks related to elective recovery are discussed at Quality Rview meetings with system partners for IB oversight and escalation as required. Harm oversight linked to elective recovery is maintained through Patient Safety Incident Response Framework (PSIRF) processes.	⇔	Reasonable	Reasonable	Limited
608	10/03/2023	SO4	Frances Shattock	Performance, Business Intelligence	**Failure to meet UEC Targets:** If UEC targets are not met and patients are not assessed with a management plan and treated, admitted and/or discharged out of the Emergency Department within 4hrs, then there is an immediate risk to patient health and wellbeing, resulting in a significant risk to patient outcomes. Additionally, there is a reputational risk to the ICB which carries a risk of NHSE interventions. The delays in assessment and treatment could cause patients with serious illnesses/conditions to wait for long periods, increasing the risk of harm to their health. These delays could also negatively impact performance targets, leading to reputational risk.	14 May 2025 - The STQI committee agreed to decrease the risk rating from 20 to 16 due to the improvement in performance since February. The 4hr standard is currently 75% (20th April) with a target of 78%. HWE are benchmarked as 15 nationally. Cat 2 Ambulance response times have also improved since the high in November and are currently c.34mins (March)	**Open**	4	4	**16**	See Operations Directorate UEC plans and Board Assurance Framework related to UEC Priority Metrics. Actions linked to Performance Improvement Trajectories. Cross reference to UEC mitigations for ENH / SWH / WE place required Performance is discussed at weekly place based senior team meetings and monitored at fortnightly place based performance meetings with providers and NHSE. Performance and operational action taken to monthly System Resilience group / Local Delivery Board meetings and discussed in line with UEC action plans with escalations to monthly UEC Board. Additionally, performance is monitored at the bi-monthly Performance Committee with escalations to the ICB board. This risk complements the Operations Directorate UEC plans and Board Assurance Framework related to UEC Priority Metrics. Actions linked to Performance Improvement Trajectories. Cross reference to UEC mitigations for ENH / SWH / WE place required Risks relating to mental health patients in ED units are also being addressed in the appropriare forums and links to risk 609. Clincial harm processes for 12 hour breaches and corridor care are in place across the ICS with minimal harm identified. Quality risks related to UEC performance (including ambulalnce handover times) are discussed at Quality Review Meetings with system partners for ICB oversight and escalation as required. HWE System Incident Meeting is in place providing a system-wide review of patient harm due to delayed 999 responses and identify improvement actions. ICB oversight of patient safety incidents includes those linked to UEC performance. Learning related to UEC performance shared through Patient Safety Incident Response Framework (PSIRF) processes.	↓	Reasonable	Substantial	*None*

Document coding guide

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

Report Author:

Tatiana Njendu, Risk & Compliance Officer

Hertfordshire and West Essex ICB's Board Assurance Framework

Date: 12/11/2024

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

Colour codes for action		Action should be taken and / or continued monitoring by the ICB.
		Immediate actions required / and continued monitoring by the ICB.
Assurance rating - measures the quality/strength	*None*	
	Limited	
	Reasonable	
	Substantial	

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

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