Hertfordshire and West Essex Integrated Care Board

Meeting Book

HWE ICB Board Meeting Held in Public - 1230 - 1500, Friday 27 June 2025

1230	**1. Welcome, apologies and housekeeping** Chair Apologies received from Paul Burstow, Ruth Bailey, Natalie Hammond and Sharn Elton.	
1235	**2. Declarations of Interest** Chair	
1235	**3. Minutes of last meeting held on 28 March 2025** Chair	Approval
	4. Action Tracker Chair	Approval
	SYSTEM, LEADERSHIP AND STRATEGY	
1240	**5. Integrated Delivery Plans - Health and Care Partnerships** SROs/Place Directors	Information/Approval
1310	**6. Mental Health Intensive and Assertive Outreach Review** Beverley Flowers	Assurance/Discussion
	ICB BUSINESS	
1320	**7. Chair's Update Report** Chair	Information
1330	**8. Chief Executive Officer's Report** Chief Executive Officer	Information
1340	**9. Governance Report** Michael Watson	Assurance
1345	**10. Committee Summary Reports** Committee Chairs	Assurance
	Front Sheet	
	10.1 Health and Care Partnership Boards SROs	
	10.2 Audit and Risk Committee Thelma Stober	
	10.3 System Transformation and Quality Improvement Committee	
	10.4 Strategic Finance and Commissioning Committee Nick Moberly	

	10.5 People Committee Tania Marcus	
	10.6 Patient Engagement Forum Alan Bellinger	
1410	**COMFORT BREAK**	
1420	**11. Integrated Report for Finance, Performance, Quality and Workforce** ICB Executive Team	Assurance/Discussion
1430	**12. Questions from:** Chair	
	12.1 Patient Engagement Forum	
	12.2 Members of the Public	
	CLOSING ITEMS	
1440	**13. What would service users, patients, carers and staff take away from our discussions today?** Chair	Discussion
1450	**14. Any other business** Chair	
1500	**15. Close of meeting** Chair	
	Date of Next Meeting: Friday 26 September 2026, Latton Bush, Harlow	
	Supporting Reports/Documents are located in Meeting Book 2	

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:**	**27 June 2025**	
Report Title:	**Committee Register of Interests**				**Agenda Item:**	**2**	
Report Author(s):	Gay Alford, IG and Governance Officer Jas Dosanjh, Governance Manager - Conflicts and Policies						
Report Presented by:	Simone Surgenor, Deputy Chief of Staff - Governance and Policies						
Report Signed off by:	Michael Watson, Chief of Staff						
Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☒	**Information** ☒
Which Strategic Objectives are relevant to this report:	▪ Relevance to all five ICB Strategic Objectives						
Key questions for the ICB Board / Committee:	▪ Please see the 'Recommendations' section						
Report History:	▪ The full ICB Declarations of Interest Register is routinely reported to the Audit & Risk Committee in line with the Committee Workplan and Terms of Reference						
Executive Summary:	▪ The Board Sub-Committees' Register of Interests are maintained in compliance with the HWE Standards of Business Conduct and Conflicts of Interest Policy and the ICBs statutory duties. ▪ All members, and those in attendance must declare any actual or potential (previously known as direct or perceived) conflicts of interest which will be recorded in the minutes. Where a conflict is identified, at the Chair's discretion, the person may be asked to leave the meeting while a particular topic is being discussed. ▪ The ICB commenced the annual Declaration of Interest refresh for 2025/26, with the requirement for colleagues to complete a new declaration of interest form and return by 31 May 2025. ▪ At the point of drafting this report, the status of committee members/regular attendees declarations for 2025/26 have been noted as follows (as included in **Appendix 1**): (i) 2025/26 declaration received and processed (white background), (ii) 2025/26 declaration received but currently being processed, the entry on the register is as per 2024/25 declaration (green background),						

	(iii) 2025/26 not received (deadline 31 May 2025), the entry on the register is as per 2024/25 declaration (yellow background). The Executive Team have been provided with the names of those with outstanding declarations and disseminated within their directorates, requesting returns to hweicbwe.declarations@nhs.net by the extended deadline of **20 June 2025**. Outstanding Board and external declarations will be followed up directly by the Governance Team and via escalation to the relevant Committee meetings where individuals hold a role.
Recommendations:	The Committee is asked to: ▪ Remind members/attendees with outstanding declarations (identified in **Appendix 1**) to complete a return for 2025/26 using the declaration of interest form included with this paper (**Appendix 2**), ▪ Note the returned declarations and whether these reflect the current membership/regular attendees for this Committee, ▪ Review any potential conflicts of interest that need to be managed at the meeting in accordance with the agenda, ▪ Remind members and regular attendees that - whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests (e.g., where an individual takes on a new role outside the ICB or enters into a new business or relationship), a further declaration should be made to reflect the change in circumstances as soon as possible, and in any event within 28 days. The revised declaration should be countersigned by their Line Manager or lead, and then forwarded to hweicbwe.declarations@nhs.net for logging.

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

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

Key:	White background indicates 2025/26 delcaration received
	2024/25 declaration - awaiting 2025/26 declaration
	2024/25 declaration - processing 2025/26 declaration
	Full Grey Line indicates staff no longer employed by ICB - declaration to remain on the register for 1 year
	Part grey line indicates the interest has ended.

Hertfordshire and West Essex Integrated Care System

Hertfordshire and West Essex ICB
Board Register of Interests

NHS Hertfordshire and West Essex Integrated Care Board

Name:		Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Type of Interest					Date of Interest		Action taken to mitigate risk
Surname	Forename			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct interest	Indirect interest	From	To	
Bailey	Ruth	Non-Executive Member, NHS HWE ICB	Undertake HR consultancy within the UK and internationally. None of the projects are healthcare related.	√					Jan-25	Present	
			Spouse is Director in UK Health Protection Agency.					√	2016	Present	
			Executive Director of People and Organisational Effectiveness for the Nursing and Midwifery Council (job share)	√					2022	Ended Jan-25	
			Non-Executive member of South West London ICB.		√				2022	Ended Aug-24	
Burstow	Rt. Hon. Paul	Non-Executive Member, NHS HWE ICB Chair NHS HWE ICB	As Managing Director of Indy Associates Limited. The company is jointly owned by myself and my spouse and undertakes consultancy, advisory and public policy work. • On 27th May 2025 – I will be acting as a presenter and facilitator at a non-promotional event for the IRIS Group which is a group of clinicians with an interest in the impact of greenhouse gas regulations and the phasing out of PFAS from propellants in inhalers with a view to mitigating risks to patient health. IRIS is supported by LEK Consulting who are funded by AstraZeneca to provide the secretariate.	√		-	-		May-15	Present	The company does not tender for work from NHS organisations. Should a discussion or paper relate to: • AstraZeneca • Boehringer Ingelheim • MHP Group • OVID Health • L.E.K. Consulting I will declare an interest either in advance of the meeting or at the point a direct or perceived conflict is identified. I play no part in any tendering, marketing, or lobbying work on behalf of clients of MHP Group or OVID Health. If any NHS organisation within the ICS were to engage MHP Communications or any of the other organisations listed I would declare the interest and would take no part in the delivery of the work
			I am chair of the trading charity, St Andrew's Healthcare. The charity provides a range of secure mental health services, primarily in the Midlands, and several community-based specialist services	√		-	-		Oct-20	Present	I play no part in the charity's tendering processes nor do I play a role in selecting contractors within the ICS. As of 31.05.25 – declared that St Andrews Healthcare had been granted core participant status in the Lampard Inquiry. Should a discussion or paper relate to this provider, I will declare an interest either in advance of the meeting or at the point a direct or perceived conflict is identified.
			I am chair of the trading charity, the Social Care Institute for Excellence. The charity undertakes consultancy and improvement support in social care and beyond.	√					Jul-17	Present	I play no part in the charity's tendering processes, nor do I play a role in selecting contractors within the ICS. Should a discussion or paper relate to this provider, I will declare an interest either in advance of the meeting or at the point a direct or perceived conflict is identified.

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

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Flowers	Beverley	Deputy Chief Executive and Director of Strategy , HWE ICB	Non remunerated Director role with Herts at Home Ltd a company established and fully owned by Hertfordshire County Council to provide care and support within the County. Herts at Home Ltd. Company number 11360947. Registered office address County Hall, Pegs Lane, Hertford, United Kingdom, SG13 8DE.)	-	√	-	-	√	Jan-19	Ongoing	Declare at meetings where relevant. Exclude self from decision making process in meetings if necessary.
Halpin	Jane	Chief Executive Officer, NHS HWE ICB	Nil								-
Hammond	Natalie	Director of Nursing & Quality, HWE ICB	Spouse - company - Aqua Kare, leak detection.	√						Ongoing	Does not commission/tender for work.
Howard -Jones	Elliott	Role of CEO at Hertfordshire Community NHS Trust Partner Member - Community Provider Representative SRO - East & North Herts HCP	Nil			-	-	-	-		
Joyce	Rachel (Dr)	Medical Director	Married to an NHS consultant who works for East and North Herts Trust.	-	-	-	-	√	Jun-01	Current	To be logged on ICB DoI registers and declared if relevant in meetings/ work
			From 2018 I was a Director for Ranine Ltd - a company that provides private medical services by one consultant (spouse as above) to local independent hospitals. From 1st April 2022, I resigned my role as Director and now act as secretary who also holds shares in the company. The company does not however provide, or intend to provide, services to the NHS, social care, or NHS patients.		-	-	-	√	2018	Current	To be logged on ICB DoI registers and declared if relevant in meetings/ work
			Director of Castellan Homes Ltd, a family company for which I am a director.	√					2024	Current	It does not have and has never had a contract with the health or social sector - operating completely out of that environment.
Khan	Iram	Corporate Governance Manager - Board & Committees	Nil	-	-	-	-	-	-	-	-
Lafferty	Thom	Chief Executive Princess Alexandra Hospital NHS Trust	Director & Owner; TWL Associates Ltd (dormant)	√					Jun-14	N/A	
			CEO The Princess Alexandra Hospital NHS Trust		√				Nov-24	Present	
			Place Lead West Essex HCP		√				Nov-25	Present	
Lavington	Adam	Director of Digital Transformation	Nil	-	-	-	-	-	-	-	-
Marcus	Tania	Chief People Office	Trustee Norwood (charity supporting neurodiverse children, adults and their families).			√			Feb-25	Present	None felt necessary However, declaring as there are some links with NHS and social care
Marovitch	Joanna	Chair VCSFE Alliance VCFSE Alliance board member Regular Attendee ICB Primary Care Transformation Committee	CEO of Hertfordshire Mind Network	√					2021	Current	
Martin	Chris	Commissioning Director – Children's services, ECC Board Rep Partner member, Local Authority, ECC	Nil								
McCarthy	Lance	Partner Member, NHS and Foundation Trusts - Acute SRO - West Essex HCP	CEO of PAHT - provider in the system	√					May-17	Current	Verbal declaration to be made at the beginning of any meeting as appropriate
			Member of NHS Employers Policy Board		√				Jan-23	Current	Verbal declaration to be made at the beginning of any meeting as appropriate
Moberly	Nick	Non-Executive Member HWE ICB	CEO MS Society UK (including Director of MS Society Nominees Ltd and MSS (Trading) Ltd)	√					Jan-19	Present	

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			Non-Executive Director, NHS Property Services	√					May-21	Present	
			Board Adviser/Chair, Dr Morton's Ltd (with small shareholding) – business has now ceased trading	√					Jan-21	Ended Dec-24	Mitigating steps to be taken surrounding Board or committee papers/agenda items.
			Director/Chair, DKWHS Ltd (new business which has acquired the business and assets of Dr Morton's on a going concern basis). Minority shareholder	√					Jan-25	Present	Mitigating steps to be taken surrounding Board or committee papers/agenda items.
			Trustee - Christian Aid			√			Dec-18	Ended Oct-24	
			Board member, MS International Federation			√			Jun-19	Ended Oct-24	
			Trustee, Medical Aid for Palestinians			√			Mar-24	Ended Oct-24	
Moodley	Pragasen	Partner Member, Primary Care for the ICB - Primary Medical services	GP Executive Partner at Stanmore Medical Group 5 Stanmore Road, Stevenage, SG1 3QA	√	-	-	√	-	2004	Continuing	Verbal declarations to be made at the beginning of any meeting
			Director of AVM Medical. Suite 3 Middlesex House, Rutherford Close, Stevenage, Hertfordshire, United Kingdom, SG1 2EF. Company number 10507387 I use this company to carry out private medicals and nursing home ward rounds	√	-	-	√	-	2016	Continuing	
			CD Stevenage North PCN	√					2022	Continuing	
			Director North Stevenage PCN Ltd	√	-	-	√	-	2024	Continuing	
			GP Partner at Larksfield Medical Practice	√	-	-	√	-	2018	Continuing	
			Partner is a GP at King George Medical Practice	-	-	√	-	√	2016	Continuing	
Perry	Dr Ian	GP Partner Member, ICB Board	GP Partner in Maynard Court Surgery	√	-	-		-	2013	To date	Verbal declaration to be made at the beginning of any meeting
			Epping Forest North PCN GP Partner	√					2019	To date	
			Stellar Healthcare Shareholder		-	-		-	2014	To date	
Pond	Alan	Chief Finance Officer, HWE ICB	I am the public sector appointed Director of Assemble Community Partnership Ltd (Company Number 06471276) and associated companies Assemble Fundco 2 Ltd (Company Number 08309498) Assemble Holdco 2 Ltd (Company Number 08309495) Wolverton Holdings (Company Number 08307564) Wolverton Fundco 1 Ltd (Company Number 08306830 Assemble Fundco 1 Ltd (Company Number 06471659) Assemble Holdco 1 Ltd (Company Number 06471233) Assemble (MKHQ) HoldCo Ltd (Company Number 06710941) Assemble (MKHQ) Ltd (Company Number 06711023) All of 128 Buckingham Palace Road, London, SW1W 9SA.			√			Jul-08	Current	My role on the Board of the LIFT Company Group is to represent the interests of the local public sector, provide insight, but also to oversee the financial and governance arrangements of the companies. The Group of Companies was created to provide benefits to the NHS locally and a conflict is highly unlikely to occur. Should any conflict of interest arise, I would excuse myself from both parties for the relevant matter and should an ongoing conflict arise I would resign my director position with the Group of Companies.
			My Partner is a GP Partner of a Practice associated with HWE ICB (at Haverfield Surgery, Kings Langley) and is engaged as a clinical lead by the HWE ICB.	-	-	-	-	√	Aug-10	Current	On matters relating to primary care generally, I would always declare my relationship to my partner so anyone could question me on my motives. For matters relating specifically to Haverfield Surgery only, I will excuse myself from any discussion and take no part in any decision making. I will keep confidential any information I receive that could be of benefit to Haverfield Surgery and/or my partner.

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Randhawa	Professor Gurch	Non Executive member, NHS HWE ICB Chair - ICB Strategy Committee Vice Chair - ICB Strategic Finance & Commissioning Committee	Professor of Diversity in Public Health & Director, Institute for Health Research University of Bedfordshire. Honorary Academic Contract, UK Health Security Honorary Academic Contract, Office for Health Improvement & Disparities Expert Advisor, NICE Centre for Guidelines, UK Facilitator, faculty of Public Health accredited Practioner Program, UK Faculty of Public Health Non-Executive Director, Forestry England. Adjunct Professor, Ton Due Thang University, Vietnam, Trustee, Race Equality Foundation, UK National Member, National Black and Minority Ethnic Transplant Alliance, UK Member, British Medical Association Ethics Committee, UK Member, Donation Ethnicity Liberty Inclusion Pontifical Academy for Life (PAL) – Vatican State-led Engagement of Religious communities (DELIVER) Project Member, Quality and safety of organs for transplantation - European Directorate for the Quality of Medicines and HealthCare (EDQM) Group of Experts, Council of Europe National Member, Mental Health Working Group, NHS Race & Health Observatory, UK National Member, Independent Stakeholder Advisory Board, National Institute for Health Research		√					Current	All interests declared with all parties.
			Deputy Lieutenant, Bedfordshire Patron of the Bedfordshire Rural Communities Charity Ambassador, Keech Hospice Care Volunteer, Luton Sikh Soup Kitchen Junior Cricket Coach, Harpenden Cricket club		√					Current	All interests declared with all parties.
			Patient, Davenport House surgery, Harpenden			√				Current	All interests declared with all parties.
			Extended family works at local Primary Care Network					√		Current	All interests declared with all parties.
Ridgwell	Angie	CEO Hertfordshire County Counci LA Partner Member to the HWE ICB Board	There may be occasions when ICB are making strategic commissioning or policy decisions that will have an impact on HCC services, creating cost, demand or delivery changes.		√				Sep-24	Current	If a conflict of interest arises this will be discussed with the chair, ICB notified and possible reclusion from the decision.
Sewell-Jones	Adam	Member HWE ICB Board	Chief Executive at East & North Hertfordshire Teaching NHS Trust					√	Apr-24	Present	
Shah	Avni	Director of Primary Care HWE ICS	Spouse works for a Pharmaceutical Industry – Scope, who distribute a number of medicines across the UK.					√	Nov-20	Current	As Director of Primary Care Transformation I am not directly involved in the local decision making process of new drugs being agreed across HWE and when reports come to PCCC or Commissioning Committee if any product from that particular industry I will outline at the meeting to managing conflict.
			Spouse provides supervision and support via CPPE to foundation year community pharmacist who required support. This is commissioned through HEE and covered London and South East Area					√	Apr-23	Current	This is commissioned directly from NHSE to CPPE hence NO involvement in commissioning and contracting of this support to local community pharmacists who can access this national support.
			Spouse is Superintendent for the group of community pharmacies - Channa Chemist based in London					√	Apr-25	Current	It not impacting across EoE as Channa does not have branches in this area.
Shattock	Frances	Director of Performance	Nil	-	-	-	-	-	-	-	-
Stober	Thelma	Non-Executive Member, NHS HWE ICB	Patient , Surgery Berkhamsted	-	-	√	-	-	2018	Current	1. HWE Conflict of interest Policy . 2. NHS England » Managing conflicts of interest in the NHS and 3. Best practice in corporate governance
			Patient, RNOH Stanmore			√			2005	Current	
			Patient, Stoke Mandeville Hospital			√			2010	Current	
			Employee of Local Government Association (11177145) (LGA)		-	√	-	-	2013	Current	
			Company Secretary for the LGA						05.12.2024	Current	

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			Company Secretary for Improvement and Development Agency for Local Government (IDeA) (0367557) a subsidiary of the LGA						28.02.2025	Current	
			Secretary of Land Data Community Interest Company (05417694)						14.01.2025	Current	
			Secretary of Public Sector Audit Appointments Limited (09178094) (a subsidiary of the IDeA)						15.08.2021	Current	
			Director/Trustee of London Emergencies Trust			√			2017	Current	
			Trustee of the National Emergencies Trust			√			2020	Current	
			Peabody Trust - Communities Committee			√			2021	Ended Dec-24	
			Deputy Lieutenant Greater London			√			Apr-22	Current	
Surgenor	Simone	Deputy Chief of Staff - Governance & Policies, NHS Herts & West Essex ICB	Director of Select Project Management Ltd	√	-	-	-		2011	Ongoing	Family company. No contracts held in the health and care sector
			Community Governor – Colne Engaine C of E Primary School (school run by the Vine Schools Trust).			√			TBC		Declaration will be flagged if relevant prior or during meetings. School sits outside of the ICB geographical area.
Taylor	Karen	Chief Executive Officer - Hertfordshire Partnership University NHS Foundation Trust	Chief Executive and employee of HPFT	√					Dec-21	Current	Declare interest
			Board Trustee - NHS Providers		√				Jul-23	Current until Jul-26	Declare interest
			East of England Provider Collaborative Lead CEO 2024		√				Jul-24	Current	Declare interest
Turnock	Philip	Managing Director of HBL ICT Shared Services	Nil	-	-	-	-	-	-	-	-
Watson	Michael	Chief of Staff, NHS HWE ICB	Nil	-	-	-	-	-	-	-	-
Webb	Matthew	ICB Place Director - S&W Hets	Partner is employed as an Associate Director with ArdenGem Commissioning Support Unit	-	-		-	√	Apr-24	Ended Dec-24	To be declared when appropriate
			Close relative is employed in the Talking therapies service at CNWL NHS Trust					√	Apr-24	Ended Oct-24	To be declared when appropriate

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DECLARATIONS OF INTEREST FORM

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

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

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

Please note:

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

2. By completing and submitting this form you:

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

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

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

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

Signed: **Date**:

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

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

***Types of Interest**

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

Hertfordshire and West Essex Integrated Care System

DRAFT MINUTES

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	**NHS Herts and West Essex Integrated Care Board meeting held in Public**			
	Meeting in public	☒	*Meeting in private (confidential)*	☐
Date:	**Friday 28 March 2025**			
Time:	**11.30am - 1.30pm**			
Venue:	**The Forum, Hemel Hempstead and remotely via MS Teams**			

MINUTES

Name	Title	Organisation
Members present:		
Ruth Bailey	Non-Executive Member	Hers and West Essex ICB
Paul Burstow (PB)	ICB Chair	Herts and West Essex ICB
Matthew Coats (MC)	SRO South West Herts Health Care Partnership	Herts and West Essex ICB
Trevor Fernadez (TF)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Beverly Flowers (BF)	Director of Strategy	Herts and West Essex ICB
Jane Haplin (JH)	Chief Executive Officer	Herts and West Essex ICB
Sarah Brierley (SB)	representing Elliot Howard-Jones Partner Member (Trusts and Foundation Trusts)	ENH Health Care Partnership
Thom Lafferty (TL)	SRO WE Health Care Partnership	Herts and West Essex ICB
Chris Martin (CM)	Partner Member (Local Authority)	Essex County Council
Nick Moberly (NM)	Non-executive Member	Herts and West Essex ICB
Prag Moodley (PM)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Ian Perry (IP)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Alan Pond (AP)	Chief Financial Officer	Herts and West Essex ICB
Angie Ridgewell (AR)	Chief Executive Officer, HCC	Hertfordshire County Council
Lucy Davies (LD)	representing Adam Sewell-Jones SRO ENH Health Care Partnership	ENH Health Care Partnership
Thelma Stober (TS)	Non-Executive Member	Herts and West Essex ICB
Karen Taylor (KT)	Partner Member (NHS Mental Health Trust)	Herts and West Essex ICB
In attendance:		
Toni Coles (TC)	Place Director, West Essex	Herts and West Essex ICB
Sharn Elton (SE)	Place Director, East and North Herts	Herts and West Essex ICB
Tania Marcus (TM)	Chief People Officer	Herts and West Essex ICB
Tracey Norris	Meeting clerk	Herts for Learning Limited
Frances Shattock FS)	Director of Performance	Herts and West Essex ICB
Michael Watson (MW)	Chief of Staff	Herts and West Essex ICB
Matt Webb (MW)	Place Director, South and West Herts	Herts and West Essex ICB
Via Microsoft Teams:		
Gurch Randhawa (GR)	Non-Executive Member	Herts and West Essex ICB
Alan Bellinger (AB)	Patient Engagement Forum chair	

ICB/13/25	**Welcome, apologies and housekeeping**
13.1	The Chair welcomed all to the meeting, with confirmation provided this was not a public meeting but a meeting being held in public (members of the public were welcome to attend to observe the meeting).
13.2	Apologies for absence had been received from: ▪ Elliott Howard-Jones (represented by Sarah Brierley) ▪ Adam Sewell-Jones (represented by Lucy Davies) Gurch Randhawa was joining the meeting via MS Teams.
ICB/14/25	**Declarations of interest**
14.1	The Chair invited members to update any declarations relating to matters on the agenda and reminded them of their responsibility to update their declarations, for example when they had ceased an association with an organisation. All members declarations were accurate and up to date with the register available on the website: Declaration of interests – Hertfordshire and West Essex NHS ICB
ICB/15/25	**Minutes of the previous meeting**
15.1	**The minutes of the previous meeting held on Friday 31 January 2025 were approved as an accurate record.**
ICB/16/25	**Action Tracker**
16.1	There were three open actions (Ref: 82.4/24, 93.11/24 and 12.2/25) with updates provided for the first two. The chair asked that an elaboration of 12.2/25 (AS-J and MC to lead a session on Digital and AI) was included in the next iteration of the action tracker.
16.2	**The Board noted the updates to the action tracker.**
ICB/17/25	**Chair's update report**
17.1	The Chair referred to his report (see pages 24-28 of the document pack) which was noted.
17.2	There were no questions arising.
17.3	**The Board noted the Chair's update**
ICB/18/25	**Chief Executive Officer's report**
18.1	Jane Halpin (JH) referred to her report (see pages 29-38 of the document pack) drawing the board's attention to the following: • Since the paper had been written, the government had announced the abolition of NHS England and some proposed changes to ICB leadership models. There were no specific details available at this time. • The impact of these decisions would be significant, and JH would share information with the board as and when received.
18.2	Questions and comments were invited: • Significant progress had been made in the area of dentistry and the report highlighted the fact that HWE ICB has been asked for the lowest contribution across East of England (5,712 out of 700,000 nationally) for additional urgent appointments, due in part to maximising the delivery of dental contracts since taking on delegated responsibility but also the local initiatives of commissioning additional urgent access to dental appointments over the last year to reduce unmet need. • The roll out of mental health support teams in schools was a great achievement, HWE had the highest number in the country.
18.3	**The Board noted the CEO's report**

ICB/19/25	**Governance Report**
19.1	Michael Watson (MW) presented the governance report (see pages 39-45 of the document pack) and highlighted the following three aspects to the report: • Governance Handbook updates • Committee Effectiveness Survey: the process of sharing feedback with committees was ongoing. • Board Assurance Framework – HWE ICB currently oversees 94 risks, with 74 fully approved. A discussion on children's commissioning services would take place at the May board meeting after first being reviewed at the Audit Committee.
19.2	**The Board approved the updates to the governance handbook and noted the Governance report**
ICB/20/25	**Operating Model**
20.1	Michael Watson (MW) presented this agenda item (see pages 46-54 of the document pack) and highlighted the following: • It had been originally intended for today's board meeting to approve the Host Provider element of the operating model. This had been temporarily put on hold pending further details from the Department of Health and Social Care re its plans for NHS England and ICBs. • Options to be explored to identify quickest route to approve and progress the operating model.
20.2	Questions and comments were invited: • Sir James Mackey had been appointed as Transition CEO of NHS England from 1 April and it was hoped that the change in leadership would give some clarity that the direction of travel the ICB had taken was the right one. • A discussion followed on the most appropriate timing for the approval of the operating model, and it was agreed that to maintain momentum this should not be delayed beyond the end of April. • It was essential for all partner members to remain invested/consulted and involved in these discussions.
20.3	**The Board agreed the delay to the approval of the operating model**
ICB/21/25	**Updates from Sub-Committees**
21.1	Committee chairs were invited to highlight the risks/challenges to escalate to board level; new template proformas had been created to support this and were included in the meeting pack (see pages 55-80 of the document pack).
21.2	**Audit and risk committee: Thelma Stober** • Risks with ratings of 12-15 would be shared with the Board. • The internal audit report for 2024/25 had graded the ICB with "reasonable assurance". • The counter fraud auditors were satisfied that adequate measures were in place. There had been 10 reports between September – February and six were now closed. • Procurement review: seven actions raised.
21.3	**System Transformation and Quality Improvement Committee: Ruth Bailey** • Review of relationship between HCPs and the committee to reduce duplication. • Updates on audiology and other long waits. • Local Maternity and Neonatal System (LMNS) records and digital disclosure update, with quality risks flagged because systems unable to speak to each other (between providers and out of area): ○ This risk had not been identified when record systems were selected.

	○ This issue had been escalated to the Digital Board to ensure greater oversight of digital innovations. ○ This was an issue nationally and not just for HWE. • More assurance was required for long term solution to ambulatory category 2 response times. • Focus on Medium Term Plan and the metrics needed to get back onto trajectory. A rolling programme of deep dives had been planned. • Items to celebrate: ○ Improvement in cancer metrics ○ The actions taken to elevate winter pressures for 24/25 ○ Special Care Dental Services and program to address severe anxiety with patient stories shared. ○ Joint project with university to research data and data optimising.
21.4	**Strategic Finance and Commissioning Committee: Nick Moberly** • An extraordinary meeting had been held on 20 February 2025 to review the 2025/26 financial plan. • The scale of challenge was recognised by all and approved at yesterday's extraordinary board meeting. • The collaborative efforts by all partners in the system was noted; the ICB had been able to submit a balanced plan.
21.5	**Strategy Committee: Gurch Randhawa** • MTP and performance dashboard. • New challenges arising from the government announcement re the future of NHSE and ICBs. • The ICB's public facing plan had been shared with NHSE for feedback and this had just been received (positive) and the plan would be published no later than Monday 31 March on the ICB's website.
21.6	**East and North Herts HCP Board: Sharn Elton** • Verbal update on a meeting held in March: ○ Progress was being made in diabetes and integrated respiratory heart failure response using population health care management information. ○ Gap analysis of ICS service model. ○ Integrated delivery plan focusing on care close to home, reducing admissions of the over 65year olds. ○ Some progress seen in metrics, 1% reduction in activity for the over 65year old cohort. The prioritisation framework for frailty would support this further. ○ Governance review of HCP. ○ Good progress in identifying clinical priorities. • Risks to escalate: ○ community paediatrics ○ Urgent and emergency care
21.7	**West Essex HCP Board: Thom Lafferty** • Verbal update on meeting held on 20 March: ○ Sign off for host and lead provider arrangements; direction of travel agreed. ○ Two key changes had been made following feedback from GPs relating to boundary services (avoiding postcode lottery) and patient choice. ○ GP/EPUT and MH leads on Board from May. ○ Work had commenced on UEC pathway with EPUT to reduce congestion. ○ Clinical summit planned for 10 July for blue sky conversations. ○ Presentation from Chris Martin on Essex family. ○ CM highlighted the 8th year of the early help offer in Essex which was unique – he hoped to be able to share this model with colleagues at a future ICB board meeting.

	○ The “one team” vision of adult mental health services needed to also apply to children.
21.8	**South West Herts HCP Board: Matthew Coats** • February meeting: see summary in meeting papers: ○ Endorsement of the delegation framework. ○ Approval of approach for proactive care pilot in Dacorum. ○ Reports from community and neighbourhood teams. • Verbal update from March meeting: ○ Preparation for new operating model completed. ○ Report on frailty; interesting partnership with MacMillan. ○ Continued development of neighbourhood teams; appointment of secondary care consultant – it was noted that this was a significant step to developing neighbourhood working.
21.9	**MHLDA HCP Board: Karen Taylor** • Verbal update from 14 March meeting: ○ Agreement to change name of board to MHLDND – the board deals with all aspects of neurodiversity not just autism. ○ Useful discussions with BF and local authority colleagues. ○ Appointment of a primary care lead. • Delivery matters: ○ Children and YP access targets have been exceeded. ○ Multi-agency review of S136s ○ Joint local government peer review of community-based services. ○ Rates of presentation of patients with mental health illnesses at UEC had fallen from 58.9 per 100,000 to 52.8 between September and February. ○ Percentage of UEC attendances of patient with mental health issues/self-harm has fallen from 3.8% in February 2024 to 3.2% in February 2025 compared to 3.3% nationally. ○ This still was not good enough and there was still a lot of work to do, presentation at UEC was often in response to crisis and having nowhere else to go. KT felt the reduction was due to better (earlier) diverting to the appropriate service rather than a reduction in the level of demand.
21.10	**Patient Engagement Forum: Alan Bellinger** • Agreement on terms of reference changes to better support the priorities of the ICB. • Good engagement with the MTP. • Focus on patient engagement, waiting lists, medicine review and other task forces. MW thanked AB and the PEF for their hard work and dedication to support the development of the ICB; it was greatly appreciated.
21.11	**The Board noted the Committee updates**
ICB/22/25	**Integrated report for finance, performance, quality and workforce**
22.1	MW introduced this agenda item (see pages 81-93 of the document pack) and invited each of the area leads to present their highlight report before opening for questions.
22.2	**Performance overview:** Frances Shattock provided the following update: • The report covered validated dated up to January 2025. • The deterioration seen in urgent care caused by the winter surge had since been on an improvement trajectory and had recovered more quickly than in previous years. • There was variation across providers. • There had been improvements in: ○ Diagnostics: paediatric audiology ○ CHC ○ All three cancer standards

	• The operational plan had been submitted on 27 March and was compliant with all standards but would require some improvements in some areas eg elective waiting times.
22.3	**Finance overview:** Alan Pond (AP) summarised the financial position: • The projected year end deficit had improved to £5.9m as of M11; this represented an improvement of £8m from the M10 position and included £4m funding from electronic record implementation. • A risk identified in M10 – the introduction of a cap on elective recovery funding by NHSE had been successfully challenged and the cap increased to £11m. • The forecast outturn was breakeven across the system, but not all partners had achieved their plan. • There had been good transparency and collaborated working practices between finance directors. • The movement between M11 and M12 was usually small, one Trust had a larger gap but this was still achievable. • Efficiencies: 96% achieved by the end of February 2025 but most were non-recurrent. This was a risk to the system; all partners would need to successfully identify **recurrent** savings. • Agency spending cap had been met. • 2025/26 plan has been submitted: all organisations were able to submit balanced plans. • Risk: little investment room in 2025/26 to develop transformation initiatives; it was hoped that this would improve by 2026/27.

22.4	**Quality overview:** Natalie Hammond (NH) provided the following update:
	• Three never events had occurred at acute sites. A patient safety investigation was underway. Immediate learnings had been shared and thematic reviews agreed.
	• Paediatric audiology progress:
	  ○ More pathways at ENH
	  ○ Site visit by regional team
	  ○ PAH and ENHT open to mutual aid
	  ○ Capital bids submitted
	  ○ Showcase of HWE approach
	• Elysium Care Homes: deescalated to enhanced oversight position.

22.5	**Workforce overview:** Tania Marcus (TM) provided the following update:
	• As of M11, there had been little change in the overall workforce:
	  ○ Reduction of 16 x WTE
	  ○ Workforce remained 2.5% over plan
	  ○ Fall in agency staff by 22 x WTE (44 less than projected in operating plan – 1%)
	  ○ Fall in Bank staff by 19 WTE (1% over operating plan)
	• The planned TUPE transfer for pathology staff had not yet taken place.
	• Staff survey results had been received and would be subject to a deep dive at next meeting.
	• Oliver McGowan mandatory training contract had been awarded.
	• Nursing band evaluation undertaken.
	• Celebration of the system development programmes (over 60 colleagues graduated).

22.6	**Questions and comments were invited:** • The enthusiasm and sense of energy gained by colleagues on development programmes was noted; this also demonstrated the power of relationships and connections across organisational boundaries. • The financial position of the system was better that at the same time last year, despite having received less support from NHSE for the deficit. It was hoped the projected headroom in 2026/27 for transformational projects would materialise. • AP thanked all for their participation and commitment to the financial plan finalisation day. This had been very productive.

	• Children's waiting times were still not reducing quickly enough, what other approaches could be taken to address this?
	• JH noted that the development of the help/support hub approach might be a way forward. Everyone was aware that demand was growing faster than capacity and it would take time for new staff to be trained/funded. Colleagues were working on what a better model of care looked like and how to streamline access.
	• There had been no funding in the expansion of MH/ND services so there would need to be an increase in productivity to meet demand on top of 5% efficiencies. This would be challenging.
	• KT had been invited to lead a MH network across East and with this came some funding. She would be looking at:
	  ○ Neuro diversity for YP
	  ○ Crisis model of care
	  ○ Out of county beds
	• GP colleagues in Essex noted the improvements made in recent years through the following appointments (change was happening, just not quickly enough):
	  ○ Children MDT
	  ○ Children's engagement officer
	  ○ Greater liaison with district council
	• The lockdown cohort had just started full time education, and the full impact of the pandemic was beginning to be understood; physical and mental health issues, lack of school readiness.

22.7	**Lampard Inquiry: Investigating mental health deaths in Essex** BF provided the following update: • The next round of hearings would take place at the end of April. • The three SROs were working together on HWE's response to any requests for evidence (it was not expected that a request for evidence would be made but confirmation would be received by the end of the day on 28 March). • Processes were in place around safeguarding issues and these were ongoing.
22.8	**The Board noted the integrated reports for finance, workforce, quality and performance**
ICB/23/25	**Questions from the public**
23.1	Three questions had been received from the public but too late to be included in the meeting's document pack. The questions and answers would be shared with board members and posted on the ICB website in due course.
ICB/24/25	**What would service users, patients, carers and staff take away from our discussion today?**
24.1	System providers and staff were continuing to work with professionalism and commitment despite the uncertain national landscape.
Date of next meeting: Friday 23 May 2025	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Herts and West Essex Integrated Care Board Board Meeting Action Tracker Last updated on 9 June 2025								
Private / Public	**Action Tracker Ref No**	**Date of Meeting**	**Subject**	**Action**	**Responsible Lead**	**Deadline Date**	**Comments and Updates**	**Status**
Public	82.4	27/09/2024	Mental Health Intensive and Assertive Outreach Review	**Update to Board on NHSE's response to the Mental Health Intensive and Assertive Outreach Review**	B Flowers	~~**31/01/2025**~~ **28/03/2025**	**21.01.2025 - BF updated that there is a delay to the planning guidance for next year, however the work is continuing to progress locally. Further update to be presented at the next meeting.** **27/6/25 - an agenda item for June Board**	**Open**
Public	12.2	31/01/2025	What would service user take away	**Lead a session on Digital and AI**	ASJ and MC			**Open**

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

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☐	*Meeting in private (confidential)*	☒
	HWE ICB Board		**Meeting Date:**	**Friday 27 June 2025**
Report Title:	**West Essex,** **East & North Herts,** **South West Herts** **Hertfordshire Mental Health, Learning Disability and Neurodiversity** **Health and Care Partnerships' Integrated Delivery Plans 25/26**		**Agenda Item:**	**5.**
Report Author(s):	Elizabeth Kerby, West Essex HCP Development Director Ruth Forbes, East & North Herts HCP Development Director Rosalind Nerio, West Herts HCP Development Director Ed Knowles, Hertfordshire Mental Health, Learning Disability and Neurodiversity HCP Development Director			
Report Presented by:	ENH – Adam Sewell-Jones WE – Thom Lafferty SWH – Matthew Coats MHLDN – Karen Taylor			
Report Signed off by:	Toni Coles- WE Place Director, Sharn Elton – E&NH Place Director and Mathew Webb – SWH Place Director, Beverley Flowers – Director of Strategy			

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

Which Strategic Objectives are relevant to this report	The Integrated Delivery Plans illustrate how HWE ICB's HCPs will deliver all of the Strategic Objectives over the next 3 years. • Increase healthy life expectancy and reduce inequality. • Give every child the best start in life. • Improve access to health and care services. • Increase the number of citizens taking steps to improve their well-being. • Achieve a balanced financial position annually.

Key questions for the ICB Board / Committee:	HWE Board is asked to approve the three HCP Integrated Delivery Plans (IDPs). The Board is also requested to consider how the ICB will hold HCPs accountable for the delivery of the IDPs.
Report History:	▪ WEHCP, ENHHCP, SWHHCP and MHLDN HCP Boards and sub committees ▪ ICB Executive Team
Executive Summary:	H&WEICB has adopted a new approach to the annual planning process for 2025/26 with HCPs producing a three-year Integrated Delivery Plan 2025/26 – 2027/28. Included in this paper are the summaries for the IDPs for West Essex, East and North Herts, South West Herts and the Hertfordshire Mental Health, Learning Disability and Neurodiversity Health and Care Partnership. The IDPs were endorsed at the executive committee meeting on the 11 April 2025 where it was acknowledged that there was clear evidence of consistency across the plans, that the IDPs incorporate the NHS operational planning requirements for 2025/26 and the HCP's contributions to delivering the H&WEICB's Medium-Term Plan for their respective population. This is in line with the HCP Planning Framework agreed by the ICB in November 2024 and the ICB's Operating Framework. The following should be noted: Finance and activity plans will be added when budgets are agreed with the ICB, budgets aligned with the ICB Financial Plan 2526. The finance, activity and workforce triangulation will also be added on completion. Plans have been produced based on some consistent principles: • Care closer to home with a focus on Neighbourhood Teams prioritising frailty in 2526 • Reducing inequalities by addressing variation and using PHM intelligence to target interventions • Focusing on performance improvement aligned with the operational plan requirements • Developing models of care that enable greater integration and drive out duplication and improve efficiency and productivity • Assume there is no additional investment and transformation will need to be enabled through the repurposing of existing resources • Outcomes measures aligned to Medium Term Plan (MTP) metrics and targets. MTP targets are based on 23/24 baseline (22/23 Hypertension QOF measures) Monitoring of the IDP will be through HCP governance structures, ensuring that progress against the activity, workforce, finance and transformation plans are delivered. How HCPs are held to account for delivery of IDPs by the ICB is to be determined.

	The full IDPs can be accessed in the Appendices to the Board papers, also circulated to Committee members.			
Recommendations:	The Board is asked to approve the IDPs.			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			X
Implications / Impact:				
Patient Safety:	N/A			
Risk:	• Rationalisation of NHSE, ICBs and provider corporate resources may affect the delivery of the Integrated Delivery Plan. The IDP was developed prior to the announcement of running cost reductions. The IDP plans may need to be reprioritised based on reduced capacity to deliver. • Cultural change to support the integration aims requires longer timeframe than the delivery of the IDP allows • Local authority re-organisation reducing capacity and focus for partnership transformation and delivery • Ability and confidence to fund the transformation by transferring resources • HCP Financial Plans yet to be finalised			
Financial Implications:	The Integrated Delivery Plan is a contribution to the delivery of the ICBs Financial Plan 2025/26.			
Patient or public engagement or consultation:	Public involvement will be undertaken as part of development and implementation of transformation programmes/projects.			
Impact Assessments: *(Completed and attached)* *Please detail key impacts the Board/Committee should note:*	***Equality Impact Assessment:***	No		
	Quality Impact Assessment:	No		
	Data Protection Impact Assessment:	N/A		

East and North Herts Health and Care Partnership

ENH Health and Care Partnership

Integrated Delivery Plan 2025-28

June 2025

Executive summary

Working together
for a healthier future

Introduction

- As part of the HCP Development process, HCPs have been asked to lead the planning process for their respective populations for 2025/26. This includes the annual operational and financial planning process, plans to deliver the ICB's Medium Term Plan and production of a 3-year Integrated Delivery Plan (IDP) for 2025/26 – 27/28

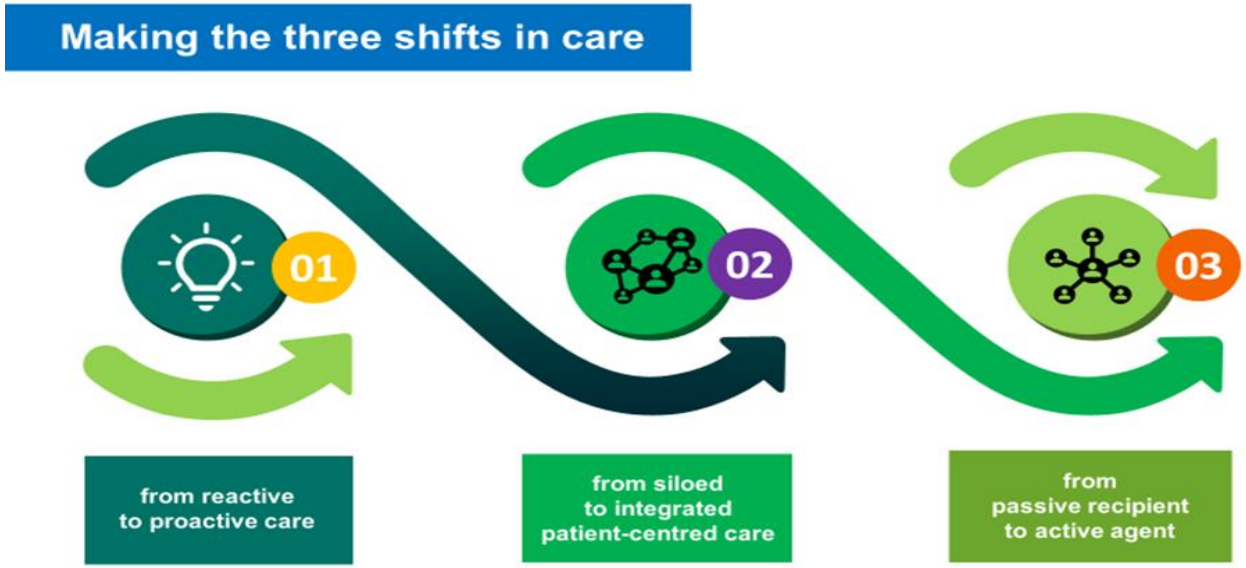
- The IDP provides a detailed update on the operational planning process for 2025/26, designed to ensure the system remains aligned around delivering key priorities while achieving financial breakeven.

- It outlines the strategic context, planning framework, financial requirements and planning assumptions for the HCP, that supports delivery of the requirements from the National Guidance, ICB strategy and Medium-Term Plan and HCP priorities.

3 Year Integrated Delivery Plan – a reminder

HWE Medium Term Plan

1. Give every child the best start in life
2. Increase health life expectancy and reduce inequality
3. Improve access to health and care services
4. Increase the number of citizens taking steps to improve their wellbeing
5. Successfully deliver our financial plan each year.



Immediate priorities 2024/25

1. Reducing waiting times for children's services.
2. Reducing inequality, with a focus on cardiovascular disease and hypertension (high blood pressure)
3. Reducing the demand for urgent and emergency care by delivering more anticipatory and same day care with a focus on frailty
4. Providing better care to people in mental health crises
5. Continuing to reduce waiting times for non-emergency/urgent surgery and diagnostic tests

East and North Herts Health and Care Partnership

Our approach

- ENH residents' needs are at the heart of our plan. We worked to understand their existing and future needs through analysing PHM data, reviewing performance against key metrics and checking alignment with national, ICS and ENH HCP priorities. We will continue to review, refine and realign activities to support delivery of services that deliver the best outcomes for our residents.

- The providers and associated member organisations that make up the ENH HCP have joint strategic intent and are working towards delivering a number of clinical services in a more integrated way and reviewing opportunities for back-office integration, including data and BI and establishing a joint learning academy

- We have a track record of delivering quality and cost-effective services. By working together, we are better able to review, challenge and transform services at a more holistic level.

- We have demonstrated an ability to meet financial demands and recognising the current challenging environment, commit to continue to deliver our services within budget. During Q1 2025/26 we will need to adapt our plans for in year delivery to meet the reduced financial envelope and refine plans for Years 2 and 3, with the expectation that new services or changes to services will be funded through efficiencies made elsewhere in the HCP.

- Despite the challenged environment, we plan that by Q4 2025/26, our work will have started to result in improvements for both our children and young people requiring access to Paediatric Audiology and Community Paediatrics services and our frail and elderly residents, with care closer to home reducing the need for urgent and emergency care through community and primary care proactive management.

Our approach

- The HCP has agreed a vision, strategy, and priorities and worked to improve relationships across the partnership. A transformation portfolio has been established covering areas including:

    - The Hospital at Home service which has supported thousands of people and currently supports c220 patients a day via a multidisciplinary team that includes doctors, ACPs, pharmacists, social workers, and support staff
    - A new Integrated Heart Failure Service;
    - Community Diagnostic Centre;
    - Ongoing work to establish and mobilise Integrated Neighbourhood Teams.

- The HCP is engaging the **voluntary sector and patients** through the Healthwatch Community Assembly which brings together a broad range of voluntary sector partners, hospices, social care and patient and carer group representatives. We are currently reviewing ways of working and how we can drive better and earlier engagement. A series of frailty workshops are planned for 30 April 2025 which will be run by our INTs and are an opportunity to share experiences and learnings

- The HCP has an engagement programme with the **District and Borough Councils** in ENH. This work is helping the HCP to identify joint priorities such as heart failure, childhood obesity and waiting well for children with autism as well as to identify opportunities for collaboration and support development of INTs.

- An ICB acute and community collaborative have been established with HCT and ENHT as active partners

HCP Priorities (Year 1, 2 and 3)

- With lower funding available for transformation in 2025/2026 the most pressing challenge for the HCP is how to deliver the change required at scale and pace to support our residents

- **The 2025/26 ENH HCP priorities for transformation build on our strategic objectives, our clinical and performance priorities, the Medium-Term Plan and the Care Closer to Home Strategy and have been agreed through a collaborative approach**. They are:

    - Paediatric audiology (provided by ENHT)
    - Community Paediatrics – ASD assessments (provided by ENHT)
    - Care Closer to Home

- As investment funding is not available, we will work to adapt our plans in Q1 2025/26 to meet the reduced financial envelope and refine plans for Years 2 and 3, with the expectation that new services or changes to services will also need to be funded through efficiencies made elsewhere in the HCP. The investment originally sought is set out on the following slide.

- Other transformation developments include working with HWE ICS to identify, agree and fund a suitable urgent and emergency minor eye care path for delivery, to be in place from April 2026.

- Moving non-urgent activities away from secondary care into community or primary care will provide patients access to advice and treatment from suitably qualified clinicians in a safe, appropriate environment closer to home and free up capacity for Urgent Eye Clinics at ENHT, whilst reducing the burden on GP resources.

Financial Summary – Investment Sought

- The additional investment which we sought for our priority areas in 2025/26 is set out below. As this investment funding is not available, as an HCP we will continue to work collaboratively on the following areas to seek efficiencies, reduce costs and transform services to benefit our population:

  - **Care Closer to Home - £1.5m total in year investment sought (£2.0m FYE)**
    - **Proactive care:** £1.0m in year (£1.4m FYE) investment sought to target 2,400 patients (in four tranches of 600 patients over a year) who are most at risk of admission (4,009 patients in total identified in ENH) for up to 12 weeks of remote monitoring. This includes the cost for the software to monitor the patient and increasing frailty clinic to 5 sessions per week. This is currently being piloted in two localities, Lower Lea Valley and Stevenage
    - **Minus-9:** £0.5m in year (£0.6m FYE) investment sought to enhance Urgent Community Response to capture patients who may otherwise be in hospital in 9 days' time and provide them with wrap-around care to prevent admission

  - **Community paediatrics (ASD assessments)**
    - £1.5m investment sought for 2025/26 and subsequent years to reduce the current neurodiversity assessment waiting list through the outsourcing of autism assessments

  - **Paediatric Audiology**
    - External investment of £887k sought in 2025/26 and subsequent years to access appropriate capacity to reduce the existing backlog of audiology patients, which combined with internal trust realignment of budgets (to allow the correct workforce to manage ongoing demand), will enable the delivery of a safe and well led service in line with recommended current practice

The Plan

- Work is in progress on all clinical priority areas. Where significant transformation is required, this has been identified within the IDP and links to our top three priority areas previously set out
- In addition to our priority areas, we retain focus on areas of improvement including efficiencies within theatres and outpatients and planned care and multi-disciplinary working on prevention.

	Work Area	Year 1	Year 2	Year 3
Children and Young People	Audiology	y	y	y
	Community Paediatrics ASD and ADHD	y	y	.
	Community Nursing	.	.	.
	Emergency Attendances and Admissions	y	.	.
Care Closer to Home	Urgent and Emergency Care	y	y	y
	Frailty – The 7 Interventions	y	y	.
	Integrated services - heart failure	y	.	.
	Integrated services - diabetes	.	y	.
	Integrated services - stroke (ICCS)	.	y	.
	Integrated services - respiratory diseases	.	.	y
	Ophthalmology (minor eye care)	.	y	.
Planned Care	Cancer	.	.	.
	Elective Recovery	.	.	.
	Diagnostics (audiology and MRI)	.	.	.
Prevention	Obesity	.	.	.
	Vaccination	.	..	

ENH HCP Alignment with ICB Medium Term Plan & Clinical Priorities 2024-26

HCP Clinical Priorities	ENH HCP Workstreams	**Priority one:** Continue our elective care recovery	**Priority 2:** Reduce UEC demand by delivering more anticipatory/same day care	**Priority 3:** Cardiovascular disease and Hypertension	**Priority 4:** Reduce waiting times in targeted children services	**Priority 5:** Provide better care to people in mental crisis
Priority LTC conditions and/or cohorts for adults	Frailty (EoL and Palliative Care)		✓	✓		Linked to MHLDA HCP Adult Community Transformation Linked to HPFT Priority 3 • Frailty pathway ad Systems Integration • Care Closer to Home Project (Mental Health Services for Older People)
	Frailty (Advanced Care Plans)		✓	✓		
	Frailty prevention (Falls)		✓	✓		
	Integrated Heart Failure Model	✓	✓	✓		
	Integrated Diabetes Model	✓	✓	✓		
	CKD	✓	✓			
	Respiratory (Diagnostic Respiratory Hubs)	✓	✓	✓		
Children & Young People	Audiology				✓	Linked to HPFT Priority 1 • Children and Young Peoples community transformation programme
	Community Nursing/Pead's		✓		✓	
	Care co-ordination		✓		✓	
	Neurodiversity				✓	
	Diabetes& Obesity				✓	
	Respiratory & Asthma		✓		✓	
Priority UEC 7 High Impact Interventions	Polypharmacy		✓	✓		Linked to MHLDA HCP Adult Community Transformation Linked to HPFT Priority 3 • Frailty pathway ad Systems Integration • Care Closer to Home Project (Mental Health Services for Older People)
	Community Falls		✓			
	Integrated Neighbourhood Teams		✓	✓		
	Advanced Card Plans		✓	✓		
	Falls Response		✓			
	Stack		✓			
	Senior Review in ED		✓	✓		

Medium Term Plan Dashboard

- The latest data shows further work is required across a number of indicators, both at ICS and ENH HCP level

Place	Priority	Indicator	Target	Previous Month	Current Month	Latest Month	Month Change
ICS	CVD and Hypertension	Hypertension QOF measures - 2% increase from baseline	15.6%	14.1%	14.1%	Dec-24	2
ICS	CVD and Hypertension	Increase % of patients with GP recorded hypertension whose last blood pressure was in target	80%	76.9%	76.9%	Dec-24	1
ICS	CVD and Hypertension	Increase age standardised prevalence of hypertension in the most deprived 20% of the population	19%	19.9%	16.0%	Sep-24	1
ICS	Improve UEC	Decrease the rate of emergency admissions for falls within the community for people aged 65+	-5.0%	1.2%	0.8%	Oct-24	1
ICS	Improve UEC	Reduction in non-elective admissions in people living with frailty	-25.0%	1.4%	2.0%	Oct-24	2
ICS	Improve UEC	Reduce the % of deaths with 3 or more emergency admissions in the last 90 days of life (all ages)	5%	6.5%	6.6%	Nov-24	2
ICS	Better Care for MH Crisis	Increase response to Community Crisis Services urgent referrals in 24/25 from 64%	67%	54.2%	49.8%	Nov-24	1
ICS	Better Care for MH Crisis	Reduce out of area inappropriate beds for adults requiring a MH inpatient stay from 16 people	4	38	23	Nov-24	1
ICS	Better Care for MH Crisis	Inpatient discharges to have 72 hour follow up	75%	93.6%	92.3%	Nov-24	1
ICS	Elective Care Recovery	Number of patients waiting more than 65 weeks for treatment	0	194	259	Nov-24	2
ICS	Elective Care Recovery	% of Surgery across HWE is consistently undertaken as day case	85%	84.6%	84.5%	Sep-24	1
ICS	Elective Care Recovery	Number of patients waiting less than 6 weeks for diagnostic	95%	58.9%	59.7%	Nov-24	2
ICS	Elective Care Recovery	Theatre productivity	85%	78.2%	79.0%	Nov-24	2
ICS	Childrens Care	Community paediatric waits greater than 65 weeks	0	3182	3238	Nov-24	2
ICS	Childrens Care	Reduction in Emergency admission rates for children and young people	-5%	4.8%	6.1%	Nov-24	2
ICS	Childrens Care	Reduction in A&E attendance for children and young people	-5%	2.9%	3.1%	Nov-24	2

Place	Priority	Indicator	Target	Previous Month	Current Month	Latest Month	Month Change
ENH	CVD and Hypertension	Hypertension QOF measures - 2% increase from baseline	15.6%	14.0%	14.0%	Dec-24	2
ENH	CVD and Hypertension	Increase % of patients with GP recorded hypertension whose last blood pressure was in target	80%	77.0%	76.8%	Dec-24	1
ENH	CVD and Hypertension	Increase prevalence of hypertension in the most deprived 20% of the population (not standardised)	-	27.5%	19.0%	Sep-24	1
ENH	Improve UEC	Decrease the rate of emergency admissions for falls within the community for people aged 65+	-5.0%	4.0%	4.9%	Oct-24	2
ENH	Improve UEC	Reduction in non-elective admissions in people living with frailty	-25.0%	1.71%	2.67%	Oct-24	2
ENH	Improve UEC	Reduce the % of deaths with 3 or more emergency admissions in the last 90 days of life (all ages)	5%	6.4%	6.4%	Nov-24	2
ENH	Better Care for MH Crisis	Increase response to Community Crisis Services urgent referrals in 24/25 from 64%	67%	51.8%	46.4%	Nov-24	1
ENH	Better Care for MH Crisis	Reduce out of area inappropriate beds for adults requiring a MH inpatient stay from 16 people	4	18	6	Nov-24	1
ENH	Better Care for MH Crisis	Inpatient discharges to have 72 hour follow up	75%	96.9%	100.0%	Nov-24	2
ENH	Elective Care Recovery	Number of patients waiting more than 65 weeks for treatment	0	45	25	Nov-24	1
ENH	Elective Care Recovery	% of Surgery across HWE is consistently undertaken as day case	85%	87.3%	87.2%	Sep-24	1
ENH	Elective Care Recovery	Number of patients waiting less than 6 weeks for diagnostic	95%	44.8%	46.5%	Nov-24	2
ENH	Elective Care Recovery	Theatre productivity	85%	81.1%	81.4%	Nov-24	2
ENH	Childrens Care	Community paediatric waits greater than 65 weeks	0	3182	3238	Nov-24	2
ENH	Childrens Care	Reduction in Emergency admission rates for children and young people	-5%	17%	18%	Nov-24	2
ENH	Childrens Care	Reduction in A&E attendance for children and young people	-5%	3%	4%	Nov-24	2

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Urgent and Emergency Care

- **Improve urgent and emergency care through more anticipatory and more same day emergency care**
- **Improve A&E waiting times and ambulance response times compared to 2024/25, with a minimum of 78% of patients seen within 4 hours in March 2026**
- **Category 2 ambulance response times should average no more than 30 minutes across 2025/26**
- **Community 2 hour response**

Impact
"What does it mean for me?"

I want to know if I need emergency care that I can access timely, high quality care	I do not want to go to hospital unless it is clinically appropriate and necessary
• Community UEC integration • SDEC • Hospital @ Home • UCR	• CB4C • H@H utilization • 7 high impact interventions • INT proactive case management • Proactive and minus-9 programmes

Performance measures
"What will we measure?"

• Community 2 hour responses for a fall • Ambulance conveyance & use of alternative pathways • Percentage of patients seen in A&E within 4hrs & 12 hrs • Category 2 ambulance response times	• % of deaths with 3+ emergency admissions in last 90 days of life • Emergency admissions for people with frailty/ falls in community/ nursing and residential homes • ED attendances for people living with frailty/living in nursing and residential homes • Completed ACPs • Medication reviews • Frailty scores

Anticipatory care

- UCCH integration and expansion
- Rapid response – patients at risk of admission within 9 days (minus-9 programme)
- INT Frailty Programme
- Falls response (EIV)

Same day emergency care and UEC

- Improved Ambulance Handover (capital required)
- Integration of Mental Health UTC with embedded ENHT UTC
- Community UEC integration, SDEC, Hospital @ Home, UCR & CB4C
- Herts IMC strategy
- ED front door – Rapid Assessment and Treatment improvement work

Frailty 25% saved admissions ambition by 27/28

Reduced frail admissions – overall ambition:
25/26 10%
26/27 15%
27/28 25%

INT proactive case management ambition (targets set at PCN level):

- 10 patients added to caseload by each PCN per month
- 10 assessed and 4-6 going into the MDT
- 94% case load aspiration/ or 23.5% reduction in frail emergency admissions (334 per annum) by April 2027

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Overview - UEC and reduction in NEL admissions 7 interventions

- ENHT has included a 1.9% ED activity increase in 2025/26 operational plans rather than the 5% forecast by NHSE. This reflects the ambition of the HCP Care Closer to Home strategy to reduce NEL frailty admissions and continuation of the UCCH work (further detail in the appendices)

- ENH Place December 2024 SUS data shows a 3% reduction in frailty admissions growth YTD for aged 65 + (from 9% to 6%)

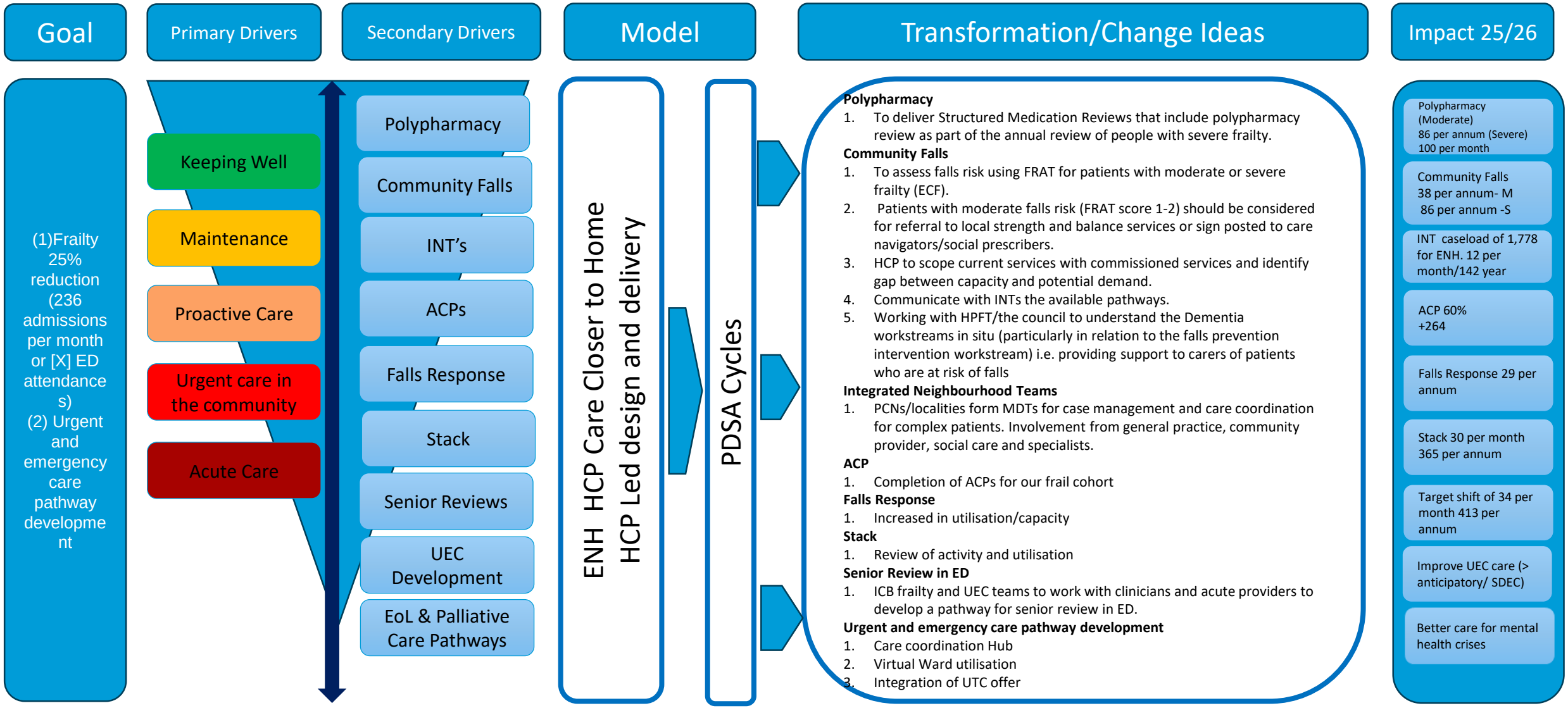
- Impact of interventions:
  - There is variation to target across all seven frailty NEL interventions, however, progress against targets has increased with the exception of Senior Reviews in ED. A review of current ED processes has taken place to understand what opportunity exists in this area
  - The HCP is working through trajectories, predicted impact and timescales to understand the challenges and corrective actions required to prioritise resources across the 7 interventions based on patient demand and staff capacity
  - The ICB's review of UTC provision across the ICS has led to system wide agreement that the ICB cannot continue with the current model of multiple access points into type 3 services, UTC fronting emergency departments, standalone UTCs, Minor Injury Units, same day access provision in primary care and standalone out of hours provision
  - Urgent Care Coordination Hubs - review showed a positive impact, with HWE being the highest performing area within the region. Since November (when the full UCCH model was implemented including Access to Stack and Call Before Convey), there has been an observable difference in the % of day-time C2-C5 ambulance incidents which get conveyed

- ENHT conducted analysis in 2023/24 which indicated that there was further opportunity in relation to culture around admission for frail elderly patients and that there is greatest opportunity amongst the more elderly and complex mild/ moderate acuity cohort of patients.

- The analysis showed:
  - 65 to 79 year olds had a close to 1:2 chance of being admitted and 80 and overs a 2:3 chance, compared to a 1:5 chance for working age
  - Differentials in admission rates for 65-79 year olds based on presenting acuity (low acuity had c.29% admission rate vs 70% for high acuity) versus 46% for the 80 and overs, even with low acuity/NEWS score

	I want to be able to access support when I need it from my GP practice	I want fair access to appropriate services irrespective of my personal circumstances	If I need specialist treatment, I don't want to have to wait a long time to be seen	If I have multiple conditions that require support from the NHS, I want access to a team of people that can help	I do not want to go to hospital unless it is clinically appropriate and necessary	I want to know if I need emergency care that I can access timely, high quality care	I want to know that every penny of taxpayers money is being spent wisely in the NHS locally
Impact *"What does it mean for me?"*							
Performance Measures *"What are we on the hook for?"* – National measures	• Patient reported access	• Reduce inequalities • Percentage of patients with hypertension treated according to NICE guidance • Percentage of patients with CVD who have their cholesterol managed	• 18 week referral to treatment time • 52 week waiters • FDS cancer targets	• Percentage of those within high risk cohorts with named clinician • Bed days/1,000 for target cohorts	-	• Percentage of patients seen in A&E within 4hrs • Category 2 ambulance response times	• Balanced net system financial position • Agency spend • Activity/ WTE gap
Performance Measures *"What are we on the hook for?"* – ICB measures	• Appointments per 1,000 patients • Average time taken to answer calls (via cloud telephony?)	• Hypertension QOF measure • Prevalence of hypertension • Percentage of people with hypertension whose blood pressure is in target	• Theatre productivity • Percentage of surgery undertaken as day case surgery	• People identified through GP IT searches • People added to the INT proactive care caseload	• Percentage of deaths with 3+ emergency admissions in the last 90 days of life • Emergency admissions for people with frailty/ falls in the community/ nursing and residential homes • ED attendances for people living with frailty/living in nursing and residential homes • Completed ACPs • Medication reviews • Frailty scores	• Community 2 hour responses for a fall • Conveyance to hospital following a 2 hour response	• Productivity measures • YTD and forecast spend against place-based allocation
Workplan *"What are we doing?"*	**Modern General Practice** • Deployment of telephony • Workforce support • Local improvement support via neighbourhoods etc	**Addressing inequalities/ Long Term Conditions** • Integrated diabetes model • Respiratory diagnostic hubs implementation • Integrated heart failure	**Elective care planning** • Reducing variation in advice and guidance • Reducing variation in referral volumes • Consistent application of ICB pathways	**INTs** • INT development • Minus-9 pathway (remote monitoring)	**Frailty and EoL** • 7 high impact interventions • Advanced support for nursing and residential homes	**Urgent and emergency care** • Care coordination hub • H@H expansion • UTC development	**Productivity and enablers** • System review of corporate functions and overheads • Shared productivity workstreams
Implementation Level *"Who is doing this?"*	Planned: ICB Delivered: Neighbourhood	Planned: ICB Delivered: HCP	Planned: HCP Delivered: Neighbourhood	Planned: Neighbourhood Delivered: Neighbourhood	Planned: HCP Delivered: HCP	Planned: HCP Delivered: HCP	Planned: HCP Delivered: HCP
	HCP oversight		**HCP-led design and delivery**				

ENH HCP Focus on Frailty- Strategic transformation driver diagram



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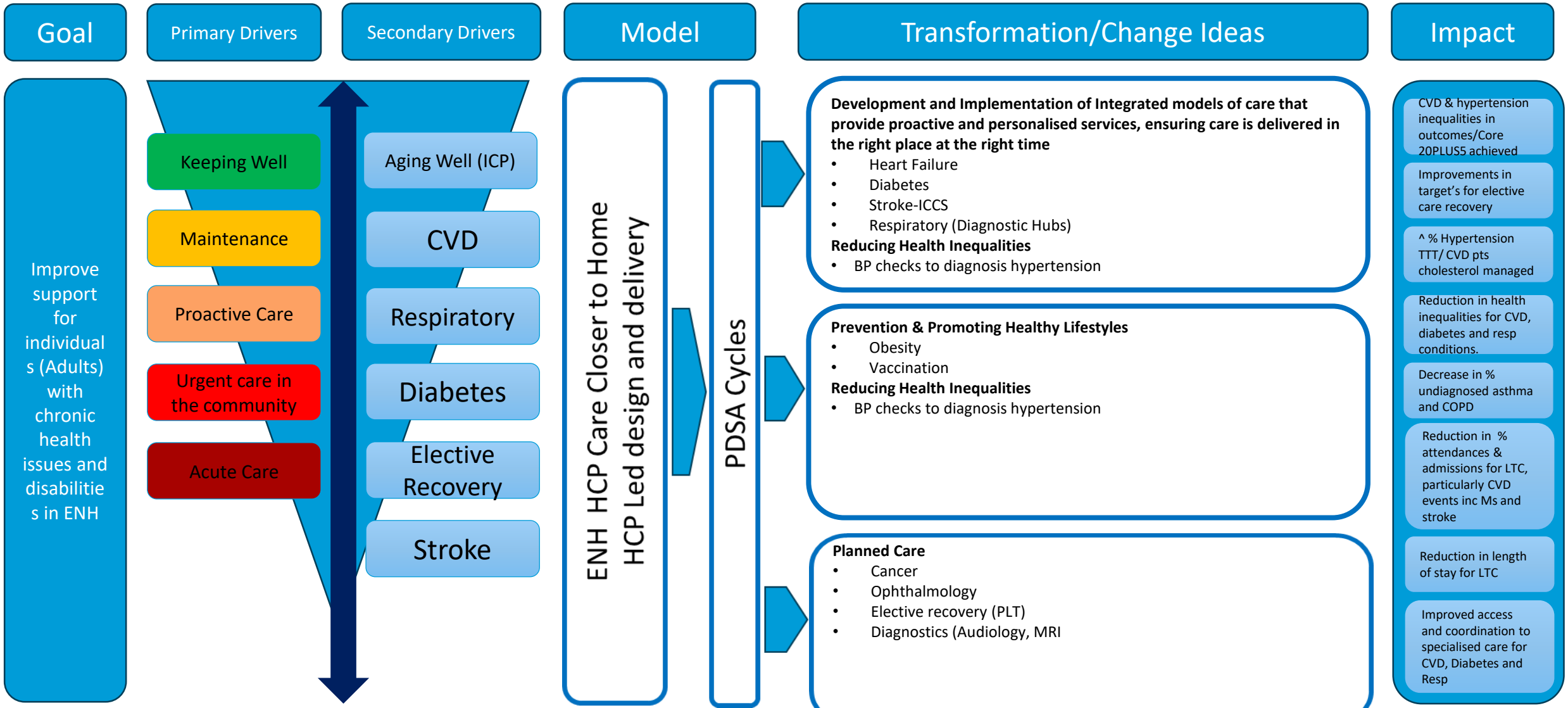
ENH HCP Focus on Adults- Strategic transformation driver diagram



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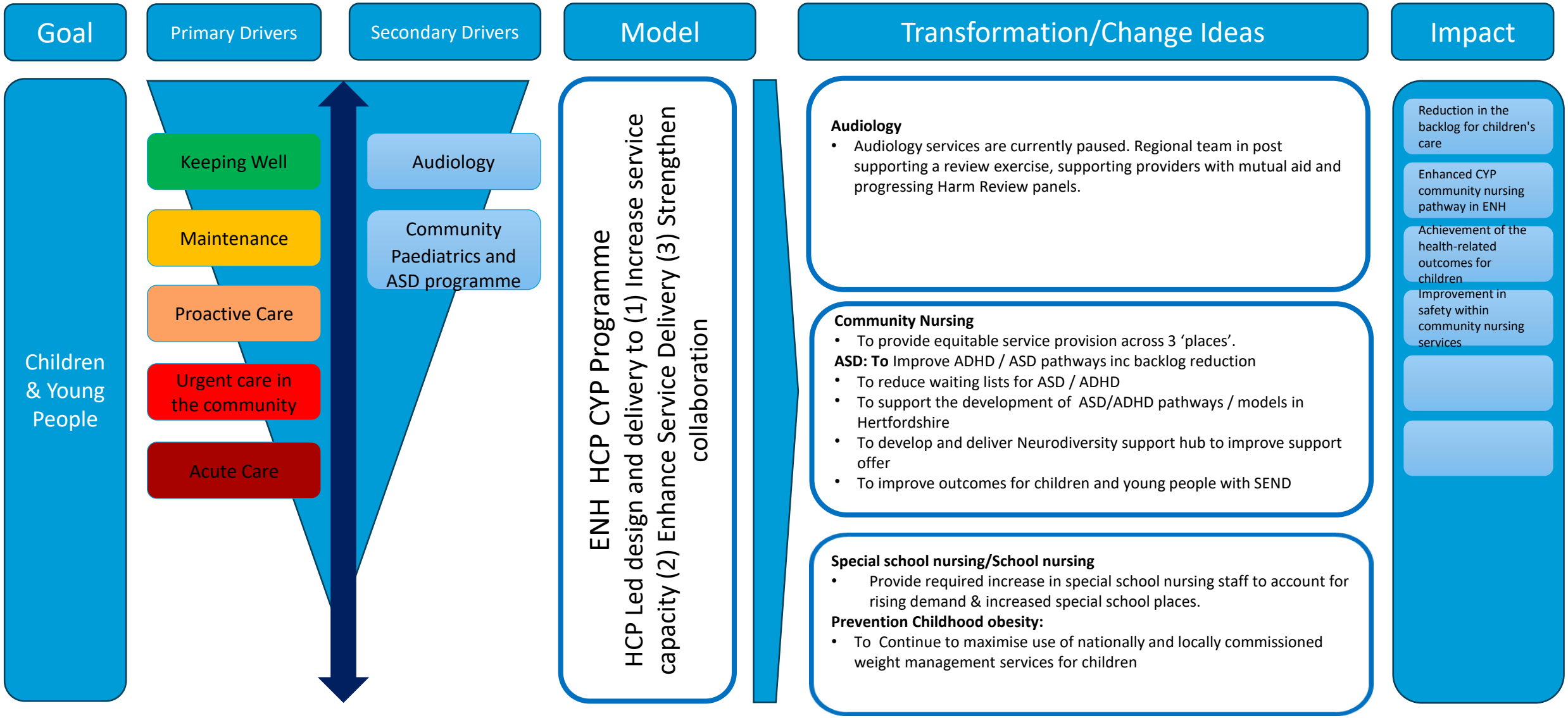
ENH HCP Focus on CYP- Strategic transformation driver diagram



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Appendices

- ENHT operational performance plan overview
- HCT, primary care and ENHT productivity plans
- ENHT improvement – planned care and UEC
- NEL frailty interventions – current progress
- Digital priorities
- Workforce
- Finance allocation 2025/26 [placeholder]
- Activity/ finance/ workforce triangulation [placeholder]

ENHT Operational Performance Plan Overview

2

Elective Performance

Compliant with national targets

Some risk to delivery e.g. T&O, gastro

64.2% of patients treated within 18 weeks at a Trust level, with nearly all services showing improvement in RTT delivery

72.2% of patients to have first appointment within 18 weeks. This excludes community paediatrics, whose waiting list will continue to grow

0.7% of total RTT waiting list to be over 52 weeks in March 2026

UEC Performance

Compliant with national targets

Ambitious trajectory for adult ED

Average 32 min ambulance handover times compared to 38 mins in 24/25, with no handovers over 45 mins

Average 73.4% of patients to be treated within 4 hours in ED, achieving **78%** in March 2026

9 percentage point reduction in patients waiting over 12 hours in ED from 17.3% in Jan 25 to 8.2% in March 2026

36.4% increase in patients seen in Same Day Emergency Care due to est. of surgical SDEC

Cancer Performance

Compliant with national targets

Proven delivery during 2024/25, but some risk on faster diagnosis with MRI

Average of 85% of patients to start cancer treatment within 62 days, achieving **86.1%** in March 2026

Average of 77.4%% of patients to have a cancer diagnosis or given the all clear within 28 days, achieving **80.4%** in March 2026

96% of patients to have started cancer treatment within 31 days

Diagnostics Performance

Audiology, ultrasound & MRI will not reach DM01 compliance

Local trajectories achievable, but risk regarding MRI transformation delivery

Many modalities profiled to achieve DM01 compliance during 2025/26 incl. gastroscopy, colonoscopy, echo, dexa & flexi sig

95% of audiology patients to remain over 6 weeks during 2025/26 due to there being no route through to backlog clearance

22.6% of MRI requests will be over 6 weeks at the end of March 2026, and **ultrasound 13.6%**

HCT - Productivity/Efficiencies and CIP Plans

HCT Improvements - efficiency/productivity/ planned care/ transformation

- HCT workforce and financial plans assume that Virtual Ward (HAH) capacity/staffing remains as is for 2025/26 – i.e. 100% occupancy of 204 beds (recognising that these are likely to be over 100% occupancy during winter months)

- UCR referrals – HCT's workforce plan assumes no growth and the number of UCR referrals is expected to remain flat

- Proactive and minus-9 pilot work is underway (further detail on these schemes is included on slide 9 and in the appendix)

- HCT has been commissioned to support the 2025/26 covid vaccination programme across the East of England, it will be offering COVID-19 vaccinations across six systems, with the goal of immunising over 84,000 individuals. Of this total, 26,000 vaccinations will be administered directly to the most vulnerable patients in their homes and an additional 13,000 vaccinations will be delivered to elderly patients within their care home settings. This operating model will be used to offer flu vaccinations at the same time to optimise efficiency of services

- In 2024 HCT was awarded the Community and School Aged Immunisation Service (CSAIS) across the East of England for a period of 4 years (plus 4). After expanding the existing footprint into BLMK and MSE, the service now operates across all 6 ICBs. The service commenced in April 2025. The key objectives of this service are to:
  - Increase the uptake of childhood vaccinations
  - Reduce health inequalities within the uptake of childhood vaccinations
  - Enable all children to receive their childhood vaccinations in accordance with national guidance, whatever their circumstances
  - Provide an immunisation team that can respond to the needs of the community, i.e., mass vaccination campaigns and outbreak control for vaccine preventable diseases and targeting hard to reach groups

HCT - Productivity/Efficiencies and CIP Plans

- **HCT Improvements - efficiency/productivity/ planned care/ transformation**
  - Productivity & efficiency pack received from NHSE identified the following cash releasing opportunities for HCT:
    - £2.8m from temporary staffing (based on out-of-date figures)
    - £2.5m from corporate services
    - £21k from commercial (procurement)
  - HCT has estimated £1.81m of this is deliverable in 25/26 based on:
    - Workforce plan identifies **£950k bank and £400k agency saving (total £1.35m)** against the £2.8m temporary staffing opportunity reflecting good work already done on bank and agency.
    - Corporate benchmarking suggests £2.3m opportunity for HCT based on lower quartile of all Trusts. The Trust has included **£535k saving based on 5.8% CIP target applied to corporate**

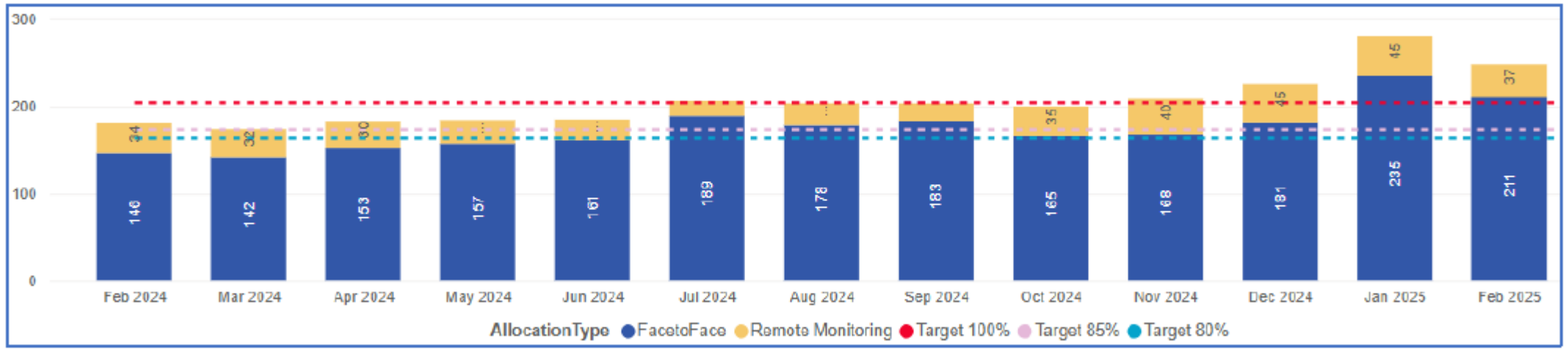

Fig.5 Hospital at Home average daily occupancy. Link

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Primary Care - Productivity/Efficiencies and improvement initiatives

- **Primary Care initiatives**
  - INT development and resource mapping is underway and leads are working to agree the level of ambition and set trajectories for each of the NEL admissions/ frailty seven interventions for 2025/26, 2026/27 and 2027/28

  - Following an evaluation of the hubs and the ENHT UTC provision, the PCNs have worked together to prepare a proposal for a one locality model for financial year 2025/26. No funding can be committed currently but the ICB's review of UTC provision across the whole system has progressed and there is system wide agreement that the ICB cannot continue with the current model of multiple access points into type 3 services (UTC fronting emergency departments, standalone UTCs, Minor Injury Units, same day access provision in primary care and standalone out of hours provision)

  - There is a commitment across the partnership to explore options for integration of same day access services to improve access for patients

ENHT productivity

- 5.0% CIP in plans
- The total productivity opportunity identified per the NHSE productivity pack is £38.6m
- The trust has identified £37m which can be delivered in 2025/26 of which £35.8m is cash releasing

The key differences between the trust and NHSE opportunities relate to:

- NEL, A&E and SDEC (£4.3m less opportunity identified)
- Elective (£1.1m greater opportunity identified)
- Temp staffing (£6.1m less opportunity identified)
- The difference is mainly made up by “other local opportunities” of £13.9m relating to space utilisation, pathway redesign and waste reduction initiatives

Productivity area	Opportunity (£m) assessment [1]	Opportunity as % of cost base [1]	Estimation of what can be delivered in 2025/26 (£m)	Estimation of how much is expected to be cash releasing (£m)	Key activities to deliver this
	From provider productivity pack	From provider productivity pack			
Non-elective overnight	3.7	2.60%	1.2	0	SEDIT and internal bed modelling indicates that the Trust is running a bed deficit compared to national benchmarking and internal bed plan. Rather than increase the available bed base, especially during winter, the Trust is planning to deliver expanded SDEC pathways that will reduce admissions and also deliver length of stay improvements that allows the bed plan to balance. There are also opportunities to change the workforce model during the summer months to support elective throughput.
A&E and SDEC	1.8	2.00%	0.0	0	The Trust is yet to identify tangible opportunities to the scale suggested by NHS England but is continuing to work through a range of analysis to identify efficiency and productivity. Part of the productivity for 2025/26 includes an increase in SDEC provision which offsets the bed imbalance that we would otherwise have but is counted under the NEL numbers above and so has not been double counted here. There are also discussions underway with system partners regarding frailty pathways to reduce attendance but which require further modelling and agreement in Q1 to understand the impact.
Elective opportunity	2.8	1.90%	3.9	3.9	Through the 2025/26 business planning process and also through robust job planning, the Trust is targeting improvements in job planned fill for leave/sickness, template changes to increase average cases per list and reduce patient cancellations in order to deliver more activity through substantive workforce and reduce the level of WLI activity in the coming year.
Outpatient opportunity	1.5	2.00%	1.5	1.5	The introduction of an electronic document management system is anticipated to release efficiency gains during 2025/26. Further, work to increase efficiency of outpatient clinics through a focus on DNA rates in services where national benchmarking shows there is an opportunity and template changes agreed through job planning are anticipated to have an in-year benefit.
Other acute activity	1.9	2.00%	1.6	1.6	There will be a focus on radiology productivity and efficiency, including optimisation of staffing models, increased adoption of AI and a critical focus on reporting efficiency and reducing high-cost outsourcing costs in 2025/26. Further, there is work underway to identify opportunities for stronger demand management for pathology and radiology requests e.g. identification of double testing on NICU for MRSA which is under review with the Infection and Prevention Control Team

ENHT productivity continued…

Productivity area	Opportunity (£m) assessment [1]	Opportunity as % of cost base [1]	Estimation of what can be delivered in 2025/26 (£m)	Estimation of how much is expected to be cash releasing (£m)	Key activities to deliver this
Temp staffing	9.8	2.20%	3.7	3.7	The Trust has forecast reducing its agency by 30% and bank by 15%. There will also be controls put in place to check and challenge temporary cover for non-patient roles, and a review of enhanced rates across the Trust to re-align them to agenda for change rates. It is anticipated that the job planning review will release productivity and efficiency in substantive sessions and allow the Trust to reduce premium rate WLI activity.
Corp services	14.2	32.60%	3.6	3.6	The introduction of an electronic document management system is anticipated to release workforce establishment during 2025/26. This will be complemented by a scoping and development of robotic process automation where this can deliver efficiencies in workflows and manual processes. The Trust will also be reviewing its non-patient facing workforce compared to pre-COVID levels and adjusting its establishment and undergoing HR processes as appropriate. This needs to be coupled with focused work on shared service opportunities with system partners. Savings are also anticipated through a focused programme of work to reduce energy consumption and reduce utility costs, and a review of off-site estate that could be consolidated back onto one of the main sites.
Medicines	1	1.20%	1.3	1.3	A full review of where bio-similar alternatives are available that are not yet in use internally, and where approriate gainshare agreements with the ICB in order to undertake patient switches are key element of this scheme. Further, the Trust is exploring opportunities regarding asceptic provision to other Trusts.
Commercial	1.9	1.00%	6.3	6.3	The Trust plans to optimise its commercial/private patient opportunities and also leverage the shared procurement team to deliver savings in 2025/26. In relation to procurement, the plan consists of bulk purchasing and contract consolidation in order to realise economies of scale; and rationalise suppliers (e.g. reduce variation in products available) and improve negotiation leverage on preferred suppliers. This will be supported by the implementation of a new inventory management system that will enhance stock visbility, reduce wate and improve supply chain efficiency. Further, the Trust intends to develop and implement a targeted strategy to maximise income for existing and new commercial streams, including through leasing underutilised estate and partnerships with private insurers.
Other local opportunities			13.9	13.9	The Trust's CIP plan is targetting opportunties through space utilisation, pathway redesign and waste reduction initiatives which will form the remainder of the broad suite of programmes that underpin the Trust's plan for 2025/26.
Total	38.6		37.0	35.8	

ENHT Improvement – planned care

- **Demand management initiatives**
  - Haematology job planning review underway, dedicated capacity for A&G being built into templates and job plans in Q1
  - Will explore opportunities for referral assessment services in specialties such as gynae, as part of a wider review of the DoS
- **Waiting list validation**
  - Over 68% of patients are validated every 12 weeks. Aiming to increase this, particularly in paediatrics, gastro and diabetes, supported by Access Team restructuring to provide greater RTT training to ensure PTLs are accurate and a focus on timely booking
  - Identifying opportunities where AI or automated processes can help rectify data quality issues and/or recording errors within PTLs
- **Outpatient transformation including PIFU**
  - PIFU exceeding 5% target in some specialities - further roll out being confirmed as part of service business plans
  - Revised outpatient transformation programme agreed in February 2025 (e.g. Rheumatology PIFU)
  - Focus on increasing straight to test in Gastro and review of urogynae pathways to ensure patients coming to the right care setting
- **Outpatient productivity**
  - Contact Centre revised model and capacity to reduce the number of calls that go unanswered implemented in Q4 2024/25
  - Revised job planning process rolled out to enable key focus specialties (T&O, ENT, gynae, haematology and gastroenterology) to undertake a review during Q1 of all job plans. To then be rolled out to each specialty
- **Inpatient productivity**
  - Focus on pre-operative assessment (POA) processes and matching capacity to demand in 2025/26
  - Aim to reduce cancellations and increase cases per list by having patients assessed and ready to fill lists at short notice
  - Testing ability to move some inpatient elective cases into daycases (same day joints and daycase hysterectomy). Have been trialled and will be subject to continual review and roll out during early 2025/26
  - Revised job planning process as above

ENHT Improvement – planned care

- **Diagnostic activity (to achieve 60% RTT and 5% improvement)**
  - Imaging Service is engaged with the Image East Imaging Network, which is focused on improving utilisation through shared learning, protocols and clinical pathways, including roll out of AI technology
  - Two areas of concern: MRI and Audiology
    - Audiology - continued work with the ICS to re-open paediatric pathways, linked to workforce trajectories and estates works. Working on competency review and clear recruitment timescales
    - MRI - Transformation case being prepared, focusing on workforce redesign. Will be supported by roll out of MRI acceleration software which will increase scanning capacity by 15% (expected to be in place during Q2)
    - CDC capacity will be reviewed monthly to ensure full utilisation
- **Cancer performance improvement**
  - Currently performing well against 62 days 85% standard and FDS despite MRI challenges
  - Trialled a care closer to home model, where eligible patients can administer and monitor their chemotherapy at home
  - Cancer Alliance bid to fund additional Cancer MRI capacity (an additional 200 scans per week) was unsuccessful
  - Additional haematology support being put in place so that cancer patients can have an on-the-day/walk-in offer for bloods
- **Cancer pathway transformation**
  - Best practice pathways for low-risk GI, breast referrals, teledermatory and non-medical biopsy for prostate have been implemented. The Trust already delivers a breast pain pathway in line with best practice
  - Funding being made available through Cancer Alliance to develop a teledermatology service at Lister Hospital, with implementation in Q2
- **Health inequalities**
  - Prioritising patients with a known learning difficulty and/or disability and treating these as a P2 priority
  - Reviewing communication and appointment offers for individuals from the most deprived geographical areas to improve access
  - Review of adolescent to adult pathways, which is a key area of inequity currently
  - Setting up a Health Equity group to identify areas where there is currently inequitable progress in health access/outcomes

ENHT Improvement - UEC

- **Alternatives to hospital admission**
  - ENHT has delivered refreshed triage training to its ED nurses to help improve their confidence and consistency in 24/7 streaming
  - New Lister UTC is now fully embedded, allowing minor injury and illness patients to be redirected away from Type 1 ED
  - Plan to implement direct to surgical assessment flows from 28th April 2025
  - Work underway with EEAST and system partners to implement direct ambulance pathways to medical SDEC/assessment, SDEC planned to open until 22.00 rather than 20.00 during the first half of 2025/26
  - Surgical SDEC to fully mobilise in April 2025 which will stream 20 patients per day
- **Mean handover response time of 15 minutes**
  - A collaborative ambulance handover working group has been established, involving operational, clinical, nursing and EEAST representatives, changes have been made to the handover team including additional portering to create flow internally to release ambulance crews earlier
  - ENHT is looking to expand its number of ambulance handover bays to reduce delays, this forms part of a capital bid submitted to region
  - Traffic light being installed on ambulance approach to ED at end of March 2025 so that Crews will know when they can come directly into ED
  - Handover process is now a 1–2-minute patient overview rather than a mini-triage that took several minutes
  - Development of direct conveyance to assessment underway but requires capacity in receiving areas to be ring-fenced. Area of focus in Q1, alongside timely transfer of patients out of ED to create cubicle space
- **Ensure best practice in hospital patient flow**
  - Plans in place to relaunch and embed internal professional standards for UEC pathways
  - Internal site meetings will be attended by Nurse in Charge of each inpatient area to increase ward ownership of discharge planning
  - Enhancements to improve overall flow and develop predictive analytics model included in capital bid to region
  - Analysis completed in March 2025 identified significant opportunity to reduce time in ED for non-admitted, non-referred patients. Improvement plan, owned by ED, being developed for implementation in April 2025
  - Relaunch of IPS in March/ April 2025 to ensure whole organisational response to patient flow and performance, including ward rounds
  - Ward leaders incorporated more into site meetings from February 2025 onwards so that they can seek timely escalation and response
  - Acute Assessment reset planned for April 2025 to ensure that it is used as a crucial pivot to release pressure in ED and not an inpatient ward

ENHT Improvement - UEC

- **Discharge to Assess**
  - Strong discharge to assess pathways in place, aided by the onsite presence of the Transfer of Care Team (ToCT) – joint weekly LLoS reviews in place from w/c 17 March to identify where discharges can be bought forward
  - Focus on understanding and embedding new pathways linked to hospital at home reconfiguration/expansion and INTs to aid quicker discharge
  - Collaborative review of the current Discharge to Assess pathway being undertaken by the ToCT with ENHT and the ICB during Q1 of 2025/26. Will also consider how to make out of area discharge process better

- **Address inequalities**
  - Ongoing joint working with the mental health UCC which is co-located with Type 1 ED
  - Undertaking joint pathway mapping with the local provider of drug and alcohol services to improve care pathways for patients attending ED with alcohol related conditions or support needs
  - High Impact User Group to be invigorated with clear measurable deliverables

Summary of progress against each of the NEL frailty 7 interventions

Intervention	Modelled potential reduction	Progress to date
1: Polypharmacy	Moderate - 18 per month / 216 per year Severe – 21 per month 252 per annum	• Data shows Meds reviews happening, expect to be able to confirm target for delivery in 25/26 . Need to increase number of reviews and ensure deprescribing is also taking place • Delivery against admission avoidance target on track for 25/26, some avoidance may have been achieved in 24/25
2: Community falls (moderate and high risk)	Moderate - 8 per month 96 per annum High - 18 per month 216 per year	• Frat Score recording needs to increase • Seeking to boost onward referral to falls prevention services (S&B or community frailty service) • Mapping work identified underutilisation in some localities of Strength and Balance capacity, but also very limited frailty service capacity. SMART target requires further work
3: INTs	30 per month 356 per year	• 1,778 patients (3 per 1000 population managed through INTs over the 12 month period) • Iterative approach within existing system resources- timescales to reach full caseload target yet to be agreed
4: Digital ACP	44 per month 528 per year	• No digital ACP system. PHM team to rework aspiration target based on manual work around • New EHCH service focused on delivering ACP, clarifying SMART targets • Outside CH looking at more consistent completion for those on EOL register
5: Falls response	76 per month, 912 per year	• 1796 falls attended by EIV in 2024/25 - target will be surpassed in year. Likely to already be reducing admissions this year • Modelling now required to confirm impact and if more could be achieved
6: Stack	6 per month, 72 per year	• Modelling underway to set trajectories • Conflicting metrics used in reporting makes progress difficult to confirm but expect good increase in numbers • Community capacity limits ability to divert and complete more
7: Senior review in ED	86 per month. 1,032 per year	• Evidence base suggested all patients with high frequency emergency admissions in frailty (UTI, heart failure, pneumonia, skin infections and wounds) receive a senior clinical review and assessment for alternatives to admission. ENHT Pilot and 25% dashboard have focused on CFS completion, therefore, not confident that this intervention will deliver against its target in 25/26. As this target is expected to deliver a significant % of the reduction, this needs to be explored further as a priority. ED review undertaken and feedback awaited

Digital priorities

In addition to developing and delivering interoperability and collaborative working through digital solutions, our partners have identified the following key digital solutions to be progressed within the next 3 years:

- HCT key priority is to proactively use remote monitoring and health technology to target community services and prevent deterioration (i.e. the Proactive minus-9 programme)
- ENHT identifying opportunities where AI or automated processes can help rectify data quality issues and/or recording errors within PTLs
- ENNT Imaging Service is engaged with the Image East Imaging Network, which is focused on improving utilisation through shared learning, protocols and clinical pathways, including roll out of AI technology
- ENHT diagnostics - MRI - Transformation case being prepared, which will be supported by roll out of MRI acceleration software that will increase scanning capacity by 15% and is expected to be in place during Q2
- BCF will continue to be used to support the preventative use of digitally enabled technology – e.g. HCC and partners rolled out a proactive pathway offer using digitally enabled sensors to collect data linked to a Dashboard (developed in collaboration with social care practitioners and families) that supports preventative care planning

Workforce

- **Agency and bank usage targets**
  - Agency expenditure: systems must reduce agency spending by 30% based on 2024/25 forecasts
  - Bank expenditure: systems must reduce bank spending by 10% from 2024/25 levels

- **Workforce assumptions made in modelling – ENHT**
  - 15% reduction in Bank usage and a 30% reduction in Agency usage
  - Planned reduction in establishment of 207 (3.1%) and a 233 (3.8%) reduction in staff in post

- **Workforce assumptions made in modelling - HCT**
  - No proposed growth in the ENH workforce
  - The 5% CIP equates to c125 WTE. The Trust plans to achieve this through maintaining a 7% Vacancy Rate (7.4 % average for 2024/25) which equates to c175 WTE
  - The plan includes a 40% reduction in agency usage and a 10% reduction in bank usage based on M10 forecast end of year position. This is expected to deliver a Temporary Staffing CIP saving of £1.35m

Activity/ finance/ workforce triangulation

[Placeholder]

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

Integrated Delivery Plan – summary

Working together
for a healthier future

MHLDN HCP – our vision, principles and outcomes

Vision

Supporting people living with mental illness, learning disabilities and autism in Hertfordshire to live longer happier and healthier lives

Guiding principles

- A strong mental health and learning disability and autism voice across the system
- Safe, high quality mental health, learning disabilities and neurodiversity support and services across Hertfordshire
- A focus on preventing people from becoming unwell and the promotion of positive health and wellbeing
- Integration of mental and physical health support and services

Our population

- People who are largely well, or people living with a long-term condition/multiple conditions who may have a need for mental health intervention and/or additional support in relation to their learning disability or neurodiversity to be able to continue to live their lives
- People who have more complex mental health, learning disability or neurodiversity needs, likely to be longer term in nature and whose behaviours may pose a risk to themselves or others and who need highly specialist, multidisciplinary intervention, support and care

Outcomes

- Supporting people with mental illness, learning disabilities and neurodivergent people to lead fulfilling lives
- Addressing the wider determinants that contribute towards an individual's recovery, wellbeing and independence
- Improving the emotional and mental wellbeing of the population across the lifespan and at different ages and stages
- Addressing inequalities in access, experience and outcomes
- Destigmatising mental illness, learning disabilities and neurodiversity

Understanding the needs of our local population

- Mental disorders represent the second largest single cause of disability in the UK across all ages, with 1 in 4 adults experiencing at least one diagnosable mental health problem each year. Half of all mental health conditions begin before the age of 14, with three-quarters established by 24 years of age. The cost of mental ill health to the UK economy is estimated at £105 billion a year, almost the cost of the entire NHS.

- In Hertfordshire and West Essex:
    - Long-term mental health conditions significantly increased by 33.5% between 2018 and 2021, in line with the national trend
    - Severe mental illness (SMI) diagnosis increased by 5% between 2017/18 and 2020/21 in Hertfordshire
    - The 2021-2023 Hertfordshire Suicide Audit reported 230 deaths concluded as suicides by the Hertfordshire Coroner Service between 2021 and 2023

- The premature mortality rate in adults with referrals to secondary mental health services in Hertfordshire has significantly increased between 2016-18 and 2020-22 (from 71 to 79 per 100,000). However, this remains significantly lower than the national rate.

- The Hertfordshire Dementia Strategy published in 2023 estimated that there are 14,638 people over 65 living with dementia in Hertfordshire and around 900 people under the age of 65 with dementia. These numbers are expected to grow substantially over the coming years.

- In 2022/23, 4,034 pupils had a primary need of moderate, severe or profound & multiple learning difficulties – most of which were in state funded primary or secondary schools

- In 2020, it was projected that there were 21,594 adults with learning disabilities in Hertfordshire. This number is predicted to increase by 7% to 23,106 adults in 2040 with the biggest increase occurring in the 65+ group.

- The LeDeR report for 2023/24 showed that the median age of death for someone with a learning disability was 62 for males and 66 for females with a learning disability (compared to 82.3 for males and 85.8 years for females without a learning disability).

- The number of deaths classified as avoidable was 47% compared to 22.8% for all deaths in the UK. The most common underlying causes were diseases of the respiratory system, cancers and diseases of the circulatory system.

- A confidential inquiry into avoidable deaths found that problems in advanced care planning, living in inappropriate accommodation, carers not being listened to and not adjusting care as needs changed contributed towards premature deaths. Other research has indicated that those with learning disabilities find it difficult to access care because reasonable adjustments are not always made and they are not always being fully involved in their care and treatment.

Our priorities to address these needs

	Mental Health discharge	Mental Health Crisis	Learning Disabilities and Neurodiversity
Key activities and programmes	• Implementing Culture of Care and National Inpatient Quality programme • Developing a new support offer for people with autism • Delivering a new service for people with Emotionally Unstable Personality Disorder • Introducing an intensive enablement service – a new mental health and social care pathway for people with complex needs	• Increased Section 136 capacity and capital investment • Development of Crisis alternatives and refreshed crisis pathway • Implementation of Mental Health Response Vehicle • System-wide review of CYP mental health crisis support	• Delivery of the All-Age Autism Strategy • Health improvement programme including STOMP/ STAMP, annual health checks and LeDeR • Development of a new Learning Disability Strategy • Implementation of national discharge guidance and Mental Health Act reforms • Minimising inpatient admissions
Alignment to Medium Term Plan	• Improve access to health and care services	• Improve access to health and care services	• Increase healthy life expectancy and reducing inequality • Improve access to health and care services • Increase the number of residents taking steps to improve their wellbeing
Alignment to Joint Forward Plan	• Better Care for Mental Health crises • Improve urgent and emergency care	• Better Care for Mental Health crises • Improve urgent and emergency care	• Reduce inequality with a focus on outcomes for cardiovascular disease and hypertension
Alignment to national priorities	• Deliver the 10 High Impact Actions for mental health discharges and ensure that system discharge plans include mental health acute pathways, reducing average lengths of stay in the adult acute mental health pathway, improving local bed availability and reducing the need for inappropriate out of area placements	• Reduce 12 hour waits in A&E through: maximising the use of crisis alternatives, including 111 mental health option, crisis resolution and home treatment teams, and community mental health services to keep people well at home; ensuring robust system oversight and implementation of the mental health OPEL framework	• Work with local system colleagues to ensure that there is high quality and accessible community infrastructure in place for people with a learning disability and autistic people
How will we know we are having an impact	• A reduction in the average length of stay from 54.8 days to 51.8 days • Reduce the number of active inappropriate adult acute mental health out of area placements across the ICS to zero (0) by March 2027	• Increase 24-hour response to Urgent Referrals to Community Crisis Services from 60% to 67%. • Reduction in proportion of MH attendances spending over 12 hours in A&E	• Improvements in LDA population health outcomes • Reduction in inpatient care for adults and children with learning disabilities and autism • Increase the number of people with learning disabilities receiving a health check

Our priorities to address these needs

	Children and Young People	Primary and Community Mental Health	Suicide Prevention
Key activities and programmes	• Implement the new Autism/ADHD pathway for children and young people • Improve access to CYP Mental Health services • Clarify national expectations around the expansion of the Mental Health Support Teams in schools offer • Implement HertsHub digital Work with schools and early years settings to improve transitions	• Delivery of MHLDA Physical Health strategy • Expansion of the Individual Placement Support scheme • Delivery of a system-wide approach to Intensive and Assertive Outreach. • Mobilisation of mental health, learning disabilities and neurodiversity elements of Care Closer to Home. • Expansion of the Depression pathway across all providers	Delivery and implementation of the new Suicide Prevention Strategy Further development of the Real Time Suicide Surveillance capability Expansion of the suicide prevention pilot within acute trusts
Alignment to Medium Term Plan	• Every child has the best start in life • Improve access to health and care services • Increase the number of residents taking steps to improve their wellbeing	• Increase healthy life expectancy and reducing inequality • Improve access to health and care services • Increase the number of residents taking steps to improve their wellbeing	• Increase healthy life expectancy and reducing inequality
Alignment to Joint Forward Plan	• A reduction in the backlog for Children's Care	Reduce inequality with a focus on outcomes for cardiovascular disease and hypertension	• Better Care for Mental Health crises
Alignment to national priorities	• Improve productivity by reducing unwarranted variation in the numbers of CYP accessing services and the number of contacts per whole time equivalent hours worked • Reduce local inequalities in access to CYP mental health services, between disadvantaged groups and the wider CYP population. • Expand Mental Health Support Teams	• Deliver effective courses of treatment within NHS Talking Therapies and reduce ill-health related inactivity, through access to Individual Placement Support (IPS)	• Reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner • Improve support for people who have self-harmed • Improve support for people bereaved by suicide
How will we know we are having an impact	• Reduced waiting lists for neurodiversity services • The number of people accessing specialist community perinatal mental health and maternal mental health services • Number of children and young people accessing mental health support	• Increase the number of people with Severe Mental Illness receiving annual health checks • Improvement in Reliable Recovery and Reliable Improvement rates for Talking Therapies • Number of people accessing the Individual Placement Support (employment support) service	• A reduction in the local suicide rate • An expansion in all-age mental health crisis services in partnership with wider system partners such as VCSE organisations, to support current demand for services. • Better equipped and knowledgeable workforce about suicide, and how they can support their own mental health • Improved awareness for professionals on signposting to available services and referral routes

Our priorities to address these needs

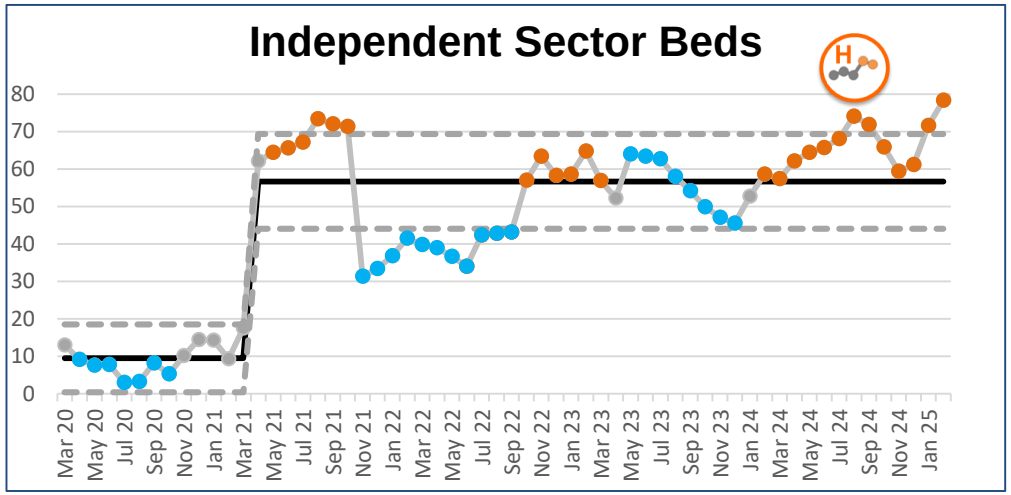
	Co-occurring Mental Health and Substance Use	Dementia	Tackling Inequalities
Key activities and programmes	• Commence 18-month pilot of 4xD&A Workers in HPFT Adult Community teams, working alongside CGL & evaluate the impact. • Improving access pathways between D&A providers and NHS MH services (inc. Talking Therapies Adult Community MH, MH Liaison). • Improve system oversight and learning from deaths of people with co-occurring MHSU.	• Identify and refer people for assessment earlier and ensuring that Hertfordshire is ready for the introduction of new drug therapies • Raise aware of young onset and rare forms of dementia and deliver age-appropriate services to people affected by these conditions • Improving access to and take-up of Carers health checks and emotional support services and increasing respite breaks for Carers	• Full implementation of the Patient and Carer Race Equality Framework • Progress the recommendations from the Equality Impact Assessment to improve for Dementia services in Hertfordshire • Adopt a cross- sector, partnership approach to focus on the physical health of people with severe mental illness, learning disabilities and neurodivergent people
Alignment to Medium Term Plan	• Increase health life expectancy and reduce inequality • Improve access to health and care services • Increase the number of residents taking steps to improve their wellbeing	• Increase healthy life expectancy and reducing inequality • Improve access to health and care services • Increase the number of residents taking steps to improve their wellbeing	• Increase healthy life expectancy and reducing inequality • Increase access to health and care services
Alignment to Joint Forward Plan	• Better Care for Mental Health crises	• Better Care for Mental Health crises	• Reduce inequality
Alignment to national priorities	• Better care for people with co-occurring mental health and alcohol/drug use conditions	• Enabling Equitable and Timely Access to Diagnosis • Ensuring People with Dementia have Equitable Access to Appropriate Health and Care Services • Supporting People Affected by Young Onset Dementia. • Supporting Carers of People with Dementia	• Reduce inequalities in line with the Core20PLUS5 approach and ensure plans reflect the needs of all age groups, including CYP
How will we know we are having an impact	• Specific indicators are being developed as part of the co-occurring MHSU programme during 25/26 to capture information and reflect the joint work across agencies.	• Improved dementia diagnosis rates across Hertfordshire • Numbers of organisations registering for and being accredited as dementia aware or dementia friendly • Improved health outcomes for people caring for someone with dementia • Improved pathways for people in hospital or moving from one care setting to another (including discharge from hospital back to home or residential care)	• Sustained improvements in the numbers of people with Severe Mental Illness and Learning Disabilities receiving an Annual Health Check • Reduction in differential for people from Black and Minority Ethnic communities in access to, experience of and outcomes from mental health support and services • Improvement in the median life expectancy of people with SMI, Learning Disabilities and neurodivergent people

Tracking our delivery

Priority	Why is this important	What we are committing to deliver
Reducing length of stay in adult and older adult mental health inpatient care	Inpatient care is the most expensive part of the mental health system. Ensuring that the time people spend in inpatient units is productive	A reduction in the average length of stay from 54.8 days to 51.8 days
Reducing inappropriate out of area placements	Out of area placements have poorer outcomes for service users than local placements	A reduction to zero inappropriate out of area placements by June, subject to agreement on local block contracts
Talking Therapies – Reliable Recovery and Reliable Improvement rates	These demonstrate whether or not Talking Therapies (primarily Cognitive Behavioural Therapy for people with mild to moderate mental ill health) has had a positive impact on the person receiving treatment	67% of people achieve reliable improvement and 48% of people achieve reliable recovery
Number of people accessing specialist community perinatal mental health and maternal mental health services	Mental health issues are the largest cause of death for mothers during the perinatal period. Good parental mental health has a positive impact on the life chances of children	At least as many people will access support as did in 2024/25
Number of children and young people accessing mental health support	Poor mental health amongst children and young people has been increasing significantly over the last 20 years. Addressing mental health concerns amongst children and young people improves their life chances	At least as many people will access support as did in 2024/25
Number of people accessing the Individual Placement Support (employment support) service	Getting or maintaining employment is correlated with a positive impact on mental health	At least as many people will access support as did in 2024/25

Scheme details - Mental health discharge

A major priority over the next three years is to reduce the number of privately provided mental health beds that are purchased. This is particularly focused on inappropriate out of area beds as clinical outcomes are poorer, with links to family, friends and local communities weakened as people spend long periods of time a long way from their local areas. As a result of the Covid pandemic there was a step change in demand for beds, leading to much higher usage of independent sector beds as set out in the graph.



Scheme	Change	Start date
Dove ward repurposed	Creation of 15 adult acute beds on HPFT estate – avoiding the need for 15 private beds	April 2026
Ascent Crisis service for those with EUPD	A reduction in inpatient admissions by 50% (50 fewer admissions) preventing 1650 bed days	Q3 2025 subject to approval and recruitment
Crisis House	Development of a new 6 bedded unit. At 85% occupancy, prevents 1862 bed days	Q3 (subject to final contract negotiations and recruitment
Developing a support offer for people with autism	A specialist autism wraparound service to support people with autism in the community – saving between 5 and 10 admissions for people with autism	Business case development over the course of 2025/26
14 beds Intensive Enablement Service	The project is block commissioned for service users with functional mental illness, often with complex needs. The Service is a social care mental health 'rehabilitation' pathway, which is aimed at supporting Service Users into semi-independent or independent living and return to live and participate in community activities.	Summer 2025
Effective procurement and contract management	Negotiations to agree block contracts for the number of beds for the year ahead. This will bring efficiencies and enable discussions on quality and safety: especially around length of stay, readmission rates	Summer 2025
Partnership working with private sector	Activity to explore how we might access additional capital by working in partnership with independent sector providers to develop jointly delivered acute beds	2026/27

Financial sustainability and productivity - headlines

- Through the Integrated Health and Care Commissioning Team, the MHLDN HCP has oversight of the pooled budget for mental health and learning disability services across Hertfordshire County Council and Hertfordshire and West Essex ICB.
- The total funding within the pooled budget is £450m – of which £255m is spent on NHS services and £198m on County Council and VCFSE services.
- The Mental Health Investment Standard (MHIS) remains in 2025/26 – each ICB must continue to ensure that their investment in mental health services rises at a faster rate than their overall budget.
- Mental Health Service Development Funding is captured within the MHIS, however money previously within the Learning Disability and Autism Service Development Fund cannot be treated in the same way. This money previously supported activity related to the development of neurodiversity services in Hertfordshire.
- National funding has been made available (through the Autumn Statement) to support the delivery of effective courses of treatment within NHS Talking Therapies and reduce ill-health related inactivity, through access to individual placement support (IPS)
- The HPFT share of the system Delivering Value savings is approximately £28m. Specific activity will be taken forward across the Trust in the following areas:
  - Talking Therapy services
  - Increasing the number of people seen by each clinician in community services for adults, children and young people
  - Reducing length of stay in inpatient services
  - Lowering temporary staffing costs
  - Ensuring corporate costs are kept to an absolute minimum
  - Exploring commercial opportunities
- HCC has a savings plan for £46m in 2025/26
- Some key elements of transformation still dependent on national clarity around funding, specifically:
  - Implementation of Intensive and Assertive outreach model
  - Expansion of Mental Health Support teams in Schools

Alignment and integration with the place-based HCPs

- The MHLDN HCP's Integrated Delivery Plan aligns with and complements the Integrated Delivery Plans of the place-based HCPs.
- The MHLDN HCP mobilises the necessary system input and clinical expertise to ensure HWE ICB priorities and place-based delivery responds to the needs of people with mental illness learning disabilities and neurodivergent people.
- As examples:
  - The MHLDN HCP has worked with Care Closer to Home team to ensure that this system-wide approach is designed and implemented so that this cohort are included from the outset.
  - The MHLDN HCP's Dementia Programme provides updates to each place's Frailty Boards to ensure alignment and best practice is shared
- The MHLDN HCP works with the place-based HCPs to ensure that mental illness, learning disabilities and neurodiversity is represented and supported through the emerging locality structures with alignment of MH and LD community teams and VCFSE support

ENH HCP Alignment with ICB Medium Term Plan & Clinical Priorities 2024-26

HCP Clinical Priorities	ENH HCP Workstreams	Priority one: Continue our elective care recovery	Priority 2: Reduce UEC demand by delivering more anticipatory/same day care	Priority 3: Cardiovascular disease and Hypertension	Priority 4: Reduce waiting times in targeted children services	Priority 5: Provide better care to people in mental crisis
Priority LTC conditions and/or cohorts for adults	Frailty (EoL and Palliative Care)		✓	✓		Linked to MHLDA HCP Adult Community Transformation Linked to HPFT Priority 3 • Frailty pathway ad Systems Integration • Care Closer to Home Project (Mental Health Services for Older People)
	Frailty (Advanced Care Plans)		✓	✓		
	Frailty prevention (Falls)		✓	✓		
	Integrated Heart Failure Model	✓	✓	✓		
	Integrated Diabetes Model	✓	✓	✓		
	CKD	✓	✓			
	Respiratory (Diagnostic Respiratory Hubs)	✓	✓	✓		
Children & Young People	Audiology				✓	Linked to HPFT Priority 1 • Children and Young Peoples community transformation programme
	Community Nursing/Pead's		✓		✓	
	Care co-ordination		✓		✓	
	Neurodiversity				✓	
	Diabetes& Obesity				✓	
	Respiratory & Asthma		✓		✓	
Priority UEC 7 High Impact Interventions	Polypharmacy		✓	✓		Linked to MHLDA HCP Adult Community Transformation Linked to HPFT Priority 3 • Frailty pathway ad Systems Integration • Care Closer to Home Project (Mental Health Services for Older People)
	Community Falls		✓			
	Integrated Neighbourhood Teams		✓	✓		
	Advanced Card Plans		✓	✓		
	Falls Response		✓			
	Stack		✓			
	Senior Review in ED		✓	✓		

Better care for mental health crises, Dementia Strategy, MHLDA Physical Health Strategy, CYP Neurodiversity Programme, Employment and Employability will be lead and delivered by the MHLDA which will support and ensure alignment with SWH programmes

Examples of aligned work delivered through the MHLDA include:

SWH HCP Programme	ICS Priority	MHLDA HCP programme	Overview
Long Term Conditions	Addressing **inequalities/ Long Term Conditions**	Delivery of MHLDA Physical Health Strategy	Support for co-occurring common mental health issues (depression anxiety), as well as health gaps for Severe Mental Illness, Learning Disabilities and Neurodiversity
Children and young people	Reduction in the backlog for **children's care**	CYP Neurodiversity Programme Delivery of all age Autism Strategy	Ensuring children and young people requiring diagnosis and support for Autism & ADHD are able to access readily
Urgent and emergency care	Improve **urgent and emergency care** through more anticipatory and more same day emergency care	MH Crisis Care Partnership Board programme (MH Urgent Care Centre, MH Joint Response Vehicle)	Ensuring urgent care provision including the transfer of care hub and virtual hospital is appropriately staffed to support diverse presenting cohorts including dementia, Severe Mental Illness, Learning Disabilities and Neurodiversity
Urgent and emergency care/ Frailty and end of life		Delivery of Dementia Strategy	Ensuring appropriate dementia care and reasonable adjustments for Severe Mental Illness, Learning Disabilities and Neurodiversity
Enablers		Supported Employment public sector pledge	

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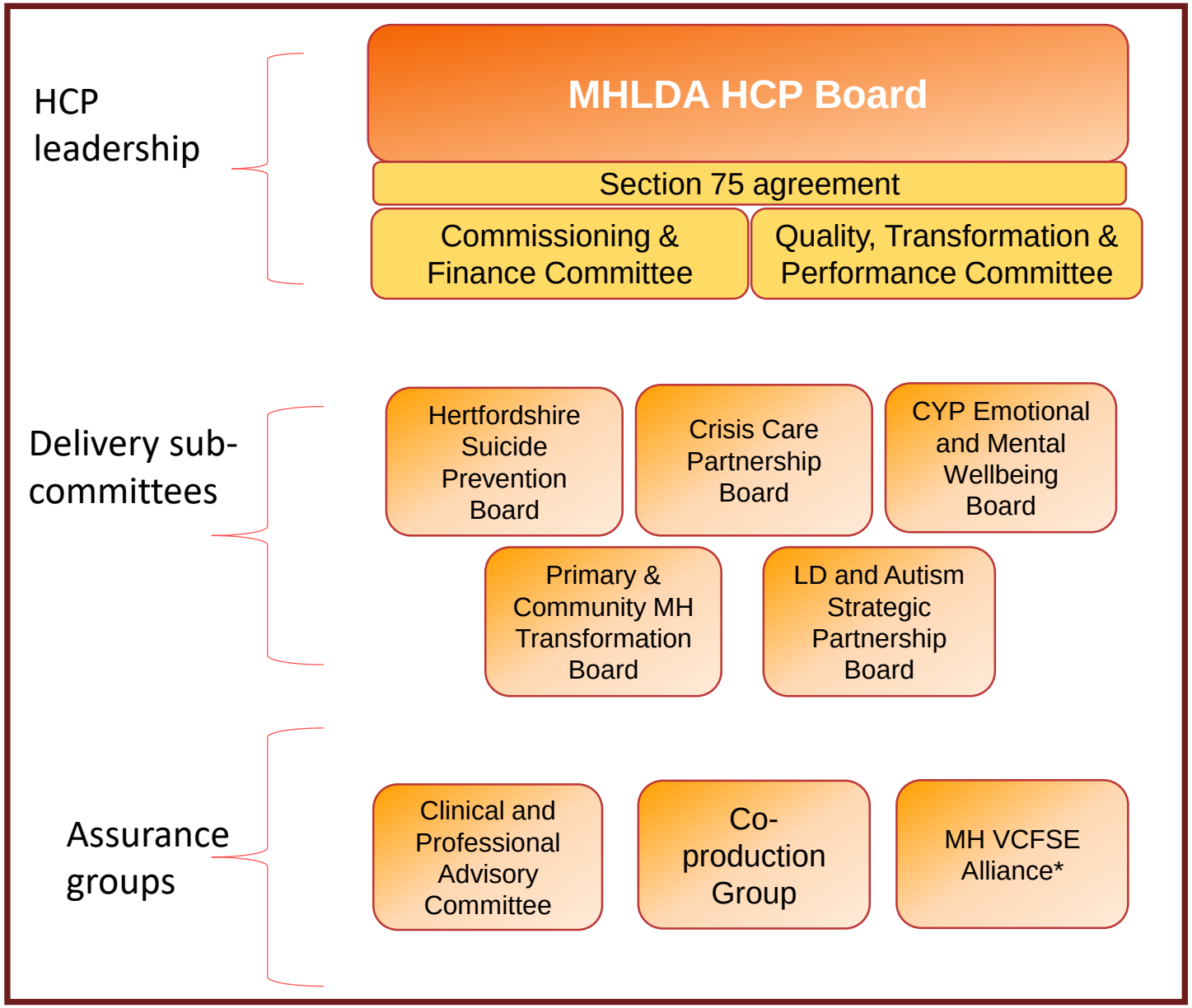
Herts Mental Health, Learning Disability and Neurodiversity Health and Care Partnership

How we will deliver the IDP

- The MHLDN has mature, multi-agency delivery committees to take forward the priorities and activity outlined in the Integrated Delivery Plan.
- The MHLDN Finance & Commissioning and Quality, Transformation & Performance committees will provide oversight and assurance for effective delivery.
- HWE ICB has confirmed that HPFT to become host provider for the MHLDN HCP from 01 July 2025.
- This presents an opportunity to embed and deepen the longstanding integration between NHS and local government services including the pooled funds for Mental Health and Learning Disabilities and the joint-commission function.
- Activity is planned over the next 6 months to finalise the required legal, financial and governance arrangements.
- The MHLDN is scheduled to review and approve the IDP at its meeting on 13 June 2025.



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

South and West Herts Health and Care Partnership

NHS Hertfordshire and West Essex Integrated Care Board

SWH HCP Integrated Delivery Plan 2025/28

Executive Summary

Working together
for a healthier future

SWH HCP Integrated Delivery Plan- Our Approach

Planning

- The Integrated Delivery Plan has been developed from the National Operational Guidance requirements for 25/26 and incorporates a programme of work on how the HCP will deliver the ICB priorities identified in the Ten-Year Strategy and the Medium-Term plan interventions
- The planning process has been supported by all HCP partners and incorporates individual organisation's strategies and plans that have informed the creation of our HCP's transformation priorities that will enable the achievement of these priorities when measured against planning objectives and financial allocations
- The operational plans for activity, finance and workforce were submitted to NHSE as 'headline submission on the 27th of February, however, we have been advised that our headline submission did not meet the required expectations with regards to our financial plan
- The IDP design is iterative with detailed planning including:
    - Financial Planning (to break-even position)
    - Detailed transformation plans with ambitions and trajectories
    - Final detailed activity plans reflecting the planned transformation delivery
    - Final workforce plans reflecting the activity and transformation
    - Productivity and efficiency plans for providers and the system reflecting opportunities to be realised for cash-releasing and non-cash releasing activities

Delivery

Our delivery will be guided by the following areas of focus:

- We will fully mobilise delivery through our four neighbourhoods
- Our neighbourhoods will be fully accountable for delivering agreed outcomes for their local populations
- We will prioritise only those transformation schemes that will have a material impact on delivery of national planning guidance requirements, Medium Term Plan and local priorities
- The HCP has made a commitment that the neighbourhoods will be its delivery arm. In doing this neighbourhoods are expected to:
    - Drive **operational delivery**
    - Develop locally delivered features of the HCP's **clinical and care operating model**
    - Identify **local priorities**
    - Drive **change**
    - Drive **efficiency and productivity** by delivering transformation
    - Seek **active engagement** with all partners working within the neighbourhood including community stakeholders

SWH HCP Integrated Delivery Plan- Planning assumptions

As an HCP we need to develop a breakeven IDP and work collaboratively on the following areas to seek efficiencies, reduce costs and transform services to benefit our population. We are expecting to deliver our priorities within the following constraints:

- After the impact of convergence and deficit pay back we expect very little growth in allocation
- Some of the System Delivery Funding (SDF) will be rolled into general allocations (yet to be determined)
- Minimum 5% Cost Improvement Plan (CIP) agreed by system
- Elective Recovery Fund (ERF) will be capped for the system for 25/26
- Deficit support funding will be lower than in 24/25

These constraints present significant risks to delivery of the national and system priorities that will require the HCP to work together using an open-book approach to delivering transformation activities that are either cash releasing and cash avoidance

		Acute planning assumptions	Community planning assumptions
Developing the 2025/26 baseline	**Starting point**	• 2024/25 Month 5 has been used as the starting point and forecast to year-end	• 2024/25 Month 5 has been used as the starting point and forecast to year-end, and this has been updated for month 9 • 3.3% pay award where this was offered has been added
	Non recurrent funding	• Non-recurrent funding (i.e. targeted ICS support and deficit support funding) has been adjusted out	• Non-recurrent system support (mainly long COVID funding) adjusted out
	Cost pressures	• Cost pressures attributed to non-ERF variables (high-cost drugs and unbundled diagnostics) added in	• Cost pressures relating to TOPs have been added

	Net uplift	• It is assumed that a net uplift of 1.65% may be applied:
		  • 4.15% inflation
		  • -2% efficiency
		  • -0.5% convergency	

Growth		• The 2.2% population growth is not included and is currently held centrally for HCP/ICB consideration	
Risks		• Non-ERF variables costs pressures increased in month 9 • ERF overperformance considering the ERF cap in 2025/26	• Current levels of activity will be maintained • Hospices request for uplifts • Tier 3 Weight Management contract changes (costs attributed to exit arrangements from HCT and injectables) • BCF agreement still being worked through • CLCH - Respiratory Contract (£307k funded through COVID funding in 24/25) and EIV (£677k previously funded through SDF)

South and West Herts Health and Care Partnership

SWH HCP Integrated Delivery Plan- Productivity

Productivity area	Opportunity (£m) assessment	Opportunity as % of cost base	Estimate of what can be delivered in 2025/26 (£m)	Estimate of how much is expected to be cash releasing (£m)
	From provider productivity pack			
Non-elective overnight	£3.9m	2.00%	1.9	1.9
A&E and SDEC	£1.8m	2.00%	0.9	0.9
Elective opportunity	*£1.9m*	*1.90%*	1.3	1.3
Outpatient opportunity	*£1m*	*2.00%*	1	0.5
Other acute activity	*£1.3m*	*2.00%*	0.7	0.7
Temp staffing	*£10m*	*2.70%*	8.2	5
Corp services	*£9.8m*	*28.80%*	1.6	1.6
Medicines	*£1.1m*	*3.70%*	0.7	0.6
Commercial	*£1.5m*	*0.80%*	0.75	0.25
Other local opportunities	*£9.9m*	5%	5	5
Total	***£42.2m***		**£22.05m**	**£17.75m**

- WHTH is working on the potential delivery of how much of the £42.2m opportunity is achievable in 25/26
- Of the benchmarked productivity opportunities, WHTH have identified £17.75m in cash releasing activities.
- The financial implications of the transformation programme are being worked through to ensure that the admission/attendance activity reductions reflect affordability aligned to the financial plan
- WHTH and system productivity/efficiency and CIP plans are still being developed and will be included in the IDP.
- Other productivity opportunities being explored are:
  - **Theatre Optimisation**
  - **Out-patient Optimisation**
  - **Bed Occupancy baseline**
  - **Day case surgery**

SWH HCP Integrated Delivery Plan- Workplan

The HCP has designed a workplan that reflects the national, system and local priorities will ensuring deliverability through a robust programme management approach. The following slides set out how our programme has been developed…

Slide 6 sets out a series of "I statements" which are the outcomes that the HCP wants to deliver for its local population, as citizens, patients and tax payers. We have aligned the national priorities (2025/26 national planning priorities) and system priorities (Medium Term Plan performance indicators) to these statements to ensure that the HCP delivers these priorities

Slide 7 sets out the programmes of work which will enable the HCP to successfully deliver the priorities aligned to these "I statements". This includes the level at which these programmes of work will be planned and delivered

Slide 8 describes the success measures for these which will enable the HCP to demonstrate when these programmes have successfully delivered these outcomes. These success measures are explicitly aligned to the quantifiable measures as set out in national and system (MTP) priorities

Slide 9 describes the enabling programme together with the success measures that will ensure we have successfully delivered the enabling workstreams

Slides 10 and 11 describe operational planning projects that will deliver tangible impacts in 2025/26 and beyond

SWH HCP Integrated Delivery Plan- Workplan "I statements"

My health situation is unique and many of these statements might apply to me simultaneously or at different times.
Above all, I should receive the right care at the right time and in the right place

		I want to be able to access support when I need it from primary care- *right care, right place*	I want fair access to appropriate services irrespective of my personal circumstances- *right care*	If I need specialist treatment, I don't want to have to wait a long time to be seen- *right time*	I want to know if I need emergency care that I can access timely, high quality care- *right care, right time*	I do not want to go to hospital unless it is clinically appropriate and necessary- *right place*	I want to know that every penny of taxpayers money is being spent wisely in the NHS locally-*right care, right time, right place*	If I have multiple conditions that require support from the NHS, I want access to a team of people that can help- *right care*
Impact *"What does it mean for me?"*								
Performance measures *"What are we on the hook for?"*	**National measures**	• Patient reported access • Number of urgent dental appointments • Winter vaccinations • Percentage of patients with SMI/ on LD registers to receive an annual health check	• Reduce inequalities • Percentage of patients with hypertension treated according to NICE guidance • Percentage of patients with CVD who have their cholesterol managed	• 18 week referral to treatment time • 52 week waiters • FDS cancer targets	• Percentage of patients seen in A&E within 4hrs • Category 2 ambulance response times	• -	• Balanced net system financial position • Agency spend • Activity/ WTE gap	• Percentage of those within high risk cohorts with named clinician • Bed days/1,000 for target cohorts
	System measures	• Appointments per 1,000 patients • Average time taken to answer calls • Increased vaccination rates	• Hypertension QOF measure • Prevalence of hypertension • Percentage of people with hypertension whose blood pressure is in target	• Theatre productivity • Percentage of surgery undertaken as day case surgery	• 2 hour responses (for a fall) • Conveyance to hospital following a 2 hour response	• Percentage of deaths with 3+ emergency admissions in the last 90 days of life • Emergency admissions for people with frailty/ falls in the community/ nursing and residential homes • ED attendances for people living with frailty/living in nursing and residential homes • Completed ACPs • Medication reviews • Frailty scores	• Productivity measures • YTD and forecast spend against place-based allocation	• People identified through GP IT searches • People added to the INT proactive care caseload

SWH HCP Integrated Delivery Plan- Workplan programmes of work

My health situation is unique and many of these statements might apply to me simultaneously or at different times.
Above all, I should receive the right care at the right time and in the right place

Impact *"What does it mean for me?"*	**I want to be able to access support when I need it from primary care- *right care, right place***	**I want fair access to appropriate services irrespective of my personal circumstances- *right care***	**If I need specialist treatment, I don't want to have to wait a long time to be seen- *right time***	**I want to know if I need emergency care that I can access timely, high quality care- *right care, right time***	**I do not want to go to hospital unless it is clinically appropriate and necessary- *right place***	**I want to know that every penny of taxpayers money is being spent wisely in the NHS locally-*right care, right time, right place***	**If I have multiple conditions that require support from the NHS, I want access to a team of people that can help- *right care***
Workplan *"What are we doing?"*	**Modern General Practice**	**Addressing inequalities/ Long Term Conditions**	**Elective care planning**	**Children & Young People**	**Urgent and emergency care**	**Frailty and End of Life**	**Productivity and enablers**	**INTs**
	• Deployment of telephony • Workforce support • Local improvement support via neighbourhoods etc • Vaccination programme	• Delivery of the ICB's LTC programme	• Reducing variation in advice and guidance • Reducing variation in referral volumes • Consistent use of ICB pathways	• Transition to the next stage of life • Prevention of admissions	• Care coordination • VH expansion • Same day urgent care • ToCH • UCR	• 7 high impact interventions • Advanced support for nursing and residential homes	• Neighbourhood development • Data and digital transformation • Workforce development • Commissioning functions • Governance and oversight	• INTs x 4 • Proactive care deployment • Implementation of Hemel Health Campus
Implementation level *"Who is doing this?"*	Planned: System Delivered: Neighbourhood	Planned: System & HCP Delivered: HCP	Planned: HCP Delivered: Neighbour-hood	Planned: HCP Delivered: HCP	Planned: HCP Delivered: HCP	Planned: HCP Delivered: HCP	Planned: HCP Delivered: HCP	Planned: Neighbourhood Delivered: Neighbourhood
	HCP oversight	**HCP-led design and delivery**						**Neighbourhood-led**

SWH HCP Integrated Delivery Plan- Workplan success measures

By April 2026, we want to have improved patient outcomes by…

HCP Programme	Success measure	National priority	System priority	How we know we will have achieved this
Addressing inequalities/ Long Term Conditions	**Increasing detection of hypertension**	Primary Care	Reducing inequalities	• Hypertension QOF measures - 2% increase from baseline • Increase age standardised prevalence of hypertension
	Improving treatment for people with hypertension	Primary Care	Reducing inequalities	• Increase the percentage of patients with hypertension whose last blood pressure was in target • Increasing the percentage of patients with hypertension treated according to NICE guidelines
Elective care planning	**Reducing elective waiting times**	Elective care	Elective care recovery	• No patients waiting more than 65 weeks for treatment • Reduce the number of patients waiting 18 weeks or longer for elective treatment to 65% • Having 0 people waiting 52 weeks or longer • Meeting the FDS cancer targets • Increase the number of patients waiting less than 6 weeks for diagnostics to 95% • Improve theatre productivity to 85%
	Reducing elective length of stay	Elective care	Elective care recovery	• Increase the percentage of surgery consistently undertaken as day case surgery to 85%
Children & Young People	**Reducing community waiting times for CYP**	Elective care	Children's care	• No community paediatric waits greater than 65 weeks
	Reducing emergency admissions for CYP	UEC	Children's care	• Reduce emergency admission rates for children and young people by 5%
	Reducing A&E attendances for CYP	UEC	Children's care	• Reduce A&E attendances for children and young people by 5%
Urgent and emergency care	**Improving transfer of care back home**	UEC	UEC	• No more than 50 patients nMCTR per day • 95% of patients discharged back to their usual place of residence
	Reducing ED waiting times	UEC	UEC	• Minimum of 78% of patient seen within 4 hours • Improving category 2 ambulance response times • A higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25;]
Urgent and emergency care/ Frailty and end of	**Reducing emergency admissions for people living with frailty/ older people**	UEC	UEC	• Decrease rate of emergency admissions for falls in the community of people aged 65+ by 5% • Reduce non elective admissions for people living with frailty by 25%

SWH HCP Integrated Delivery Plan- Workplan success measures (enablers)

National priority	Success measure	Enabling workstream	How we know we will have achieved this
Reform	• Maturing neighbourhood health service models • Neighbourhood transformation initiatives explicitly aligned to population need	**Neighbourhood development**	• Fully resourced neighbourhood teams (as per the neighbourhood team structures described in section 3) • Neighbourhoods demonstrate an understanding of their local population's health and care needs • Neighbourhoods have identified transformation priorities aligned to their population's health and care needs
Reform	• Established approach to change and transformation that addresses our immediate priorities and ensures sustainability	**Transformation methodology**	• Fully articulated theory of change which will include approaches to decision-making, prioritisation and evaluation • Adoption of consistent QI methodologies across the HCP • Culture of shared ownership and joint problem-solving embedded throughout the HCP
Reform	• Data platforms and performance reporting enable effective information sharing, transparency of performance and data-driven decision making	**Data and digital transformation**	• 100% GP sign up to data sharing agreement • Consistently applied data definitions and agreed baseline positions against which progress will be measured • Data platform made available at neighbourhood level and used to inform neighbourhood transformation priorities • All transformation initiatives have clear trajectories, targets and are appropriately monitored based on real-time data
Resources	• Empowered workforce enabled to frictionlessly work across the HCP partnership- *to include building on existing work across the ICB*	**Workforce development**	• Shared training and development • Honorary contracts or staff passports available to staff working across organisational boundaries • Staff rotations across HCP partner organisations in applicable workstreams
Resources	• Fully resourced commissioning function appropriate skills and capability embedded within the function	**Maturing commissioning function**	• Clearly defined roles, responsibilities required to deliver all delegated functions • Delegated functions appropriately resourced
Resources	• Effective management of delegated budgets		• Proposals for risk sharing agreement and outcomes-based contracting agreed with partners • Commencement of process (e.g. re-procurement) of CLCH contract
Resources	• Joint ownership of system-wide financial performance	**Establishing effective**	• Balanced net system financial position • Year to date forecast and actual expenditure against place-based allocation • 30% reduction in agency and 15% reduction in bank usage
	• System-wide visibility of performance		• Performance reporting explicitly aligned to national and local priorities

SWH HCP Integrated Delivery Plan- Operational planning projects (2025/26)

The following operational planning projects are anticipated to have an in-year, tangible impact on activity:

HCP Programme	Workstream	Project
Addressing inequalities/ Long Term Conditions	Hypertension	• Continued engagement with ICB-wide hypertension plans, including hypertension champions, delivery of initiatives in acute and community providers
	Winter vaccine rollout	• Roll out of winter vaccine programme to ensure equitable uptake of vaccinations
	Integrated heart failure	• Implementation of an integrated heart failure service model of that will integrate specialist management of heart failure across providers and by disease stage, to improve clinical outcomes and quality of life for people with heart failure
Elective care planning	CDC	• Community diagnostic centre development at WHTH
	Elective care transformation	• Transformation of elective care including elective care recovery at WHTH
	Advice and guidance	• Using consultant connect rapid advice service to including improving appropriate utilisation of advice and guidance
Urgent and emergency care	UCR resource mapping	• Focus on additional UCR resource required to deliver the contribution to the 25% reduction in non-elective activity
	Care coordination	• To create a single point of care co-ordination for clinicians where patients require timely and seamless access to urgent same day supported decision making
	ToCH development	• Development of a transfer of care hub for South West Hertfordshire managing the transfer of care from acute sites to community and from community and DTA beds to onward care
	Virtual Hospital	• Expansion of frailty H@H and increase step up.
	Improving Same Day Access	• Strategic review of urgent on day demand provision across SWH to provide equity of provision and enhanced access
Frailty and end of life	Care closer to home	• Integrated Neighbourhood Teams (across all four neighbourhoods) • 2 hour UCR response • Hospital at home/ virtual ward • Intermediate care- community hospital beds • Hertsmere proactive care pilot
	Deprescribing	• Medication reviews and deprescribing for patients with polypharmacy
	Community falls	• ECF target of 60% of moderate and severe frailty cohort having a FRAT assessment. Actions are taken with onward referral to falls

SWH HCP Integrated Delivery Plan- Operational planning projects (2026/27)

The following operational planning projects are anticipated to have a tangible impact on activity in 2026/27 and beyond:

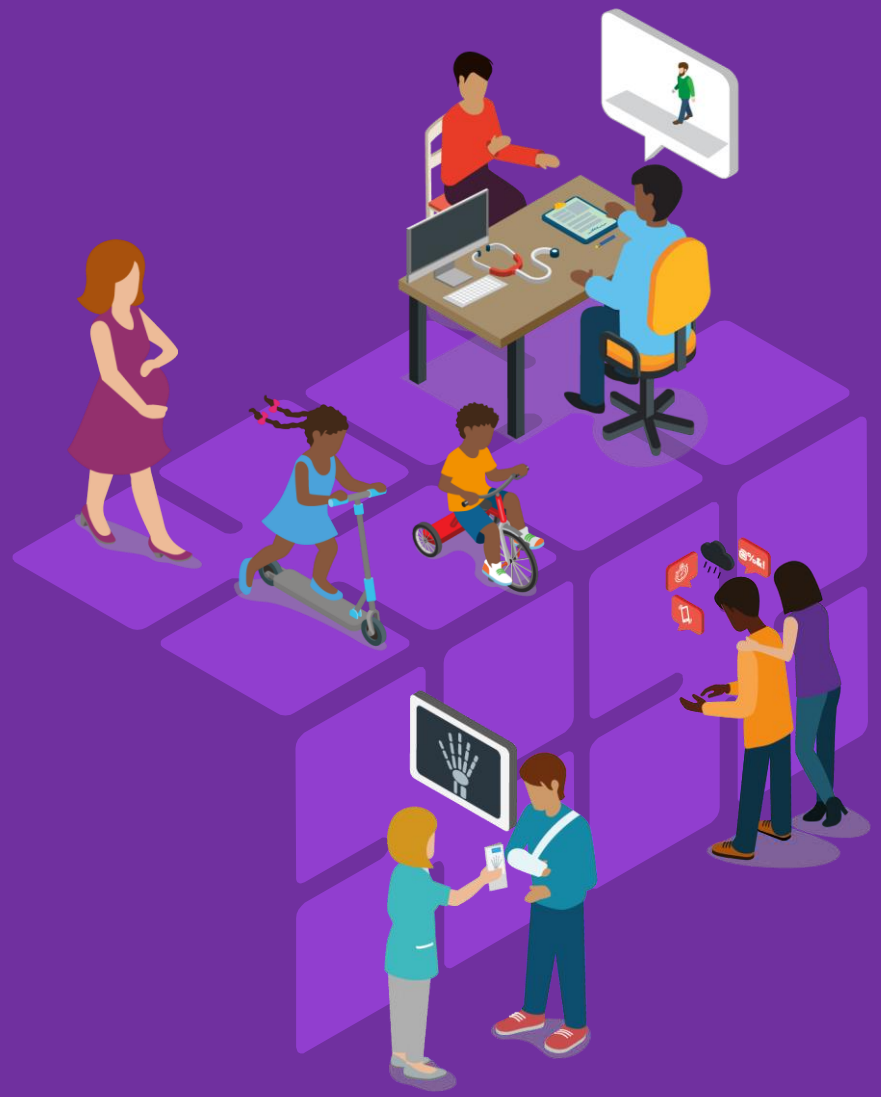
HCP Programme	Workstream	Project
Addressing inequalities/ Long Term Conditions	**Weight management service**	• ICS wide review of weight management services
	Tobacco dependency	• Delivery of national tobacco dependency programme
	Respiratory: Asthma diagnostic hubs	• Implementation of PCN/locality level asthma diagnostic hubs, incorporating FeNO
Children & Young People	**Children's virtual hospital**	• Three pathways for children's VH: jaundice, IV in the community and prevention of admission (to include ACP run clinics which could be collocated with UTR/ EDs)
	Paediatric prevention of admissions	• For frequent attenders and highly complex care, to include care coordination for SEND- to be fully scoped and linked to the care coordination programme
	Transition to next stage of life	• Closing gaps in transition from CYP to adult services- to be fully scoped and exploring opportunities to improve children's readiness for school
	Prescribing	• Embedding paediatric prescribers in the community to streamline repeat prescriptions for children
	Community Paediatrics (HCT)	• Additional capacity to address demand & improve waiting times (also inc associated blood tests)
	Paediatric audiology (HCT)	• Additional capacity to address demand and improve waiting times in SWH
	Increase in SWH SEND school places (HCT)	• Funding to address impact of this on CYP services
Frailty and end of life	**Front door frailty**	• Improvement including a range of initiatives such as implementation of senior review at the front door, accuracy of CFS scoring, workforce development of junior doctors, ACPs and nurses, consultant recruitment, educational programme
	INTs	• Hertsmere frailty • Watford and Three Rivers top 300 frailty project • Proactive care pilot • St Albans and Harpenden Neighbourhood INT

West Essex Health and Care Partnership

West Essex HCP
Integrated Delivery Plan 2025 -2028

ICB Strategy Committee Summary

June 2025



Working together
for a healthier future

The West Essex Health and Care Partnership

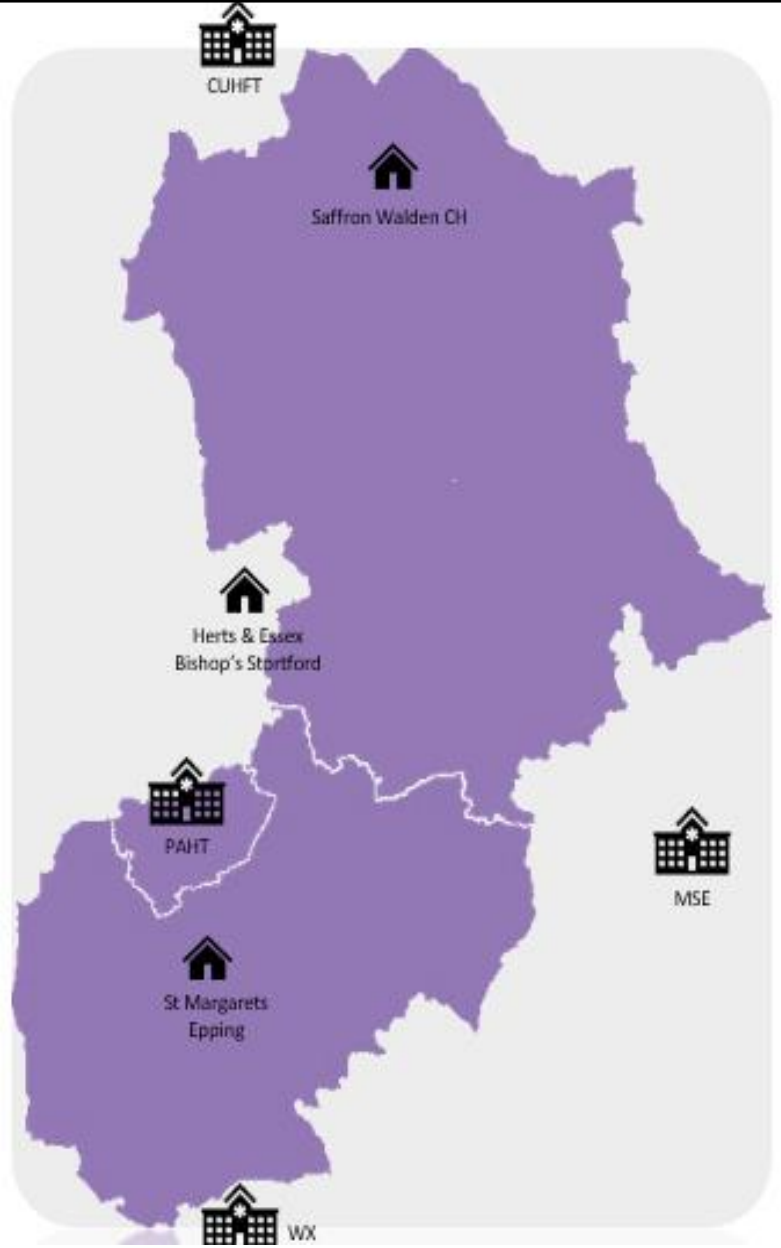
From April 2025 Princess Alexandra Hospital (PAHT) will take on the responsibility as host provider, with delegated responsibility for the commissioning and management of NHS services from the Hertfordshire and West Essex Integrated Care Board (ICB), operating through the West Essex (WE) Health and Care Partnership (HCP). As part of this delegated responsibility WEHCP will be responsible for the delivering this IDP .

WEHCP brings together provider and commissioning organisations with a common purpose of improving health outcomes for the population of west Essex . It works together to take joint action to improve and integrate services, to influence the wider determinants of health and to improve the sustainability of our health and care system.. **"To help everyone in our area live long and healthy lives by supporting independence and providing seamless care"**

WEHCP partners include Princess Alexandra Hospital Trust , H&WE ICB, Essex Partnership University NHS Foundation Trust (EPUT), Essex County Council, Primary Care Networks, Epping Forest, Harlow and Uttlesford District Councils and our Voluntary Sector.

Our priorities for the next three years are

- Addressing health inequalities with a particular focus on Harlow
- Addressing the dependency on our acute hospitals for our frail population
- Improving access to our urgent and emergency care services moving to more urgent care delivered in the community
- Delivering operational planning requirements for elective recovery
- Improving outcomes for our children and young people through integrated pathways
- Improving use our combined resources, workforce, estate and finance



West Essex Health and Care Partnership

Our Population

Our population of 334,000 represents 20% of the H&WEICB. It has complicated patient flows with significant acute hospital flows outside of west Essex to CUHFT, MSE and WX (27% of population). West Essex represents 63 % of PAHTs ED activity flows to PAHT from East and North Herts represents 35% of ED activity.
It has a similar population profile to the ICB average with general levels of good health. However, there are areas of deprivation in Harlow and Epping Forest that are associated with poor outcomes. People in these areas are more likely to live with long term conditions requiring emergency care. Harlow has the poorest health outcomes within the ICB. Among older people there has been a reduction on the rate of emergency admissions, admissions for falls and the proportion of people with multiple admissions in their last days of life.

Significant population growth is expected with Gilston Garden Town with circa 16,000 homes by 2033 and 6000 further homes after that which will need sustainable health infrastructure.

Epping Forest

Population: 130,294 39% of WEHCP
Locality Clinical Lead: Dr Stephen Rebel
LBC INT
Population: 62,490
A&E flows: 22% Barts Health, 42% PAHT
Epping North INT
Population 67,804
A&E flows: 70% PAHT

Population snapshot

LBC population profile is slightly older it has pockets of deprivation and affluence.
Higher rates of childhood obesity.
Highest volume of care home beds.
Epping North population profile is slightly older and younger 0-4 years than England average.
One of the most deprived PCNs within the ICB accept for older people in poverty.

Harlow

Population :106,702 32% of WEHCP
Locality Clinical Lead: Dr Michael Napal-David
Harlow South INT
Population; 42,903
A&E flows: 92% PAHT
Harlow North INT
Population: 63,799
A&E flows: 90% PAHT

Population snapshot

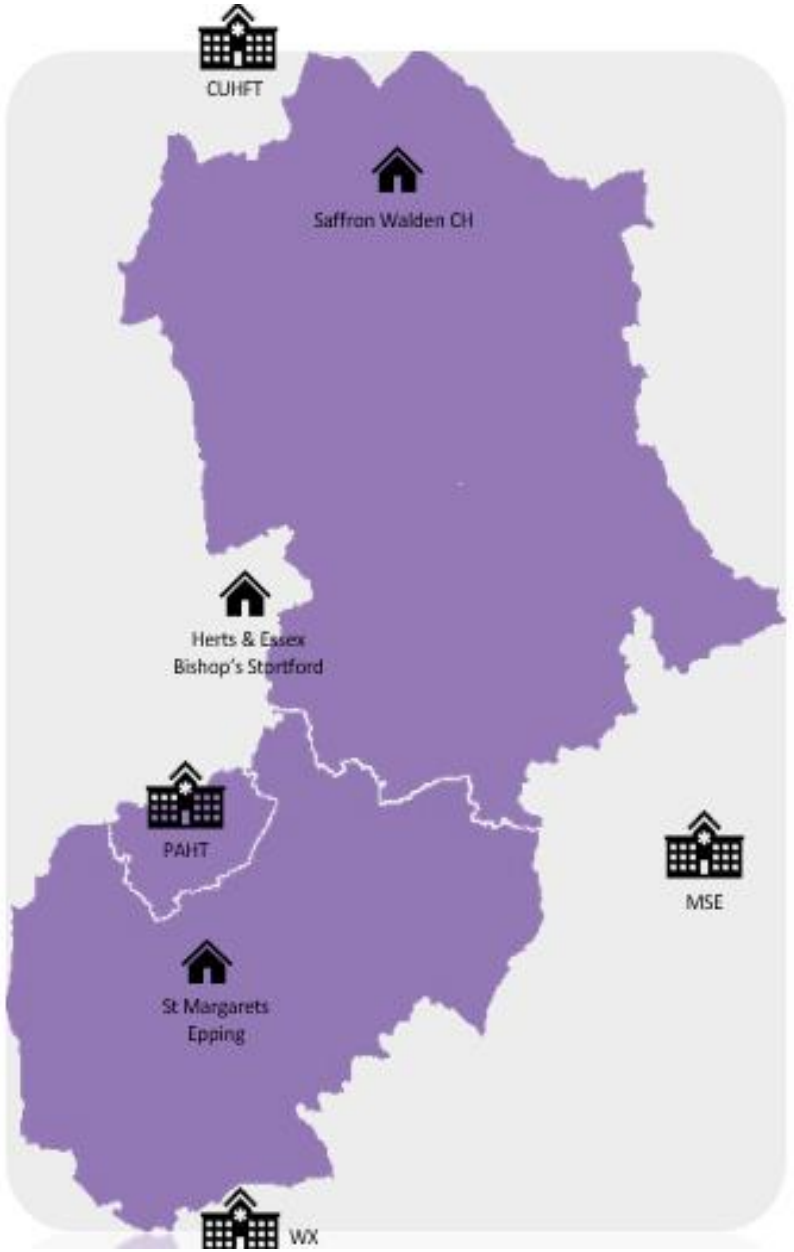
Harlow south and north have a younger population profile than England average.
Higher rates of childhood obesity.
Wider determinants data shows Harlow south is the most deprived PCN within the ICB, Harlow north one of the most deprived.
The average number of chronic conditions for people is higher than the ICB and has highest usage of acute and GP services.
A higher proportion of people within the younger age groups are living with long term conditions compare with England.

Uttlesford

Population 97,812 29% of WEHCP
Locality Clinical Lead: Dr Richard Boyce
Uttlesford South PCN
Population; 55,338
A&E flows 41% PAHT, 34% MSE
Uttlesford North PCN
Population; 42,474
A&E flows: 90% CUHFT

Population snapshot

Uttlesford south population profile has more younger and older people than England average. Uttlesford north has an older population compared to England average.
Majority of the population access services outside of the ICB.
The PCN is one of the least deprived within the ICB except for housing and environment.



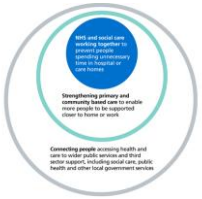
West Essex Health and Care Partnership

Principles underpinning our priorities and plans

Principles

•Shifting service delivery to care closer to home	Delivering through our localities and INTs	Reducing inequalities	Maintaining equity of access	Better winter	Integration
•Focus on delivering models of care that are fit for the future and enable person-centred and proactive health and care to be delivered closer to home. Prioritising the implementation of the 5 steps of the Care Close to Home core model for our adult population.	Planning and delivery of neighbourhood models of care led by those who understand their communities. Building on our successes of our Integrated Neighbourhood teams in Harlow, Epping and Uttlesford.	Targeting our priorities and collective resources to address variations in outcomes. Using PHM intelligence to identify segments of the population, identify need and assess impact of our interventions. Deliver measurable improvements in health outcomes	Working through our localities build relationships with all our acute & community providers to ensure we support patients' NHS Constitutional rights of access to the right care, right time and place., ensuring consistent standards of care in line with the national Operating Guidance.	Our programmes and interventions are focussed on preventing our residents' ill health and our urgent and emergency care services from being overwhelmed this coming winter	Proactively developing our models of health and care that will enable greater integration across pathways to drive out duplication and improve efficiency.

The principles that underly our plan also encompass the foundations of the Neighbourhood Health approach to health and care recently published by NHSE. We are committed to the delivery of the core 6 components of Neighbourhood Health – Population Health Management approach to commissioning,Modern general practice, Standardising community health services,Neighbourhood multi-disciplinary teams, Integrated intermediate care with a "Home First" approach, Urgent neighbourhood services. The significant contribution to this model of care from secondary care services is also a principle built into the IDP through bringing our teams together to develop and implement plans and delivered through an integrated workforce approach.



West Essex Health and Care Partnership

Our 3 Year Priorities

What success looks like Patient outcomes

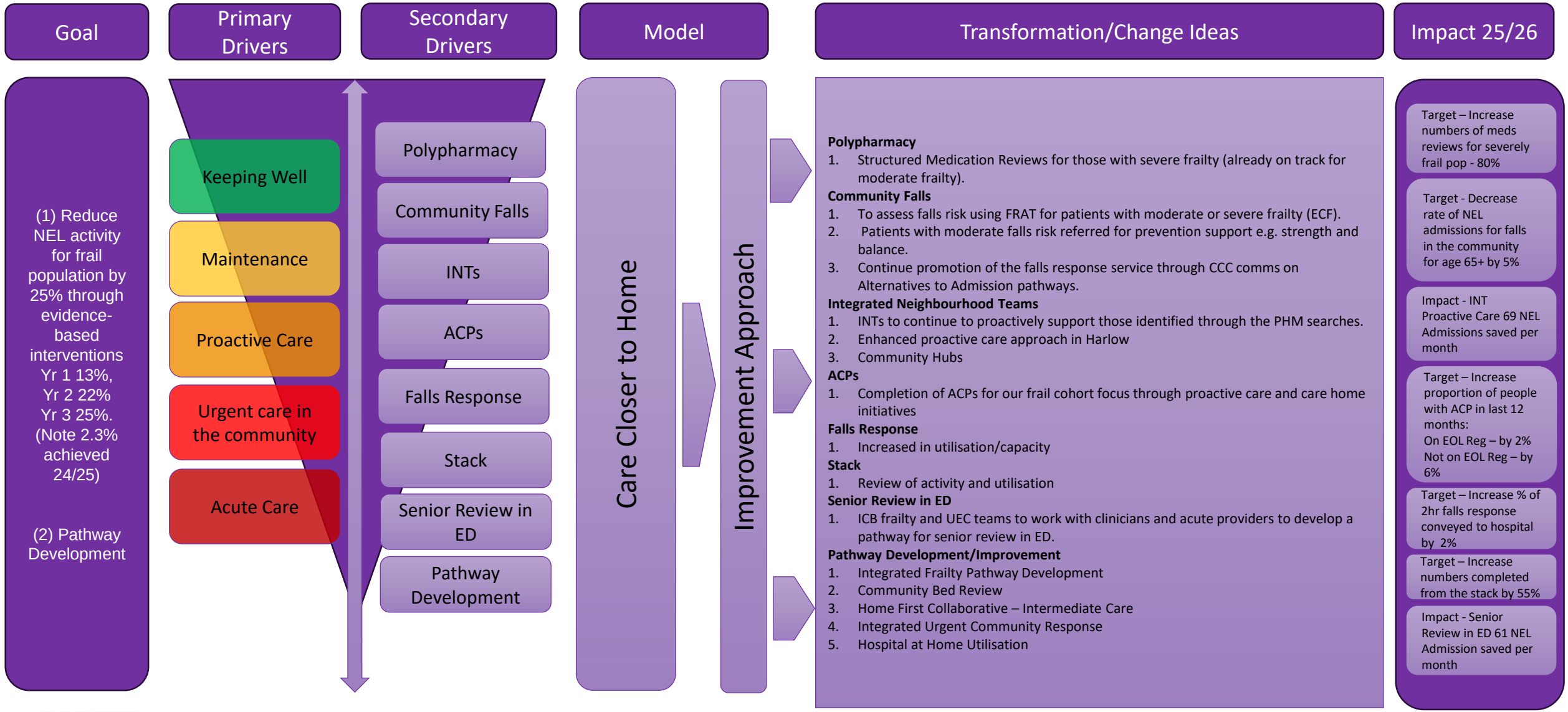
IDP Strategic Priorities	Success measure	Key Programmes	ICB priority	How we know we will have achieved this
Addressing inequalities	**Reducing obesity** **Increasing detection of hypertension** **Reducing unwarranted variation in outcomes**	HCP wide: Identification of people with hypertension, Every Contact Counts winter vaccinations, Community Hubs. Harlow and Epping Forest : Childhood obesity. Harlow : Adult mental health and wellbeing in Harlow, Active Essex and Healthy Places, Integrated Heart Failure Pathway.	Reducing inequalities	▪ Increase detection of CVD by 2% from baseline of 14.9% by Mar 26 ▪ Childhood obesity prevalence reduction (Epping Forest & Harlow) TBD % ▪ Improve the winter vaccination rates in residents & provider staff by TBD%
Addressing dependency on acute hospitals for our frail population	**Reducing emergency admissions for people living with frailty/ older people** **Improving end of life care**	HCP wide: Proactive care including core INT CCH model and Frailty interventions. Development of Frailty Pathway (note UEC Programmes to support management of crisis in the community)	Urgent and emergency care	▪ Decrease rate of emergency admissions for falls in the community of people aged 65+ by 5% ▪ Reduce non elective admissions for people living with frailty Yr 1 13%, Yr 2 22% yr 3 25%. (Note 2.3% achieved Mar 24)
Improving access to Urgent and Emergency Care service for adults & children	**Reducing ED waiting times** **More of adult's urgent care needs met in the community**	HCP wide: Integrated Community UEC Pathways including VW & UCR. Discharge improvement programme including TOCH & CCC. Intermediate Care, Community bed utilisation. PAHT: UEC Improvement programme, IUATC primary care led front door, SDEC	Urgent and emergency care	▪ Achievement of minimum of 78% of patient seen within 4 hours by Mar 26 ▪ Reduction in PAHT adult UEC admissions in yr 1 6%, yr 2 & yr 3, 7% (excludes impact of winter vaccination project) ▪ OPAL & AAU used as assessment areas not bedded ▪ Reduction in PAHT bed occupancy 92% October 2025, 89% March 2026. ▪ Reduced use of surge capacity

Our 3 Year Priorities

What success looks like Patient outcomes

IDP Strategic Priorities	Success measure	Programmes	ICB priority	How we know we will have achieved this
Delivering elective care recovery	**Reducing elective waiting time** **Reducing elective length of stay** **Maintaining equity of access across population**	PAHT: Elective recovery programme, cancer programme (including dermatology) Outpatient and theatre utilisation programmes HCP wide: faster diagnosis pathways including CDC Strategic: Options for elective Hub STM site (Yr 2)	Elective care recovery	▪ No patients waiting more than 65 weeks for treatment ▪ Reduce number of adults waiting for more than 52 weeks to less than 1% of waiting list ▪ No children waiting more than 52 weeks by 31/3/26 ▪ Reduce the number of patients waiting 18 weeks or longer for elective treatment to 65% (minimum 5% improvement) ▪ 80% of patients on a suspected cancer pathway receive diagnosis by 28 days ▪ 62 day cancer treatment standard 75% by March 2026
Improving outcomes for our children and young people through integrated pathways	**Reducing A&E attendances**	Harlow: Childrens' family hub in Harlow PAHT: Paediatric Front door HCP wide: Paediatric INTs Yr 2	Children's care	▪ Reducing A&E attendances for CYP by 5%, (1% Nov 2024) ▪ Reducing emergency admission rates for CYP by 5% (2% Nov 2024)
	Improvement in outcomes	Procurement of new Essex Child & Family Wellbeing Service Contract with ECC	Children's care	▪ Reducing community waiting times for CYP
Efficient use of our collective resources	**Financial balance**	HCP wide: Frailty and UEC programmes, One estate , Contracts review Provider CIPs	Financial Sustainability	▪ Deliver within budgets allocated as part of ICB financial plan in collaboration with partners ▪ Shift of financial resources to the community setting including voluntary sector ▪ Delivery of £2m cost reductions through transformation

Example : Addressing dependency on acute hospitals for our frail population



West Essex Health and Care Partnership

Contributions to financial sustainability-Addressing dependency on acute hospitals for our frail population and Improving access to Urgent and Emergency Care service for adults & children

	West Essex HCP			PAHT		
NEL admission savings	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
INTs (Frail population)	832	1,456	1,716	936	1560	1872
Senior review in ED (UEC)	730	365	0	730	365	0
UCRT expansion of capacity (UEC)	639	639	639	639	639	639
Jaundice - Billie Blankets (CYP)	130	130	130	130	130	130
	2,331	2,590	2,485	2,435	2,694	2,641
Cumulative %tage of NEL admissions 23/24 (24/25 forecast PAHT)	**8%**	**18%**	**25%**	**6%**	**13%**	**20%**
ED attendance savings						
INTs (Frail population)	832	1,456	1,716	936	1560	1872
UCRT expansion of capacity (UEC)	1278	1278	1278	1278	1278	1278
Jaundice - Billie Blankets (CYP)	130	130	130	130	130	130
	2,240	2,864	3,124	2,344	2,968	3,280
Cumulative %tage of ED attendances 23/24 (25/26 plan PAHT)	**2%**	**4%**	**7%**	**2%**	**4%**	**7%**
PAHT average NEL length of stay 8.9 days Dec 24 Model Hospital				21,672	23,977	23,505
Bed Occupancy delivered				**89%**	**89%**	**89%**
Number of beds that can be released for assessment/reduced occupancy				**59**	**66**	**64**

Funding stream for schemes 2526:

INTs – Extended commissioning framework in primary care, Better Care Fund and EPUT adult community services contract re- alignment

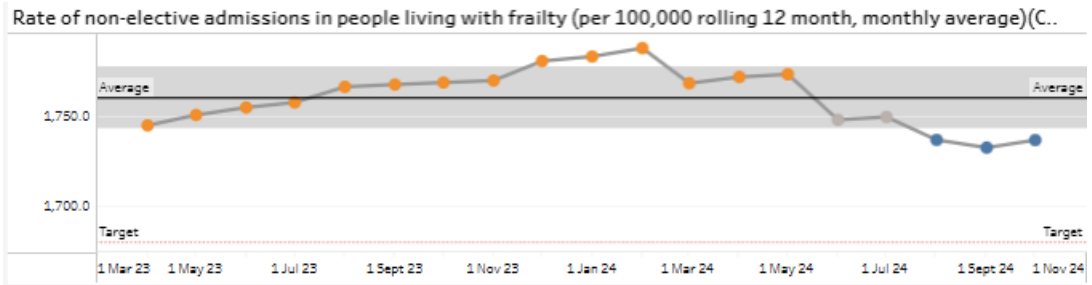
Senior review in ED – PAH contract

UCRT expansion – EPUT contract re-alignment

Billie- blankets – TBC

Transformation savings 2526:

Release of £2mill agency/bank spend on additional capacity for winter, periods of pressure and vacancy. Contributing to PAHT CIP target of 5.8%.



West Essex Health and Care Partnership

Delivering through our localities and neighbourhoods

Several initiatives will be designed once as an HCP and then delivered through localities, eg Integrated Frailty Pathway Design, designing the INT networks (including Community Hub Development, INT Proactive Care Rollout & evaluation).
Locality transformation will be led by a locality leadership team and delivered by a locality delivery team made up of resources from across system partners.

Epping Forest

Population: 130,294 39% of WEHCP
Locality Clinical Lead: Dr Stephen Rebel
LBC INT
A&E flows: 22% Barts Health, 42% PAHT
Epping North INT
A&E flows: 70% PAHT

Harlow

Population :106,702 32% of WEHCP
Locality Clinical Lead: Dr Michael Napal- David
Harlow South INT
A&E flows: 92% PAHT
Harlow North INT
A&E flows: 90% PAHT

Uttlesford

Population 97,812 29% of WEHCP
Locality Clinical Lead: Dr Richard Boyce
Uttlesford South PCN
A&E flows 41% PAHT, 34% MSE
Uttlesford North PCN
A&E flows: 90% CUHFT

Stort Valley and Hoddesdon

Population 111,636
Locality Clinical Lead:
Dr Alison Jackson
Dr Keith Remedios
Dr Jay Kuruvatti
35% of PAHT A&E Flows

Epping Forest

Proactive Care: Delivery of Proactive Care through INTs achieving 260 reduction in NEL admissions for frail population in Yr1.

UEC (including prevention of admission): 521 PAH attendances Year 1

Harlow Locality

Proactive Care: Delivery of Proactive Care through INTs achieving 312 reduction in NEL admissions for frail population in Yr1.

UEC (including prevention of admission): 781 PAH attendances Year 1

Uttlesford

Proactive Care: Delivery of Proactive Care through INTs achieving 260 reduction in NEL admissions for frail population in Yr1.

UEC (including prevention of admission): 260 PAH attendances Year 1

Stort Valley and Villages

Proactive Care: Delivery of Proactive Care through INTs achieving 312 reduction in NEL admissions for frail population in Yr1.

UEC (including prevention of admission): 781 PAH attendances Year 1

Progress so far – May 2025

What success looks like Patient outcomes

IDP Strategic Priorities	Success measure	Key Programmes	Outcomes 31/3/26	Achievements to date
Addressing inequalities	**Reducing obesity** **Increasing detection of hypertension** **Reducing unwarranted variation in outcomes**	HCP wide: Identification of people with hypertension, Every Contact Counts winter vaccinations, Community Hubs. Harlow and Epping Forest : Childhood obesity. Harlow : Adult mental health and wellbeing in Harlow, Active Essex and Healthy Places, Integrated Heart Failure Pathway.	Increase detection of CVD to 16.9% Decrease childhood obesity prevalence Improve winter vaccination rates	14.4% hypertension (QOF), improved over last 6 months (Apr 24 13.6%) Data source DELPPHI Obesity data not available monthly Not commenced
Addressing dependency on acute hospitals for our frail population	**Reducing emergency admissions for people living with frailty/ older people** **Improving end of life care**	HCP wide: Proactive care including core INT CCH model and Frailty interventions. Development of Frailty Pathway (note UEC Programmes to support management of crisis in the community)	Reduce rate of admissions for falls by 5% Reduce frailty non elective admissions by 13%	3.2% reduction in falls March 25 compared to April 2024 Non elective admissions data to be refreshed after national recording change for SDEC, reduction expected Data source DELPPHI
Improving access to Urgent and Emergency Care service for adults & children	**Reducing ED waiting times** **More of adult's urgent care needs met in the community**	HCP wide: Integrated Community UEC Pathways including VW & UCR. Discharge improvement programme including TOCH & CCC. Intermediate Care, Community bed utilisation. PAHT: UEC Improvement programme, IUATC primary care led front door, SDEC	78% of patients seen within 4 hours Reduce PAHT adult admissions by 6% OPAL & AAU used as assessment Reduce PAHT bed occupancy 89%	PAHT 65.6% against plan 69%, on recovery trajectory April (source May Tiering meeting data) PAHT adult admissions data to be refreshed after national recording change for SDEC OPAL & AAU used as assessment from June 25 PAHT bed occupancy = 91.2% May (PAHT data source)

Progress so far – May 2025

What success looks like Patient outcomes

IDP Strategic Priorities	Success measure	Programmes	Outcomes 31/3/26	Achievements to date
Delivering elective care recovery	**Reducing elective waiting time** **Reducing elective length of stay** **Maintaining equity of access across population**	PAHT: Elective recovery programme, cancer programme (including dermatology) Outpatient and theatre utilisation programmes HCP wide: faster diagnosis pathways including CDC Strategic: Options for elective Hub STM site (Yr 2)	0 patients >65 weeks 52 week waits <1% of waiting list 0 children > 52 weeks 18 week waits 65% 28 day cancer diagnosis 80% 62 day cancer treatment 75%	PAHT – Waiting list recovery (Source Tiering Pack) 44 patients > 65 weeks (18/5) > 52 weeks Forecast 4.6% in line with plan for May – (Apr exceeded plan) 18 week RTT Forecast 49.9% in line with plan for May- (Apr exceeded plan) 28 day = 70.2% March 25 below plan (data PAHT Tiering) 62 day = 52.2% March 25below plan (data PAHT Tiering)
Improving outcomes for our children and young people through integrated pathways	**Reducing A&E attendances**	Harlow: Children's family hub in Harlow PAHT: Paediatric Front door HCP wide: Paediatric INTs Yr 2	Reduce CYP A&E attendances by 5% Reduce CYP emerg admissions by 5%	0.5% reduction since April 2024 CYP A&E attendances per 100,000. Actual attendances increased by 0.2% 24-25 4.5% increase in emergency admission rate per 100,000 since April 2024. Actual admissions reduced by 4.6%
	Improvement in outcomes	Procurement of new Essex Child & Family Wellbeing Service Contract with ECC	Reduce community waiting times for CYP	Data not currently available due to cyber incident recovery
Efficient use of our collective resources	**Financial balance**	HCP wide: Frailty and UEC programmes, One estate , Contracts review Provider CIPs	Deliver within budget Shift of financial resources to community Delivery of £2mill cost reduction thro' transformation	HCP Budget 2526 to be agreed

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	NHS Hertfordshire and West Essex Integrated Care Board Meeting		**Meeting Date:**	**27/06/2025**
Report Title:	**Mental Health Intensive and Assertive Outreach Review**		**Agenda Item:**	**6.**
Report Author(s):	David Wallace- Deputy Director of Nursing HWEICB			
Report Presented by:	Beverley Flowers – Deputy Chief Executive & Director of Strategy			
Report Signed off by:	Beverley Flowers – Deputy Chief Executive & Director of Strategy			

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

Which Strategic Objectives are relevant to this report **[Please list]**	▪ Reduce health inequalities. ▪ Have a more anticipatory, community-based model of care. ▪ Deliver true integration of our services. ▪ Support patients to engage in self-management and collaborative care planning
Key questions for the ICB Board / Committee:	• Board to receive an update on the progress of the Mental Health Intensive and Assertive Outreach Review to date. • Board to note the contexts of the report.
Report History:	• N/A
Executive Summary:	• The purpose of this paper is to provide an update and to provide assurance to the ICB Board, that EPUT and HPFT are proactively working to implement the findings of the CQC Section 48 Report, and that both Trusts will provide their overall action plans to NHSE by the end of June 2025 as requested in the letter to Trusts and ICBs from NHS England in February 2025. • Report also summarises progress of key system wide actions across the HWEICB footprint.
Recommendations:	• The board is asked to note progress on the review and the contents of the report and accompanying presentation.

Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A			
Implications / Impact:				
Patient Safety:	*The review and subsequent actions will steer system improvements to improve patient safety for this cohort.*			
Risk: *Link to Risk Register*	-			
Financial Implications:	-			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***		N/A	
	Quality Impact Assessment:		N/A	
	Data Protection Impact Assessment:		N/A	

1. Executive summary

As previously reported to this Board, following the conviction of Valdo Calocane (VC) in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber, the former Secretary of State for Health and Social Care commissioned the Care Quality Commission (CQC) to conduct a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under section 48 of the Health and Social Care Act 2008 which was published on the 13th August 2024. The final report which can be accessed here (Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2 - Care Quality Commission).

In addition to the CQC Section 48 report, NHSE Commissioned Theemis Consulting Ltd to conduct an Independent investigation into the care and treatment provided to VC and which was published in January 2025 (Independent investigation into the care and treatment provided to VC).

The purpose of this investigation was to scrutinise and understand the events leading up to that day, with a focus on the circumstances surrounding VC's care, the decision-making processes involved, and the interventions provided by NHS professionals. The final report presents a detailed analysis which sets out both strengths and weakness identified during the course of the investigation and as such will be vital in ensuring learning and changes to policy, practice and delivery of services moving into the future.

NHS England has accepted the national recommendations in the report in full and has already taken steps to implement the 2 national recommendations from the independent review.

Further to the publication of the independent investigation ICBs and Mental Health Trusts have been asked to complete further reviews of action plans against the findings of the independent report.

2. Requirements of Mental Health Trusts and ICBs

Alongside the publication of the independent investigation report, NHSE wrote to Mental Health Trust and Integrated Care Boards (ICBs) on 5th February 2025 setting out their expectations (NHS England » Independent Mental Health Homicide Review into the tragedies in Nottingham), asking that local action plans be reviewed against the key findings of the independent investigation and requesting they prioritise the following key areas:

- **Personalised Risk Assessments:** Ensuring that risk assessments are tailored to the individual, considering their unique needs and circumstances across both community and inpatient teams. This approach should be holistic and dynamic, adjusting to changes in the individual's mental health and life situation.

- **Collaborative Discharge Planning:** Promoting a coordinated approach to discharge planning, which includes input from the individual receiving care, their family, inpatient and community teams, and any other relevant agencies. This collaborative model ensures that all perspectives are considered, and that the discharge process is safe, effective, and sustainable.

- **Effective Multi-Agency Collaboration and Information Sharing:** Strengthening the collaboration and information-sharing protocols between agencies involved in a patient's care. Clear communication and shared understanding between healthcare

professionals, social services, law enforcement, and other relevant bodies are crucial to providing integrated and continuous care.

- **Engagement with Families:** Ensuring that families and caregivers are closely involved in the care process, with an emphasis on their role in supporting the individual's recovery journey. This includes clear communication, regular updates, and involvement in decision-making at every stage of care.

- **Elimination of Out of Area Placements:** Aligning with ICBs' 3-year plans to eliminate out-of-area placements, where patients are placed in facilities far from home. This is aimed at ensuring more personalised, community-based care and reducing the potential for isolation and disconnection from local support networks.

Trust and ICB plans to be updated to reflect the outcomes of these reviews and any actions identified to make improvements locally, and those plans should be discussed at Trust and ICB public board meetings by no later than 30 June 2025. This timeline will ensure:

- ongoing accountability regarding actions and progress in response to the tragic events in Nottinghamshire,
- a transparent process and open reporting of progress made and those key actions to protect our patients
- delivery of meaningful and sustainable change through improved quality, safety and effectiveness.

3. Progress against the requirements

3.1 **Mental Health Trust**: Both Hertfordshire Partnership University Foundation Trust (HPFT) and Essex Partnership University Trust (EPUT) have carried out the review of their plans in line with the requirements from NHSE, and have provided HWE with detailed progress reports, including actions completed and work ongoing, Both are on trajectory to submit their updated action plans to NHSE by the end of June 2025 and have robust internal governance mechanisms in place to ensure Executive and Board level oversight of progress.

Each Trust has reviewed policies and procedures to reflect the requirements and have also ensured the involvement of service users.

As the Mental Health Trust provider across Essex, EPUT continues to work through agreed mechanisms to report to Hertfordshire and West Essex (HWE) ICB and the 3 Essex ICBs.

3.2 **Progress against wider system level actions:**

In the HWE ICB response to NHSE the recommendations were presented as short, and long-term actions, specifying areas that to the system needed to progress and areas that Trusts respectively will be taking forward.

NHSE have confirmed that high level action plans are required at this stage, which will be refined and developed as work continues.

The ICB action plan originally agreed in September 2024 is summarised below, with June 25 updates in italics.

3.2.1 Short Term System Actions

I. Develop options for enabling intensive/assertive working - early indications from the review suggest there are significant gaps against full fidelity of model, and significant resource constraints.

- *Initial outline costings have been developed and submitted to NHSE indicating how the system could deliver a Dartmouth assertive community treatment scale (DACT) compliant model with caseloads of 10-12. At the time of writing this report, we are still awaiting confirmation through the government spending review and resulting NHSE planning as to whether any additional funding will be available to implement a new model of care for this group.*

II. Run partner workshops to identify further support needed by VCSFE, primary care, Drug & Alcohol (D&A), housing teams regarding identification and support for this cohort, including those with neurodiversity.

- *Workshops held with wide engagement with system partners that support the cohort. The main local system proposal was to understand any overlap between caseloads of different services, develop the local Multi-disciplinary Team (MDT) joint working and information sharing so that service users can access the right support quicker, and look at resourcing of the crisis teams to speed up specialist input / advice when it is needed by local outreach providers. These actions continue to develop.*

III. Review the caseloads of mental health clinicians deployed to preventative/early intervention services, to ensure expertise is appropriately directed to people.

- *This is intended to ensure experienced specialist staff in preventative/early intervention services e.g. Additional Roles Reimbursement Scheme (ARRS) workers are able to engage with and support this cohort – for discussion with HPFT and EPUT leads at HWE assurance.*

- *Further conversations suggest that Primary Care Mental Health (MH) workers are oriented to Severe Mental Illness (SMI) cohorts but wouldn't be working intensively. There is currently no system strategy to reorient the focus of Primary Care MH workers.*

- *In west Essex, the regular Assertive Outreach meeting has focussed on functions of the teams, the existing provision commissioned and addressing the gaps to fidelity.*

IV. Crisis Care Partnerships (CCP) in HWE continue working to support to this cohort of individuals, including support from Street Triage and crisis response services.

- *The High intensity user group in Herts continue to discuss this cohort, making sure that the support is offered by the relevant services (NHS / VCFE).*
- *The CCP promote collaborative working between partner organisations and ensure a clear pathway for support for everyone, hence if these individuals*

present at various access point within in the system, they get the right support. For example, support via Street Triage and MH Response Vehicles (MHRV), or support from crisis services, MH Urgent Care Centre (MHUCC), and crisis alternatives.

3.2.2 Longer Term System Actions

i. Continue our transformation of community mental health services, so that the role of system partners in supporting SMI patients is clarified and supported, and SMI patient contact is balanced across the system.

- *Stock take on Community transformation projects and what the common priority actions are across them – look to report around Feb/ March 2026.*

- *HPFT are leading on Integrated MDT pilot:*
  - *Provides a forum to discuss service users with complex needs which are best met by a multi-disciplinary team*
  - *Improves access to appropriate clinical services in the right setting to meet the service, service users and carers needs*
  - *Integrated MDT Meeting Procedure*
  - *Pilot/operational in Stort Valley and Village MH MST Meeting*
  - *Plan to roll out Integrated MDT initiative*

- *EPUT continue to deliver a combined model of physical and mental health support locally integrated with primary care*

ii. Work with Business Intelligence (BI) and Population Health Management (PHM) colleagues to develop our ability to identify people at risk of disengagement from services, e.g. Emergency Department attendances.

- *Implementation of new BI platform in ICB is ongoing. PHM team are reviewing whether the new platform can identify the population of people with psychosis presentation who are not currently open to a service, and therefore may need further follow up/ engagement.*

- *In west Essex, the BI team attended the Assertive Outreach meeting and provided data they could capture going forward. Suffolk and North East Essex (SNEE) data was provided to the Project Manager who has used this to draft an SMI Cohort Dashboard which has helped to identify the people at risk.*

iii. Review the current pathway for D&A induced psychosis and develop options.

- *This work is ongoing, resource and model are yet to be identified for this pathway.*

iv. Commissioners to reflect learning from this review in future commissioning strategies and service design for secondary services, VCSFE services, and primary care.

- *Intensive Assertive Outreach (IAO) work will be reflected in new voluntary sector community service specifications from Sept 2025 (these are being developed currently).*

- *VCSFE complex needs commissioners in Hertfordshire County Council (HCC) working together to identify commissioning gaps*

3.2.3 Short Term Provider Actions (some across both Trusts, some specific)

i. Continue developing and implementing post-Care Programme Approach (CPA) care pathways, ensuring suitable provision for this cohort.

- *In HPFT, the refreshed Delivery of Care Policy is in draft, to go through Divisional, then Trust governance routes. Further training in Person Centred Care and Support Planning for all staff to support coproduction of care plans with all service users irrespective of their method of engagement.*

- *The trust policy on discharge and transfer of care has been reviewed adding a section on discharge of service users with severe mental illness, discharged for lack of engagement. To be completed.*

- *The Delivery of care trust policy has been modified adding a section about the assertive engagement of people with SMI and poor engagement. To be completed.*

ii. Continue developing and implementing the psychosis pathway to support this cohort.

- *Psychosis Pathway - includes the main "pillars" of the pathway, the interventions the pathway will deliver, and each Outcome Measure. Version has been approved by the steering group but is still undergoing amendments.*

- *National Clinical Audit of Psychosis (NCAP) 23-24 - In all domains, the audit has demonstrated that HPFT are either classified as 'Top Performing' or 'Performing Well.'*

- *Although findings have generally improved since the last cycle in 2023 for Psychosis: Prevention, Assessment Treatment in Hertfordshire (PATH) services, there is still much work to be done in improving compliance. In particularly, Cognitive Behavioural Therapy (CBT), Family Intervention, and Supported Employment and Education programmes require further focus. Additionally, though demonstrating improvement, Outcome Measures and to a larger extent Carer focused education and support programmes also require further improvement*

iii. Review and embed clinical guidance in pathways for people with a history of violence and/or offending.

- *In Adult Community Mental Health Service (ACMHS) staff are aware that concerns about those with a history of violence or offending should trigger a referral to the Enhanced Risk Assessment (ERA) team for support and*

completion of an ERA attached to PARIS , use the PARIS Alerts to highlight the concerns; making referrals to external services (including police and criminal justice forums, and others); update the Paris Risk Assessment, and give consideration to sharing information with others (family/carers, partners).

iv. Include the persons MH Act (MHA) detention history in appropriate risk protocols.

- *In HPFT, the Enhanced Risk Assessment contains a background information section which details the current section status, though does not specifically require details of any history of detention. Similarly, the current Adult Mental Health Service/Child Adolescent Mental Health Service risk assessment does not contain a section regarding history of MHA detentions though individual clinicians may record this under History of risks.*

- *Legal status history is recorded on the EPR (under MHA status). However there is acknowledgement that this is not easily accessible / visible to clinicians and a CAB request has been submitted with a request that the MHA legal history, for a minimum of the previous 2 years to be shown on the EPR front page or as an alternative that there is a button/ link on the front page linking directly to the legal history in the MHA App.*

- *In EPUT, Operations Managers have checked systems and MHA information is readily available on the Trust EPR.*

v. Ensure learning from Early Intervention in Psychosis and Psychosis: Prevention, Assessment and Treatment services is brought into Community Mental Health Teams.

- *In HPFT, PATH Decision-Making Process for Discharging Patients with Psychosis who are Disengaging or asking for discharge against medical advice.*

- *There is now a protocol for disengagement: "Supporting safer discharge for service users with psychosis who are disengaging or requesting discharge against medical advice". PATH is now using this.*

- *In EPUT, Core training for all staff has been costed including some CBT for psychosis*

3.2.4 Longer Term Provider Actions (some across both Trusts, some specific)

1. Continue family and carer engagement work, focussing on improving consistency and recording communication.

- *A range of actions are underway in HPFT as this forms part of wider work:*
  - *Internal practice audits evidence mixed results on family involvement in Ward Rounds and Discharge Planning meetings.*
  - *Trust wide carer working group established Sep 2024 to oversee implementation of this pathway and associated work packages.*
  - *New carer practice policy in development.*
  - *Mandatory carers' essential training in place.*

- *Developing a comms campaign, 'Think Carer'*
- *Coproduce a structured approach to involvement of family and carers including proactive contact with family and carer and involvement in care planning, risk management, crisis and discharge planning*
- *Develop enhanced guidance and training on Confidentiality, which will include context of risk and also related factors such as Nearest Relative.*

- *In EPUT, work is underway to review policy and clinical guidelines, Care Act and personalisation guidance, e.g. Triangle of Care and agree recommendations for improvement*

2. Continue PCREF and related work to improve data and understanding of health inequalities for this group.

- *Both Trusts continue to implement PCREF with a clear and sustained focus on embedding equity into all aspects of care delivery. Central to this work is the advancement of our understanding and response to health inequalities, particularly as they affect ethnically diverse and other underserved communities.*

- *In HPFT, all Trust divisions are now actively engaged in a Trust-wide data quality improvement plan, supported by tailored SPIKE reports, guidance, and regular performance reviews. To support this, the Trust developed and launched a comprehensive PCREF dashboard that provides insights into patterns of access, experience, and outcomes across protected characteristics. This tool is helping services to better understand where inequalities exist and how targeted interventions can be deployed. For example, divisions are using the data to explore and respond to differential use of restrictive practices, variations in service outcomes, and the impact of social determinants of health.*

- *While PCREF retains a specific focus on ethnic inequalities, HPFT has taken the strategic decision to broaden its lens and adopt a more intersectional, multi-stranded approach. We now routinely explore the interplay of ethnicity with socioeconomic deprivation, disability, gender, housing status, and other key determinants. This ensures that our understanding of inequality is both deeper and more holistic.*

- *Looking ahead, in 2025/26 we will be further strengthening this work through the newly established PCREF Partnership Group, which brings together service users, carers, community partners, and staff from across the organisation. This group will have focus on data quality, data interpretation, and lived experience intelligence. It will provide external challenge, shape priorities, and ensure our data is both meaningful and actionable—especially for communities most affected by systemic disadvantage. In addition, the Trust will migrate the PCREF dashboard onto a more sophisticated platform to provide near real-time insights for operational and clinical leads. This will enhance decision-making, enabling faster, more responsive actions to address inequality.*

3. Further expand and embed the role of experts by experience in service development programmes.

- *In EPUT a Quality Improvement Project locally is working alongside patients and carers, with rollout across Essex scheduled for 25/26.*

- *In HPFT, Lived Experience roles, sit operationally but are professionally led, need to assess assurance / compliance. Further training in Person Centred Care and Support Planning for all staff to support coproduction of care plans with all service users irrespective of their method of engagement.*

4. Further refinement of Electronic Patient Record systems to flag disengagement and barriers to engagement.

4. Risks and Challenges

- **Funding:** The 2025/26 operational planning guidance has not allocated any dedicated funding to support implementation of the Intensive Assertive Outreach model. Despite this Trusts were asked to provide outline costs for implementation which both HPFT and EPUT have provided and requires Trust and ICB to consider creative solutions to achieve the desired outcomes, whilst not adversely impacting on other service provision. Discussion between ICBs and NHSE has identified a range of low/medium cost options which are being considered to support and mitigate aspects of financial risk however these may not address all of the challenges.

- **Cohort Identification:** Whist this has presented challenge, each trust has however identified a mechanism to overcome this challenge and has confirmed their cohort of eligible people.

  Cohort size:
  - EPUT (West Essex) cohort size 57 individuals (May 25)
  - HPFT – Cohort size: 359 individuals (May 25)

- **Fidelity to workforce model:** Modelling of the community workforce is an essential component of this programme, and existing community mental health teams responsible for the delivery of an intensive assertive programme for this vulnerable and high-risk group. Further guidance on Mental health community-based staffing is awaited from NHSE**.** Neither of our Mental Health Trusts have dedicated Intensive Assertive Outreach Teams, but in each case robustly manage risk through use of an MDT approach. EPUT has identified specific complexities in their current workforce and service model across its Essex footprint is implementing a Community First approach to standardise Community Mental health teams – working closely with the 3 ICBs across Essex.

- **Caseload:** Remains an area of challenge - Trusts have procedures for monitoring and adjusting caseloads across clinicians to meet patient needs. However, and as previously

identified, in order to achieve full fidelity to the DART standards for Intensive and Assertive Outreach teams, caseloads would need to drop significantly from current levels.

- **National Core Standards Guidelines:** The publication of the National Core standards Guidelines is currently scheduled late summer 2025, and this may have implications for aspects of plan delivery if delayed beyond this date.

5. Recommendations

The Board is asked to review this summary report for information and assurance, and to note that a statutory Inquiry into the events in Nottingham is being established. Chair appointed for public inquiry into Nottingham attack - GOV.UK

6. Next Steps

- Ongoing participation with local, regional and national colleagues to review progress against delivery, to review risks and mitigation.
- Action plans to be submitted to NHSE by the end of June 2025 and engagement with regional teams to review and discuss detailed delivery against action plans.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**27 June 2025**	
Report Title:	**Chair's Report**				**Agenda Item:**	**7**	
Report Author(s):	Rt. Hon. Paul Burstow, ICB Chair						
Report Presented by:	Rt. Hon. Paul Burstow, ICB Chair						
Report Signed off by:							
Purpose:	**Approval / Decision**	☐	**Assurance**	☒	**Discussion**	☐	**Information** ☐
Which Strategic Objectives are relevant to this report **[Please list]**	• Increase healthy life expectancy and reduce inequality • Give every child the best start in life • Improve access to health and care services • Achieve a balanced financial position annually						
Key questions for the ICB Board / Committee:	N/A						
Report History:	N/A						
Executive Summary:	This report is being presented to the ICB Board meeting on 27th June 2025. Board will note specific reference to the: • Neighbourhood health model • System Delivery and Local Innovation • ICB Transition and Integration • Cost reduction						
Recommendations:	The Board is asked to note the contents of this report.						
	Indirect	☐	***Non-Financial Professional***	☐			

Potential Conflicts of Interest:	***Financial***	☐	***Non-Financial Personal***	☐
	None identified			☒
	No conflicts have been identified for the purpose of discussion at this session.			
Implications / Impact:				
Patient Safety:	*N/A*			
Risk: *Link to Risk Register*	*N/A*			
Financial Implications:	*N/A*			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***		An impact assessment has not been undertaken for this paper. It provides a high-level update.	
	Quality Impact Assessment:		Please see above.	
	Data Protection Impact Assessment:		Please see above.	

Introduction

As we approach the end of Q1 2025/26, I want to take the opportunity to reaffirm our strategic direction amidst continued progress and transition. We remain focused on our core mission: to improve health outcomes, reduce inequalities, and sustain high-quality integrated care across Hertfordshire and West Essex.

This month's update continues the themes set out in the May report—delivery, transition, and transformation—while also shining a light on the strength of our neighbourhood health model, which will be critical to our identity and impact within the future ICB configuration.

Building on Delivery Success

The achievements highlighted in May remain both relevant and encouraging. System-wide progress in planned care, workforce sustainability, and digital transformation continues to offer tangible benefits to our population. Notably:

- Agency workforce usage remains 40% lower year-on-year, generating significant efficiency gains and improving workforce continuity.
- GP access continues to improve, supported by triage redesign and expanded additional roles.
- Children's mental health support in schools is now embedded in nearly half of all settings—a substantial local success story against national targets.

These examples reflect the collective discipline and innovation across our system, supported by strong provider engagement and aligned place-based planning.

Neighbourhood Health – Our Local Strength in a Changing Landscape

In this time of organisational change, it is important to highlight enduring strengths that must be preserved and scaled. Our neighbourhood health model is one such strength.

Over recent years, we have built a robust neighbourhood delivery framework that is both practical and deeply rooted in local contexts. Across South and West Hertfordshire, East and North Hertfordshire, and West Essex, Integrated Neighbourhood Teams (INTs) are now operating with increasing maturity, delivering proactive, person-centred care to populations of 30,000–50,000.

Our Care Closer to Home (CCH) framework sets out a structured approach to supporting people through all phases of need—from prevention and long-term condition management to crisis response and end-of-life care. This model is already delivering real impact:

- Enhanced frailty support and personalised care plans are now routine in several localities.
- Shared caseloads and PHM-driven targeting are reducing avoidable admissions.
- Dashboards track outcomes in real time, enabling continual learning and improvement.

These are not pilot initiatives—they represent a sustainable, scalable model of integrated care that positions us well for the future and exemplifies what effective local health delivery should look like.

System Delivery and Local Innovation

Alongside continued improvements in access and workforce sustainability, we are seeing further evidence of local innovation and delivery strength across the system. In particular:

- The **appointment of a Programme Director for the Hemel Hempstead Health Campus** marks an important milestone in the development of a modern, community-focused hub for health, care, and wellbeing services in the town. This initiative reflects our commitment to aligning strategic estates planning with population need and partnership working.
- The **successful delivery of the spring COVID-19 vaccination programme,** supported by over 150 pharmacies across the system, demonstrates our ability to mobilise local assets and protect vulnerable residents efficiently and effectively. This campaign has also strengthened collaborative ties between primary care, public health, and community pharmacy.

These developments underscore our system's capacity to deliver both short-term operational gains and long-term transformation, rooted in population health, integration, and responsiveness to local need.

Transition and Integration – Preparing for the Future ICB Footprint

As set out in the Model ICB Blueprint, the move toward a more strategic, outcomes-focused, and cost-effective operating model is now well underway. Our submission of cost reduction plans by the 30 May deadline marked a key milestone in aligning with the revised £18.76 per head operating cost envelope and the future structure of Integrated Care Boards (ICBs).

To manage this complex transition, we have put in place strong local governance arrangements. The ICB Transition Committee is focused on planning, workforce, and delivery continuity across Hertfordshire and West Essex. In parallel, a joint transition committee, chaired by John O'Brien and supported by Senior Responsible Officer Felicity Cox, has been established across the three ICBs of Hertfordshire and West Essex, Cambridgeshire and Peterborough, and BLMK to provide strategic coordination and oversight.

At the time of writing, similar arrangements are being established to support the formation of a new Essex ICB, which will incorporate the West Essex element of our current system.

These arrangements are designed to safeguard delivery and statutory functions, maintain organisational stability, and support our transition to a more streamlined operating model.

Cost Reduction and ICB Reorganisation

Across the country, the scale and pace of the mandated ICB running cost reductions—set at 50% by the end of Q3 2025/26—are generating increasing concern. Recent national discussions have highlighted the continued lack of clarity around how functions will be transferred, how funding will flow within the £18.76 per head envelope, and what the future scope of ICBs as system convenors will be.

At the time of writing, ICBs are still awaiting confirmation from HM Treasury on whether prior approval will be granted for voluntary and compulsory redundancy arrangements, and whether

central government will underwrite some or all of the associated costs. This uncertainty, combined with unresolved questions around executive appointments and workforce transitions, reinforces the need for urgent national guidance to enable safe and effective local implementation.

Risk and Governance

The Board has rightly held serious and thoughtful discussion on the risks inherent in the transition process. These include operational, legal, and workforce considerations that are both complex and interdependent.

Rather than detail these risks individually here, I want to assure colleagues that they are being actively managed. Key themes include the safeguarding of statutory functions, the protection of frontline leadership capacity, and the need for rigorous staff engagement. These are embedded in our risk and assurance frameworks, and we are working closely with regional teams and regulators to maintain oversight and compliance.

Local Government Reform

On 3 June 2025, Jim McMahon MP, Minister of State for Local Government and English Devolution, issued an update on the local government reorganisation (LGR) programme. This confirmed the allocation of proposal development contributions to 21 areas, alongside new statutory guidance encouraging the formation of robust and sustainable unitary proposals. Importantly, the minister reiterated that a population size of 500,000 remains a guiding principle—not a fixed threshold—and flexibility will be applied in considering housing growth and local context.

The letter further emphasised the importance of embedding community engagement through neighbourhood governance models such as Neighbourhood Area Committees, reinforcing the national direction of travel toward more devolved and place-based decision-making.

Leadership Appointment Processes

At the time of writing, NHS England has not yet finalised the arrangements for confirming and appointing Chairs and Chief Executives for the proposed ICB footprints. This introduces a degree of uncertainty into the leadership landscape, which is critical for ensuring continuity and strategic direction during the transition to the new ICB structures. The establishment of clear and timely appointment processes will be essential to maintain momentum in implementing the Model ICB Blueprint and to uphold the high governance and accountability standards expected of all public bodies.

Extension of Partner Member Terms During Transition

As part of our commitment to maintaining stability and continuity during this period of structural transition, we intend to extend the current terms of office for our Partner Members. This extension will ensure that experienced voices remain in place to support effective governance, preserve institutional knowledge, and provide reassurance to our communities and partners

as we move toward the proposed new ICB configurations. Formal confirmation of these extensions will follow in accordance with our governance procedures.

Investment and Strategic Commissioning

The 2025 Comprehensive Spending Review delivers long-awaited investment in NHS infrastructure and digital transformation, with £29 billion in additional revenue funding by 2028–29 and up to £30 billion in capital over five years. This represents a major opportunity—but also a clear challenge for Integrated Care Boards.

Locally, this new headroom aligns well with our ambitions for modernised community hubs and enhanced digital pathways. But investment alone is not enough. We must avoid short-termism and ensure spending decisions focus on long-term impact—prioritising prevention, disinvesting from low-value activity, and strengthening community-based care.

This is a moment to act as the strategic commissioner envisioned in the Model ICB Blueprint: aligning resources with population health, not just maintaining existing services. The funding is real; whether it translates into better outcomes will depend on the choices we make now.

Hertfordshire and West Essex – National Recognition

Our system's work continues to gain profile on the national stage. At this month's NHS ConfedExpo, Hertfordshire and West Essex was referenced in both the keynote address and breakout sessions as an example of local leadership and innovation. In his keynote, NHS Confederation Chief Executive Matthew Taylor highlighted "great work at place level" observed in West Hertfordshire, underscoring the importance of trust leaders operating beyond organisational boundaries.

We also welcomed national coverage of the virtual ward research study led by West Hertfordshire Teaching Hospitals NHS Trust. Featured in the *Health Service Journal*, the study evaluated one of the largest virtual ward programmes in the country. Findings show significant patient preference for home-based care (over 95%) and demonstrate clear economic benefit—estimated at £1.3 million in annual savings. These results reinforce our system's leadership in scalable, person-centred care and our ongoing commitment to transformation grounded in evidence and impact.

Conclusion

As we move into the next phase of 2025/26, we do so with strong foundations, a clear strategic direction, and a governance framework that enables us to manage complexity while staying focused on outcomes. Our neighbourhood health model continues to demonstrate the benefits of integrated, person-centred care, and our system-wide delivery—most recently illustrated through our estates planning and vaccination programmes—reflects a shared commitment to innovation and resilience.

Through collaboration, clarity of purpose, and strong leadership, we are well positioned to keep our eye on the path ahead as we navigate national uncertainty, maintain momentum on transformation, and protect what we know works locally.

Paul Burstow

Chair, Hertfordshire and West Essex ICB

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Board meeting held in Public				**Meeting Date:**	**27 June 2025**	
Report Title:	**Chief Executive's Report**				**Agenda Item:**	**8.**	
Report Author(s):	With contributions from the ICB Executive Team and Partner Members						
Report Presented by:	Dr Jane Halpin, Chief Executive Officer						
Report Signed off by:	Dr Jane Halpin, Chief Executive Officer						
Purpose:	**Approval / Decision**	☐	**Assurance**	☒	**Discussion**	☐	**Information** ☐
Which Strategic Objectives are relevant to this report	▪ Increase healthy life expectancy and reduce inequality ▪ Give every child the best start in life ▪ Improve access to health and care services ▪ Increase the number if citizens taking steps to improve their wellbeing ▪ Achieve a balanced financial position annually						
Key questions for the ICB Board / Committee:	N/A						
Report History:	N/A						
Executive Summary:	This report is being presented to the HWE ICB Board for its meeting on the 27 June 2025. Board will note specific reference to the: ▪ ICB Change Process ▪ Financial plan delivery ▪ Winter planning ▪ Progressing our Operating Model ▪ Integrated Neighbourhood Teams						

Recommendations:	The Board is asked to note the contents of this report.			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
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Implications / Impact:				
Patient Safety:	*N/A*			
Risk: *Link to Risk Register*	*N/A*			
Financial Implications:	*N/A*			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***		A separate impact assessment has not been undertaken for this paper, as it provides a high-level update.	
	Quality Impact Assessment:		Please see above.	
	Data Protection Impact Assessment:		Please see above.	

ICB Change Process

As the board will be aware, the ICB change process continues to be the main focus for myself and my executive team.

Since the board met in May we have joined with colleagues in the relevant ICBs to submit plans to NHS England for the creation of two ICB clusters - the creation of the Greater Essex cluster, and the cluster containing Hertfordshire, Bedfordshire, Luton, Milton Keynes, Cambridgeshire and Peterborough. At the time of writing, we have not yet had feedback from NHS England on these plans, which set out the changes we will need to make to be able to live within the £18.76 per head of population spending envelope.

Work on the design of those two clusters is continuing, as we seek to meet the nationally mandated timetable for implementing these changes. There are a number of key outstanding questions that will need to be resolved in order for the arrangements to be finalised.

I would say however that across both of the clusters that Hertfordshire and West Essex will help to form our working arrangements with colleagues from across each component ICB are strong, and there is a collective sense of the opportunity presented by these changes - along with the risks that accompany it.

I would also like to recognise the impact of the ongoing uncertainty on our staff, and to thank them for their professionalism and dedication during what is inevitably a difficult time. Across the ICB we are committed as a team to continuing to deliver for the people of Hertfordshire and West Essex as we have done since the ICB's creation in 2022.

Delivering our financial plan

One of the areas in which we are continuing to deliver our usual business is in relation to delivery of our system's financial plan. The board will receive an update on our performance as a system against this plan to date. Delivery of the plan will require significant effort from the ICB and our provider organisations - both to deliver our individual cost improvement programmes and the system transformation we have collectively agreed, and which underpins the plan.

This will need to continue to be a key area of focus for the board and the wider ICB in coming months.

Winter

The Board's move to quarterly meetings means that by the time we meet next in September our preparations for the coming winter will need to be close to completion. It has been agreed that ICBs will continue to hold responsibility for oversight of their systems' performance over winter - and we have begun our usual planning process with system partners. It will be important that we take the learning and improvements we have developed as a system over the last three winters and utilise it to ensure our performance this winter continues on the same improved trajectory, we saw last year.

Progressing our Operating Model

Work is continuing on our system operating model, in which we are seeking to accelerate the ICB's journey towards a focus on strategic commissioning whilst empowering our local health and care partnerships to be responsible for the planning, integration and delivery of the services for their local population.

East and North Hertfordshire NHS Trust remain on track to assume host provider responsibility for the East and North Herts HCP, with the intention that these arrangements will begin in July.

In our existing host providers, we are working with West Hertfordshire Teaching Hospitals NHS trust to scope a proposal for the next phase of delegation and the readiness criteria that will need to be met to progress to that next phase. We also have an outline agreement with PAH on the development of a lead provider model for Adult Community Services, and this will be developed further in the coming weeks.

Integrated Neighbourhood Teams

Integrated Neighbourhood Teams (INTs) in Hertfordshire and West Essex are a key part of the local health and care system, designed to provide joined-up care closer to people's homes. These teams bring together professionals from various organisations involved in primary care, community care, mental health, social care, and the voluntary sector to address the needs of our communities.

I had the pleasure of attending a showcase event on the work of INTs in West Essex earlier this month, and it was truly impressive to see the range of work that they are driving. They are and will continue to be vital to the delivery of the ambitions we set in the longer term plan to deliver higher quality, more integrated care that is closer to the patient's home.

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐				
	HWE ICB Board Meeting – in public				**Meeting Date:**	**27/06/2025**		
Report Title:	**Governance report**				**Agenda Item:**	**09**		
Report Author(s):	• Simone Surgenor – Deputy Chief of Staff, Governance and Policies • Tatiana Njendu – Risk and Compliance Officer							
Report Presented by:	• Michael Watson, Chief of Staff							
Report Signed off by:	• Michael Watson- Chief of Staff							
Purpose:	**Approval / Decision**	☒	**Assurance**	☐	**Discussion**	☐	**Information**	☐
Which Strategic Objectives are relevant to this report	• Increase healthy life expectancy, and reduce inequality • Give every child the best start in life • Improve access to health and care services • Increase the numbers of citizens taking steps to improve their wellbeing • Achieve a balanced financial position annually							
Key questions for the ICB Board / Committee:								
Report History:	This report forms part of a regular agenda item with the HWE Board.							
Executive Summary:	The purpose of the Governance report is to update the board on key areas relating to governance, key areas for decision and to present the Board Assurance Framework. Today's paper covers: • Constitution – proposed updates to the ICBs Constitution • Board Assurance Framework • This report provides assurance on the effectiveness of the ICB's risk management processes, highlighting key changes in the risk profile, ICB transition, risk governance and the internal audit progress.							
Recommendations:	Members are kindly requested to: ▪ Approval – Constitution update as referenced at paragraph 2.1 below.							

<table>
<tr><td></td><td colspan="4">▪ Noting - Board Assurance Framework – as referenced at paragraph 2.2 below.</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☒</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☐</td></tr>
<tr><td colspan="4">Updates to the Governance Handbook include terms of ICB Board member tenures. The Board is not being asked to approve the new terms, but merely and in compliance with ICB governance - the updates to this ICBs Governance Handbook.</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">This update provides core governance framework updates, and therefore supports patient safety.</td></tr>
<tr><td>Risk: Link to Risk Register</td><td colspan="4">[Refer to latest Risk Register when completing]</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">No additional implications to report in this paper.</td></tr>
<tr><td>Patient or public engagement or consultation:</td><td colspan="4">Nothing in addition to note, over and above the work undertaken in support of the documented services.</td></tr>
<tr><td rowspan="3">Impact Assessments:
(Completed and attached)</td><td colspan="2">Equality Impact Assessment:</td><td colspan="2">A separate EIA has not been completed for this paper – as the services, policies or appointments referenced would as part of their due diligence, undertaken relevant impact assessments. Guidance continues to be gained through the HWE ICB Equality Lead.</td></tr>
<tr><td colspan="2">Quality Impact Assessment:</td><td colspan="2">Please see the response provided against the EIA entry above.</td></tr>
<tr><td colspan="2">Data Protection Impact Assessment:</td><td colspan="2">Please see the response provided against the EIA entry above.</td></tr>
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1. Background

Constitution – the Board is asked to approve the proposed update to HWE ICBs Constitution:

2. Issues

2.1 ICB Constitution – for approval

NHS Hertfordshire and West Essex ICBs Constitution in paragraph 3.5.4 (b) currently precludes the Chief Executive from holding any other employment of executive role (see below). Given the re-configuration of ICBs it is proposed to request NHS England to approve the deletion of this sentence

4. "Individuals will not be eligible if:

(a) Any of the disqualification criteria set out in 3.2 apply.

(b) ~~*Subject to clause 3.4.3(a), they hold any other employment or executive role."*~~

Recommendation - That the Board agrees the proposed change to the Constitution in relation to Chief Executive **Officers holding more than one executive role, and requests approval from NHSE for this alteration.**

2.2 ICB Board Assurance Framework – for noting and discussion:

The Board Assurance Framework comprises of strategic risks as defined by the board: the major risks that could prevent the board from fulfilling the objectives in the ICBs strategy.

The following report provides assurance on the effectiveness of the ICB's risk management processes, highlighting key changes in corporate risks.

Risk Profile:

- 21 corporate risks are scored 12 and above, of which 5 are on the Board Assurance Framework (BAF)
- New risk, Risk 680 related to the Lampard Inquiry preparedness (score: 12).
- Risk 650 (elective recovery) – Closed following recovery in performance.
- Risk 669 (legacy server risk) – Downgraded following control improvements.

Risk Governance

The ICB's significant transition towards a cluster operating model (driven by national 50% cost reduction requirements) is actively generating new risks. To manage these and other issues, a dedicated Transition Committee has been established. Teams are systematically identifying and logging these emerging transition risks into the newly consolidated DatixWeb platform, which provides enhanced monitoring capabilities. While this structured approach strengthens oversight, the lack of a formally approved and embedded Risk Management Policy (expired

Feb 2025) poses a potential governance risk to consistent handling during this period of change.

Next Steps

- Continue aligning risk oversight with emerging ICB governance structures.
- Support transition risk reporting and thematic assurance through cluster leads.
- Strengthen executive engagement and data quality ahead of the next Board Assurance Framework refresh in autumn.

All risk registers are living documents, and the Risk Team will continue to provide ongoing support to directorates in updating their risk:

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 Board 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, five 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

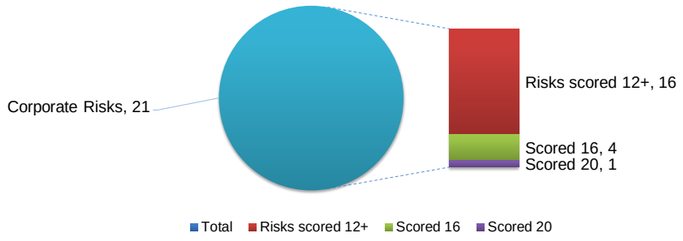
Progress: g

TRIGGER ZONES FOR MANGEMENT ACTION PLANS

Risk Matrix		Consequence (C)				
		1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
Likelihood (L)	5. Almost Certain			1		
	4. Highly Likely			4	3	1
	3. Possibly				12	
	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)	8
5	Performance (Business Intelligence & Performance)	2
6	Primary Care	2
7	Quality and Nursing	2
8	ICB Strategy (People, Workforce, Strategy)	4
		21

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
5															
679	16/05/2024	SO5	Alan Pond	Finance & Premises	**Financial Efficiency Risk**: If the Integrated Care System and its component organisations fail to deliver the agreed efficiencies contained within the 24/25 financial plan, and the additional measures required to deliver that plan, then the system will end the year with a financial deficit, resulting in reduced funding in future years and potential harm to future service delivery and organisational reputation.	The System has a control total deficit for 2024/25 of £20m, which is less than the ICB's fair share of resources being retained nationally by NHSE. If achieved there will be no financial consequences. However, to deliver this plan the System needs to deliver efficiency, produsctivity and/or cost savings of 5%. Not all savings are fully identified and there is risk to delivery currently assessed at c£20m. This equates to more than 0.5% of the ICB's budget and without developed plans with action owners is highly likely to materialise as a variance to plan. If such variance arose, the overspend would become repayable over 3 years from 2026/27.	Seek	4	5	20	Budgetary control framework in each organisation and assessment against HFMA governance control and grip framework Triple-lock framework which requires expenditure in scope to be second/third approved by ICB and NHSE Income and expenditure reporting and analysis and maintain oversight of financial position at least monthly Efficiency programme and organisational oversight and reporting through Programme Management Offices	⇔	Reasonable	Reasonable	Reasonable
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.	May 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 both PAH and HCT at risk of requiring full cohort recall.	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 target to reach zero 65week waits by the end of December is challenging although plans are in place for delivery. DM01 diagnostics rates for September was c56% across the system with variation across each place.	**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	*None*
526	**06/09/2022**	**SO2**	Beverly Flowers	Strategy (including people and workforce)	**Increased Demand on Childrens Services:** If the demand for children's community services continues to increase then statutory requirements will not be met resulting in delays to accessing care, poor patient experience and poorer patient outcomes (wellbeing and educational)The main services impacted include: Community Paediatrics incl. ASD/ADHD, Children's Therapies (OT/SLT), Community Allergy and Dietetics, Community Audiology, Special School Nursing.	The reduction in risk is due to a key piece of work that is supported by a business case and modelling documents that are held with the MHLDA. There are monthly system wide meetings across the partnership. The work is ongoing via the MHLDA. This risk relates to the ASD/ADHD risk, other risks around community paeds are noted in the Herts SEND data uptake and reported through the SEND herts data dash board and the Essex SEND data dashboard.	**Open**	4	4	**16**	1. Demand and capacity analysis for impacted services has been completed to inform business cases for additional investment. Investment to clear ASD backlog in Herts; some investment for backlog in WE. In September 2022 further money was agreed to clear the ADHD backlog in South and West Hertfordshire. 2. Across the ICB the CYP teams are proposing to develop a Community Paediatric Transformation Programme which will review all community paediatric services including ASD and ADHD to ensure there is consistency of outcomes and financial input, as well as being able to identify the most efficient, effective and high quality way of session issues.Sharing learning across the ICS and Essex systems. 3.Clinical prioritisation is being undertaken within impacted services. Transformation programmes in place for some areas e.g. therapies programmes, ASD/ADHD transformation programmes, community paediatrics transformation (S&W Herts only). 4.Regularly review and monitoring of data through contract management and performance meetings. Escalation of risk to the ICB and within impacted providers. 5.Quality intelligence is reviewed in order to build up a picture of the impact to patients/their families and Quality remains a standing item on the provider CQRMs 6. focused discussion at WE Transformation Committee, highlighting pressures and contributing factors, escalating concerns with the Place Director, WE Health Care Partnership and advising of need to address the capacity gap. 7. Business case in development	↔	Reasonable	Reasonable	Reasonable
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 colour codes for action		Review no action required.
		Continue to watch. Action is discretionary.
		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 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.

<table>
<tr><td rowspan="2">Meeting:</td><td>Meeting in public</td><td>☒</td><td>Meeting in private (confidential)</td><td>☐</td></tr>
<tr><td colspan="2">NHS HWE ICB Board meeting held in Public</td><td>Meeting Date:</td><td>27/06/2025</td></tr>
<tr><td>Report Title:</td><td colspan="2">ICB Committee Summary Reports</td><td>Agenda Item:</td><td>10</td></tr>
<tr><td>Report Author(s):</td><td colspan="4">Governance Leads, HWE ICB</td></tr>
<tr><td>Report Presented by:</td><td colspan="4">Committee Chairs / Executive Leads</td></tr>
<tr><td>Report Signed off by:</td><td colspan="4">Michael Watson, Chief of Staff</td></tr>
<tr><td>Purpose:</td><td colspan="4">Approval / Decision ☐ Assurance ☐ Discussion ☐ Information ☒</td></tr>
<tr><td>Which Strategic Objectives are relevant to this report
[Please list]</td><td colspan="4">▪ Increase healthy life expectancy, and reduce inequality
▪ Give every child the best start in life
▪ Improve access to health and care services
▪ Increase the numbers of citizens taking steps to improve their wellbeing
▪ Achieve a balanced financial position annually</td></tr>
<tr><td>Key questions for the ICB Board / Committee:</td><td colspan="4">N/A</td></tr>
<tr><td>Report History:</td><td colspan="4">N/A</td></tr>
<tr><td>Executive Summary:</td><td colspan="4">Each ICB Sub-Committee has produced a summary document providing an update from the last meeting.

All summary reports can be found in the information section of the agenda.

<table>
<tr><th>Committee</th><th>Date of meeting</th><th>Chair</th></tr>
<tr><td>Audit and Risk Committee</td><td>21st March 2025</td><td>Thelma Stober</td></tr>
<tr><td>System Transformation and Quality Improvement Committee</td><td>14th May 2025</td><td>Ruth Bailey</td></tr>
<tr><td>Strategic Finance and Commissioning Committee</td><td>8th May 2025</td><td>Nick Moberly</td></tr>
<tr><td>ENH HCP Board</td><td>6th June 2025</td><td>Elliott Howard-Jones, Adam Sewekk-Jones</td></tr>
<tr><td>WE HCP Board</td><td>5th June 2025</td><td>Thom Lafferty</td></tr>
</table>
</td></tr>
</table>

	SWH HCP Board	30th April 2025	Matthew Coates
	Mental Health, Learning Disabilities and Autism Health and Care Partnership Board	13th June 2025	Karen Taylor/ Chris Badger
	People Committee	15th May 2025	Ruth Bailey

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

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

ICB Committee Summary Document –

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

[Insert committee/board title] [Date of meeting]:	**Mental Health and Learning Disability and Neurodiversity Health and Care Partnership Board 13 June 2025**			
Signed off by Chair and Executive Lead:	**Chair – Chris Badger and Karen Taylor Executives – Beverley Flowers**			
Report Author:	**Simone Surgenor – ICB Deputy Chief of Staff – Governance and Policies**			
Report to the ICB Board	**In public**		**In private**	**x**

Agenda items covered:

Quoracy

- The meeting was quorate.

Declarations of Interest

- No declarations made. MHLDN HCP Board considered the register of interests and noted outstanding declarations.

Minutes

- Minutes from 09 May 2025 were approved as an accurate record.

Action tracker

- The MHLDA HCP Board noted the action tracker.

Development Director's Report

- The Board noted activity that had taken place across the MHLDA HCP since its last meeting and received updates regarding:
  - Positive news in relation to Learning Disabilities Annual Health Checks performance, once again exceeding the national target. Subsequent discussion highlighted the difference in practice and resource between Annual Health Checks for people with learning disabilities and Annual Health Checks for people with severe mental illness.
  - Publication of new JSNAs for both Adult Mental Health and Children's Mental Health with reference and thanks to Public Health for the partnership work that has underpinned these publications
  - A Dementia focused discussion took place at the MHLDN HCP's most recent Clinical and Practice Advisory Committee outlining how the HCP will continue to prioritise the monitoring of Dementia diagnosis rates in Hertfordshire even though it will no longer be monitored nationally
  - Consideration of the role the MHLDN HCP Board should play in relation to the new Children's Social Care White Paper and the Families First approach
  - The activity by Healthwatch Hertfordshire to understand what information and support autistic adults are given after receiving their diagnosis

- The relaunch of the Hertfordshire Suicide Prevention Board to be co-chaired by Aideen Dunne (HCC) and Emma Wadey (HPFT)
    - **Name of board** and the proposal to retitle it to the Mental Health, Learning Disability and Neurodiversity Health and Care Partnership to better reflect the areas and activity it covers. With agreement from MHLDA HCP Board members, this will be formally proposed to HWE ICB.
    - **Updates from sub-committees and transformation programmes** including the launch of a new resource guide to support carers, families and individuals affected by a relative's suicide attempt and the formal approval of the Hertfordshire Drug & Alcohol Strategy, with co-occurring mental illness and substance use included as a key priority.

Pathways to Work Green Paper summary and implications

- The MHLDN HCP Board received a presentation summarising the key elements of the Pathways to Work Green Paper and considering the potential impact of the proposed changes for people with mental illness, people with learning disabilities and neurodivergent people.

- The MHLDN HCP Board noted that:
    - Based on national figures, Hertfordshire could expect 87% of those on standard rate and 13% of those on enhanced rate to be at risk of losing PIP. This would be 16,000 and 3,000 respectively, or 19,000 people in total out of the current 42,000 caseload
    - The Government's analysis had concluded that approximately 150,000 unwaged carers could lose money – in addition to the money the people they care for might lose. In Hertfordshire, it is estimated that approximately 2,000 carers might lose income under the current proposals
    - Anxiety, depression and autistic spectrum disorders have been the main conditions contributing to the growth in Personal Independence Payments (PIP) awards since the COVID-19 pandemic.
    - There may be increased demand on local health, social care and VCFSE services as people seek support in completing their assessments.
    - Anxiety around these changes is already being seen with existing service users and carers, even though the changes are not yet in place

- The MHLDN HCP Board agreed to further progress its activity around Supported Employment in Hertfordshire – noting the potential mismatch between the skills of people currently economically inactive and the needs of the labour market. The MHLDN HCP Board agreed to produce communication/briefing to support frontline staff to understand the changes.

Mental Health Act implications

- The MHLDN HCP Board received a paper outlining the policy and practice implications arising from the new Mental Health Bill, currently making its way through Parliament. The MHLDN noted that changes would be required across all NHS Trusts and local authorities, not just Mental Health Trusts.

- The MHLDN HCP agreed to establish a multi-agency working group to undertake a gap analysis and propose the activity required to effect the necessary clinical and practice changes. The new multi-agency group was also tasked with considering how all the changes would be communicated to staff and people accessing services and support.

MHLDN HCP operating model update

- The MHLDN HCP Board received an update on the development of its operating model. Work in now underway to renew the MHLDN HCP's Memorandum of Understanding so that it can act as the partnership agreement for the new arrangements. Discussion are underway with other Mental Health collaboratives across the country to assess further opportunities and activity is taking place to formalise the role of the MHLDN HCP in HCC's governance.
- MHLDN HCP Board considered how risk would be held and shared in the new arrangements. The MHDLN HCP agreed to maintain a focus on reducing bureaucracy and noted the strong partnerships that underpin its delivery and its success as an HCP.

MHLDN HCP Integrated Delivery Plan

- The MHLDN HCP approved the Integrated Delivery Plan, recognising that it may need further revision following the publication of the NHS 10 Year Plan and the output of the Social Care Review.

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

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

- Potential impact of PIP reforms to people accessing services and their carers in Hertfordshire

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

- Noted as above

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

- Integrated Delivery Plan – the strength of the plan, its system link including clear inclusion of primary care, and the care taken to it representing both HWE ICB and wider system and partner priorities

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

- Strong performance again in relation to the number of people with Learning Disabilities receiving Annual Health Checks,

Forward plan issues:	• Impact of the new Mental Health Act of patients with Learning Difficulties. • HPFT Dove Ward/4 Bowlers Green Bed Reconfiguration Proposals – acute stages to come back to next meeting.
Date of next meeting	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

ICB Committee Summary Document –

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

[Insert committee/board title] [Date of meeting]:	**ENH HCP Board – 6th June 2025**			
Signed off by Chair and Executive Lead:	**Chair – Elliot Howard-Jones** **Executives – Sharn Elton**			
Report Author:				
Report to the ICB Board	**In public**		**In private**	**x**

Agenda items covered:

- **ENH Development Directors Update**
- **Integrated Delivery Plan –** agenda item June ICB Board.
- **Audiology, ADHD/neurodiversity assessments, community paediatrics and mental health provisions in schools –** noting escalating pressures and ongoing focus on identifying priorities in challenged financial climate. Identified this is an area where the transformation work is important and understanding whether the system is maximising existing opportunities in the wider collaborative including utilising capital opportunities alongside findings from research plus IT technology solutions model of social hubs and bringing it to the local level. Action - development of a coherent plan surrounding funding, alongside implications of not taking steps to address.
- **Transformation Portfolio Overview**
- Care Closer to Home Update
  - Work underway to reduce the amount of patients with multiple plans.
  - Frailty – noting new platform in place including the risk stratification tool to support INT's. Benefits pending evaluations.
  - INT's – noting challenges including with system partners in understanding their aim and aspiration. Local locality reports being developed to support reporting. In respect of the reduction target, a clear understanding of steps to be taken for enacting. Challenge raise over resource to implement. Clarity sought over the 10% and target.
- Primary Care Update – INT resourcing, localised events including myth busting events. Mapping work being undertaken, to aid identify what the INT's need to progress their work. Dental – noted improved activity and delivery of UDA's. Transformation work in the community dentistry space with identified improvements in waits being noted.
- **ENH HCP - Operating Model**
- Overview of Approach –
- ENH HCP Host Provider Operating Model –
  - Document provide sets out the vehicle, engagement and partners.
  - How we illustrate patient benefit strengthening the hearing clinical/patient voice.
  - Engagement – workshops and taking everyone through the same process undertaking scenario testing.
  - Utilising inclusion of Primary Medical Services, Local Authority Representation and wider system partners.
  - Identifying wider clarity over what change looks like from 1st July – therefore more detail to come back.
- **2025-26 Finance update –** noting financial risk surrounding efficiency ask for the ICS and impact. Working being undertaken on distant from target.
- **Performance Review –** In support of earlier Board discussions, noting community paediatric figures. Identifying delays in reports coming through and discharge summaries. Further detail sought on trajectories and who this can be improved further.

ENH HCP Sub-committee reports – received and noted.
Key discussion points and matters to be escalated from the meeting: *(From agenda)*
Alert: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy
•
Advise: The Board – of areas subject to on-going monitoring or development or where there is insufficient assurance
• **Audiology, ADHD/neurodiversity assessments, community paediatrics and mental health provisions in schools – noting the detail above.**
Assure: Inform the Board – where positive assurance has been received.
•
Celebrating Success: Share any practice, innovation or action that the Committee considers to be outstanding
•

Forward plan issues:	•
Date of next meeting	

BOARD OF DIRECTORS:	**Trust Board – 5th June 2025**			**AGENDA ITEM: X.X**
REPORT TO THE BOARD FROM:	**West Essex Health & Care Partnership Board (WE HCP Board)**			
REPORT FROM:	**Thom Lafferty - Committee Chair**			
DATE OF COMMITTEE MEETING:	**15.05.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
9. Proactive Care – a patient's experience	Y	Y	N	Presentation illustrating a patient & carer experience of urgent care this year and the improved experience in 2025/26 with the Care Closer to Home & Proactive models of care that are in place and being enhanced with partnership working.
Integrated Delivery Plan	Y	Y	N	The Integrated Delivery Plan is the West Essex 3 year prioritised transformation plan, created & delivered collaboratively across the partnership, to be monitored through the partnership governance structure, at locality & place level. Standardised reporting and an outcomes dashboard being developed. The Board discussed specific actions for the partners to deliver swift transformation to deliver proactive care closer to patient's homes. The WE HCP Board approved the Integrated Delivery Plan.
10. Priorities Highlight Report – review of 24/25 delivery	Y	Y	N	The locality clinical leads described the progress made during 24/25 on the delivery plan, successes and learning.
5. Delegation Framework	Y	N	N	The PAHT Board approved Delegation Framework (DF) was approved by the WE HCP Board. The locality governance structure that underpins the DF was presented to the Board and it was agreed to add additional details to support future levels of delegation to localities.

BOARD OF DIRECTORS:	**Trust Board – 5th June 2025**			**AGENDA ITEM: X.X**
REPORT TO THE BOARD FROM:	**West Essex Health & Care Partnership Board (WE HCP Board)**			
REPORT FROM:	**Thom Lafferty - Committee Chair**			
DATE OF COMMITTEE MEETING:	**15.05.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
6. WE HCP Board Terms of Reference	Y	N	Y	The Terms of Reference for the WE HCP Board were discussed and two changes requested – remove the exclusion regarding mental health and include the E&NHerts GP clinical lead representative in the membership. These amended Terms of Reference are recommended for approval by the PAHT Board. (See Appendix)
7. ICB Operating Model	Y	Y	N	Verbal updated from the WE Place Director on the future ICB structure and reorganisation timetable.
8. Local Government reorganisation	Y	Y	N	Verbal update from Head of Integration & Partnerships at Essex County Council highlighting initial comments from the national team on the proposed model are being responded to. There will be two business cases submitted, 5 unitary authorities and 3. UK government decision expected February 2026.
11 – 13 Sub-committee reports	Y	Y	N	Quality & Transformation Committee is focussing on the development of a quality dashboard and refining the role of the committee. No escalations from the Operational Delivery & Performance Committee Finance & Commissioning Committee are developing effective partnership finance reports that reflect both the organisations' financial position and the interconnected partnership finances.

BOARD OF DIRECTORS:	**Trust Board – 5th June 2025**			**AGENDA ITEM: X.X**
REPORT TO THE BOARD FROM:	**West Essex Health & Care Partnership Board (WE HCP Board)**			
REPORT FROM:	**Thom Lafferty - Committee Chair**			
DATE OF COMMITTEE MEETING:	**15.05.25**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
14. HCP Communications	Y	Y	N	Discussed the development of a WE HCP communications plan for both staff and the public including sharing of events and making every opportunity of public events to share prevention work and opportunities.

The Princess Alexandra Hospital NHS Trust

West Essex Health & Care Partnership Board

Terms of Reference 2025 v6

1. Constitution

1.1 As the NHS statutory organisation in West Essex, PAHT take on the host provider role for West Essex Health & Care Partnership (the HCP) enabling effective partnership working between health & care organisations in West Essex.

1.2 The Delegation Framework between Hertfordshire and West Essex ICB and The Princess Alexandra Hospital NHS Trust sets out the accountability and responsibility for hosting the WE HCP Board.

1.3 The HCP Board has been constituted as a committee of the PAHT Trust Board. This committee functions to enable the HCP to adopt an integrated approach to healthcare delivery, having delegated responsibility for the commissioning and management of NHS services from the ICB for the population of West Essex and the population in Hertfordshire that accesses PAHT for the majority of its urgent and elective care. The HCP acts as central coordinator to enable integrated care whilst avoiding duplication and fragmentation of services for all patients, not just those accessing care at PAHT.

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

2. Authority

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

The role of the West Essex Health Care Partnership Board ("HCP Board") is to provide the multi-agency, system leadership to the HCP. The detailed responsibilities are set out in the Delegation Framework between HWE ICB and PAHT.

In time it is expected that the HCP will take on full delegation ('category 3 delegation') for all services commissioned on behalf of the population of WE only, ~~with the exception of any services that will be fully delegated to the Mental Health, Learning Disability and Autism HCP. The HCP will take on partial delegation ('category 2' delegation) for the services currently commissioned jointly on behalf of the population of West Essex and/or the ICB.~~

In year one the HCP will take on full delegated responsibility ('category 3' delegation) of a range of community services which are commissioned on behalf of the population of WE. Delegation will be for both statutory responsibilities and operational responsibilities for these services.

2.2 In summary the HCP Board is authorised by the PAHT Boards to:

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

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

3. Responsibilities and functions

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

Core Business

- To take accountability for the development and delivery of the overall financial plan for West Essex within the specified delegated budgets of the HCP.
- To scrutinise and approve recommendations proposed by the HCP Strategic Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee, or through whatever model of managing these responsibilities the HCP agrees. This will include investment and spending decisions up to £1 million (or up to £2 million if the contract exceeds 12 months). And recommending to the ICB Commissioning Committee contracts or services up to £2.5 million (or up to £5 million if the contract exceeds 12 months).
- To approve recommendations for activity/interventions arising from the HCP's Clinical Transformation workstreams, the enabling workstreams and the task and finish groups.
- Receive updates from the HCP Finance & Commissioning Committee and the HCP System Transformation and Quality Improvement Committee (or equivalent) and to review the HCP's risk register
- To assure and drive the performance and delivery of Integrated Neighbourhood Team transformation work in West Essex.

Strategic Leadership

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

In addition in 2025/26 the HCP will take on full delegated responsibility ('category 3' delegation) of a range of community services which are commissioned on behalf of the population of WE. Delegation will be for both statutory responsibilities and operational responsibilities for these services.

The HCP responsibilities for this sub-set of services are:

Statutory responsibilities:

Improving population health and reducing inequalities: The HCP will plan and commission services with the express intention of improving population health and reducing inequalities, including inequalities in terms of access to and outcomes from health and care services.

Quadruple aim: The HCP has four aims to improve health and care outcomes, reduce inequalities in outcomes, experience, and access, increase productivity and value for money and help the NHS support broader social and economic development within its strategic priorities and are embedded within the HCP's core values.

Planning and funding services: The HCP will plan services around the health and care needs of the population it services, allocating resources according to need. In doing so the HCP will be responsible for achieving value for money and operating within its delegated budgets (achieving a breakeven position) such that it exercises its delegated functions effectively, efficiently and economically

Engaging with partners and communities: The WEHCP Board will be responsible for designing and delivering services and the Board comprises representatives of health and care partners across the HCP, including county and district council partners.

Involving patients and public in planning and decision making: The HCP will seek active public and patient involvement for through a newly developed patient engagement process. This process will ensure that the HCP is seeking appropriate involvement for planning and decision making with regard to all delegated services.

Promote innovation, research, education and training: The HCP will actively promote innovation, research, education and training through its transformation work and such promotion will be actively considered in reviewing all service developments.

Climate Change: Climate change will be a key consideration for any commissioning decisions and service transformations within the HCP

Safeguarding and Quality assurance: The HCP will promote safety and quality of commissioned services and will actively manage provider performance through the HCP's quality and performance committee.

Supporting the NHS workforce: The WEHCP Board Committee will ensure an HCP-wide approach to workforce planning, recruitment and retention through establishment of a single workforce.

Regulatory compliance: The HCP will ensure compliance with all legal and policy requirements including (but not limited to) the Equality Act and GDPR data regulations, the management of Conflicts of Interest, the National Oversight and Assessment Framework (NHSE) and the requirements of the Care Quality Commission. The ICB will continue to hold overall responsibility for regulatory compliance of the system in the areas dictated by statute or NHS England, but the HCP will ensure compliance within delegated areas.

Operational responsibilities:

Contract oversight: The HCP will evaluate performance against financial, quality and performance metrics as set out in contracts, address challenges and make provision for necessary adjustments to meet objectives.

Performance and quality monitoring: Assurance of performance through the HCP's Quality and Transformation Committee which will include evaluation of performance against performance metrics and KPIs as specified in contracts with provider partners, as well as against specific outcomes measure developed for the population of South and West Hertfordshire

Population health management and insights: Analysis of population health data to identify trends risks and priorities. Determining opportunities for reducing health inequalities

Financial and Resource management: Managing delegated budgets, monitoring financial performance and ensuring productivity and efficiency measures are implemented

Digital and data transformation: The HCP will ensure use of digital tools to improve access to care, managing data-sharing agreements and using data analytics and improving system performance

Delivery of the ICS Medium Term Plan: The HCP will continue to implement the Medium-Term Plan for Hertfordshire and West Essex.

4. Composition and Quoracy

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

Arrangement	Description of expectation
Chair and Vice Chair	The Board will be chaired by the HCP Senior Responsible Officer. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.
Membership	The Board members shall be appointed by the HCP Board through the contract between the ICB & PAHT. Membership shall comprise the following roles: • HCP Senior Responsible Officer (CEO PAHT) • Non-Executive Member of the Integrated Care Board • Non-executive member of PAHT Board • ICB Place Director for West Essex • Chief Finance & Infrastructure Officer of PAHT • PAHT Medical Director or Director of Nursing • ICB Medical Director or Director of Nursing (or Deputy) • ICB Partner Member (GP Care Closer to Home Clinical Lead) • ECC Partner Member (Adult) • ECC Partner Member (Children) • District Council leads • Four GP locality leads • Healthwatch • VCSFE • Director of Community Services EPUT Members from partner organisations within the Health Care Partnership and West Essex HCP Place Director. Members of the HCP Board will operate with the individual delegated responsibility from their employing organisation to enable the Partnership to carry out its responsibilities and functions. In some circumstances this will necessitate decisions being taken through each organisation's specific governance processes. Named deputies are permitted to attend meetings where individuals above are unable to attend but may not exercise a vote. When determining the membership of the Board, active consideration will be made to diversity and equality.
Attendees	Only members of the Board have the right to attend meetings, however all meetings of this Board will also be attended by the following individuals who are not members of this Board: • Development Director for West Essex HCP

	• Chief Strategy Officer PAHT • Chief Transformation Officer • SROs and programme lead(s) for transformation programmes • Specific project or programme leads from across the system • Director of Corporate Governance PAHT • Secretariat The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.
Meeting frequency and Quorum	The Board will meet a minimum of six times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The PAHT Board or the HCP Senior Responsible Officer may ask the Board to convene further meetings to discuss particular issues on which they want the committee's advice. In accordance with the PAHTs Standing Orders, this Board may meet virtually when necessary and members attending using electronic means will be counted towards the quorum. A quorum will be at least 50% of membership and include at least one member from each of the • ICB, • Primary Care, • PAHT • ECC, • and includes a member from each locality. If any member of the Board has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
Decision making and voting	Voting will be taken in according with the PAHTs Standing Orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. On all matters, all members have one vote, and a majority will be conclusive. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

5. Behaviours and Conduct

5.1 Benchmarking and Guidance

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

5.2 Values

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

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

5.3 Conflicts of Interest

The members of the Board must comply fully with the NHS England Guidance, as reflected in the ICB & PAHT Standards of Business Conduct.

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

5.4 Equality Diversity and Inclusion

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

6. Accountability and Reporting

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

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

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

7. Administration and Review

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

Document Control:

Version	Date	Approved By	Review	Change made
V1	Friday 24 May 2024	HWE ICB Board	Annually	N/A
V2	March 2025			Change of accountability of the Board from the ICB Board to PAHT Board.
V3	April 2025			
V5	May 1st 2025	PAHT Board	6 months	Change of accountability of the Board from the ICB Board to PAHT Board reflecting the TOR requirements from the Delegation Framework.
V6	May 19th	WE HCP Board	6 Months	Removed reference to Mental Health, 4 GP locality leads to include E&NH border

South and West Herts Health and Care Partnership

South and West Herts Health and Care Partnership
Board summary, 30th April 2025

The SWH HCP Board met on 30th April to discuss the work that has been ongoing to improve the health and wellbeing of residents of South and West Hertfordshire.

Some of the key discussions and takeaways of this were:

1. The Board noted that this is the first meeting of the HCP Board as a committee of WHTH's Board under the host provider arrangement agreed with the ICB. Following formal agreement the HCP will now take on delegated commissioning responsibility for a sub-set of adult community services this year.
2. The Board received updates from each of the Neighbourhoods and highlights from each neighbourhood include:
    - **Dacorum:** The proactive care pilot is being mobilised with a go-live date of early summer
    - **Hertsmere:** The Neighbourhood has commenced work on its frailty project and the first tranche of patients have been consented and will then be assessed
    - **Watford and Three Rivers:** The Neighbourhood is working with district councils and Everyone Active to deliver consultations for people with hypertension in gyms to promote positive lifestyle changes
    - **St Albans and Harpenden:** The Neighbourhood is focusing on opportunities in mental health, including working with HPFT to optimize use of GP+ workers and establishing and embedding clinics for children and young people
3. The Board approved the HCP's **implementation plan** which sets out our programme of work for 2025/26. Our implementation plan includes the following workstreams:
    - **Long term conditions**: Embedding the ICB-led long term conditions pathways at HCP level, including locally designing and implementing the integrated heart failure pathway and engaging with the ICB's plans for hypertension
    - **Elective and planned care**: Reducing inappropriate and avoidable referrals through addressing variation in advice and guidance, referral volumes and application of the ICB's pathways to support primary care decision making
    - **Children and young people**: Ensuring children are ready to transition to the next stage of their life and reducing avoidable admissions by developing a nurse-led prevention of admissions pathway
    - **Urgent and emergency care**: Improving access and flow through enhanced care coordination for same day care and establishing a transfer of care hub, expanding the virtual hospital
    - **Frailty and end of life care**: Reducing avoidable ED attendances and NEL admissions through implementation of the ICB's 7 high impact interventions including a programme of advanced support for nursing and residential homes

    To find out more about this work, or to get involved, please contact Ros Nerio
4. The Board noted the progress in developing our **Neighbourhood leadership teams** including the recent appointment of secondary care consultant leads and integration leads to each neighbourhood.
5. The Board also received an update from HCC on the BCF which funds initiatives focusing on prevention and integration such as the community navigation service, early intervention vehicle and enhanced discharge support.

Hertfordshire and West Essex Integrated Care System

ICB Committee Summary Document

NHS Hertfordshire and West Essex Integrated Care Board

Audit and Risk Committee, 21st March 2025	
Signed off by Chair and Executive Lead:	**TS MW**
Key items discussed: ***(From agenda)***	• Quorate meeting, minutes of February committee approved. • Governance Update • Risk and Board Assurance Report • Information Governance/SIRO report • Year End timetable and progress • Review of tender waivers • LCFS progress report • Internal Audit Progress Report • External Audit Update
Key points made / Decisions taken:	**Governance Update –** Board effectiveness survey results noted as positive, consideration of further improvements across 2025/26. ICB seal used for Section 75 agreement relating to the Better Care Fund on 17/03/2025, no special payments noted, ToR **agreed** to recommended for Board approval. **Risk and Board Assurance Report** – Executive sub-committee have met twice, the meeting sequence to ensure the flow to Audit and Risk and Board are timely.Deep dives being scheduled. Update on Datix licence consolidation, due to be completed in April. Risk Review Group meetings, working towards development of System risk register which will come to the next meeting. Proposed de-escalation of risk relating to children's services and community, this would remove the risk from the BAF, would like to discuss further at Board to ensure the Board is happy to de-escalate. Risk Management training and development update provided. Given the uncertainty of coming months, pace and scale of change, the risks may need to be reprofiled. Discussion centred on an understanding the effectiveness of controls and mitigation. The committtee **noted** the report **Information Governance/SIRO report** – An overview of activity and compliance across FOI, SAR, IG breaches, DPIAs and training. Compliance rates remain high as does activity with lean resources. The committee **noted** to report **Annual Report –** The early draft report has been bought to the committee for assurance, Board and Exec feedback has been received. This amended draft will be shared with auditors shortly, the timetable for submission of the draft and final report were provided. An extraordinary meeting will be stood up at or close to 17th June to ensure the committee has an appropriate timeframe in which to approve the final report and auditors report. The committee **noted** the draft report **LCFS progress report** – Fraud and Bribery risk assessment undertaken.

	National exercise into procuement exercise undertaken 2 medium actions and a number of low priority Fraud risk alerts shared to ensure staff aware and vigilant. 5 referrals received, 3 closed, 4 investigations remain ongoing. Awareness raising sessions, induction, training, regular communications. **Internal Audit Progress Report** – Draft HoIA opinion of adequate opinion. Risk Management report achieved reasonable assurance, GPIT services report in draft, CHC audit in QA review stage. Managements action follow up, of note the high prioirity CHC action temains outstanding. Briefings and risk radar circulated to the committee **Counter Fraud Strategy** – Committee **approved** the strategy. **Audit Strategy Plan -** Plan for 25/26 created following discussion with Executives, consideration of planned Performance Management, HCPs audit and the focus of the Primary Care audit may also need to be revisited. The committee **approved** the strategy noting that we expect to need to agree changes to the plan in relating to policy announcements. **Year End Timetable** – Update provided on progress, plan issued across the respective teams and fully operational, making good progress and don't see any blockages, draft accounts well underway, awaiting NHSE consolidation template expected 24/03/25 and further guidance relating to appropriate wording to be included in relation to recent announcements. Draft accounts to CFO by 17/04/25. Further assurance that the teams involved are very experienced 20 years+. Interim audit undertaken by BDO including walkthroughs, interim testing, intensive analytical review based on M9 position, interim audit concluded in February, audit went well and highlight good working relationship with BDO. Successful interim audit to reduce pressure towards the final stages both for ICB team and audit team. The committee **noted** the update and thanked the finance team for their continued work. **Review of tender waivers** – Work to develop central register for all new procurements and contracts (e.g. IT and primary care) PSR review concluded, minimal changes to guidance with exception of exclusion and barring. Will be attending workshops and deep dives on future guidance changes. All risks mitigated without the need for representation. Nominated lead for digital platform, 3 super-user and 3 attending deep dive training. The main challenge for the team will be posting all contracts centrally. The committee **noted** the report **External Audit Update** – Updated plan from December committee. Risk assessment processes completed on VFM, 2 risks (Financial sustainability and Governance) Statement relating to M9 position to be amended and agreed between AP and RB. The committee **noted** the report
Committees to note:	•
Forward plan issues:	Extraordinary Annual Report and Accounts meeting to be stood up for 17th June
Date of next meeting	20th June 2025

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

ICB Committee Summary Document

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

Committee/board title **Date of meeting:**	**ICB System Transformation and Quality Improvement Committee** **Wednesday 14 May 2025**			
Signed off by Chair and Executive Lead:	**Chair – Ruth Bailey** **Executives – Natalie Hammond and Frances Shattock**			
Report Author:	**Jas Dosanjh and Simone Surgenor**			
Report to the ICB Board:	**In public**		**In private**	✓

Agenda items covered (from agenda):

- **Meeting** – quorate.
- **Declarations** – reminder that updated declarations for 25/26 were required by 31 May. Committee also notified that member declarations are being reviewed against regular Committee papers.
- **Minutes** – amendments noted.
- **Action tracker** – updates noted.
- **Committee Workplan** – noted workplan for 2025/26. No changes recommended at this stage but developing a better understanding of organisational changes and the scope of ICB responsibilities which will impact on the remit of this Committee. To keep under review.
- **Update from Health Care Partnership (HCP) Quality and Performance Committees** – Noted transition of WE and SWH HCPs to Host Provider arrangement since 1st May 2025, with ENH and MHLP HCPs mirroring from 1st July 2025. Chair feedback that standardisation of reporting including summaries, actions being taken by the HCPs and matters requiring this Committees attention was still required. Further linking Medium Term Plan and key priorities, alongside identifying any blockages. Noted that South and West Herts HCP summary provides the information required by the Committee clearly and succinctly. Discussion on performance issues;
  - East and North Herts HCP – Paediatric audiology and Community paediatric waits – outlined actions being undertaken to improve the position. Noted concerns surrounding workforce capacity in audiology and steps being taken to mitigate. Long waits noted in pediatric audiology mirroring national perspective.
  - West Essex HCP – Cancer 62d and Elective RTT – assurance provided via actions taken to improve in these areas.

- **HWE Integrated Quality and Performance Report –**
  - **Performance –**
    - Comprehensive reporting noted and from a national perspective a focus on delivery against plan. ICB will continue to monitor planning guidance and maintaining access and quality. Reflection on deficit reduction plan and any risks being identified – feedback from committee – focus for neurodiversity waiting lists appears to be centered on keeping waiting list static and need to be clear in discussion about the trajectory for reducing waiting lists alongside what is causing the blockages if reductions are not possible e.g. finance, workforce etc.
    - *Areas of improvement:*
      - UEC – Cat 2 response times, with best performance since June 21. 4 hours performance reached 77%, again best performance since June 21 – although some variation between providers.
      - Planned Care – diagnostics, and RTT 52 weeks continue on a trend of improvement
    - *For noting:*
      - RTT has plateaued at 55% and is an area of high risk, with variation by provider.
      - Next months report will show a significant increase in Adult community waiting lists, due to inclusion of data from Circle, and adult community MSK provider.
      - Cancer – 62 day wait notable variation by Trust with PAH remaining as most challenged in these areas, data issues and pathways.
      - Children – waiting lists remain high for community waits (in particular Paeds, Therapies and Audiology), Autism Spectrum Disorder, CAMHS
      - PAHT and data with new EPR – being monitored with timeline for addressing the issues.
  - **Quality –**
    - Paper includes a summary of quality visits undertaken by the Quality team, gives context to wider work, strengths and opportunities and challenges, linked to HCPs and will be feedback to the HCP Committees.
    - *Areas of improvement:*
      - Wheelchair services overall breaches are in decline with performance improvements. Ongoing action with system partners to support business as usual. Breaches are in significant decline. Area of particularly focus – children and paediatric. Committee to be kept updated.
      - Trust successes: HCT – SEND and local PAH – impact of trauma committee initiatives, ENHT – staff survey results and awarded teaching trust status, West Herts – improved A&E wait times.
    - *Areas of challenge:*
      - Never events recent increase across acute trusts, committee noting emerging increase nationally. ICB undertaking a thematic review to have wider system collective understanding to reduce the risk of them happening in future and support the learning.
      - Elysium Healthcare update – Stepped down from a system quality escalation approach to a quality assurance approach. Further care home updates to be received by next committee.
  - **ICS Quality Dashboard Highlight Report –** Committee support one dashboard across the HCPs, exploring digital platform to review the data to

ensure scope and depth of detail included. Reviewing feasibility of developing risk matrix for each HCP, will update Committee regarding progress.

- **Quality Strategy Year End Update** – noted year 2 achievement as 83% (45 deliverables) against the 55 deliverables set out in the ICS Quality Strategy delivery plan (3-year plan). Deliverables either all achieved or on track for completion into 2025/26; year 3 position to be reported mid-year. Discussion on how this could be bought to life better in next update.
- **Medium Term Dashboard** – High level view, going forward there will be a final cut-off date for data included to allow a comparable summary. MTP workstreams not delivering improvement towards targets set, assurance required regarding actions to improve this position with a request from the Committee to have a clear view from SROs on whether current actions are sufficient or whether additional actions were required to meet targets set.
- **Deep Dive: Mental Health** – Committee noted the activity taking place through the Hertfordshire Mental Health, Learning Disability and Autism Health and Care Partnership, specifically the partnership work being delivered through the Hertfordshire Crisis Care Partnership Board. Transitions is an area of challenge, especially with young people, due to complexity of moving through the system and financial priority in this area. Data issues to be addressed to ensure there is a clear picture of the impact of the actions being undertaken to meet targets of the medium-term. Committee noting the evaluation work in place over the Haven Café.
- **Deep Dive: CDiff and Antimicrobial Stewardship** – overview of the steps to reduce inappropriate broad-spectrum prescribing and implement antimicrobial stewardship (AMS) strategies consistently across the system. Committee requested assurance regarding which Clinician groups this is occurring in and why with these groups targeted for actions to address increases, whether there is a training gap to be addressed and whether data recording in this area can be defined.
- **ICB Risk Register** – Risk 608 UEC reduced the risk to a score of 16 due to the improving performance in the 4hour standard, ambulance handovers and Cat2 ambulance response times. No other significantly changes. Noted focus on risks through the meeting.
- **Feedback from the Patient Quality Subgroup** – verbal update noted.
- **New Risks and Escalations from Committee and Review of Actions** – refer to section next section for key points/escalations (Alert/Advise/Assure).

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

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

- None identified at this stage, with the Board to note areas logged under "Advise" below.

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

- Health Care Partnerships reporting – ongoing review of HCP feed into this Committee, the assurance sought and mitigate against potential duplication.
- Princess Alexandra Hospital NHS Trust – moved into Tier 1 (national) oversight for Cancer, RTT and diagnostics, challenge remains and Committee to be kept informed of this area.
- Never events increase – challenges within trusts to be monitored by the Committee and an update provided at the next Committee meeting.

- Autism spectrum funding – ongoing review, in particular against finance planning for 25/26. Being reviewed against current risks logged.
- Medium Term Plan – progress and reporting with noted. Committee requires further assurance regarding what is having an impact, actions being undertaken if areas are off-track and how they will be delivered.

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

- UEC performance risk – improving performance in the 4hour standard, ambulance handovers and Cat2 ambulance response times.
- Improvements in maternity care linked to improvements with strategy.
- Quality Progress Report – wider work and triggering sharing of insight. Feeding into developed reporting moving forward.

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

- Noted improvements in maternity care.

Forward plan issues:	• Committee workplan dependent on the outcome of the future agreed remit of the ICB as part of the multi-layered changes across the NHS. • Further reporting on Never Events
Date of next meeting:	Wednesday 09 July 2025, 09:30 – 12:30.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

ICB Committee Summary Document –

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

[Insert committee/board title] [Date of meeting]:	**HWE ICB Strategic Finance and Commissioning Committee – 8th May 2025.**			
Signed off by Chair and Executive Lead:	**Chair – Nick Moberly – Non-Executive Member** **Executives – Alan Pond – Chief Financial Officer**			
Report Author:	**Simone Surgenor – Deputy Chief of Staff, Governance and policies.**			
Report to the ICB Board	**In public**	**X**	**In private**	

Agenda items covered:

- Declarations of interest – noted. Committee noting call for returns in line with 2025/2026 refresh.
- Workplan – noted, with proposed changes regarding reporting. Noted changing landscape and flexibility sought.
- Terms of reference – no changes recommended, and therefore version 1.0 approved for a further year.
- 2024/25 Month 12 Finance Report - HWE Integrated Care System (ICS) reported an outturn position of £0.042m underspend, which aligns with the breakeven plan. This was an in-month improvement of £2.53m compared to the Month 11 Year-to-Date position, which was expected to improve by £2.488m.
- 2025/26 Financial Plan for HWE ICS – this ICB has submitted a balanced plan for 2025/26. All six organisations within the System submitted balanced plans, however, significant efficiencies required to deliver collectively as a system and within organizational plans.
- 2025/26 ICB Commissioning Costs - To deliver the expected savings in ICB Commissioning Cost and achieve the target spend per head of Weighted Population of £18.76, the HWE ICB will need to reduce costs by 54.9%. Committee noting the likely anticipated change to ICB footprints and workforce. Committee recognizing the difficulties being faced and impact as more detail comes through.
- HWE Financial Recovery Board Summary Update – committee noting West Essex and, South West Herts HCPs have moved to Host Provider arrangements from 1st May 2025. East and North Herts plus the Mental Health and Learning Disability and Neurodiversity Health and Care Partnership HCP's moving to a Host Provider arrangement from 1st July 2025. Updates noted through agenda papers.
- Prescribing Report – committee endorsing the approach presented and efficiency plans that include reducing unwarranted variation in prescribing practice in 25/26.
- All Age Continuing Care Report – noted uncertainty over future approach to CHC, as the picture surrounding future ICB structures is clarified. Noted significant work understand including supporting education over Fast Track pathway against CHC pathway and Care Closer to Home.
- HWE ICB/ICS – Capital Allocations and distributions 2025-2026 - Committee noting the allocations received from NHSE and the method of allocation by the ICB to Trust providers.
- Primary Care Commissioning Committee update – 15th April 2025
- Hertfordshire and West Essex Area Prescribing Committee – 27th March 2025. Noted approval of decisions taken.
-

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

Alert: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy
• Board to note as above.
Advise: The Board – of areas subject to on-going monitoring or development or where there is insufficient assurance
• 2025/26 ICB Commissioning Costs – with noted concerns including loss of clinical input against triple aim of good quality care against alignment with policy.
Assure: Inform the Board – where positive assurance has been received.
• Financial Report – a thank you from the committee for the finance work. Also, the work undertaken on prescribing and Continuing Health Care delivery plans by this ICB. • Capital Allocations and distributions 2025-2026 – assurance noted by Committee from the work being undertaken.
Celebrating Success: Share any practice, innovation or action that the Committee considers to be outstanding
• No additional points raised.

Forward plan issues:	• To keep under review.
Date of next meeting	10th July 2025

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

ICB Committee Summary Document –

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

[Insert committee/board title] [Date of meeting]:	**People Committee Thursday 15th May 2025**			
Signed off by Chair and Executive Lead:	**Chair – Ruth Badger Executives – Tania Marcus**			
Report Author:	**Anna Cason**			
Report to the ICB Board	**In public**		**In private**	✓

Agenda items covered:

Quoracy

- The meeting was quorate.

Declarations of Interest

No declarations made. People Committee considered the register of interests, noted declarations refresh to be completed by 31st May and prompted relevant committee members to make their return. People Committee notified that member register of interests will be included in the papers at each People Committee meeting.

Minutes

- Minutes from 20 March 2025 were approved as an accurate record.

Action tracker

- The M People Committee noted the action tracker and noting actions 80, 81 & 82 can be closed.

HWE Workforce Update

- The Board noted Workforce Transformation Programme Report including a recap on transition including ICB cluster proposals and model ICB, position is fast moving, transparent communication and support for staff. ICB will see significant job losses. Support requested from CPO colleagues to share vacancies to try and retain talent within the system.
- Trade Union colleagues updates in relation to impending changes, communication and support.

System Staff Survey results and actions

- NHS staff survey, currently awaiting Social care survey and pulse survey results from primary care. HWE above average across all themes, variety of results across the system, ENHT and WHHT most significant improvements on 2023, HCT highest scoring community trust across some indicators. Using results to decide on priorities in EDI committee. WHHT, HPFT, HCT, ENHT and PAH provided insights into results, areas of acheivement, themes for work to address improvements. Trusts to share good pracitce. Clear themes reflecting disproportionate experience for staff with protected characteristics. Positive benefits of collaboration need to be maintained across the system with support of provider colleagues.

Workforce Risk and Assurance Report–

- Workforce data risk score reduced, talent risk redrafted in light of ICB changes impacting workforce transformation workstream, Oliver McGowan risk score decreased, staff establishment risk increased – operational plan bank usage reductions are far more ambitious, B5/6 rebanding risk steady establishing system network. New significant risk re workforce transformation programme. Need to ensure improvement achieved around workforce

data isn't lost.

25/26 Operational and Workforce Planning and Running Cost Reduction programme

- Bank 3% over WTE usage, substantive 1.5% over utilisation, paybill £25m over plan. Strong reduction on agency, 8% under projections.. Forecasting 4.8% reductions, variation across the system well understood. Significant reduction for bank usage requirement. Forecasting 4% increased in primary care workforce, positive trends for GPs in training. Increased grip and control, governance and monitoring supported achievements in 24/25 but 25/26 plans much more ambitious – role of people committee to gain assurance from CPOs that underlying actions in place to deliver reductions. 60% increase in trainee places, ARRS key to MDT working to deliver neighbourhood health. Increased reporting rigour needed for all staff groups for 25/26. Collaborative transformation work e.g. frailty key enabler of reduced bank. Need to better understand drivers for winter increase. Full M1 data not yet available, next meeting data will help support focus in on areas of risk.

Health and Care Academy

- Key workstream for the system supporting equitable access across the population for all areas of health and social care. Academy has range of KPIs set by NHSE, work experience portal, engagement with all schools, growing ambassador progamme, UoH events, colleague, career expo, employability sessions, apprenticeship promotion.
  System T&F group to decide which workstream to retain, which key resources to retain, how to improve collaboration on apprenticeships.

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

- No matters identified for escalation.

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

- M1 data not yet available to be able to monitor progress around the operational plan, July meeting to provide a strong focus on assurance.
- Immigration white paper and impacts on social care, in particular home-care provision need to be understood further.

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

-

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

- Acknowledge considerable achievements of the Health and Care Academy; engagement, number of placements supported, CPD portal, work experience portal, employability, careers events in schools and FE colleges.

Forward plan issues:	• To explore workforce planning and ICB change impact at the next meeting.
Date of next meeting	17th July 2025

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	NHS HWE ICB Board meeting held in Public				**Meeting Date:**	**tbc**	
Report Title:	**Integrated report for finance, performance, quality and workforce v2.0**				**Agenda Item:**	**tbc**	
Report Author(s):	Shirley Potter, Programme Manager, Executive Team Member(s)						
Report Presented by:	Alan Pond, Frances Shattock, Tania Marcus, Natalie Hammond, Michael Watson						
Report Signed off by:	Alan Pond, Frances Shattock, Tania Marcus, Natalie Hammond, Michael Watson						
Purpose:	**Approval / Decision**	☐	**Assurance**	☒	**Discussion**	☐	**Information** ☒
Which Strategic Objectives are relevant to this report [Please list]	▪ Increase healthy life expectancy, and reduce inequality ▪ Give every child the best start in life ▪ Improve access to health and care services ▪ Increase the numbers of citizens taking steps to improve their wellbeing ▪ Achieve a balanced financial position annually						
Key questions for the ICB Board / Committee:	Areas for discussion are identified in the summary section of the paper.						
Report History:	N/A						
Executive Summary:	This report provides a summary of the quality, performance and finance reporting shared elsewhere on the agenda, whilst also providing an update on workforce across the ICS. **Board members should also review the more detailed reports in the for information section of the today's board agenda.**						
Recommendations:	The Board is asked to consider the report and the areas highlighted for discussion.						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified	☒					
	N/A						
Implications / Impact:							
Patient Safety:	No						
Risk: *Link to Risk Register*	No						
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:***	No					
	Quality Impact Assessment:	No					
	Data Protection Impact Assessment:	No					

1. Summary

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

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

Please note that performance relates to the report presented at the May STQI Committee which contained the latest data at time of publication (Feb/March). As such, any references to performance against plan are for the 24/25 operational plan. The performance report for July STQI Committee is currently in production which contains March/April data and will also reference the 25/26 operational plan.

2. Key issues highlighted

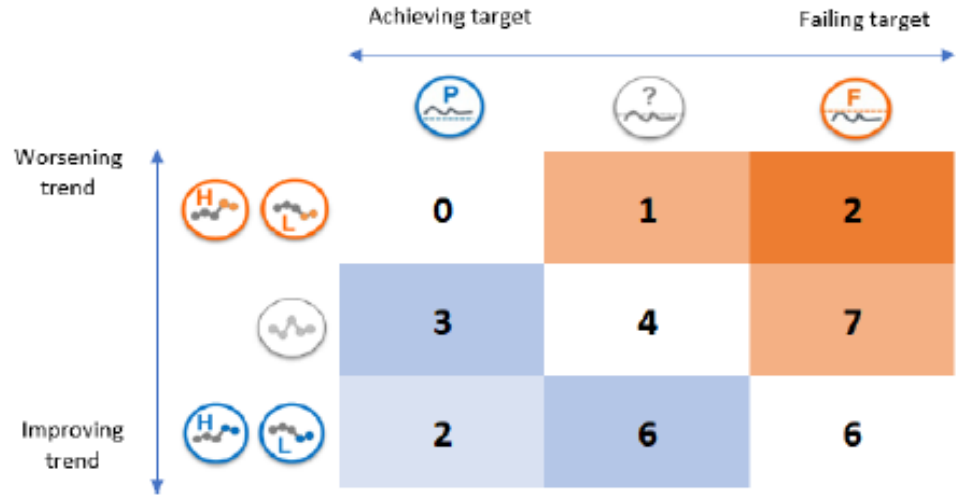
The executive team would like to bring the follow key areas to the Board's attention, which have an impact on quality and performance- and will need to be considered carefully as we deliver our plans in relation to finance and workforce.

Area of concern/ improvement	**Current situation**
Finance position	The Hertfordshire and West Essex Integrated Care System reported a high-level spending position in April 2025/26, with an overspend of £13.566m, a £0.122m favourable year-to-date position. Most Trusts reported underspent payroll costs, except for WHTH, which reported an overspend of £0.769m.
Agency spend update	In Month 1, the Hertfordshire and West Essex Integrated Care System performed well, total workforce 1.7% below plan. Substantive staff usage lower than planned, while bank usage over plan and agency staffing 15.5% under plan. Trusts including HCT, PAH, and WHTH had lower than expected substantive staffing due to hiring delays. The system applied for funding to support entry-level recruitment, reduce vacancies and is actively involved in the *Get Britain Working* white paper which has advanced to phase two of the Public Health Investment Programme.
Performance	**Urgent and Emergency Care** • Improvements have been seen in all areas of UEC; Category 2 response times continued to reduce in March, with the best performance levels since June 21 and hours lost to handover also saw significant improvements moving from an area of highest risk to high risk. March ED 4 hour performance also achieved the best performance since June 21 and moved from variable to low risk; improvements were seen at all Places and most notably in West Essex. • Performance broadly continued at similar levels across April and May although some variation by Provider was seen with PAH slightly below planned levels. **Planned Care** • Some improvements were seen in diagnostics moving from a declining to variable trend and from an area of highest risk to high risk. There does however remain significant challenges to paediatric audiology, particularly at ENHT (impacting DM01 performance) with focused work continuing to look at levelling up waiting times across the system. • RTT 65 weeks continued to reduce however has not yet met the 0 target. Although 52 weeks also continues on a trend of improvement, some increases were seen in Jan and Feb. The 18 wk position has plateaued with common cause variation; this remains significantly below national standard and an area of high risk with variation by Provider

	Children and Young People • Our area of highest risk remains community waits for children with the main pressures being Community Paediatrics, Therapies, Audiology, ASD and ADHD. We continue to see waiting lists grow and times to treatment increase as funding/investment remains unresolved.

Performance Report:

Executive Summary: KPI Risk Summary



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

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

Lowest Risk	Programme
Learning Disability (LD) Health Checks	Primary Care
CHC Assessments in Acute	Community

Low Risk	Programme
2 Hour UCR	UEC
NHS 111 Calls Abandoned	UEC
No Criteria to Reside (NCTR)	UEC
Community Waits (Adults)	Community
% of on the day GP Appointments	Primary Care
ED 4 Hour Standard	UEC
31 Day Standard	Cancer
62 Day Standard	Cancer
CHC Assessments < 28 Days	Community

Variable Risk	Programme
28 Day Faster Diagnosis	Cancer
% of <14-day GP Appointments	Primary Care
Dementia Diagnosis	Primary Care
Patients discharged before Noon	UEC
Talking Therapies	Mental Health
Severe Mental Illness (SMI) Health Checks	Mental Health
62 Day Backlog	Cancer
RTT 65 Week Waits	Elective
RTT 52 Week Waits	Elective
Community MH - Adult Waits for 2nd Appt	Mental Health

High Risk	Programme
Ambulance Handovers	UEC
18 Week RTT	Elective
6 Week Waits	Diagnostics
Ambulance Response Times	UEC
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

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 with performance meeting standard.
- Cat 2 ambulance response times continue to reduce and reached 34 minutes in March; although the best performance since June 21, times remain outside the national 30-min std and are longer than regional average.
- Hours lost to handover has improved significantly since January; performance is on a variable trend, close to the fair shares handover target and has moved from highest to high risk category.
- 4 hour ED performance continues on a variable trend and improved to 77% in March; this is the best since June 21 and better than national and regional average, moving from variable to low risk. Improvements have been made across all 3 places with the biggest improvement seen in West Essex.

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

- The overall elective PTL size remains high; a significant increase was seen in January with deferred referrals being added to the PAH PTL.
- 65 wk waits have continued to reduce to 89 in February; clearance is currently forecast for May 25. 52 wk waits have continued on a trend of improvement although increases were seen in Jan and Feb.
- The 18 wk position has plateaued at around 55% with common cause variation; this remains significantly below national standard and an area of high 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 improved trajectory although has declined since Dec. 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 improved however moving from a declining to variable trend and from highest to high risk.

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

- 28-day Faster Diagnosis Standard (FDS) performance continues to meet this year's ambition of 77% although has moved from an improving to variable trend and moved from a low to variable risk. 31-day performance also continues to meet the national standard of 96%. 62-day performance continues to meet the 70% planning target but there remains notable variation by Trust with PAH the most challenged (moved up to low risk).

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

- Learning Disability Annual Health Check (LDAHC) performance remains strong with all Places exceeding their equivalent 23/24 positions; the 75% target was met in 23/24 and remains on track to deliver in 24/25.
- Overall increase in number of HWE Out of Areas Placements at 37 against plan of 6. Winter pressures resulted in an increase in out of area bed placements in Herts with plan in place to reduce to 0 by end of June.
- Community Adult MH median waits for a 2nd contact decreased in February at 50 days, which benchmarks well against the national average and moves from high to variable risk.

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 with children's community waits continuing as an area of highest risk. Waits over 52 weeks increased in Feb to 4,396.
- 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 Paediatric, 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.
- The 28-day CAMHS access standard in Hertfordshire has not been achieved since 2021. Performance has seen some recovery to 61% in March 2025 moving to a variable trend. Vacancy rates continue to impact.
- Children's waits for a Community MH 1st appointment decreased to 125 days in Feb and continue to better the national average (253 days); there remains variation across the system.

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

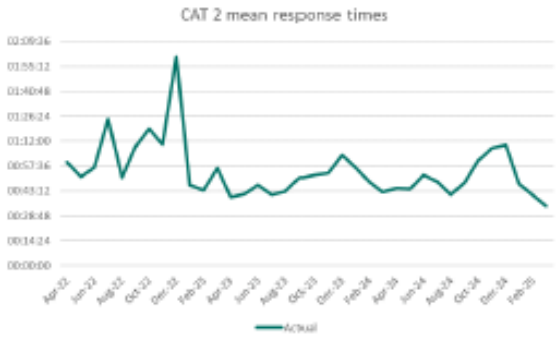
- The % of adults waiting <18 weeks remains comparatively strong at 91.8% compared to the national average of 85%.

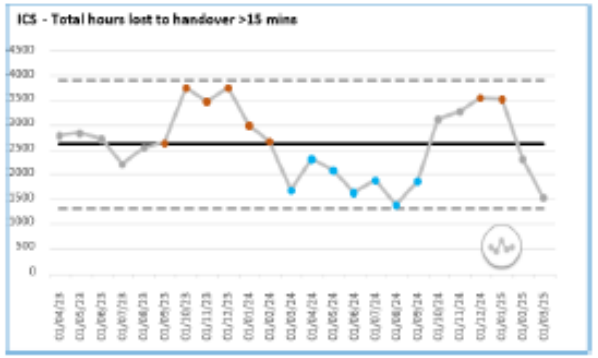
PRIMARY CARE & CHC **CHC Assessments Within 28 Days:** **HWE better than regional and national average**

- There has been sustained improvement in the % of gp appts seen on 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 assessments <28 days have continued to see significant improvements and met the 80% standard for the first time in Feb. Moving from variable to low risk, performance is better than regional & national average.

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

Recovery Trajectories





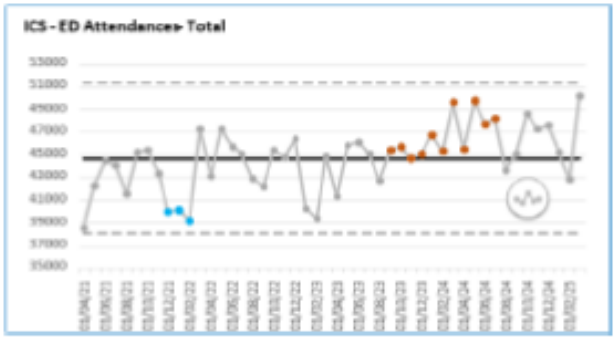
What the charts tell us

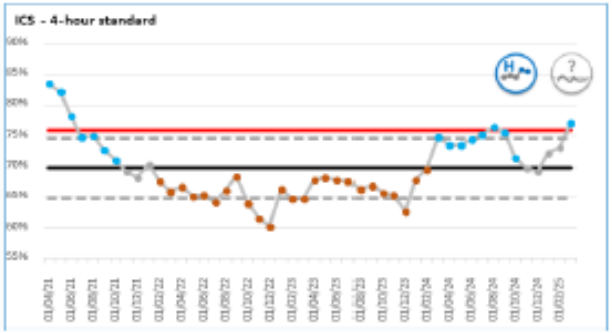
- The mean Category 2 ambulance response time has been reducing over the last four months and reached 34 minutes in March. This remains above the 30 minute target, but is the best performance since Jun-21
- However, mean C2 response times in HWE remain longer than the regional average (Mar-25 = 32 mins) and were the second longest in the region
- Hours lost to handover >15 mins have reduced significantly since January. In Mar-25, 1525 hours were lost over 15 minutes which is close to the fair-shares target for the system (1515 hours)

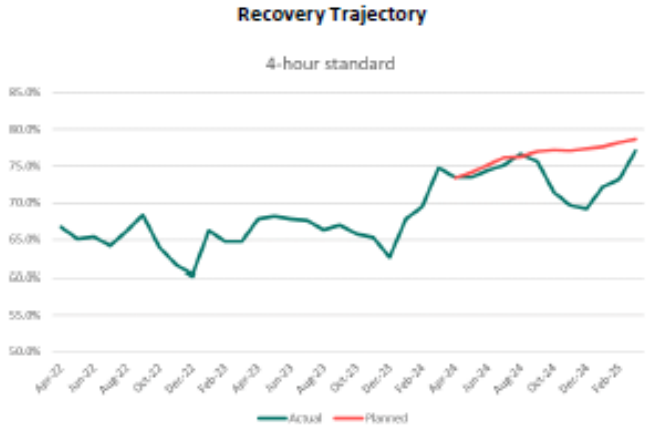
ICB Issues and actions

- The number of ambulance incidents (A7) in HWE remain high. The number of incidents in Mar-25 was 6.2% higher than in Mar-24
- However, the number of conveyances in HWE was 1.5% lower in Mar-25 compared to Mar-24 as a result of the reduced conveyance rate
- During Q4 of FY2425, EEAST put in place a number of initiatives aimed at increasing staffing hours in HWE to improve C2 response times. These included: HWE crews that have gone out-of-area only booking on once they're back in HWE; internal transfer incentive; moving 5 EEAST ambulance resources into HWE each day from neighbouring sectors; weekend over-time incentives
- Analysis suggested that the impact of these initiatives was to reduce C2 response times by 8 minutes, with the other reductions coming as a result of improvements in factors such as hours lost to handover.
- Hours lost to handover have improved following a number of initiatives at the acute front doors, including: senior clinical reviews of ambulance patients; continued focus on fit-to-sit patients; and increased nursing establishment

UEC – Emergency Department



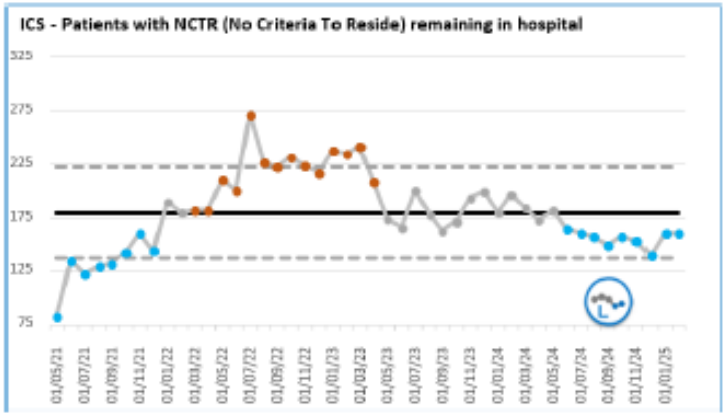


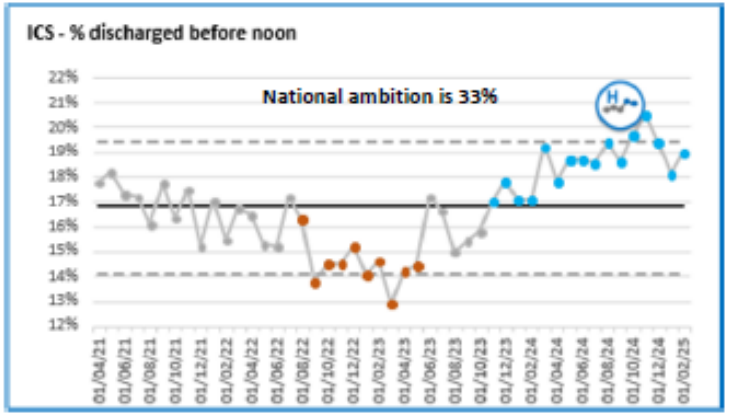


What the charts tell us	Issues	Actions

• In January and February, ED attendances across the system were relatively low, however they were the highest for four years in March. This was mainly driven by increases in type 3 activity at ENHT and WHHT
• ED performance also improved to 77.1% in March. This is slightly below plan, but is the best performance since Jun-21
• There was an improvement for all three places in March
	• There remains significant variation at place level with PAH the most challenged. In March:
	  ○ SWH = 81.9%
	  ○ ENH = 76.3%
	  ○ WE = 72%
	• However, West Essex has observed the greatest improvements in performance over Q4 of FY2425
	• There remains continued high demand. ED attendances were 3.5% higher during FY2425 compared to FY2324. This rise in demand has come from walk-in patients rather than ambulance conveyances
	• There is some evidence that there has been a general increase in acuity in ED presentations over the past two years
	• Mental Health (MH) presentations at ED remain high
		System
		• The Unscheduled Care and Coordination Hub (UCCH) has been effective at reducing the % of C2-C5 conveyances to ED during the day-time which has helped to mitigate the increased ED demand from walk-in patients
		• Front-door audits completed at each acute site during March
		East and North Herts
		• Additional paediatric registrar added to the rota in January (2pm-10pm shift)
		• CDU changed to a non-admitted area in Feb 2025 to support with non-admitted performance and ED flow
		• A new UEC programme with four separate workstreams established in Mar-25. The focus of one of the workstreams is on improving 4-hour performance through improving triage and senior decision making
		West Essex
		• MADE event w/c 17th March with a focus on frailty. 4-hour performance in West Essex in March was the highest since Jun-21
		• NHSE clinical support package now agreed. Focus on behaviours / culture and non-admitted ED
		• UEC capital bids to improve children's ED environment (inc. CYP MH Room), and UEC Corridor
		South and West Herts
		• Trial of having an ED Consultant in the care coordination centre is now complete and decision taken to stand-down following the trial
		• Final amendments being made to falls management pathway before roll-out
		• HAARC and CLCH to agree process for HAARC to link with CLCH urgent community response

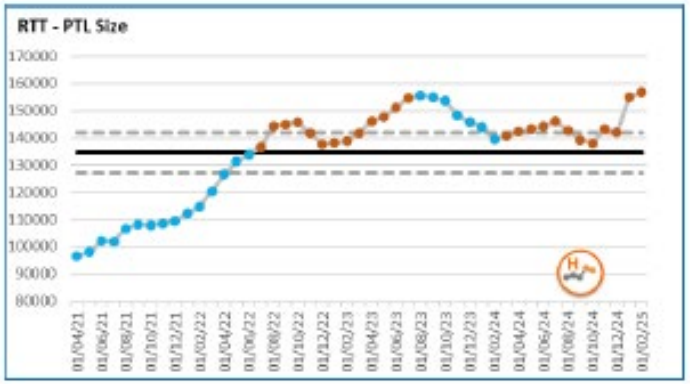
UEC – Discharge & Flow

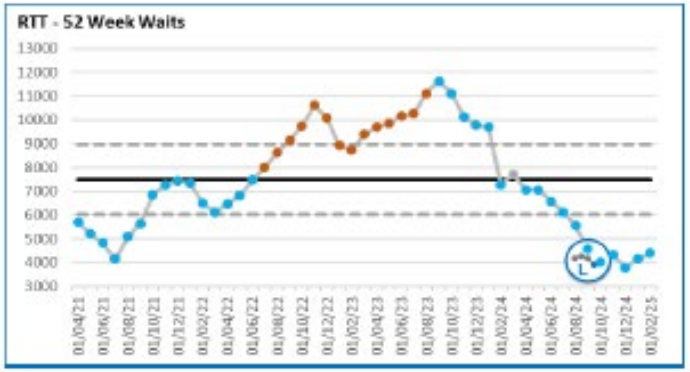


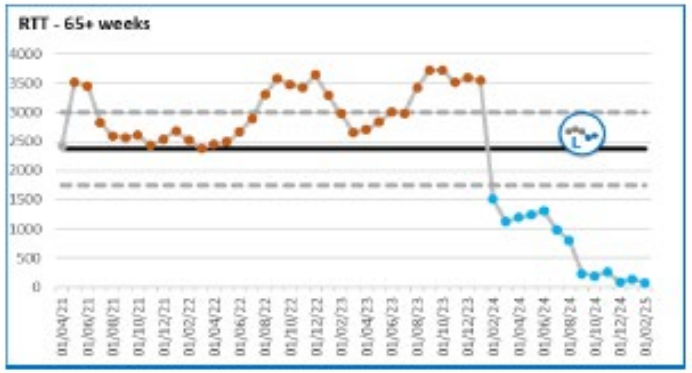


What the charts tell us	Issues	Actions
• The system-level daily average number of patients with no criteria to reside remaining in hospital has consistently been below average for the last nine months and planning targets have been met • The % of patients discharged before noon remains above the historical mean, but is currently not as high between Nov-24 and Jan-25	• There remains significant variation across the three HWE acute trusts for the % of patients discharged before Noon. In Mar-25: o ENHT – 17% o WHTH – 27.1% o PAH – 12.3% • 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 event took place during the first week of April at ENHT • Change to site management meetings to increase ward ownership and focus on earlier, safer and more effective discharges has been in place since the end of Feb **West Essex** • Discharge Improvement Programme re-launched in January and trajectories agreed to increase pre-Noon discharges and Discharge Lounge utilisation • Weekend discharge processes refreshed resulting in increased weekend discharges **South and West Herts** • Transfer of Care Hub soft launch on 3rd March • Pathway 1 discharge-to-assess at home support work ongoing

Planned Care – PTL Size and Long Waits







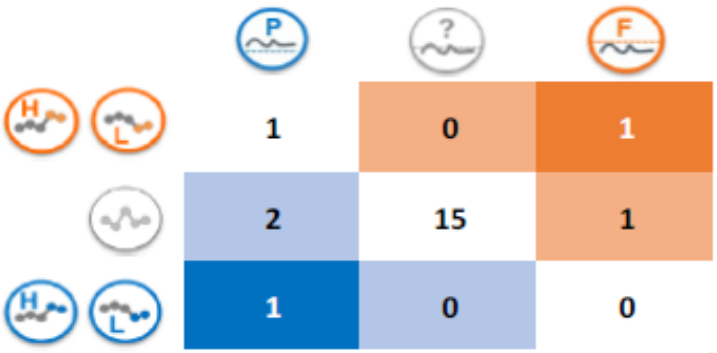
Community Paediatrics patients have been excluded from RTT reporting from February 2024 in line with national guidance
Waiting lists therefore show significant reductions

Planned Care – PTL Size and Long Waits

ICB Area	What the charts tell us	Issues	Actions

HWE	• The overall PTL size remains high with a significant increase in January and further increase in February. The ASIs were added to the PAH PTL in January which accounts for c.10k patients
	• The overall number of patients waiting >65 weeks has decreased significantly, although the December zero target was not achieved. There remains variation at place level but the ICB overall number of breaches at the end of February was 89
	• The number of patients waiting >52 weeks had been consistently improving since summer 2023 although January & February saw increases
	• The number of patients waiting 18 weeks remains static
	• Due to the change in national guidance, Community Paediatric patients have been excluded from RTT reporting from February 2024. Waiting lists therefore show significant reductions from February 2024. These waits are included within the Community section of this report
		• The end of February 65ww was 89:
		  • ENHT: 30
		  • WHTH: 0
		  • PAH: 51
		  • ISP: 8
		• The 65ww forecast for end of April is 47
		• Trauma and Orthopaedics (T&O) remains the main specialty under pressure, with ENT also a notable risk
		• Staffing remains a challenge
		• There will be increased focus on patients waiting longer than 52 weeks in 2025/26 currently there are c.4k patients across the system
			• Princess Alexandra Hospital is in Tier 2 of the national oversight and support infrastructure for Elective (including Diagnostics) recovery. Fortnightly tiering meetings with the NHSE EOE regional team remain in place
			Management of waiting lists
			• System focus on reducing number of patients waiting >65 weeks, with regional and national oversight
			• Demand, capacity & recovery plans are in place to monitor RTT
			• Weekly KLOEs in place with NHSE to track 65-week positions
			• Fortnightly performance meetings with each of the three acute Trusts are in place with NHSE support
			• Validation and robust PTL management in place
			Increasing capacity and improving productivity
			• Pro-active identification of pressured specialties with mutual aid sought via local, regional & national processes
			• Outpatients has a full programme of work to increase productivity including PIFU (patient initiated follow up), reducing follow ups including discharging where appropriate, and increasing take up of Advice & Guidance
			• Maximising use of ISP capacity and WLIs where possible
			• ICB wide GIRFT programme to improve productivity: Theatre Utilisation, Ophthalmology, MSK, Urology, Gynae and ENT

Quality KPI Risk Summary*



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

Highest Risk	Programme
Paediatric Audiology - HWE	Paitent Safety

High Risk	Programme
Maintaining High Quality Care	Patient Safety

Lowest Risk	Programme
Quality Improvement Progress	Nursing & Quality

Low Risk	Programme
Antenatal Education	LMNS
Digitilisation Progress	LMNS

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

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

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

Quality Executive Summary

East and North Hertfordshire NHS Trust (ENHT) - Never Event. Under current escalation to HWE ICB Regional Quality Group (RQG). Slide 17

Position since Previous Report: **NEW.**

- Misplaced nasogastric tube. Duty of Candour completed with family. Rapid work has been carried out with clinical teams from relevant wards and further work planned with all specialities involved in the care. Incident to be managed in line with Patient Safety Incident Response Framework (PSIRF).

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

Position since Previous Report: **NEW.**

- Oral rather than intravenous medication administered. Patient nursed post-incident with no further complications. Duty of Candour completed. Incident to be managed in line with PSIRF.

East of England Ambulance Service Trust (EEAST). Under escalation to RQG. Slide 17

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

- Progress being made in mandatory training, call waiting times, and medicines management. Longer-term actions around Emergency Operations Centre staffing, cultural improvements, and incorporating staff feedback remain under review through Rapid Quality Review and routine processes.

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

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

- Regular review of pathway development status to support opening of further pathways. Hearing Aid pathway opened March 2025 and Auditory Brainstem Response pathway opened May 2025.
- System mutual aid discussions being held. Current timeline for ENHT under 3s is Spring 2026 due to required estates work.

Elysium Healthcare – Care Home. Under current escalation to HWE ICB SQG and RQG. Slide 21

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

- Improvement against actions in key areas, to support de-escalation planning. Admission embargos have been fully lifted for both homes.

AJM Wheelchair Services. Under current escalation to HWE ICB SQG and RQG. Slide 19

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

- Improvements being seen in performance and quality of service.

Sharing Best Practice / Learning from Excellence

Hertfordshire Community NHS Trust (HCT) Special Recognition Honour award.
On Thursday 13 February Hertfordshire Community NHS Trust (HCT) Special Educational Needs and Disabilities (SEND) Mental Health Support Team (MHST) attended a celebration of best practice for SEND which was held by NHS England. The team were delighted to receive a Special Recognition Honour award in the Health and Education SEND Partnership category. SEND MHST support both SEND and mainstream schools with a high SEND need across the ICB, supporting early intervention mental health and wellbeing. They focus on direct targeted work for children and young people, for parents and for school staff, developing a whole school approach to emotional wellbeing signposting support. Congratulations to everyone in SEND MHST for their well-deserved recognition in supporting the mental health needs of children and young people in their communities.

Princess Alexandra Hospital Trust (PAHT) - impact of Trauma Committee training initiatives.
Significantly enhanced trauma care capabilities through comprehensive training programs led by the Trauma Committee. Over 95% of emergency medicine nurses have achieved Level 1 trauma sign-off via the Trauma Teams Essentials Course, and advanced training for Advanced Care Practitioners, paramedics, and other healthcare professionals through Advanced Trauma Life Support (ATLS) courses. These initiatives include both adult and paediatric nurses, ensuring comprehensive trauma care across all age groups. The Trust is aiming towards Royal College of Surgeons recognised ATLS Centre status demonstrating commitment to trauma care excellence.

ENHT NHS staff survey 2024 results.
ENHT have been listed as the fourth most improved Trust nationally, with a 4% increase compared to 2023. The Trust also saw a 4.8% increase of staff “agreeing” or “strongly agreeing” they would recommend it as a place to work, which was the third most improved in the East of England. The NHS Staff Survey is focused around the 9 NHS People Promises, in which the Trust saw improvements across all 9.

ENHT awarded Teaching Trust status.
Following an application to the Department of Health and Social Care, ENHT was granted teaching status from 1st April 2025 as a reflection of their ongoing commitment to teaching, training and education and is now recognised as a teaching trust. The Trust are passionate about unlocking the potential of their staff and supporting everyone to be the best they can be including access to over 40 different apprenticeships. Every day the Trust works with partners to welcome students on placements including nursing and midwifery students from the University of Hertfordshire and student doctors from Cambridge University and University College London Medical Schools. The Trust are excited to be working with the University of Hertfordshire in establishing the new Hertfordshire Medical School opening in 2026.

West Hertfordshire Teaching Hospitals NHS Trust (WHTHT) Accident and Emergency (A&E).
Ranked 8th of 122 acute Trusts in the country (Trusts with Type 1 A&E facilities) for 4-hour A&E waiting times in December 2024. Improved 4-hour performance demonstrates improved experience of care for patients, their families and carers. The pace of improvement is based against ever-increasing attendances illustrating robust triage systems and patient pathways.

Key updates

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

ENHT continue to progress their improvement plans, and since the previous report a further two pathways have re-opened. In addition to the open pathways for 3–5-year-olds and over 5s, the pathways for hearing aids and the auditory brainstem response (ABR) pathway are now open.

The main risk relates to the lack of estates at ENHT to see the youngest cohort of children (0-3 years), and limited mutual aid identified to support this cohort to date. Both the ICB and NHSE regional team continue to support discussions to identify mutual aid from within the system and beyond. This includes repatriation of children to Bedford, Luton and Milton Keynes (BLMK) ICB. Additionally, the ICB is working with system partners and NHSE regional colleagues on exploring an approach to 'levelling up' to support consistency in the management of waiting lists and ensure children are seen in order of clinical need.

Elysium
Previously we have reported quality concerns relating to two Elysium nursing homes. Concerns related to safeguarding, nutrition and dietetics, pharmacy, leadership and governance. The concerns have been managed in line with the Hertfordshire Safety Improvement Process (SIP), with regular meetings led by HWE ICB and attended by wider commissioners, extended partners and Elysium Health Care. Support has also been provided through regular quality visits and specific ICB input regarding medicines management and nutrition.

Following positive progress with evidenced improvements the embargo for new admissions was fully lifted in April. Ongoing monitoring and partnership work has taken place and at the June meeting, following further sustained improvements, it has been agreed that the two nursing homes will exit the Safety Improvement Process.

Enhanced monitoring will take place over the coming months to ensure progress is sustained and that appropriate support continues to be offered to both homes.

EEAST CQC
Previously updates have been provided to the Board to advise that the Care Quality Commission (CQC) have issued a Section 29A warning notice and a Section 64 warning notice to EEAST in January 2025 for failing to meet requirements relating to staff training, staffing levels, investigation and mitigation of controlled drug incidents, call wait times, the culture of the service and category 2 response times.

NHS Suffolk and North-east Essex are the lead commissioner for EEAST and are working closely with the provider in relation to the ongoing improvement work. Associate commissioners including HWE ICB are regularly updated with progress and attend the Rapid Quality Review Meetings where progress is overseen. Positive progress has been reported via these meetings, including improved training compliance, call waiting times and oversight and learning from controlled drug incidents. Work is taking place to set agreed exit criteria which will be required to be met in order to step down from enhanced surveillance to routine surveillance.

Finance

The Hertfordshire and West Essex Integrated Care System reported a high level Month 1 (April) 2025/26 position, concentrating on key areas of spend. The ICS planned to be £13.688m overspent at Month 1 and reported an overspend of £13.566m, which is £0.122m favourable year-to-date position, with all organisations remaining on plan or better.

The payroll costs for the Trusts were reported as underspent of £0.808m against plan, with most Trusts reporting an underspend, except for WHTH, who reported an overspend of £0.769m in the month.

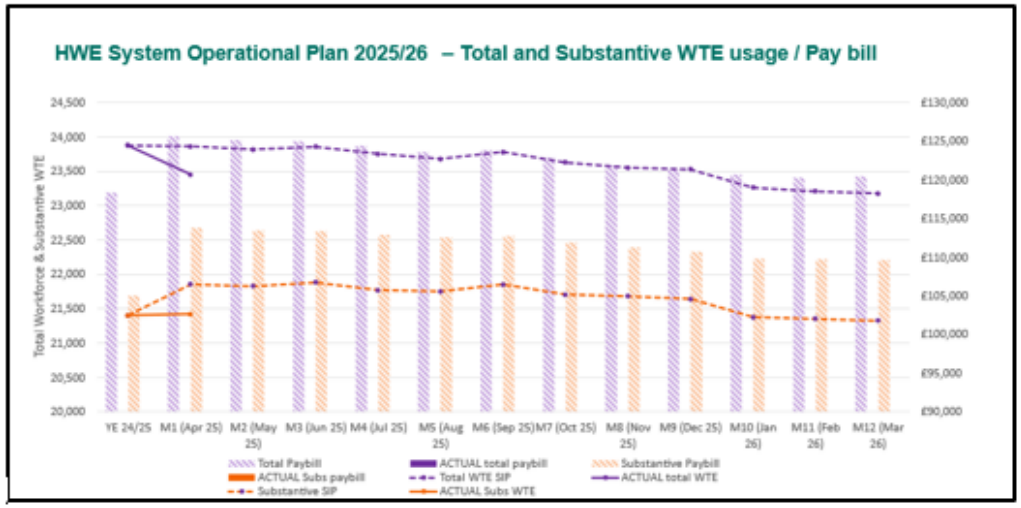
At Month 1, 56% of the efficiency schemes were fully developed, with only 5% reported as unidentified. 54% of the schemes have been rated as low risk, with 15% rated as high risk. The ratings vary between individual organisations.

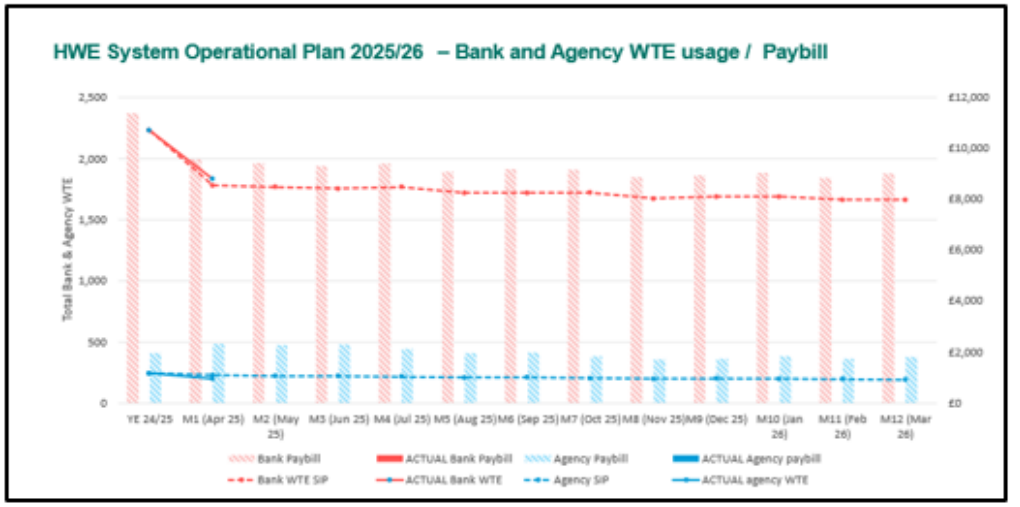
Workforce

The system showed a good performance in M1 in terms of wte usage. For total workforce, the system was 1.7% below plan, this was particularly supported by less use of substantive staff within the system at 2% under plan. This compensated bank usage which was 2.9% over plan. Agency staffing restrictions continue to perform well and was 15.5% under plan. Pay bill analysis will be included in M3 once PFRs begin to be completed. We will also look to bring in performance data to enable full triangulation.

At provider level – most followed the overall trend of meeting plan – HCT, PAH and WHTH were all signficantly below their M1 substantive staffing use – it was fed back that this was predominantly caused by time to hire delays. This reduction seemed to cause an increased reliance on bank staff usage at WHTH particularly, showing themselves to be significantly over target on bank staff for M1.

The system transformation programme has applied for several bids to support the entry level access supply route and reduce the current vacancies level in this area of work. The system is a key partner with Hertfordshire and Essex in supporting delivery of the Get Britain Working white paper and recently received news that the system has successfully progressed to phase two of the Public Health Investment Programme to support our population off FIT notes and into active employment. The system is awaiting to hear news on key bids that support pre-employment support targeted at young people in areas of deprivation as well as introduction of t-level placements across health and care.

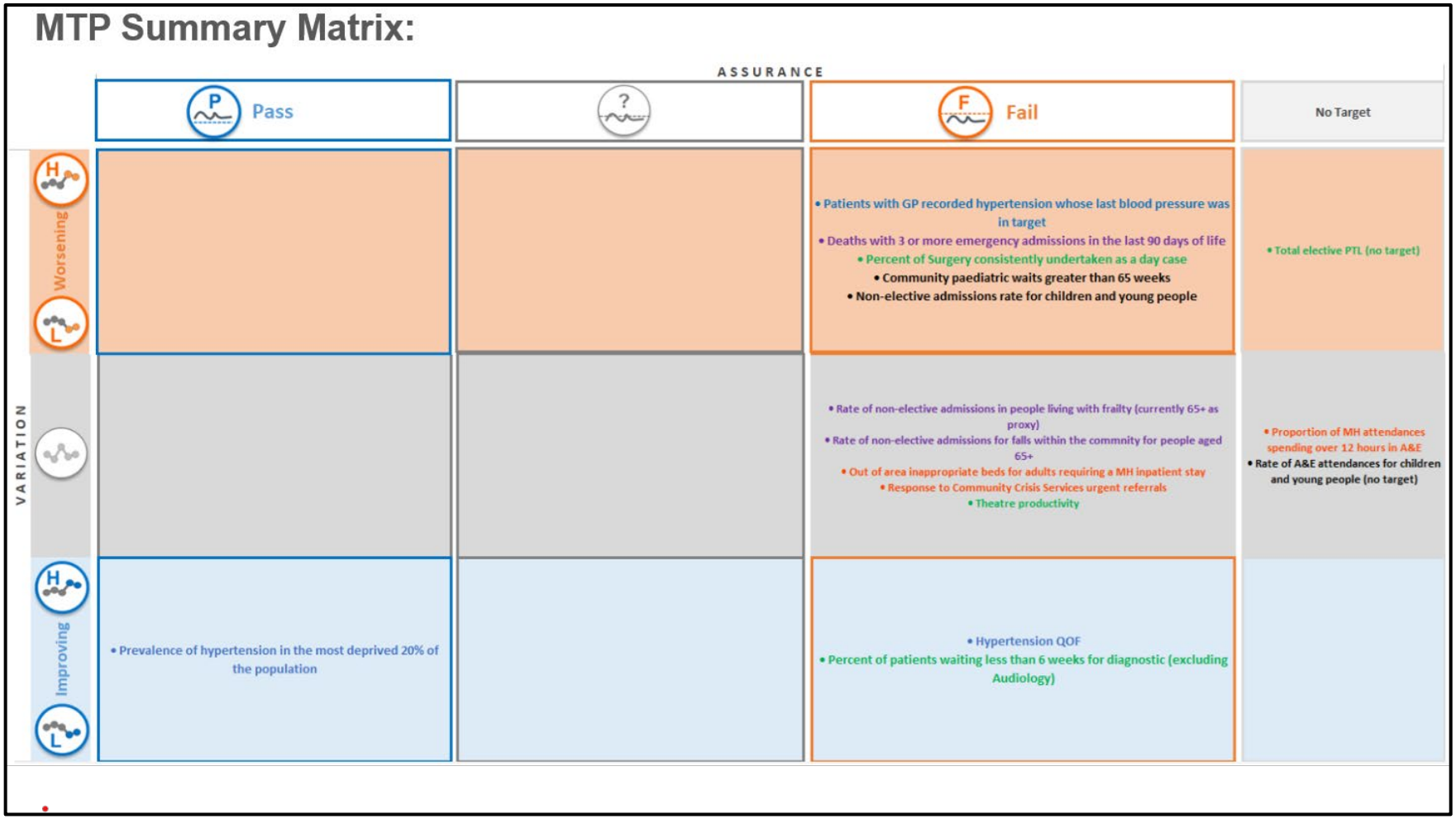




Medium Term Plan delivery:

Below provides a summary position for the system delivery against our Medium Term Plan (MTP) priorities. Further review of MTP reporting is being developed through the System Transformation and Improvement Committee. Future dashboard reporting will include place based narrative to give greater assurance of progress against anticipated trajectories, as well as risks to implementation of our transformation programmes and any mitigating actions.

MTP Summary Matrix:



Source: extracted from MTP Dashboard